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THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

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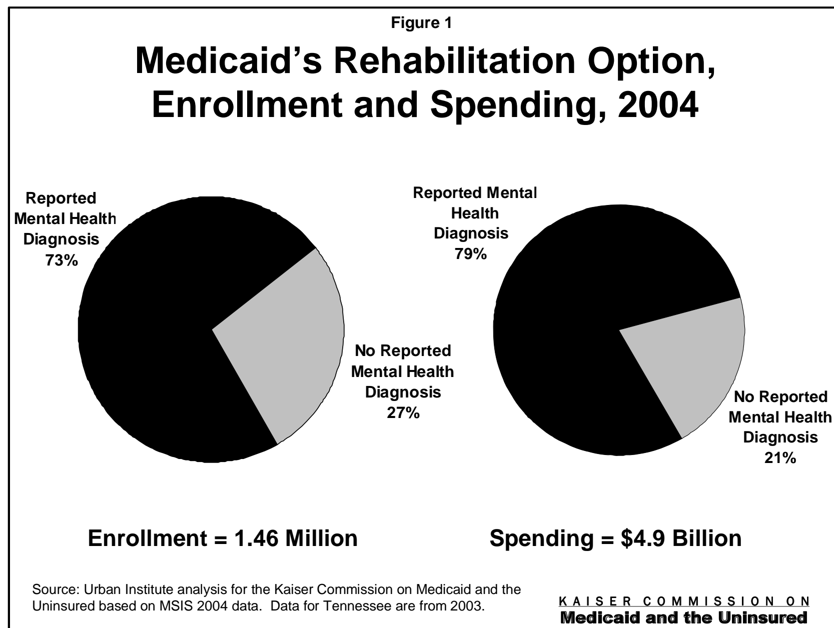
Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues

Prepared by Jeffrey S. Crowley, Health Policy Institute, Georgetown University
and Molly O'Malley, Kaiser Commission on Medicaid and the Uninsured

EXECUTIVE SUMMARY

In 2007, the President reintroduced a plan to place new restrictions on the types of services allowable under the Medicaid rehabilitation services option (called the rehab option) to yield federal budget savings of $2.29 billion over the next five years. States and other stakeholders are awaiting the issuance of a notice of proposed rulemaking (NPRM) outlining proposed changes.

Currently, 47 states plus the District of Columbia provide at least some type of mental health, substance abuse, and physical health services under the rehab option.[1] Excluding services provided through managed care programs, an estimated 1.46 million individuals received services under the option in 2004 at a total cost of $4.9 billion.[2] States can use the rehab option to provide a variety of services, although a dominant way that states use the option is for the rehabilitation of people with mental illness. In 2004, nearly three-fourths of Medicaid beneficiaries receiving rehab services (73%) were people with mental health needs, and these beneficiaries were responsible for 79% of rehab spending under the option, although not all of this spending was necessarily for mental health services **(Figure 1)**.



1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/kcmu

Compared to other service categories, the rehab option offers states unique flexibility in delivering services. This includes permitting rehab option services to be provided in community settings, including a person's home or work environment; it permits services to be provided by a broader range of professionals than some other options including community paraprofessionals; and, it permits coverage of a broader range of services, including those that assist in acquiring skills essential for everyday functioning.

The number of states that use the rehab option to serve people with mental illness has grown considerably in recent years, following state efforts to close many state psychiatric facilities in favor of delivering community-based mental health services. States have increasingly turned to the rehab option to deliver psychosocial rehabilitation services (*i.e. rehabilitation for people with mental illness*) during a period of significant change in the treatment of mental illness. Two major areas of policy change are an increased focus on the recovery of persons with mental illness and focusing the delivery of services on implementing evidence-based practices.[3] The President's New Freedom Commission on Mental Health, which was charged with conducting a review of the U.S. mental health delivery system and making recommendations for improvement to the President, has recognized the importance of Medicaid services and urged that they be focused on recovery.[4] Federal policy makers have also worked with the mental health community and other private entities to develop a consensus around evidence-based practices, such as assertive community treatment (ACT) programs. In 2005, the Centers for Medicare and Medicaid Services (CMS) confirmed (with certain restrictions) that these interventions (or aspects of them) can be covered under the rehab option.[5]

Current Policy Issues

The unique and important role of the rehab option in nearly every state Medicaid program is not well understood. Indeed, the significant differences in how the rehab option is used by states when compared to how rehabilitation is commonly conceived (with a bias toward physical rehabilitation) naturally leads to confusion.

What are the issues in how states are using the rehab option?

The increasing reliance of states on the rehab option over the last two decades and the concomitant increases in spending has raised questions by policy makers over whether the option is being used properly and whether the option is appropriately targeted. The Bush Administration believes that states are using the option in inappropriate ways, while many states, providers, and beneficiary advocates have sought to protect the flexibility in the option for states to operate innovative, evidence-based programs that they could not operate through other Medicaid service categories.

Testimony by Dennis G. Smith, Director of the Center for Medicaid and State Operations at CMS (the entity within HHS responsible for administering the Medicaid program) before the Senate Finance Committee in June 2005 sheds lights on the Administration's perspective. He stated that states are billing Medicaid for rehabilitation services that are "intrinsic elements of non-Medicaid programs" and he asserted that

"the definition of rehabilitation services is so broad that there is a risk for federal dollars to be inappropriately claimed."[6]

A small number of states have had their rehab option programs audited by the HHS Office of the Inspector General (OIG) (See Appendix 2). Notwithstanding the small sample size, the audits show:

- Large numbers of reviewed claims were disallowed;
- Inadequate documentation and billing errors caused many claims to be disallowed; and,
- Many claims were disallowed because auditors found services not to be rehabilitative in nature.

Some of these audit findings have been challenged by states, by beneficiary advocates and by provider groups. In particular, Iowa, the subject of five audits of various rehab option programs, has challenged several of the OIG's findings.[7]

What changes are being considered?

Given federal concerns, it is appropriate to examine what types of changes are being contemplated. It should also be noted that this policy debate effectively pertains only to adult Medicaid beneficiaries. The early, periodic, screening, diagnostic and treatment services (EPSDT) benefit and actions by a previous Congress requiring coverage for services in individualized educational plans (IEPs) and individualized family services plans (IFSPs) under the Individuals with Disabilities Educational Act (IDEA) constrains the ability of the Administration to limit through rulemaking access to rehab option services for children. Many stakeholders have expressed concern that federal budgetary savings would be generated by imposing new limits on states' ability to deliver rehab option services, such as through durational limits on receiving services. Other potential changes that would narrow the rehab option include:

- **Adoption of an "intrinsic element" test to restrict rehab services**

An intrinsic element restriction is related to, but distinct from third party liability restrictions. In the past, the Congress and other policy makers have sought assurances that Medicaid is not acting as the primary payer when a third party has an obligation to pay for medical assistance services to Medicaid beneficiaries. By contrast, an intrinsic element test seeks not to ensure that a third party satisfies its payment obligations first while protecting access to the underlying service, but seeks to prevent Medicaid from paying for a service if another program provides this service. Recently, the Congress enacted new Medicaid third party liability provisions in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) yet considered and rejected an intrinsic element test for rehab option services. The implementation of new third party liability restrictions and the adoption of an intrinsic element test would raise several policy questions, including how the intrinsic element test would be devised, what services would be excluded from coverage, and what the impact would be on Medicaid beneficiaries.

- **Limiting coverage to services that lead to a measurable restoration of function**

It is unclear whether the Administration will propose a further limitation on services by requiring that they lead to a "measurable" restoration of function. On the one hand, it is reasonable for federal policy makers to ensure that providers are accountable for achieving measurable improvements in function. However, differences in the nature of psychosocial rehabilitation from physical rehabilitation could make it difficult to measure, especially given the potential need for ongoing treatment.

- **Restricting how states pay for rehab option services**

Various stakeholders have expressed concerns that federal officials are already denying approval of state plan amendments for rehab option services—and may go further through rulemaking to limit state payment flexibility—when states propose to pay providers with case rate payments, per diem payments, and so-called "bundled" payments.[8] Several mental health providers have asserted that fee-for-service payments tied to discrete time units of service are difficult to use effectively when operating assertive community treatment (ACT) and other evidence-based practices.[9]

- **Expanding the definition of habilitation services to exclude more services under the rehab option**

In order to restrict more services from being covered under the rehab option, the Bush Administration may be planning an expansion of how it defines habilitation services. In the past, the Congress has distinguished between habilitation and rehabilitation in order to limit coverage of day habilitation services for persons with intellectual and other developmental disabilities under the rehab option. Recent OIG audits show that some services have been deemed habilitative and not coverable under the rehab option when services have been provided to people with mental illness who do not have other developmental disabilities. This is a significant policy change that has not been accompanied by legislative action.

Outlook and Conclusion

Current policy discussions that balance state flexibility to operate innovative programs under the rehab option while responding to legitimate federal concerns to protect the program from waste and abuse are important. To address these issues, careful attention is warranted to ensure that any changes do not impose unmanageable burdens for states seeking to use the option to implement proven treatment programs for vulnerable populations. A collaborative dialogue between federal officials, states, and various stakeholders may be a productive way to reach a clearer understanding of key issues and to identify strategies for achieving federal objectives of eliminating waste and abuse without harming the Medicaid beneficiaries who depend on rehab option programs.

Introduction

Currently, 47 states plus the District of Columbia provide at least some type of mental health, substance abuse, and physical health services under the Medicaid rehabilitation services option (called the rehab option). Excluding services provided through managed care programs, an estimated 1.46 million individuals received services under the option in 2004 at a total cost of $4.9 billion.[10] States use the option to cover a variety of services for several populations including individuals with mental illness, individuals with physical disabilities, and children receiving foster care.[11]

The President's FY 2008 budget request to Congress reintroduced a plan to place new restrictions on the types of services allowable under the Medicaid rehab option to yield federal budget savings of $230 million in FY 2008 and $2.29 billion over the next five years. This regulatory proposal also follows a series of audits of state rehab option programs in recent years conducted by the HHS Office of the Inspector General (OIG).

Currently, states and other stakeholders are awaiting the issuance of a notice of proposed rulemaking (NPRM), an official publication in the *Federal Register* that describes the types of changes being proposed to the rehab option and that provides an opportunity for the public to comment on these changes before they are finalized and implemented. This policy brief provides an overview of the rehab option and discusses several current policy issues related to the role that the option plays in addressing a variety of short and long-term functional limitations.

The Rehab Option Under Existing Medicaid Law

The rehab option offers states unique flexibility in delivering services because the option does not have some of the constraints of other service categories, such as the clinic services option. For this reason, it has become a central component of nearly every state Medicaid program. The preamble to the Medicaid Act indicates that providing rehabilitation services is a central purpose of the program and shows that Congress had a broad conception of rehabilitation when establishing the Medicaid program, as it includes both attaining and retaining capability for independence. Section 1901 of the Social Security Act reads,

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish…(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

The statutory provision that establishes the rehab option also uses broad language to permit states to cover services that may not be coverable under other service categories.

Scope of the Rehab Option

Under the Rehab Option, states can cover:

> "other diagnostic, screening, preventive, and 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."

Source: § 1905(a)(13) of the Social Security Act.

Key parameters of the rehab option include:

- **Where services can be provided:** Rehab option services can be provided in community settings, including a person's home or work environment, whereas some other service categories specify the setting in which services can be provided;

- **Types of providers:** Rehab option services can be provided by a broader range of professionals than some other options; the rehab option does not require services to be provided under the direction of a physician; and it permits community paraprofessionals and peer specialists to provide services; and,

- **Scope of coverage:** A broader range of services can be covered than the clinical treatment of a condition, including those that assist individuals in acquiring skills essential for everyday functioning such as skills training services that assist individuals in developing interpersonal interaction skills that are necessary to maintaining employment and that may be provided at the individual's job site.

The rehab option provides for coverage of services for the maximum reduction of disability and restoration of function. Differences of interpretation have arisen over whether just one or both of these criteria must be met. The "whole act rule" of statutory interpretation posits that in interpreting a subsection, it must be considered in the context of the whole statute. Therefore, to make sense of the rehab option, we must consider it in the context of the preamble. Nothing in the language of the option indicates that the Congress was intending to narrow its broad conceptualization of rehabilitation found in the preamble.

The Role of the Rehab Option in State Medicaid Programs

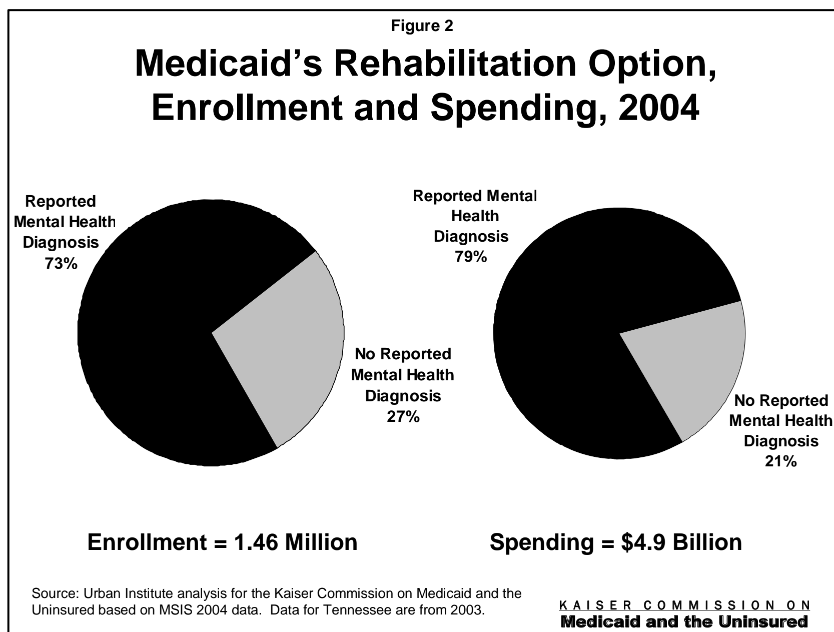
States can use the rehab option to provide a variety of services related to the rehabilitation of mental and physical health conditions, although a dominant way that states use the option is for the rehabilitation of people with mental illness. While states can use the rehab option to cover post-acute rehabilitation following an injury (such as

an auto accident or sports injury), states also have several other benefit categories to cover this type of rehabilitation (such as the inpatient hospital benefit, the physician services benefit, the clinic services option, or separate options for physical, occupational, and speech therapies). The rehab option does not appear to be the main service category that states use to pay for this type of rehabilitation. Instead, states may limit their rehab option programs to provide services they cannot provide effectively through other Medicaid service categories and which depend on the unique flexibility afforded by the rehab option.

Medicaid beneficiaries who need services in non-clinical settings, who benefit from receiving services from non-traditional providers, and whose treatment needs include an expansive range of services appear to be the populations for which states develop rehab option programs. A related Medicaid service is targeted case management (TCM). Case management services help individuals gain access to needed medical, social, educational, and other services. TCM is a separate Medicaid option that permits states to limit services to certain populations, as defined by the state. All states have taken advantage of the TCM option to serve at least some Medicaid populations, and many states provide TCM services in tandem with rehab option services to more comprehensively meet the needs of populations at high risk for being underserved, including persons with mental illness and substance abuse problems, as well as children receiving foster care and people who are homeless.

States use a variety of mechanisms to pay for rehab option services. Some states operate managed care programs where some or all Medicaid services are provided under contract with managed care organizations and all states operate at least one waiver program that provides rehabilitation services. These services are generally not billed under the rehab option. In considering only services provided under the rehab option, the majority of states pay for rehabilitation services using fee-for-service payments (used by 40 states) wherein the state has established a maximum payment for a particular service. Nine states make cost-based payments wherein the payment rates are generally based on historical cost, or some documentation of the actual cost is provided after services have been delivered; and three states use capitation payments. Only nine states charge co-payments for rehab services.[12]

In 2004, nearly three-fourths of Medicaid beneficiaries receiving rehab option services (73%) were people with mental health needs and these beneficiaries were responsible for 79% of rehab spending under the option **(Figure 2)**.[13] Not all of this spending was necessarily for mental health services; some of the services could have been for physical rehabilitation services for people who also had a mental health diagnosis.



The Role of the Rehab Option in Providing Psychosocial Rehabilitation

The number of states that use the rehab option to serve people with mental illness has grown considerably in recent years. In 1988, only nine states used the option to provide psychosocial rehabilitation (*i.e. rehabilitation for people with mental illness*), but by 2007, nearly all states had adopted programs to cover mental health services.[14] The growth in the use of the rehab option also appears to bear an inverse relationship to states' reliance on state psychiatric institutions—as states have successfully deinstitutionalized persons with serious mental illness, they have turned to the rehab option to assist them in developing effective models for delivering community-based services.

Psychosocial rehabilitation services are designed to assist the recovery of adults with serious mental illness and children and youth with emotional, behavioral, and mental disorders. Such disorders cause significant deficits in functioning, including deficits in daily living skills, impaired social interactions and behavior, ineffective problem solving, a diminished ability to maintain relationships and a marked impairment in role function, including age-appropriate behavior and functioning in children.

States have taken up the rehab option to deliver psychosocial rehabilitation services during a period of significant change in the treatment of mental illness. Two major areas of policy change relate to orienting the delivery of services to focus on supporting the recovery of persons with mental illness and to focusing the delivery of services on implementing, where applicable, evidence-based practices for the treatment of mental illness.[15]

The concept of "recovery" in the context of mental health treatment is an important consideration in setting policies for permissible and impermissible practices and services. In its final report in 2003, *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health defined recovery as,

> "the process in which people are able to live, work, and learn, and participate fully in their communities. For some individuals recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery."[16]

The New Freedom Commission recognized the importance of Medicaid services and urged that they be focused on recovery because this could have, "a powerful impact on fostering consumer's independence and their ability to live, work, learn and participate fully in their communities."[17] Unlike individuals recovering from a physical injury in which intensive rehabilitation may be needed for a short, time-limited period, rehabilitative services needed by people with mental illness may be medically necessary over a lifetime.

Federal policy makers have worked with the mental health community and other private entities over the past decade to develop a consensus around evidence-based practices. The following are all evidence-based practices for which there is a consensus that they are effective (See Appendix 1 for descriptions of each practice):

- Assertive community treatment (ACT);
- Family psychoeducation;
- Illness management and recovery;
- Integrated dual disorders treatment;
- Medication management; and,
- Supported employment.

Assertive community treatment (ACT) programs, in particular, have generated a great deal of interest within the mental health community. Many people with serious mental illness may engage in inappropriate behaviors that can lead to their discharge or expulsion from more traditional treatment programs. ACT programs make a long-term commitment to their clients and work collaboratively with individuals to comprehensively address their needs—a client's behavior will not cause them to be dropped from a treatment program. Services are furnished 24 hours a day, seven days a week and they involve interdisciplinary treatment teams and assertive outreach in order to provide treatment in an individual's own environment.[18]

Questions have arisen in the past over which psychiatric rehabilitation services are coverable under the rehab option. In 1992, HCFA addressed some of these questions through a letter to HCFA regional administrators.[19] The letter states that, "while it is not

always possible to determine whether a specific service is rehabilitative by scrutinizing the service itself, it is more meaningful to consider the goal of the treatment." The letter also provided guidance on Medicaid coverage of key services including basic living skills training, social skills training, and counseling and therapy services. In June 1999, federal officials further clarified through a State Medicaid Directors letter that Medicaid funds could be used to pay for ACT programs.[20]

In more recent guidance, in 2005, the Centers for Medicare and Medicaid Services (CMS) has recognized all of the listed evidence-based practices as promising practices and has confirmed (with certain restrictions) that these interventions (or aspects of them) can be covered under the rehab option.[21]

Current Policy Issues

The unique and important role of the rehab option in nearly every state Medicaid program is not well understood. Indeed, the significant differences in how the rehab option is used by states when compared to how rehabilitation is commonly conceived (with a bias toward physical rehabilitation) naturally leads to confusion. Given the centrality of the rehab option in providing evidence-based mental health and substance abuse treatment, this problem is exacerbated by a general lack of knowledge about the standard of care for treating serious mental illness and substance abuse.

To explore some of the current policy issues, we examine the following questions:

- What are the issues in how states are using the rehab option?
- What changes are being considered?

What are the issues in how states are using the rehab option?

The increasing reliance of states on the rehab option over the last two decades and the concomitant increases in spending under the option has raised questions by policy makers over whether the option is being used properly. The Bush Administration believes that states are using the option in inappropriate ways, while many states, providers, and beneficiary advocates have sought to protect the flexibility in the option for states to operate innovative, evidence-based programs that they could not operate through other Medicaid service categories.

Testimony by Dennis G. Smith, Director of the Center for Medicaid and State Operations at CMS (the entity within HHS responsible for administering the Medicaid program) before the Senate Finance Committee in June 2005 sheds lights on the Administration's perspective. Here, in explaining various Administration proposals for countering Medicaid fraud and abuse, he described the Administration's policy goals for changes to the rehab option. He stated that states are billing Medicaid for rehabilitation services that are "intrinsic elements of non-Medicaid programs" and he asserted that

"the definition of rehabilitation services is so broad that there is a risk for federal dollars to be inappropriately claimed."[22]

Recent rehab option audits conducted by the HHS Office of the Inspector General (OIG) raise areas of federal concern over the scope and payment of services.

Further insight into the Administration's position with regard to potential abuses of the rehab option can be gleaned by reviewing the record of audits of state Medicaid rehab option programs conducted by the HHS OIG.[23]

A relatively small number of states have had their rehab programs audited by the OIG (See Appendix 2 for summaries of audit findings), making it difficult to generalize into patterns of behavior across the states. Nonetheless, review of the audits show:

- **Large numbers of reviewed claims were disallowed.** Notwithstanding the very small sample size of seven audits in a total of three states, it is notable that the percentage of reviewed claims that were disallowed (requiring repayment of matching funds to the federal government) was quite large; audits disallowed from 15-86% of sampled claims, with an average of 37.3% of sampled claims disallowed;

- **Inadequate documentation and billing errors caused many claims to be disallowed.** Undocumented or incorrectly billed claims were found in all audits; in one audit, 65 of 100 sampled claims had missing or inadequate documents;

- **Many claims were disallowed because auditors found services not to be rehabilitative in nature.** Each audit identified claims where auditors did not believe that services were rehabilitative; in one audit, 53 of 100 claims were said to be habilitative or social services; another audit found that many services were directed toward a family member, despite the Medicaid requirement that services must be directed exclusively to a covered beneficiary; and the third audit found that services appeared to involve observation and monitoring, and not medical or remedial services.

Some of these audit findings have been challenged by states, by beneficiary advocates and by provider groups. In particular, Iowa, the subject of five audits of various rehab option programs, has challenged several of the OIG's findings.

Iowa has had five of its rehab option programs audited. It has contested some of the OIG's findings. In particular, the state disagreed with auditors that determined that many claims were not rehabilitative. In one audit, the state disputed half of the claims that were determined not to be rehabilitative. The state asserted that services were rehabilitative and were directed toward the needs of the client. The state also asserted that some payment errors would have been routinely identified and corrected in the state's own financial audit program.[24]

It is interesting to note that, in April 2007, Iowa was the first state to receive federal approval of a state plan amendment (SPA) to operate an HCBS state option program. Established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), the option was intended to give states the ability to provide HCBS waiver services without the need to receive a waiver. Iowa's HCBS option program is limited to persons undergoing psychiatric treatment with a history of psychiatric illness (a population not previously covered under an HCBS waiver), and many of the services provided include the types of services challenged by OIG audits. It appears that the OIG audits had the effect of limiting the state's ability to provide community-based mental health services under the rehab option so that the state turned to this new Medicaid option to provide a similar package of services.

What changes are being considered?

Given that there are federal concerns with the scope of the rehab option, it is appropriate to examine what types of changes are being contemplated. It should be noted, however, that this policy debate effectively pertains only to adult Medicaid beneficiaries. The early, periodic, diagnostic, and screening services (EPSDT) benefit guarantees children Medicaid beneficiaries access to Medicaid coverable rehab option services. Given the nature of the services provided under the rehab option to children, children that require such services would be provided to children pursuant to an individualized educational plan (IEP) or for infants and toddlers, pursuant to an individualized family services plan (IFSP) under the Individuals with Disabilities Education Act (IDEA). The sources of funding available to fund services under IEPs and IFSPs have been a contentious issue in the past. Some time ago, the Health Care Financing Administration (HCFA, the predecessor to CMS) attempted to limit the availability of Medicaid funding for services under IEPs. In 1988, the Congress addressed the issue in enacting the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) in which it clarified that Medicaid coverage is available for Medicaid services provided to Medicaid-eligible children under an IEP or IFSP, and in which it prohibited the Secretary from denying payment for coverable medical assistance services provided under an IEP or IFSP. Therefore, the Administration is constrained in its ability to limit access to rehab option services for children through rulemaking.

Until a proposed rule is issued, it is not possible to know the full extent of the Administration's planned changes. Many stakeholders have expressed concern that federal budgetary savings would be generated by imposing new limits on states' ability to deliver rehab option services—such as through durational limits (such as limiting rehab option services to a period of a certain number of months), quantity limits on the number of units of rehab option services an individual can receive, or dollar limits for specific services (such as through annual limits on services). Other potential changes that would narrow the rehab option include:

- **Adoption of an "intrinsic element" test to restrict rehab services**

Echoing the aforementioned testimony by Dennis G. Smith, one potential policy change would be to restrict coverage of rehab option services when these services are determined to be an "intrinsic element" of another federal, state, or local government program.

An intrinsic element restriction is related to, but distinct from policy considerations related to third party liability. In the past, the Congress and other policy makers have sought assurances that Medicaid is not acting as the primary payer when another party has an obligation to pay for medical assistance services to Medicaid beneficiaries. This obligation of another party to pay for services is called a third party liability. By contrast, an intrinsic element test seeks not to ensure that a third party satisfies its payment obligations first while protecting access to the underlying service, but seeks to prevent Medicaid from paying for a service if another program provides this service. An intrinsic element test could prevent Medicaid coverage for services even if another party was not actually available to pay for a medically necessary service.

Recently, the Congress enacted new Medicaid third party liability provisions in the DRA that seek to enhance the identification and payment from third parties and prohibit Medicaid from paying for case management and targeted case management services if another party is liable to pay for these services.[25] However, the Congress considered and rejected an intrinsic element test for rehab option services. Notwithstanding recent Medicaid third party liability policy changes, the Administration maintains that Medicaid is still paying for services that should be paid by other third parties and has sought to enact new broader restrictions in Medicaid, not only related to the rehab option.[26] As the Administration has continued to state its intention to engage in rulemaking to restrict access to rehab option services, Members of Congress have written the Bush Administration raising concerns over the implementation of an intrinsic element test and asking for greater clarity on which services would be affected.[27]

The adoption of an intrinsic element test would raise several policy questions, including how the intrinsic element test would be devised, what services would be excluded from coverage, and what the impact would be on Medicaid beneficiaries. Other programs may exist that provide services similar in nature to services covered under the rehab option, but these services may not be available to Medicaid beneficiaries. Or, discretionary programs could have services interrupted or limited due to funding constraints. Some safety net programs are specifically intended to fill in gaps left by programs such as Medicaid, and they are not intended to supplant Medicaid coverage of medically necessary services for Medicaid-eligible individuals. It is possible that an intrinsic element test and third party liability requirements could have the impact of shifting costs away from Medicaid onto other payers not equipped to handle the scale of the Medicaid population or it could lead to people being denied medically necessary services that previously were provided by Medicaid.

- **Limiting coverage of services to those that lead to a measurable restoration of function**

As discussed, there is a question of statutory interpretation over whether rehab option services are available solely to achieve a maximum reduction of physical or mental disability—or whether services can only be provided if they will also restore an individual to the best possible functional level. Again, testimony by Dennis G. Smith before the Senate Finance Committee indicates that the Administration is interpreting the statute narrowly—meaning that rehab services can only be covered if they are necessary both to reduce disability and restore function.

It is unclear whether the Administration will propose a further limitation on services by requiring that they lead to a "measurable" restoration of function. On the one hand, it is reasonable for federal policy makers to ensure that providers are accountable for achieving measurable improvements in function. However, differences in the nature of psychosocial rehabilitation from physical rehabilitation could make it difficult to measure, for example, restoration of function in an individual with serious mental illness who receives rehab services on an ongoing basis and whose needs and the level of services they access vary over time. Beneficiary advocates have argued that this narrow interpretation of the statute reflects a change from longstanding policy.[28]

- **Restricting how states pay for rehab option services**

Given the significant increases in spending under the rehab option in recent years, it is natural for federal officials to scrutinize federal payments to states for rehab option services. Nonetheless, this scrutiny has raised fears that federal officials are denying approval of state plan amendments (a required approval for states to receive federal matching payments under Medicaid) for rehab option services when states propose to pay providers with case rate payments, per diem payments, and so-called "bundled" payments.[29] Several mental health providers have asserted that bundled payments are critical to their ability to operate ACT programs and other evidence-based practices.[30] Informal communications with a variety of Medicaid stakeholders have suggested that federal officials may view all payment methodologies that do not depend on a fee-for-service payment for a unit of service to be inherently fraudulent.

Federal officials have not formally promulgated new policies for rehab option payments, although increased scrutiny of state claims for matching payments has been an Administration priority. If new payment restrictions are proposed, it will be interesting to see whether they simply prohibit specific payment approaches for rehab services (potentially payment approaches promoted in other parts of the Medicaid program, such as capitated payments or payment incentives, such as pay for performance initiatives), or whether they seek to retain flexibility for states while ensuring greater transparency and accountability for federal matching funds.

- **Expanding the definition of habilitation services to exclude more services under the rehab option**

In its efforts to limit access to services under the rehab option, the Bush Administration may be planning an expansion of how it defines habilitation services, in order to restrict more services from being covered under the rehab option. Giving credence to this possibility are the OIG audits of Iowa's Medicaid rehab option programs for people with mental illness in which several services were determined to be habilitative and non-rehabilitative.[31] It should be noted that these audits relied on definitions of habilitation found in Iowa state law, but they may set a precedent for future federal action.
In the past, the Congress has distinguished between habilitation and rehabilitation in order to limit coverage of day habilitation services for persons with intellectual and other developmental disabilities under the rehab option. In the 1970s and 1980s, several states received federal approval to cover day services for persons with developmental disabilities under either the rehab or clinic options. Eventually, HCFA determined that these services were habilitative and could not be covered. Traditionally, habilitation services have been defined as services for people with intellectual and other developmental disabilities and include, "services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.[32]

In 1989, the Congress acted to permit states with day programs for people with developmental disabilities to continue them, but effectively prohibited states from adding such coverage.[33] A few states have maintained coverage of these services, but many have dismantled these programs, instead covering day programs for people with developmental disabilities through the HCBS waiver program (in which habilitation services are a covered waiver service, but which has more strict eligibility criteria than the rehab option.[34] An analysis of spending on services for people with developmental disabilities confirms that the rehab option is not being used extensively to cover services for people with developmental disabilities. Less than one percent (0.9%) of spending on Medicaid developmental disability services in 2004 was through the rehab option.[35]

Distinguishing Habilitation From Rehabilitation

The difference between habilitative and rehabilitative services is not clearly discernible. In communications between federal officials and the state of Florida in 1991 wherein the federal government told the state that habilitation services could not be covered under the rehab option, it stated,

> "Habilitation type services are those that are similar in some ways to rehabilitation services, but which incorporate elements of training specifically designed for persons with developmental disabilities.
>
> The principal distinction between the two types of services is that habilitation services are designed for the purpose of developing functional abilities of persons who have never acquired them, specifically mentally retarded or developmentally disabled individual(s).
>
> Rehabilitation services are for the purpose of restoring certain functional losses".

Source: Somers, S. "Q&A: Medicaid Coverage of Habilitation Versus Rehabilitation Services, Including Impact of the DRA of 2005," National Health Law Program developed for the National Disability Rights Network Training and Advocacy Support Center, October 2006.

Outlook and Conclusion

Resolving tensions between the federal government and the states over the amount of flexibility to be afforded states in operating their Medicaid programs has been a key dynamic of the federal-state partnership since Medicaid was created. Current policy discussions over the amount of flexibility states retain to operate innovative programs under the rehab option while responding to legitimate federal concerns to protect the program from waste and abuse is part of this ongoing and evolving relationship.

There are several areas of uncertainty over federal policies and the appropriateness of current state practices. Policy clarifications are likely needed. Some parties have questioned the statutory authorization for CMS to engage in new rulemaking at this time, given that the Congress has not enacted new restrictions to the rehab option, and it apparently rejected some CMS proposals when enacting recent changes to Medicaid. It is beyond the scope of this paper to evaluate those claims. Nonetheless, it is unclear whether rulemaking is the most effective way of achieving federal policy objectives.

To address these issues, careful attention is warranted to ensure that any changes or new restrictions do not impose unmanageable burdens for states seeking to use the option to implement proven treatment programs for vulnerable populations. A collaborative dialogue between federal officials, states, and various stakeholders may be a productive way to reach a clearer understanding of key issues and to identify

strategies for achieving federal objectives of eliminating waste and abuse without harming the Medicaid beneficiaries who depend on rehab option programs.

Acknowledgment
The authors would like to thank Mindy Cohen of the Urban Institute for conducting the MSIS data analysis described in this report.

[1] Kaiser Commission on Medicaid and the Uninsured. Medicaid Benefits Database, data as of October 2006.
[2] Urban Institute analysis for the Kaiser Commission on Medicaid and the Uninsured based on MSIS 2004 data. These data reflect fee-for-service spending only, and excludes rehabilitation spending in managed care programs and in home- and community-based (HCBS) waiver programs. Data for Tennessee, included in the national total, are from 2003.
[3] Jacobson, N. & Curtis, L. "Recovery as Policy in Mental Health Services: Strategies Emerging from the States," *Psychosocial Rehabilitation Journal*, Spring 2000.
[4] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub. No. SMA-03-3932. Rockville, MD: 2003.
[5] *Medicaid Support of Evidence-Based Practices in Mental Health Programs*, Centers for Medicare and Medicaid Services, October 2005. Available at http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf.
[6] Testimony of Dennis G. Smith before the Senate Finance Committee on June 28, 2005 is available at www.senate.gov/~finance/hearings/testimony/2005test/DStest062805.pdf.
[7] See, for example, auditee's comments of OIG audit report # A-07-02-03023 and audit report # A-07-02-03024 in which the state asserts that many errors are identified and recoupments are made during the state's own audit process.
[8] Informal communication with a former State Medicaid Director.
[9] For example, see statement by Richard Van Horn, page 30 in *Profiles of Medicaid's High Cost Populations*, Kaiser Commission on Medicaid and the Uninsured, December 2006.
[10] Urban Institute analysis for the Kaiser Commission on Medicaid and the Uninsured based on MSIS 2004 data. These data reflect fee-for-service spending only, and excludes rehabilitation spending in managed care programs and in home- and community-based (HCBS) waiver programs. Data for Tennessee, included in the national total, are from 2003.
[11] It should be noted that individuals with substance abuse and addiction disorders are ineligible for Supplemental Security Income (SSI) benefits on the basis of disability if alcoholism or drug addiction is "material" to the disability determination. It is considered material if the individual would not be considered disabled in the absence of alcoholism or drug addiction. Receipt of SSI is the primary pathway by which individuals with disabilities gain access to Medicaid. This provision of law means that individuals with disabilities receiving Medicaid substance abuse treatment services also have another co-occurring disabling condition. Anecdotal evidence suggests that the majority of persons receiving substance abuse treatment under Medicaid have a co-occurring mental illness. See Section 105 (Denial of Disability Benefits to Drug Addicts and Alcoholics) of the Contract with America Advancement Act of 1996 (P.L. 104-121).
[12] KCMU Medicaid Benefits Database, data as of October 2006.
[13] Data presented in this report on enrollment and spending reflect only fee-for-service rehab spending under the rehab option. These results are based on an analysis of FY 2004 Medicaid Statistical Information System (MSIS) data for KCMU by the Urban Institute. These data specifically exclude spending under waiver programs and other service categories, as well as rehab option spending through managed care programs. MSIS enrollment and spending data that stratifies people by mental health diagnosis is based on new data on chronic disease first available in 2003. This reporting gives CMS and researchers important new capabilities to analyze data on the basis of population, but it carries some

limitations. MSIS contains a "flag" for individuals having mental illness conditions. This flag, created by CMS, is determined by the presence of certain ICD-9 codes related to mental illness on the individual's health care claims during the year. Most organic and non-organic mental illnesses are covered under the flag created by CMS, including schizophrenic, neurotic, and personality disorders, and adult and childhood emotional disorders. However, mental retardation diagnoses (IDC-9 codes 316-319) are not included in this flag. Underreporting of diagnosis codes is a limitation of these flags, which occurs primarily for three major reasons. First, MSIS only captures individuals who received treatment for their mental illness, and will therefore exclude individuals with undiagnosed mental illness or diagnosed illness but no treatment. Second, although an individual may have received treatment for their illness during the timeline of our study, that information may not be captured due to claim reporting errors or lack of reporting requirements. Third, there is a concern about physicians excluding a mental illness/substance abuse diagnosis on a patient's claim due to the stigma of these illnesses.

[14] Note: O'Brien, J. *Community Living Briefs: The Medicaid Rehabilitative Services ("Rehab") Option*, ILRU Community Living Partnership: National State-to-State Technical Assistance Center, May 2005 states that all state Medicaid programs have added the rehab option to cover mental health services. This presents a discrepancy of three states with the KCMU Medicaid Benefits Database.

[15] Jacobson, N. & Curtis, L. "Recovery as Policy in Mental Health Services: Strategies Emerging from the States," *Psychosocial Rehabilitation Journal*, Spring 2000.

[16] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub. No. SMA-03-3932. Rockville, MD: 2003. Available at www.mentalhealthcommission.gov/reports/reports.htm.

[17] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub. No. SMA-03-3932. Rockville, MD: 2003.

[18] *Recovery in the Community: Funding Mental Health Rehabilitative Approaches Under Medicaid*, Bazelon Center for Mental Health Law, November 2001.

[19] "Rehabilitation Services for the Mentally Ill – Information Memorandum from Director, Medicaid Bureau, Health Care Financing Administration, U.S. Department of Human Services to All Regional Administrators," June 1, 1992 (FME-42).

[20] June 7, 1999 State Medicaid Director letter from Sally K. Richardson.

[21] *Medicaid Support of Evidence-Based Practices in Mental Health Programs*, Centers for Medicare and Medicaid Services, October 2005. Available at http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf.

[22] Testimony of Dennis G. Smith before the Senate Finance Committee on June 28, 2005 is available at www.senate.gov/~finance/hearings/testimony/2005test/DStest062805.pdf.

[23] In reviewing these audits, we accessed the public website of the OIG and searched for audits related to CMS programs with the search parameters of "Medicaid rehabilitation". This yielded numerous audits, the majority of which were related to the Medicare inpatient rehabilitation benefit. We excluded audits related to Medicare, and we also excluded audits for administrative expenses for rehabilitation services that were not reimbursed under the rehabilitation option. Given the large number of audits conducted, it is possible that other relevant audits were conducted, but not captured for review. Based on a review over more than the last decade, however, we identified seven audits directly related to state's use of the rehab option.

[24] See, for example, auditee's comments of OIG audit report # A-07-02-03023 in which the state disagreed with 17 of 35 sample claims for services that were non-rehabilitative and 16 of 31 sample claims for services that did not provide direct patient care and OIG audit report # A-07-02-03024 in which the state asserts that many errors are identified and recoupments are made during the state's own audit process.

[25] See §§ 6037 and 6052 of the Conference Report of the Deficit Reduction Act of 2005, P.L. 109-171.

[26] See, for example, the President's Medicaid budget proposal for FY 2008, calling for legislative third party liability changes, available at http://www.hhs.gov/budget/08budget/2008BudgetInBrief.pdf.

[27] See letter to CMS Administrator Mark McClellan from Senators Harkin, Bingaman, and others dated July 7, 2006.

[28] See *Talking Points: The Administration's Proposals for the Medicaid Rehabilitation and Targeted Case Management Options*, Bazelon Center for Mental Health Law, October 2005.

[29] Informal communication with a former State Medicaid Director.

[30] For example, see statement by Richard Van Horn, page 30 in *Profiles of Medicaid's High Cost Populations*, Kaiser Commission on Medicaid and the Uninsured, December 2006.
[31] See, for example, OIG audit report # A-07-03-03041
[32] See for example definition of habilitation in the attachments to a February 20, 1998 State Medicaid Director Letter from Sally K. Richardson with respect to habilitation services under HCBS waiver programs.
[33] Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239.
[34] See discussion of rehabilitation services in, *Understanding Medicaid Home and Community Services: A Primer*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, October 2000.
[35] Braddock, D. State of the States in Developmental Disabilities Data Base. Boulder: University of Colorado Department of Psychiatry, 2007.

Appendices

Appendix 1: Evidence-Based Mental Health Practices.

Practice	Key Features	Can Be Covered Under the Rehab Option?	Notes
Assertive Community Treatment (ACT)			
	For people who experience the most severe symptoms of mental illness who often have problems taking care of even their most basic needs; the goal is to help people stay out of the hospital and develop skills for living in the community so that their lives on not driven by having mental illness. ACT offers services customized to the individual related to: managing symptoms, housing, finances, employment, medical care, substance abuse, family life, and activities of daily living. Services are available 24 hours a day, and there are no time limits on how long someone can receive services.	Yes	As of 2005, 8 states have included ACT in their Medicaid programs: Delaware, District of Columbia, Florida, Georgia, Hawaii, Maine, New Mexico (pending), and North Carolina.
Family Psychoeducation			
	Helps individuals and their families and supporters learn about mental illness, master new ways to manage it, reduce family tension and stress, provide social support and encouragement, focus on the future (instead of the past), and find ways for families and supporters to help consumers in their recovery. People work toward recovery by developing skills for overcoming everyday problems and illness-related issues. The result is that individuals have fewer symptoms, higher success with employment, and improved family relationships.	Yes, with restrictions	Covered services can include education for family caregivers about the covered individual's mental illness, training and support for dealing with crises, crisis intervention, and training in problem solving skills. Medicaid payments can be made only for services directed exclusively to a covered beneficiary, and cannot cover services to assist individuals with their own problems, unless they are also Medicaid beneficiaries.
Illness Management and Recovery			
	Helps individuals learn about mental illness and strategies for treatment, decrease symptoms, reduce relapse, and make progress toward goals and towards recovery. Consists of a series of weekly sessions with specially trained mental health practitioners who help people develop personal strategies for coping with mental illness and moving forward in their lives. Program strongly emphasizes setting and pursuing personal goals and putting strategies into action in their everyday lives.	Yes	New Hampshire was one of the states to pioneer this approach with their program, Mental Illness Management Service (MIMS).

Practice	Key Features	Can Be Covered Under the Rehab Option?	Notes
Integrated Dual Disorders Treatment			
	For people with co-occurring disorders of mental illness and addiction. Helps individuals to recover by offering mental health and substance abuse services together, in one setting, at the same time. This is a long-term approach to treatment that has hope and optimism as core beliefs and which helps people to manage both their mental illness and substance abuse their they can pursue meaningful life goals. Services can be provided in stages and can include basic education about the illnesses, case management, help with housing, money management, and specialized counseling.	Yes	Hawaii and Louisiana have implemented programs.
Medication Management			
	Medication Management Approaches in Psychiatry Medications (MedMAP) involves using medications in a systematic and effective way as part of the overall treatment for persons with severe mental illnesses. Programs provide guidelines and decision-making steps for choosing medications based on current research into clinical outcomes.	Yes	Common feature of many rehab programs.
Supported Employment			
	Approach to helping people with mental illness find and keep competitive employment (work in the community available to anyone, that pays at least the minimum wage). Programs are staffed by employment specialists who meet with the treatment team to integrate supported employment with mental health treatment. Support from the employment specialist continues as long as the individual wants assistance. Help can include assistance outside of the workplace and help from other practitioners, family members, coworkers, and supervisors.	Yes, with restrictions	Medicaid does not cover vocational services. Many people with mental illness are able to obtain jobs and have the core skills, but lack the interpersonal skills to maintain employment. Restoration of skills is a Medicaid-covered rehab service, as training in basic, daily-living, or social skills.

Sources: Based on summaries of each practice provided by the Dartmouth Psychiatric Research Center; Assessment of Medicaid coverage of each practice relied on both *Recovery in the Community: Funding Mental Health Rehabilitative Approaches Under Medicaid*, Bazelon Center for Mental Health Law, November 2001 and O'Brien, J. *Community Living Briefs: The Medicaid Rehabilitative Services ("Rehab") Option*, ILRU Community Living Partnership: National State-to-State Technical Assistance Center, May 2005.

Appendix 2: HHS Office of Inspector General (OIG) Audits of State Rehabilitation Programs: Review of Selected Audits.

State	Audited Program	Review Period	Audit Findings	Federal Funds to be Re-Paid	Percentage of Federal Payments Disallowed
Indiana	**Audit #: A-05-05-00057 (April 2007)**				
		10/01/2002-09/30/2003	Sample of 200 claims found: **–Missing or inadequate documentation:** (58 claims) **–Services paid incorrectly by state's fiscal agent:** (5 claims) **–Ineligible service:** (1 claim) **–Provider with inadequate credentials:** (1 claim)	$21.2 million of $144 million in federal payments	15%
Iowa	**Audit #: A-07-02-03023 (July 2004)**				
	Rehabilitation Treatment Services: Family Centered Program (for children 20 and under to prevent and alleviate child abuse, neglect, delinquency, and out-of-home placements)	10/01/2000-09/30/2001	Sample of 100 claims found: **–Services not rehabilitative:** Services directed toward a family member and not the beneficiary (31 claims) **–Lack of direct patient care:** (25 claims) **–Missing or inadequate documentation:** (10 claims) **–Day Treatment:** State plan excludes coverage of rehab services for children in day treatment programs (13 claims)	$2.5 million of $8 million in federal payments	32%
Iowa	**Audit #: A-07-02-03024 (April 2004)**				
	Rehabilitation Treatment Services: Family Preservation (Services for families in crisis with children in imminent or high risk of placement outside the home)	10/01/2000-09/30/2001	Sample of 100 claims found: **–Missing or inadequate documentation:** (30 claims) **–Services not rehabilitative:** (7 claims)	$113,040 of $403,117 in federal payments	28%
Iowa	**Audit #: A-07-02-03025 (May 2004)**				
	Rehabilitation Treatment Services: Family Foster Care (Treatment services in a foster home setting and to the child's family when there are needs related to emotional or behavioral disturbances)	10/01/2000-09/30/2001	Sample of 100 claims found: **– Services not rehabilitative:** (24 claims) **–Lack of direct patient care:** (13 claims) **–Missing or inadequate documentation:** (10 claims)	$386,092 of $2.1 million in federal payments	18%

State	Audited Program	Review Period	Audit Findings	Federal Funds to be Re-Paid	Percentage of Federal Payments Disallowed
Iowa	**Audit #: A-07-02-03026 (September 2004)**				
	Rehabilitation Treatment Services: Group Care Program (Highly structured treatment services in a group care setting for children with emotional disturbances, aggressive behavior, or multiple disabilities)	10/01/2000-09/30/2001	**–Missing or inadequate documentation:** (32 claims) **–Minimum time requirement for therapy and counseling services not met:** Iowa Administrative Code sets a minimum amount of therapy and counseling services that must be provided before a claim is submitted for payment, based on the number of days in a month the client is in a facility. (21 claims) **– Services not rehabilitative:** (5 claims)	$3.3 million of $14.4 million in federal payments	23%
Iowa	**Audit 3: A-07-03-03041 (March 2005)**				
	Adult Rehabilitation Services Program (for persons with chronic mental illness)	10/01/2001-09/30/2002	Sample of 100 claims found: **–Missing or inadequate documentation:** (65 claims) **–Services not rehabilitative:** Services were determined to be habilitative or social services (53 claims) **–Conflicts of Interest:** Providers authorized and rendered services (30 claims) **–No Services Provided or Beneficiary not Present:** (11 claims)	$6.2 million of $10.5 million in federal payments	59%
West Virginia	**Audit #: A-03-95-00200 (October 1995)**				
	Behavioral health rehabilitation services (for mental illness, substance abuse, and/or drug dependency) provided by Abraxas Foundation in Parkersburg, West Virginia	10/01/1993-03/31/1994	Review of 35 sampling units found: **–Services do not meet state plan definition of rehabilitation:** Services appear to be observation and monitoring of clients, not medical or remedial services **–Services undocumented or incorrectly billed** **–Except for time at school, services were billed for all time that the client was awake** Identified 100 sampling units, but, at HCFA (precursor to Centers for Medicare and Medicaid Services, CMS) direction, limited review to 35 sampling units. A sampling unit contains all rehab services paid on behalf of a beneficiary for a month.	$102,717 in federal payments (for specific reviewed claims only), no repayment demanded for broader universe of related claims	86%

Notes: Audit reports are available at http://oig.hhs.gov/oas/oas/cms.html. Audits were selected by searching all CMS audits for “Medicaid rehabilitation”. These audits are illustrative only and do not necessarily reflect all audits related to Medicaid rehabilitation services conducted in recent years.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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