



NASMHPD
Adult Services Division
NASMD

Rehabilitative Services
in the State Plan and
1915(i)

Shawn Terrell

Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

Rehabilitation

To qualify for Federal financial participation under Medicaid, rehabilitation services SHOULD:

- Meet the definition of rehabilitation services (i.e., maximize the reduction of a physical or mental disability and restore a recipient to his best possible functional level);
- Be included in the Medicaid state plan;
- Adhere to all provider qualifications set forth by the Code of Federal Regulations;

Rehabilitation

Rehabilitative services SHOULD:

- Be available to all eligible Medicaid recipients based upon medical necessity;
- Be based on a specific claim delineating services provided to an eligible individual;
- Be paid by a State Medicaid program only when documentation is consistent with the Medicaid State Plan; and
- Comply with all Medicaid payment rules.

Rehabilitation

Medicaid rehabilitation services should NOT:

- Be defined by provider type instead of service (e.g., adult medical day care, schools, etc.);
- Be reimbursed without identification and description in the State's Medicaid Plan;
- Be delivered by non-qualified staff;
- Be limited to Medicaid recipients based upon a specific diagnosis, type of illness, or condition;

Rehabilitation

Rehabilitative services should NOT:

- Be “habilitative” in nature instead of “rehabilitative;”
- Duplicate payments made by any other source for the same activity; or
- Include payment for services that are provided at no charge to non-Medicaid individuals.

Rehabilitation Policy Update

This Administration is firmly committed to ensuring the integrity of the Medicaid program by clarifying appropriate Medicaid payments for rehabilitative services and defining allowable services.

Rehabilitation Policy Update

In his 2007 budget proposal, the President seeks to clarify and refine the rehabilitation benefit through a regulation that will define allowable services and exclude payment for services that are intrinsic to programs other than Medicaid, such as foster care, juvenile justice, and education.

Policy Guidance

CMS recommends that States provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records.

Policy Guidance

- The person-centered plan should include the active participation of the individual, a focus on recovery goals, and periodic reevaluation of the plan as needed.
- The Medicaid goal is to deliver and pay for the clinically-appropriate, Medicaid-covered services that are active interventions which contribute to the treatment goal.

Policy Guidance

States have the flexibility to develop provider qualifications that are appropriate to the services being delivered.

Policy Guidance

The rehabilitation plan should identify the rehabilitation objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities.

Policy Guidance

If it has been determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitative strategy including revision of the rehabilitative goals, services and/or methods.

Rehabilitation Regulation

This regulation will be published as a notice of proposed rulemaking and will provide an opportunity for public comment before the final regulation is published.

CMS SPA Process

CMS recommends that for each of the services provided within a model of care or program, that the State provide a specific service description for each component. For example, describe each of the service components such as mental health assessment, individual therapy, peer support services, etc.

CMS SPA Process

CMS recommends that for each of these specific services, the State identify the providers that are providing that service, and the provider qualifications.

CMS SPA Process

- The provider qualifications should include the level of education/degree required, and any additional general information related to licensing, credentialing, or registration.
- The provider qualifications should also reference any required supervision. The State has the option of whether to reference their State codes in addition to this basic information.

Contact Information

- Shawn Terrell
410-786-0672
Shawn.Terrell@cms.hhs.gov

1915(i) State Plan Home and Community-Based Services (HCBS) Benefit



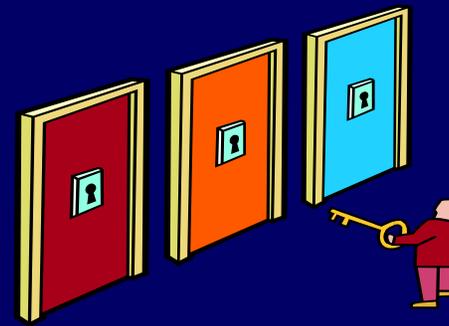
NASMHPD & NASMD Teleconference
August 7, 2007

Kathy Poisal kathryn.poisal@cms.hhs.gov 410-786-5940

State Plan HCBS Benefit

- New section 1915(i) established by DRA of 2005. Effective January 1, 2007
- State option to amend the state plan to offer HCBS as a state plan benefit
- Unique State plan benefit with similarities to HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care now required under 1915(c) HCBS waivers

Services



1915(i) permits the statutory 1915(c) services:

- Case management
 - Homemaker
 - Home Health Aide
 - Personal Care
 - Adult Day Health
 - Habilitation
 - Respite Care
- For Chronic Mental Illness:
- Day treatment or Partial Hosp.
 - Psychosocial Rehab
 - Clinic Services

But NOT the 1915(c) "Other" flexibility to design unique HCBS waiver services

Similarities: HCBS Under 1915(i) State plan and HCBS under 1915(c) Waivers

- Evaluation to determine program eligibility
- Assessment of need for services
- Plan of care
- Option to Limit Number of Participants
- Quality Assurance requirements
- Self Direction option
- Ability to not apply state-wideness and income and resource rules for the medically needy

Differences: HCBS Under 1915(i) State plan and HCBS under 1915(c) Waivers

- Financial Eligibility Criteria
- Waiver of Comparability
- Program Eligibility
- Institutional care requirements
- Length of time for operation
- Financial estimates
- Services

Financial Eligibility Criteria

1915(c)

- Must be eligible for institutional LOC under state plan
- Eligibility group included in SP
- Post eligibility for those eligible using institutional rules (e.g., special income level group).



1915(i)

- Eligible under State Plan
- 150% of FPL
- Uses community deeming rules
- For medically needy only, can use institutional deeming rules

Waiver of Comparability (Targeting)

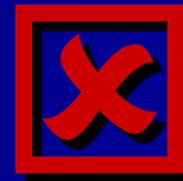
1915(c)

- May waive comparability



1915(i)

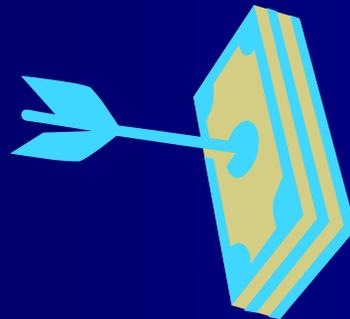
- May not waive comparability



Program Eligibility

1915(c)

- Must target by LOC
- May additionally target by participant characteristics
 - Disease or condition
 - Age

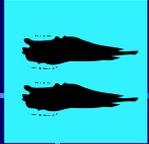


1915(i)

- No ability to target by population characteristics
- States have to establish needs-based criteria for the benefit
- States may additionally establish needs-based criteria specific to individual service(s)



Institutional Care Requirements



1915(c)

- Must have eligibility criteria at least as stringent as the institutions
- LOC must be:
= or > institution
but not < institution

1915(i)

- Needs based, not tied to institutional LOC
- But, institutional criteria must be more stringent
- Needs-based eligibility criteria must be:
< institution

Length of Time for Operation

1915(c)

- 3 years initial
- 5 years upon renewal

1915(i)

- Indefinite



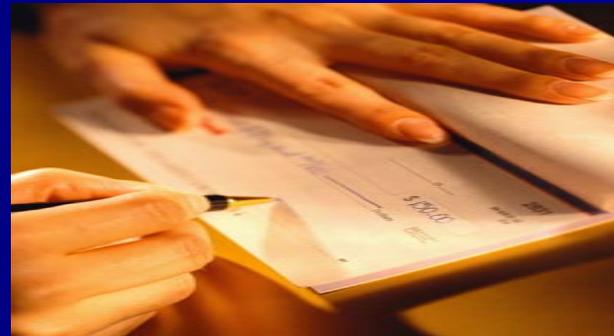
Financial Estimates

1915(c)

- Reasonable estimates of cost and utilization.
- Program must be cost neutral compared to institutional care

1915(i)

- Reveal payment methodology on Attachment 4.19-B of the State Plan.



Practicalities: Request for §1915(i) State Plan HCBS Benefit

- Only one State plan HCBS benefit per State
- State decides what the benefit will be
- Technical assistance available from CMS
- State Medicaid Agency submits State plan amendment

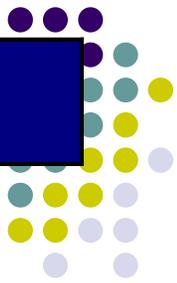
State Plan Amendment for §1915(i) HCBS Benefit

- Template of about 15 pages available
- Follows structure & format of 1915(c) application but much simpler
- Experience with 1915(c) waivers will help

State: §1915(i) State Plan HCBS Benefit State Plan Attachment 3.1 – C:
TN: Page 1
Effective: Approved: Supersedes:

State Plan HCBS Benefit Administration and Operation

State Plan HCBS Benefit Administration and Operation



Draft - CMS Use

1. **Program Title** (optional):

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2. **State-wideness.** (Select one):

<input type="radio"/>	The State implements this benefit statewide, per §1902(a)(1) of the Act
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. (Check each that applies):
<input type="checkbox"/>	Geographic Limitation. This state plan benefit will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. (Specify the areas to which this option applies):
<input type="checkbox"/>	Limited Implementation of Participant-Direction. This state plan benefit will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. (Specify the areas of the State affected by this option):

3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** (Select one):

<input type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the Medicaid agency division/unit that has line authority for the operation of the State plan HCBS benefit (select one):	
<input type="radio"/>	The Medical Assistance Unit (name of unit):	
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (name of division/unit)	
<input type="radio"/>	The State plan HCBS benefit is operated by (name of agency), a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

State plan HCBS benefit for Persons with Mental Illness

- Services for persons with chronic mental illness:
 - Day Treatment or Partial Hospitalization
 - Psychosocial Rehabilitation
 - Clinic Services
- No requirement that individuals meet an institutional level of care; no cost neutrality requirement

State plan Home and Community Based Services

- Iowa was first State to add HCBS to its Medicaid State plan
- Approved April 5, 2007
- Includes Case Management and Habilitation

Next Steps



- State Medicaid Directors Letter in clearance
- Regulation to be published in 2007



Discussion and Questions