

State Profiles of Mental Health and Substance Abuse Services in Medicaid



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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KEY FINDINGS

Research conducted during an 18-month period over 2002–2003 determined that all States¹ provided mental health services through Medicaid and the State Children’s Health Insurance Program (SCHIP), and most also provided some substance abuse services. States combined the use of eligibility standards, service selection, and service limits to manage service delivery in these programs. The way such controls were used in concert reflected States’ priorities as to which individuals should have received services, which services should have been provided, and how many services could have been provided. States had the choice of delivering services through some form of managed care or through traditional fee-for-service delivery systems.

With funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), staff from Abt Associates Inc. and the National Academy for State Health Policy (NASHP) conducted an examination of State Medicaid and SCHIP programs. The purpose of this study was to identify State policies related to those who were covered under the programs, what services the programs provided, and how the services were delivered. This effort revealed four key findings, described below.

Key Finding Number 1: All States provided mental health services to their Medicaid and SCHIP program participants, and most provided some substance abuse services.

All Medicaid programs provided inpatient mental health services, outpatient testing, and treatment services to Medicaid beneficiaries, and most also provided a broad range of other services. Most States specified that they covered inpatient substance abuse services (often limited to detoxification), outpatient testing and treatment for substance abuse, and opioid treatments. It was difficult to identify the specific services covered under separate SCHIP programs, but all covered both inpatient and outpatient mental health and substance abuse services, and 15 provided the Medicaid package of mental health and substance abuse services.

Each optional Medicaid category germane to the delivery of behavioral health services was used by more than half of Medicaid programs, with the rehabilitation option used by nearly all (96 percent of) Medicaid programs.

Optional Medicaid Category	Number of Medicaid Plans	Percentage
Other Licensed Practitioner	30	59%
Clinic	29	57%
Inpatient Under Age 21	43	84%
Rehabilitation	49	96%
Targeted Case Management	46	90%

Figure 1. States’ use of optional Medicaid categories.

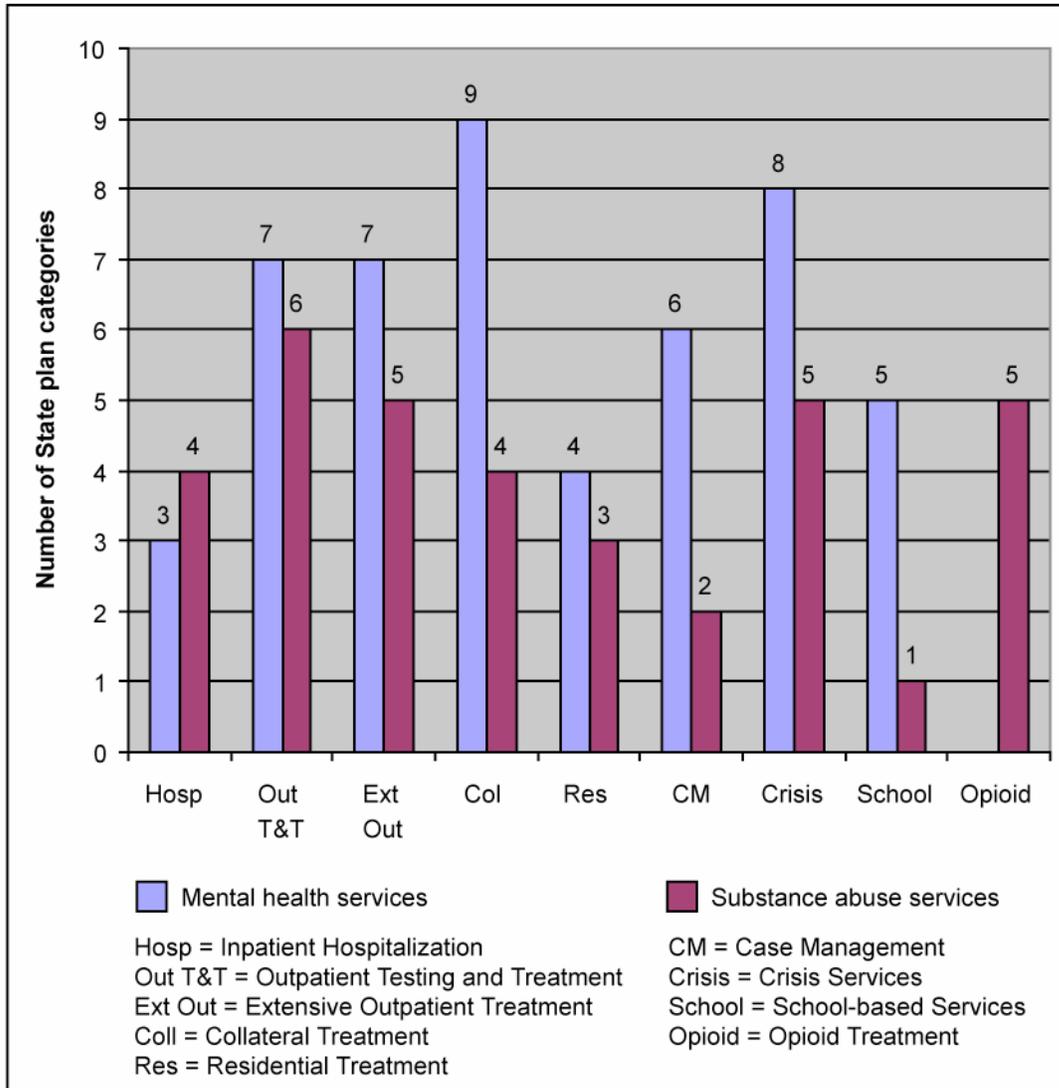


Figure 2. States can establish the same behavioral health service in multiple State categories.

Key Finding Number 2: Limits on mental health and substance abuse services in Medicaid and SCHIP tended to follow common patterns and were based on a relatively small number of criteria.

Among others, those criteria included the number of units of service, the type of service, and the type of diagnosis. Medicaid, in particular, allowed limits to be exceeded under circumstances that included diagnosis, approval of the Medicaid agency and/or its agent, or pending reporting by the attending physician.

Inpatient Behavioral Health Service Limits

- 18 (35 percent) of 51 States provided an explicit limit on adult inpatient days for mental health problems in an acute care facility (either a mental health ward of a general hospital or a designated psychiatric hospital), with most limits in the range of 20–30 days per year.

- 40 (78 percent) of the 51 Medicaid inpatient programs required some form of authorization or approval.
- 16 (80 percent) of the 20 States with separate SCHIP benefits that were distinct from Medicaid benefits limited the number of inpatient days that were covered, most commonly to 30 inpatient days.
- 4 (24 percent) of the 17 separate SCHIP programs with limits on inpatient days also allowed inpatient days to be converted into outpatient services.

Outpatient Behavioral Health Service Limits

- In Medicaid programs, many States limited the number of visits, while others limited the number of hours of service. Most Medicaid programs used the time period of a year—either fiscal or calendar—over which a designated limit of benefits could be used.
- 17 (85 percent) of the 20 separate SCHIP programs that did not provide the Medicaid benefit set specific limits on the number of outpatient visits. The highest number of visits—60—was allowed by Mississippi, New York, and North Carolina.
- 11 (55 percent) of the 20 separate SCHIP programs that did not provide the Medicaid benefit did provide a different benefit for substance abuse service than for mental health services.
- Florida and Kansas were the only two States to specifically exclude coverage of methadone maintenance and LAAM (levo-alpha-acetyl-methadol, synthetic opioid used for opiate addiction) in their separate SCHIP programs.

Key Finding Number 3: Most States used some form of managed care to deliver behavioral health services in Medicaid and SCHIP.

Mental health and substance abuse services in SCHIP and Medicaid were often being delivered through managed care. However, individuals receiving Medicaid services in States that provided some behavioral health services through a managed care organization (MCO) could still opt to use the fee-for-service system (described in detail in Section III).

Medicaid

- 35 States and the District of Columbia (80 percent of Medicaid agencies) delivered some or all mental health or substance abuse services through a managed care delivery system.
 - 51 percent used a comprehensive MCO.
 - 33 percent used a prepaid inpatient health plan (PIHP).
 - 6 percent used primary care case management (PCCM).
- Many States continued to rely on the fee-for-service delivery system for Medicaid.
 - 31 percent of the 51 Medicaid agencies delivered all behavioral health care through a fee-for-service system.
 - 6 (50 percent) of the 12 Medicaid agencies providing limited behavioral health services in an MCO provided the remaining behavioral health benefit through the fee-for-service system.

I. INTRODUCTION

Medicaid and the State Children's Health Insurance Program (SCHIP) are both State-Federal partnerships. Medicaid primarily serves low-income families and children, certain people with disabilities, and elders. SCHIP serves low-income children and rarely other low-income people, such as the parents of eligible children. Each State designs both its Medicaid and SCHIP programs within broad Federal guidelines. The Federal government establishes those groups that States *must* cover and those they *may* cover, which services they *must* provide and which they *may* provide, and how services may be delivered. States have more latitude in SCHIP program design than in the Medicaid design. While the Federal government pays a portion of the costs of both programs, it pays a greater portion of SCHIP costs than Medicaid costs. Together, these programs are the biggest financers of health care services in the United States.

- In 2002, total Medicaid costs (State and Federal) were \$248 billion (CMS, 2004), and in 2000, Medicaid covered 44.3 million people (Kaiser, 2004).
- In 2003, total SCHIP costs (State and Federal) were \$5.3 billion (CMS, 2004), and as of June 2003, SCHIP covered 3.9 million people (Kaiser, 2004).

Medicaid and SCHIP are both very important to the delivery of mental health and substance abuse services in the United States. In 1993, Medicaid, by itself, accounted for almost a third of public mental health spending (Mark, et al., n.d.) Mental health services are also a significant factor in Medicaid expenditures. One study of Medicaid spending in 10 States also found the following:

- 7–13 percent of Medicaid beneficiaries in the 10 States used mental health or substance abuse services.
- 11 percent of total Medicaid expenditures in these States were for mental health and substance abuse services (Buck, et al., 2003).

It is vitally important for those concerned with the delivery of mental health care to understand who can access services in these programs, what services can be accessed, and how services are delivered. However, there is little existing information that summarizes State coverage of mental health and substance abuse services in these programs. To begin to meet this need, staff from Abt Associates Inc. and the National Academy for State Health Policy (NASHP) (with funding from the Substance Abuse and Mental Health Services Administration [SAMHSA]) worked for an 18-month interval during 2002–2003 to profile each State's coverage of behavioral health in Medicaid and SCHIP—and to summarize that coverage to produce a snapshot of program policies governing the delivery of mental health and substance abuse services in these programs. This report presents the results of that effort.

The report begins with a brief overview of Medicaid and SCHIP and then provides a snapshot of coverage of mental health and substance abuse services in Medicaid and SCHIP. The snapshot is based on information abstracted from individual State profiles, and it specifically addresses the following issues:

1. Who was covered by each program?

2. What services were available in each program?
3. How had States limited service coverage?
4. What delivery systems did States use to provide covered services?

Complete profiles for each State are on the enclosed CD. A glossary of commonly used terms, acronyms, and abbreviations appears in Appendix C.

II. METHODOLOGY AND NOTES REGARDING THE DATA

Abt Associates Inc. and NASHP collected, collated, and analyzed information about the mental health and substance abuse services that were available in each State through Medicaid and SCHIP. NASHP worked closely with a few States and other experts to design a profile template that would be easy to complete and would highlight significant similarities and differences between and among States.

Throughout the latter months of 2003, Abt research assistants completed State profiles based on information contained in each of the State plans approved by the Center for Medicare and Medicaid Services (CMS) as of July 2003. Research included searches of each State's Web site for additional information on eligibility and service coverage. The profiles were sent to State Medicaid and/or SCHIP directors to confirm accuracy and to contribute enrollment and cost data that helped to complete the overall picture of mental health and substance abuse services. Once the State profiles were confirmed for accuracy, researchers used the information to produce the charts contained in this report, which were also checked for accuracy by Medicaid and SCHIP program representatives.

In total, data was returned and verified by 43 of the 51 Medicaid programs, and 46 of the 49 SCHIP programs. It is important to note that Tennessee reported its State Medicaid plan (Tennessee has no SCHIP program) to be all but completely obviated by the State's extensive use of a §1115 research and demonstration waiver (which can be used to waive almost any Federal Medicaid or SCHIP law). The information in Tennessee's summary section was derived from the waiver, not the State plan.

In this report, much of the specific information on services relates to those covered by the fee-for-service delivery system. This approach recognized that even where States use managed care, the fee-for-service system was the base-requirement for all States. In other words, Medicaid beneficiaries remained entitled to all services identified in the State plan, even when enrolled in a managed care program.

Each profile is presented in four sections. The first section provides a broad overview of the Medicaid and SCHIP programs for each State, including—

- Total enrollment in Medicaid and SCHIP
- Income eligibility limits
- Description of programs in use: separate SCHIP program, a Medicaid Expansion SCHIP program, or a combination of the two
- Description of the health care delivery system: whether and to what extent the State employed managed care techniques

The second section is an in-depth investigation of State Medicaid coverage. It identifies—

- Groups of people eligible for Medicaid
- Services that were covered
- Major service coverage limits

The third section reports on whether or not the State had a Medicaid Expansion SCHIP program. If the State had a program, the section—

- Identifies the people covered under the program
- Reminds that participants in this program received the full Medicaid benefit package

The fourth section—

- Reports on whether a State had a separate SCHIP program
- Reports, when applicable, on the eligibility criteria for participation and any limits to service coverage

The information on service coverage contained in the profiles is limited to the delivery of mental health and substance abuse services. For example, the report lists States as having targeted case management or home and community-based services waivers only where they specifically concerned the delivery of mental health or substance abuse services. The only States with a home and community-based service waiver to be discussed in this report were Kansas, New York, Vermont, and Colorado. Furthermore, an individual with autism or an autism spectrum disorder was not a priori defined as having a mental health or substance abuse need—services targeted to this group are not included in this analysis.

Where possible, the report summary examines Medicaid and SCHIP in separate sections. However, section VI, *Limits on Mental Health and Substance Abuse Services in Medicaid and SCHIP*, combines discussion to avoid repeating information. Although these programs were usually examined separately, it is important to note that many States with SCHIP Medicaid Expansion and Medicaid look-alike programs were apt to consider Medicaid and SCHIP as the same program with different funding mechanisms.

III. INTRODUCTION TO MEDICAID

Created by the Federal Government in 1965, Medicaid² is a State-Federal partnership designed to fund health care for individuals living in poverty, and certain others who are national priorities. Federal Medicaid statutes, regulations, and rules define the broad framework within which States must operate their programs. They require, among other rulings, that States operate within a federally approved plan and that they expend dollars, which are in turn matched by the Federal Government at rates particular to each State.

Importantly, Medicaid is an entitlement program, meaning that States and the Federal government are obligated to enroll all individuals who meet eligibility requirements established by the State. States are entitled to Federal funding, at their specified matching rate, for all qualified services provided to qualified individuals. Medicaid is one of the biggest financers of health care services in the United States. In 2002, State and Federal spending on Medicaid accounted for 16 percent, or \$248 billion, of the \$1.6 trillion spent on health care in the United States (CMS, 2004). Medicaid covered 44.3 million individuals in 2000 (Kaiser, 2004).

While States have a great deal of flexibility to create State-specific benefit packages, they must meet certain standards as codified in Federal statute, regulations, and rules. To participate in Medicaid, States are required to provide a defined set of services that must be available to certain groups of individuals. If desired, States may choose to provide additional services to a broader range of individuals, either by utilizing the optional categories provided, or by applying for special waiver authority that must be approved by the Secretary of Health and Human Services. States may also choose to provide all or some Medicaid services, including behavioral health, through managed care. Medicaid regulations require each State to maintain a State Medicaid plan that shows compliance with mandatory Federal requirements and identifies which options each has chosen. The Federal government has the right to approve these State plans.

A general outline follows of the mandatory and optional groups and services that are available to States participating in Medicaid, particularly as they relate to mental health and substance abuse services. Information is also presented regarding delivery system requirements and the use of waivers in Medicaid. This discussion is not intended to be exhaustive, but rather to provide background information to readers who are unfamiliar with the program. Those seeking additional detail are encouraged to examine resources focused specifically on Medicaid.

Medicaid Eligibility

Regarding Medicaid eligibility, Federal rules currently define almost 50 groups of people that States either *must* cover (mandatory eligibility groups) or *may choose* to cover (optional eligibility groups).³ These groups, or eligibility categories, are defined by financial criteria (income and resource limits) and nonfinancial criteria (age, disability, the presence of children in the home, receipt of another type of assistance, etc). If an individual does not meet the nonfinancial criteria of one of the groups, a State may not cover that person under Medicaid without a federally approved §1115 waiver. In effect, these rules allow coverage of low-income families and children, the aged, and those unable to work because of a disability. They exclude

childless adults who are not old enough to qualify for Medicare or sick enough to qualify for disability coverage.

States have more flexibility in establishing income and resource limits. Essentially, Federal law creates a floor, albeit an uneven one, below which States cannot set income or asset limits. States can, however, choose to extend Medicaid eligibility to additional people through several mechanisms that will be discussed here. The floor is set by the establishment of the mandatory eligibility categories. If a State does not cover members of these groups, the State cannot receive Federal Medicaid matching funds.

Mandatory Categorically Needy Groups

States must cover at least the following groups of people:

- Children under age 6 and pregnant women in families with incomes up to 133 percent FPL; States are required to cover infants and pregnant women at higher income levels if the State had a higher level in effect on December 19, 1989
- Children aged 6–19 in families with incomes up to 100 percent FPL
- Low-income families with children as described in §1931 of the Social Security Act. Essentially, this requires States to cover at least those who would have qualified for Aid to Families With Dependent Children (AFDC) under the State plan in effect as of July 16, 1996; thus, the required income limits for this group vary by State and by family size—in most cases they cannot be related to a single percent of the Federal Poverty Level⁴
- Children who qualify for foster care and adoption assistance under Title IV-E
- Recipients of Federal Supplemental Security Income (SSI)⁵; however, States (referred to as 209[b] States) that were using more restrictive criteria than the SSI program may continue to use those more restrictive criteria if they were in place in the State’s approved Medicaid plan as of January 1, 1972
- Certain other groups of Medicaid beneficiaries may keep Medicaid for a time even if they cease to qualify for the program; for example, families receiving Medicaid coverage following loss of eligibility under §1931 as a result of increased earnings may retain Medicaid for a time.

Optional Categorically Needy Groups

The first mechanism that States can use to expand Medicaid eligibility beyond minimum Federal requirements is to implement optional eligibility groups. These groups are specifically defined in Federal law, but States choose whether or not they wish to cover each group. Optional groups include the following:

- Infants under age 1 and pregnant women in families with incomes up to 185 percent FPL
- Children from families with incomes of up to 200 percent FPL (this group was established in SCHIP regulations; in States that have opted to include this group, they are often referred to as SCHIP Medicaid Expansion Participants)
- Recipients of State Supplemental Payments (SSP)
- ABD adults who have incomes below 100 percent FPL

- Institutionalized individuals with income and resources below specified limits
- People who would be eligible if institutionalized but are receiving care under home and community-based services waivers
- Low-income, uninsured women screened and diagnosed through a Centers for Disease Control and Prevention’s Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast or cervical cancer
- Working individuals aged 16–64 who meet the SSI definition of disability (or medically improved disability) and who have incomes and assets below a limit established by the State; States have full flexibility to establish income and asset limits—including choosing to eliminate limits entirely; they also have full flexibility to require individuals to pay premiums or otherwise share in the cost of their care

Medically Needy Program

The second mechanism States can use to expand Medicaid eligibility beyond Federal minimums is to operate a medically needy program. A medically needy program allows States to extend eligibility to various groups of people, including pregnant women, children, the aged, and people with disabilities whose income is too high to qualify for Medicaid—if they have sufficient medical expenses to effectively reduce their income to below the Medicaid limit. States may also establish an income limit for the medically needy different from that for the categorically needy populations.

Other Mechanisms for Expanding Medicaid Eligibility

States have other mechanisms available to them for expanding Medicaid eligibility beyond minimum Federal requirements, as follows:

1. States may choose to establish more liberal methods of calculating income or resources for purposes of determining Medicaid eligibility under §1931 (families) or §1902(r)(2) (poverty level groups, such as poor children). For example, a State could choose to exclude all income between 100 percent FPL and the limits set in the 1996 AFDC plan—effectively increasing the income limit for parents to 100 percent FPL.
2. States may choose to implement a SCHIP program that is an expansion of Medicaid. (Technically this group is considered an optional group, like those previously described, but it is listed separately here because it was created under Title XXI of the Act, not Title XIX.)
3. States may obtain a §1115 waiver from the Federal government to expand eligibility beyond the Federal requirements, or create coverage groups that are not normally allowed under Medicaid, such as uninsured adults.

Medicaid Covered Services

Just as with eligibility groups, Federal rules define the categories of services that States may cover in their Medicaid programs. Below is an abridged discussion of the mandatory and optional service categories that are available in Medicaid, as not all service categories are

relevant to mental health and substance abuse services. Most service categories are not mutually exclusive, and many overlap extensively.

Mandatory Service Categories

There are 12 mandatory services that States must provide to participate in Medicaid. Those listed below can deliver a mental health or substance abuse service. Early periodic screening, diagnosis, and treatment (EPSDT) services, which are also mandatory, will be addressed in a separate section below. Mandatory services include—

- Inpatient hospital services
- Outpatient hospital services
- Federally qualified health center services
- Rural health center services
- Physician services

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Medicaid regulations specify that all children enrolled in Medicaid must be screened and tested at regular intervals to detect any conditions needing treatment, including developmental delays—physical, mental, emotional, cognitive, and others. Once a need is identified through an EPSDT screen, the State is then obligated to provide all Medicaid services needed to correct or ameliorate the condition that can be covered under Medicaid, regardless of whether that service is otherwise available in the State. This is particularly important because it means that EPSDT can be used to deliver behavioral health services that are not available to adults and are specifically targeted towards children.

Optional Service Categories

Although States are not required to provide any of the categories of services listed below, all have chosen to provide one or more. This is not a complete list of optional services. Rather, it is a list of those optional service categories under which States can establish coverage of mental health and substance abuse services.

- Other licensed practitioners (for mental health and substance abuse services, this might include a family therapist, Certified Alcohol and Substance Abuse Counselor (CASAC), psychologist, etc.)
- Clinic services
- Inpatient hospital services for children under age 22
- Rehabilitation services
- Targeted case management
- Home- and community-based services

Delivery Systems: Fee-for-Service and Managed Care

Federal Medicaid rules also define how States may deliver services and under what conditions they may choose to deliver services through managed care. Until the 1990s, most Medicaid

beneficiaries received services through a fee-for-service system. In this type of delivery system, Medicaid agencies pay providers for each service provided. The amount paid for each service is based on the amount the provider bills (subject to a cap that varies by service). Agencies manage utilization through mechanisms such as prior authorization.⁶

In the 1980s, State Medicaid agencies began using various types of managed care delivery systems, and according to the Centers for Medicare & Medicaid Services (CMS), by 1998 over half of all Medicaid beneficiaries received some or all covered services through a managed care system (CMS, 2004). (There are currently four types of managed care delivery systems⁷ in use by Medicaid agencies.

1. *Comprehensive Managed Care Organization (MCO)*: A comprehensive MCO is a health plan that delivers a comprehensive⁸ set of services to an enrolled population. MCOs receive a set monthly payment (capitation payment) for each enrolled beneficiary (enrollee). In return, the MCO generally accepts full financial risk for providing the defined set of services. Beneficiaries enrolled in an MCO must follow the procedures established by the MCO for accessing MCO-covered services, including using only those providers designated by the MCO (for example, a health maintenance organization or HMO would be referred to in Medicaid as a comprehensive MCO).
2. *Prepaid Inpatient Health Plan (PIHP)*: A PIHP is a health plan that provides less than comprehensive services to Medicaid beneficiaries but provides, arranges for, or otherwise has responsibility for any inpatient hospital or institutional service. Most PIHPs are paid through capitation and accept financial risk for provision of a defined set of benefits to an enrolled group. In most cases, PIHPs deliver only a single type of service, such as behavioral health services. A PIHP usually serves a geographical area—which may be defined as the entire State. Beneficiaries enrolled in a PIHP must follow the procedures established by the PIHP for accessing PIHP-covered services, including using only designated providers.
3. *Prepaid Ambulatory Health Plan (PAHP)*: A PAHP is almost identical to a PIHP except that a PAHP does *not* provide, arrange for, or otherwise have responsibility for any inpatient hospital or institutional service.
4. *Primary Care Case Management (PCCM)*: A PCCM is a program in which the Medicaid agency contracts with a provider to locate, coordinate, and monitor covered primary care and sometimes additional services, such as mental health services. Usually, the provider is a physician or physician group practice, but sometimes other providers such as nurse practitioners may serve as PCCM providers. Beneficiaries enrolled in a PCCM program may not access services that are part of the PCCM provider's scope of authority without their PCCM provider's permission. Most PCCM providers are reimbursed for each service they provide plus a small (\$2–3) monthly case management fee for each beneficiary enrolled with them. Some, however, receive a capitation payment for providing a defined set of services. These PCCM providers are reported here as PIHPs or PAHPs.

Agencies can (and almost all do) use more than one of these five types of delivery systems (the four managed care systems and the fee-for-service system). For example, some use an MCO to

deliver care to people who qualify for Medicaid because they are part of a low-income family, while delivering care to people who qualify because of age or disability through a fee-for-service system. Individual beneficiaries may also obtain care from more than one delivery system. For example, in Massachusetts, those beneficiaries who are enrolled in a PCCM program receive their physical health care through that system, but their behavioral health services from a PIHP.

States can require beneficiaries to enroll in managed care under three Federal authorities: a §1931 State plan amendment; a 1915(b) “freedom-of-choice” waiver; or a §1115 “research and demonstration” waiver. Under §1931 authority, States may require all beneficiaries except children with special health care needs, American Indians/Alaska Natives, and dual eligibles (those who qualify for both Medicaid and Medicare) to enroll in managed care programs established under §1931. The program may be established by submitting a State plan amendment and must meet certain requirements, including paying actuarially sound rates and providing the choice for beneficiaries of at least two health plans or a choice of a plan and a PCCM program.

If a managed care program does not meet the requirements of §1931, a State Medicaid agency must obtain a waiver to require beneficiaries to enroll in the program. For example, if a State wishes to require children with special health care needs to enroll or to not offer a choice of plan/program, the agency will need to obtain a waiver. Whether the agency will need a §1915(b) or a §1115 waiver will depend on program design. A §1915(b) waiver allows mandatory enrollment in managed care programs that do not meet §1931 requirements. A §1115 waiver will be needed if the agency wants to also deviate from Medicaid requirements that govern areas other than managed care, such as providing some beneficiaries with a benefit package that does not contain all mandatory services.

Medicaid Waivers

The concept of Medicaid waivers has already been introduced. This section summarizes the types of waivers States may request from the Federal government. As previously indicated, waivers are a mechanism allowing States to deviate from standard Medicaid rules. They may only be implemented upon the approval of the Secretary of the Department of Health and Social Services (DHHS) and must be budget neutral.⁹ There are three types of waivers in use by State Medicaid programs:

- §1915(b) freedom-of-choice waivers
- §1115 research and demonstration waivers
- §1915(c) home- and community-based service program (HCBO) waivers

Section 1915(b) freedom-of-choice waivers are used primarily to require beneficiaries to enroll in managed care programs that do not meet §1931 requirements. These waivers allow States to restrict beneficiaries’ choice of providers—thus they are often referred to as freedom-of-choice waivers. They may also be used to restrict beneficiary choice of nonmanaged care providers, such as hospitals. These waivers must generally be renewed every 3 years. In recent years, CMS has streamlined the process of obtaining a §1915(b) waiver—for example, by creating a template for State use.

Section 1115 research and demonstration waivers offer the most flexibility to States. Under these waivers, States may request a waiver of almost any Federal Medicaid law and accomplish any of the following:

- Offer a benefit package that includes services that could not otherwise be offered.
- Exclude services that otherwise must be offered.
- Cover groups of people the State could not otherwise cover.
- Exclude groups it would otherwise be required to cover.

Section 1115 waivers must generally be renewed every 5 years and must feature an independent evaluation. In 2001, the Federal government announced a new approval process for §1115 waivers that meet certain requirements. The *Health Insurance Flexibility and Accountability (HIFA)* initiative provides for an expedited review of §1115 waivers that expand coverage, are statewide, and coordinate with private sector coverage.

Section 1915(c) (HCBO) waivers are used to operate home- and community-based services programs. Under these waivers, States can offer services that are not normally covered under Medicaid and that help beneficiaries who would otherwise require nursing home care to remain in their own homes. For example, a State can offer homemaker services or respite care to waiver program participants. In one sense, these waivers also allow expansions of eligibility since States may cover certain people who live in the community who, under standard Medicaid rules, would be covered only upon admission to a nursing home. States define the groups of people they will cover under these waivers and the absolute number of people they will cover. For example, a State could restrict waiver participation to 300 children with special needs who live in a specific county in the State.

IV. INTRODUCTION TO THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP)

In August 1997, the Balanced Budget Act (BBA) was passed, and it included authorization of Title XXI of the Social Security Act, known as the State Children’s Health Insurance Program or SCHIP (Pernice, et al, 2001). The SCHIP program was passed by Congress to assist State efforts to initiate and expand the provision of child health insurance primarily in the form of health benefits coverage to uninsured, low-income children.

Through SCHIP, States can provide coverage by using one of three options:

- Create a separate, child health program that meets the requirements specified under §2103 of the Act, known as separate SCHIP programs.
- Expand eligibility for benefits under the State’s Medicaid plan under Title XIX of the Act, known as Medicaid Expansion SCHIP programs.
- Use both approaches in combination.

Medicaid Expansion SCHIP programs, including those that are part of a combination approach, must adhere to all the rules and regulations applicable in Medicaid. Separate SCHIP programs, including those that are part of a combination approach, have much flexibility in how they are implemented and administered by States. Such flexibility includes the option to cap enrollment or define eligibility levels for specific populations. There are no Federal rules governing State choice of delivery system. Even more flexibility is available to States under a §1115 waiver. As in Medicaid, States can use these waivers to cover people such as parents of enrolled children who would not otherwise qualify for Medicaid.

SCHIP is a jointly funded program financed by the Federal and State governments and is administered by the States. Within Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years 1998 through 2007.

SCHIP is targeted to children in families with incomes up to 200 percent of the FPL, or 50 percentage points above the Medicaid income limit for children in a State as of March 31, 1997. States are not required to create a program that serves all children up to 200 percent FPL but are strongly encouraged to do so. States may also choose to provide all or some SCHIP services, including behavioral health, through managed care.

The Federal matching rate to State expenditures is more generous than that provided through Medicaid. In 2003, State and Federal spending on SCHIP accounted for \$5.3 billion of the \$1.6 trillion spent on health care nationally (CMS, 2004). In June 2003, the most recent date for which national enrollment data is available, there were 3.9 million individuals enrolled in SCHIP (Kaiser, 2004).

V. SNAPSHOT OF STATE MEDICAID POLICIES GOVERNING THE DELIVERY OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

All Medicaid programs offer mental health services, and most offer substance abuse services to defined groups of people. Exactly who qualifies for Medicaid, what services are available to them, and how those services are delivered varies widely among States. This section of the report presents a snapshot of the options States have chosen for the delivery of mental health and substance abuse services.

Who Can Access Medicaid-Covered Mental Health and Substance Abuse Services?

To access Medicaid-covered services, an individual must first be found eligible for the program. Federal Medicaid law provides States with several options for covering different populations. The groups of people States have chosen to cover under the Medicaid program are examined here. The two broadest categories for grouping the options are (1) families, and (2) the ABD population.

Eligibility for Families

Of the numerous eligibility groups for State Medicaid coverage to families and children, most individuals qualify in the following categories, which *must* be covered:

1. All members of low-income families that meet the requirements of §1931. This requires States, at a minimum, to cover all members of families with children who would have qualified under the State's AFDC plan in place July 16, 1996. Since the income limits to qualify for AFDC were very low, and there are higher income limit requirements for children under age 19, this requirement means in practice that States are required to cover parents in low-income families.
2. All pregnant women and all children aged 0–5 from families with incomes of 133 percent FPL or less.
3. All children aged 6–18 from families with incomes of 100 percent FPL or less. (This requirement was phased in but now applies to all children under age 19.)

States may choose to go beyond these requirements through one of five mechanisms:

1. Implement an optional Medicaid categorical eligibility group. For example, choose to cover children under age 1 and pregnant women with incomes of no more than 185 percent FPL.
2. Establish more liberal methods of calculating income or resources for purposes of determining Medicaid eligibility under §1931 (families) or §1902(r)(2) (poverty level groups, such as poor children). For example, a State could choose to exclude all income between 100 percent FPL and the limits set in the 1996 AFDC plan—effectively increasing the income limit for parents to 100 percent FPL.

3. Implement a medically needy program, which allows States to extend eligibility to various groups of people, including pregnant women, children, and families whose income is too high to qualify for Medicaid—if they have sufficient medical expenses to effectively reduce their income to Medicaid levels.
4. Implement a SCHIP program that is an expansion of Medicaid. (Technically, this group is considered an optional group, like that described in 1, but it is listed separately here because it was created under Title XXI of the Act, not Title XIX.)
5. Obtain a §1115 waiver from the Federal government to expand eligibility beyond the Federal requirements, or create coverage groups that are not normally allowed under Medicaid, such as uninsured adults.

This report considers five groupings that were developed to capture the major policy differences among States:

1. Parents
2. Pregnant women and children under age 1
3. Children aged 1–5
4. Children aged 6–18
5. SCHIP Medicaid expansion groups

Examination of data gathered from the individual State profiles revealed that most States expanded Medicaid eligibility for families and children beyond minimum Federal requirements (Figure 4). Specifically, 45 States and the District of Columbia (90 percent of the 51 Medicaid agencies examined in this report) had used one of the four mechanisms available to them to expand Medicaid eligibility beyond minimum Federal requirements for covering some or all low-income families and children.

The five States that did not go beyond minimum Federal requirements were Alabama, Colorado, Montana, Nevada, and Wyoming. Among these five States, Montana, although it had not expanded eligibility for families beyond the minimum Federal requirements, had established a medically needy program for pregnant women and children under 19. Under this program, members of the groups with incomes above the Medicaid income limit could have qualified for Medicaid if they had sufficient medical expenses. Finally, Utah used a §1115 waiver to expand eligibility for all low-income uninsured adults (including parents) with incomes up to 150 percent FPL, but members of the expansion population did not receive any mental health or substance abuse benefits.

Examining Medicaid eligibility among the 46 agencies that exceeded Federal Medicaid eligibility requirements and delivered behavioral health services to members of the nonmandatory groups revealed that most chose to extend coverage to higher-income pregnant women and infants (children under age 1). Specifically—

- 17 (37 percent) of the 46 agencies expanded eligibility for *parents* beyond that required under §1931. The majority of these States extended eligibility to parents with incomes of 100 percent FPL or less.
- 41 (89 percent) of the 46 agencies expanded eligibility for *infants and pregnant women* beyond the federally required minimum of 133 percent FPL. The majority of these States expanded eligibility to infants and pregnant women with incomes of 185 percent FPL or less. In some cases, this expansion was for a subset of this group. For example, New Jersey reported covering pregnant women with incomes of no more than 200 percent FPL and infants from families with incomes of no more than 185 percent FPL.
- 13 (28 percent) of the 46 agencies expanded eligibility to *children aged 1–5* beyond the federally required minimum of 133 percent FPL. Again, some of these expansions were for subsets of the group. For example, Wisconsin, under a §1115 waiver, expanded eligibility for all applicants who were members of low-income families up to 185 percent FPL *and* allowed them to retain eligibility until their income exceeded 200 percent FPL.
- 14 (30 percent) of the 46 agencies expanded eligibility to *children aged 6–18* beyond the federally required minimum of 100 percent. Again, some of these expansions were for subsets of the group. For example, Arkansas used a §1115 waiver to expand eligibility for *uninsured* children up to 200 percent FPL.
- 30 (65 percent) of the 46 agencies implemented a *SCHIP Medicaid expansion program* to expand eligibility for children of various agencies, and four States expanded eligibility for either parents or pregnant women in addition to children (parents: Michigan, Rhode Island, and Wisconsin; pregnant women: New Jersey.) These expansions for adults were accomplished through §1115 waivers.

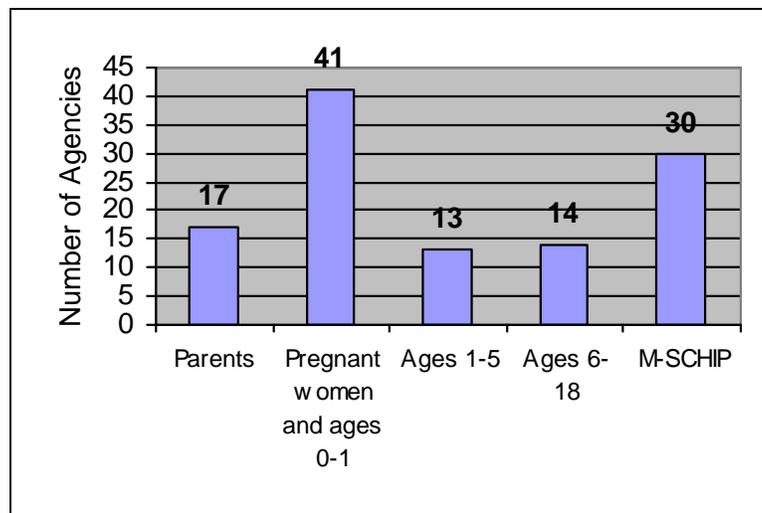


Figure 4. Most agencies have expanded eligibility for families beyond minimum requirements.

Eligibility for the Aged, Blind, and Disabled (ABD)

Compared to family coverage, there are fewer Federal minimum requirements for covering the ABD eligibility groups. The largest group that most States are required to cover is defined as “those receiving Supplemental Security Income (SSI),” but even that requirement does not apply to all States. States may use more restrictive criteria than those of the SSI program if those criteria were in place in the State’s approved Medicaid plan as of January 1, 1972. These States, often referred to as 209(b) States, can use a stricter definition of disability than the Federal definition, higher income and lower assets limits than the Federal SSI program, and so on. Analysis of the individual State profiles found eight States that used more restrictive criteria. Among those eight States—

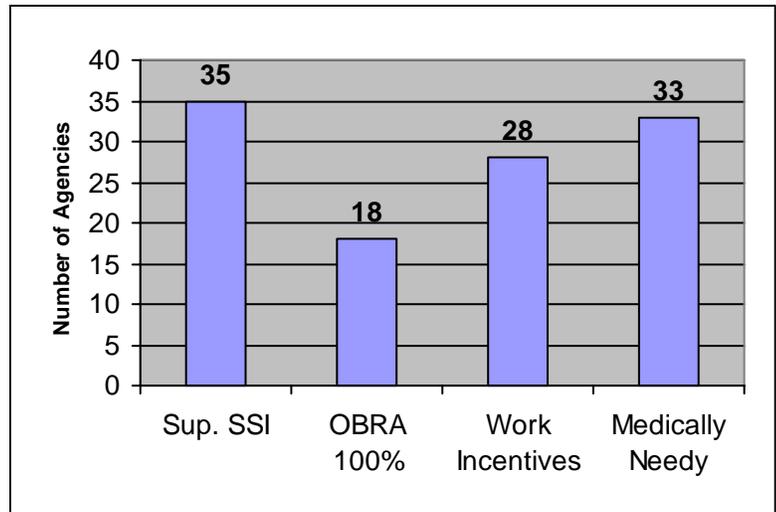


Figure 5: All agencies have expanded eligibility for ABD populations beyond Federal requirements.

- Five States (Connecticut, Hawaii, New Hampshire, North Dakota, and Ohio) used a more restrictive income limit.
- Three States (Indiana, Missouri, and New Hampshire) used a more restrictive definition: Indiana and New Hampshire used a more restrictive definition of disability, and Missouri used a more restrictive definition of blindness. Incidentally,
- Indiana allowed a higher income limit (100 percent FPL) than the Federal SSI limit.

As in family coverage, States may also choose to expand coverage for ABD individuals. The five mechanisms States can use for this purpose are—

1. Implement a Medicaid optional eligibility category. The two most frequently used are certain ABD individuals who have incomes above those requiring mandatory coverage, but below the FPL; and recipients of State supplementary payments.
2. Establish a more liberal method of calculating income or resources for purposes of determining Medicaid eligibility under §1902(r)(2).
3. Implement a medically needy program, which allows States to extend eligibility to various groups of people, including those who are ABD whose incomes are too high to qualify for Medicaid—if they have sufficient medical expenses to effectively reduce their income to Medicaid levels.
4. Implement a work incentives program, which allows States to extend Medicaid eligibility to

individuals considered to be *working disabled*—working people with a disability between the ages of 16 and 64 who do not meet the standard Medicaid income limit because of excess income. This program actually consists of several eligibility groups. For purposes of this discussion, however, States can establish, through use of these groups, any income or resource limits they wish (including no limit) and require beneficiaries to share in their cost of care through payment of premiums or other means.

5. Obtain a §1115 waiver from the Federal government to expand eligibility beyond the Federal requirements or create coverage groups that are not normally allowed under Medicaid, such as uninsured adults.

An examination of the information contained in the 51 individual profiles indicated that all 51 agencies profiled had used one or more of these mechanisms to extend Medicaid eligibility beyond minimum Federal Medicaid requirements for coverage of the ABD population (Figure 5).

- 38 (75 percent) of the 51 Medicaid agencies examined expanded eligibility for the ABD population beyond the Federal minimum requirements by implementing one or both of the two optional categories examined here. Specifically—
 - 35 (69 percent) of the 51 Medicaid agencies examined in this report provided Medicaid to some or all people to whom they provided State supplemental income.¹⁰ Most of these agencies (26) provided Medicaid to all who received the supplemental payments.
 - 18 (35 percent) of 51 Medicaid agencies implemented the authority provided to them in OBRA '86, the Omnibus Budget Reconciliation Act of 1986 that gave States the option to expand Medicaid benefits to the ABD population with incomes up to 100 percent FPL. Only five of these agencies expanded eligibility to a limit other than 100 percent FPL. Florida, Illinois, Minnesota, and Virginia established a lower income limit, and California used §1902(r)(2) to establish a higher limit.
- 25 (55 percent) of 51 Medicaid agencies established a work incentives program in which working people with disabilities who did not otherwise qualify for Medicaid because of income could buy Medicaid coverage.
 - All but one of these agencies (Wyoming) established an income limit of 200 percent FPL or more, including four that had no upper income limit (Idaho, Indiana, Massachusetts, and Minnesota).
 - All but four of these agencies (Arkansas, South Carolina, New Mexico, and Vermont) charged all or some participants a premium for participation.
- 33 (65 percent) of States expanded eligibility beyond Federal minimum requirements for the ABD population by operating a medically needy program for members of that group.

In addition to the ABD-specific expansions discussed above, 10 agencies used §1115 waivers to expand Medicaid eligibility to various groups of adults who would not otherwise qualify for Medicaid. They thus provided these new eligible groups with a benefit package that included

mental health and substance abuse services. The groups included those who have a disability or are over age 65 but do not otherwise qualify for Medicaid. Most of these expansions increased the income limit to 100 percent FPL or higher.

What Mental Health and Substance Abuse Services Do Medicaid Programs Cover?

States can choose whether or not they will cover mental health and substance abuse services under Medicaid. All have chosen to cover mental health services, and all but two also cover at least a limited package of substance abuse services for adults.¹¹ Because States are not required to cover these services, they have much flexibility in defining the services they will cover. Because there is no single optional category labeled “behavioral health,” States again have much flexibility as to where they describe the service in their State plans.

This section of the report examines the information collected in each of the 51 profiled programs to identify both the common clinical services covered—and the State plan category in which these services were defined. Here are some caveats regarding the information presented here:

- Some States described in detail the mental health and substance abuse services they offered; others used more general terms to describe available services.
- States described the mental health and substance abuse services in multiple, State plan categories. For example, a single State plan may have described “individual therapy” as a covered service under physician services, other practitioners, clinic services, and rehabilitation services.
- To ensure that Medicaid coverage was not overstated, this report only identified a Medicaid program as one covering a service that was specifically identified as a covered service in the documents reviewed to develop State profiles,¹² or so indicated by State staff reviewing the profiles. As a result, the information presented here may be incomplete: a State that is *not* listed as providing a service may have actually been providing the service.

State Plan Categories Used by Medicaid Agencies To Establish Coverage of Mental Health and Substance Abuse Services

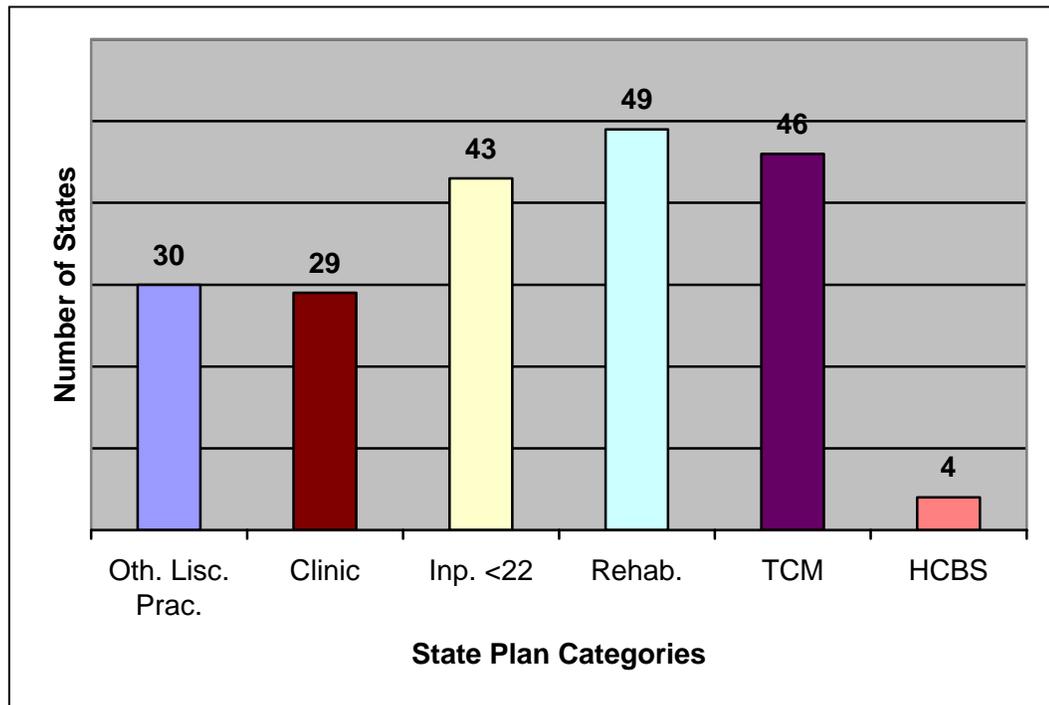


Figure 6. Most States established behavioral health service coverage in the rehabilitation services category.

In almost all cases, States define their mental health and substance abuse coverage in the optional Medicaid service categories. In some cases, however, a State does establish coverage in the mandatory service categories. Most notably, coverage for acute inpatient mental health and substance abuse services is almost always provided under the inpatient hospital services category. All States use more than one optional category to establish mental health and substance abuse services. Nearly all States (49) use the rehabilitation option to provide mental health services (Figure 6). In the study, Colorado, Kansas, New York, and Vermont were the only States to use an HCBS waiver to deliver mental health and substance abuse services. Finally, different States often cover the same service under different service categories (Figure 7).

EPSDT is not included in Figure 6 because it is a mandatory service. However, it is a key service category for children. As previously described, Medicaid regulations specify that all children enrolled in Medicaid must be screened and tested at regular intervals to detect any conditions needing treatment. Once a need is identified through an EPSDT screen, the State is then obligated to provide all Medicaid services needed to correct or ameliorate the condition that can be covered under Medicaid, regardless of whether that service is otherwise available in the State. States have much flexibility in defining a screen, the services that are covered only under EPSDT, and the mechanism for obtaining those services. For example, North Carolina established a requirement that an EPSDT screen include a specific mental health screening instrument, such as the Ages and Stages Questionnaire: Social-Emotional (ASQ-SE).¹³ Many States define specific behavioral health services that a beneficiary may obtain as an EPSDT

screen. Others simply specify that they cover “all services needed to treat or ameliorate a condition identified in a screen.”

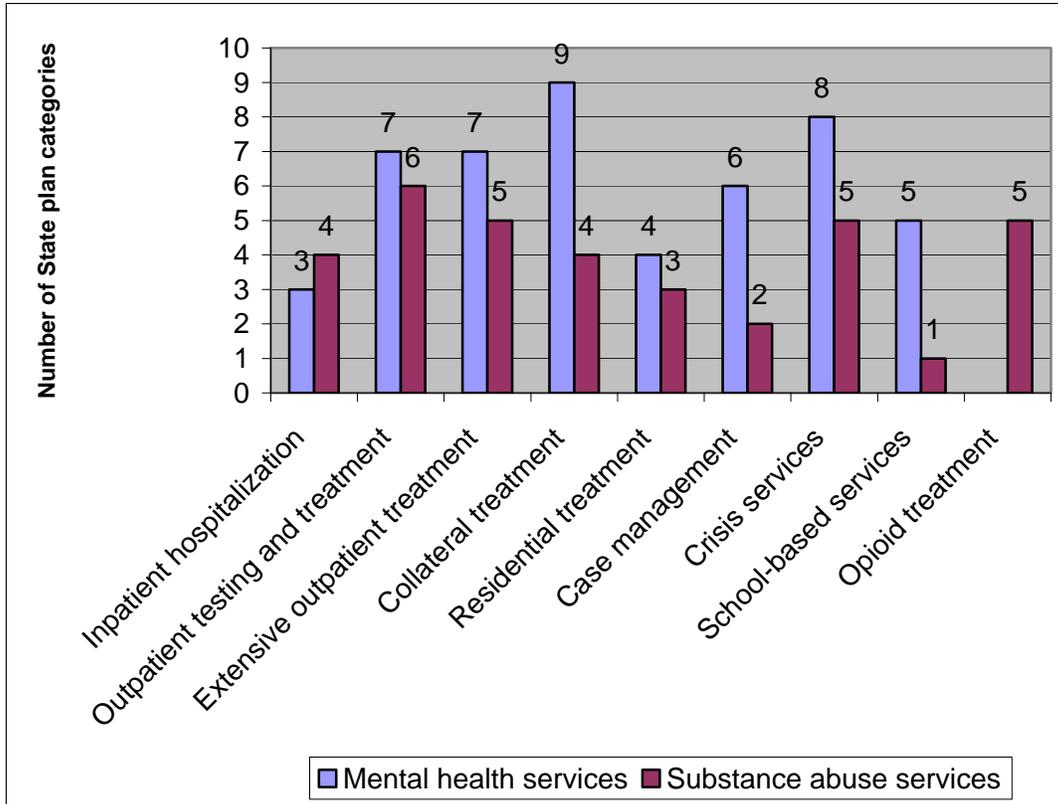


Figure 7. States can establish the same behavioral health service in multiple State plan categories

Services Covered by Medicaid

Of interest are the State plan categories where States chose to establish mental health and substance abuse services, and the specific services States chose to cover under one or more State plan categories. To extract information about service coverage from the individual profiles, broad definitions were used to identify certain kinds of services that researchers identified as being most useful and relevant to practitioners and consumers. All services except opioid treatment were available in both mental health and substance abuse settings. The service categories used to examine coverage were—

1. Inpatient hospitalization
2. Outpatient testing and treatment
3. Extensive outpatient services
4. Collateral services
5. Residential services
6. Case management [targeted case management?]

7. Crisis services
8. School-based services
9. Opioid treatment

The remainder of this section examines State coverage of these broad clinical services categories.

Inpatient Hospitalization

Inpatient hospitalization is defined as any kind of temporary inpatient care in a hospital setting or long-term placement in a psychiatric hospital. As of July 2003—

- All 51 Medicaid programs profiled here covered inpatient hospitalization for mental health treatment.
- 40¹⁴ (78 percent) covered inpatient hospitalization for substance abuse—most often acute admissions for detoxification.
- 45 (88 percent) covered long-term placements for children in a psychiatric facility¹⁵—all except Delaware, Massachusetts, Michigan, South Dakota, Texas, and Virginia. It is important to note that even those States that reported not covering long-term placements in a psychiatric facility may be required to offer that service to children through Federal EPSDT regulations.

Outpatient Testing and Treatment

Outpatient testing and treatment are defined as individual/group/family counseling and/or psychotherapy, diagnosis, treatment, assessment, and medication management and/or monitoring. Often these are the kinds of services that are delivered in a mental health clinic by a physician. Outpatient testing and treatment were covered by all 51 Medicaid programs for mental health. Forty-three (84 percent) of 51 programs covered substance abuse–related outpatient testing and treatment services—all but Arkansas, Colorado, Hawaii, Idaho, Kentucky, Mississippi, Nevada, and New Hampshire.

Extensive Outpatient Services

Extensive outpatient services are services that are often available during daylight and/or business hours to provide a daytime place for individuals with a mental illness or a substance abuse disorder to spend time while receiving treatment. Commonly, these outpatient programs offer an environment that encourages positive social interactions, peer support, and opportunities to acquire and perfect activities of daily living. These programs typically serve individuals with more severe impairments.

The specific clinical services included in this category were continuing day treatment, day treatment, behavioral health day programs, therapeutic day programs, sheltered workshops, psychosocial rehabilitation, occupational therapy, supervised day programs, and activity therapy. As of July 2003, among the 51 State Medicaid agencies profiled (Figure 8), 45 (88 percent) covered the service for those with a mental health condition, and 25 (49 percent) covered extensive outpatient services for substance abuse.

As of July 2003, among the 51 Medicaid agencies profiled—

- 38 (75 percent) covered collateral services for treatment of a mental health condition.
- Twelve (24 percent) covered collateral services for substance abuse (Figure 9).

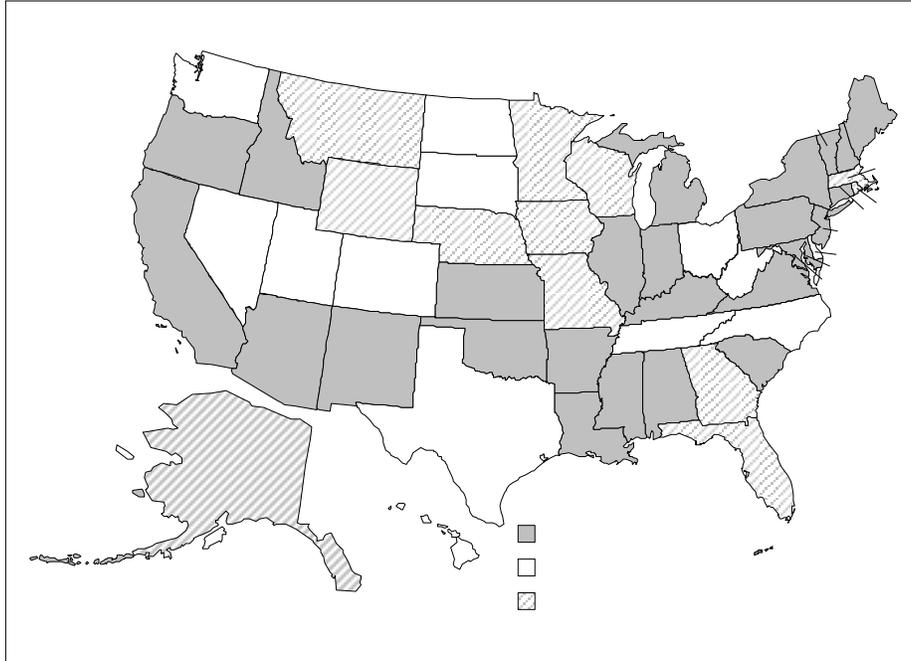


Figure 9. Provision of mental health and substance abuse services: collateral services

Crisis Services

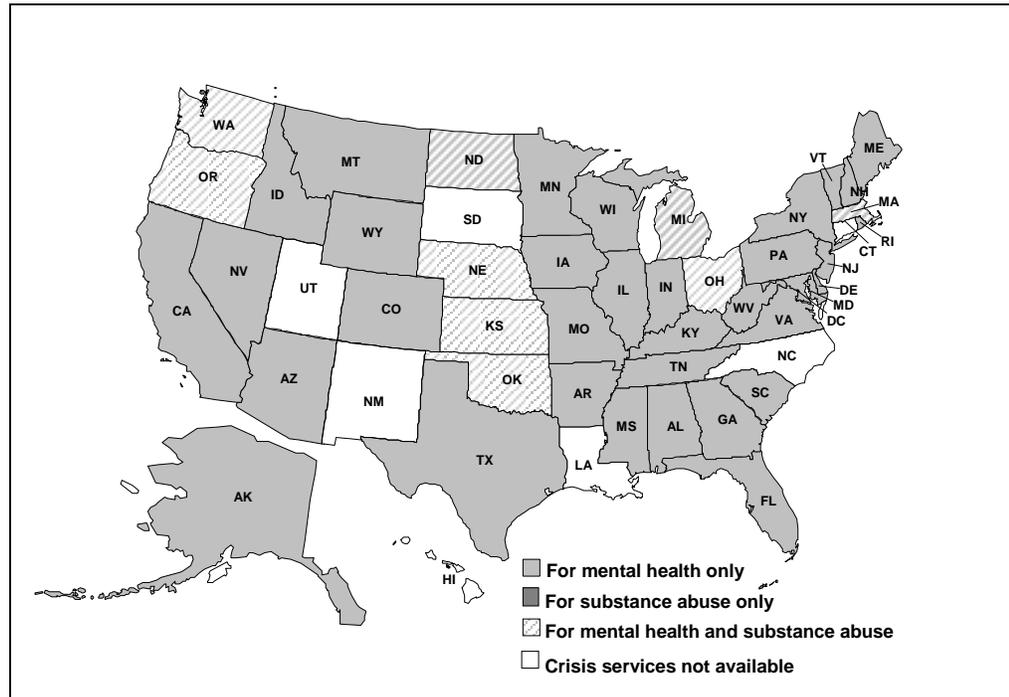


Figure 11. Provision of mental health and substance abuse services: crisis services.

Because of the cyclical nature of mental illnesses, crisis services are occasionally necessary to ameliorate and reverse episodic decompensation.¹⁶ Services might include the deployment of a team of practitioners and support staff to intervene proactively. There is also a growing body of literature on the efficacy of assertive community treatment (ACT) teams serving people with mental illness. This report identifies the following specific services as crisis services: crisis management, ACT teams, crisis intervention, crisis assistance, etc.

As of July 2003—

- 43 (84 percent) of 51 Medicaid programs covered mental health crisis services—all but Connecticut, the District of Columbia, Hawaii, Louisiana, New Mexico, North Carolina, South Dakota, and Utah.
- 9 (18 percent) of 51 Medicaid plans provided crisis substance abuse services (Figure H).

School-Based Services

The defining characteristics of school-based services are that they must be provided in a school setting and targeted towards school-age children. The services can include mental health and substance abuse services, counseling, therapy, and so on.

As of July 2003, 25 (49 percent) of 51 Medicaid programs covered school-based mental health services. Washington was the only State to specifically mention school-based substance abuse services, which were authorized through the rehabilitation option.

Opioid Treatment

Opioid treatment is a substance abuse treatment designed to ameliorate the effects, most commonly, of heroin addiction. The two most common opioid treatments are methadone maintenance and levo-alpha-acetyl-methadol, or LAAM. Both are controlled substances. Buprenorphine, which has made a recent appearance as an opioid agonist, was not mentioned by name in any State profile though States were not specifically prohibited from using it.

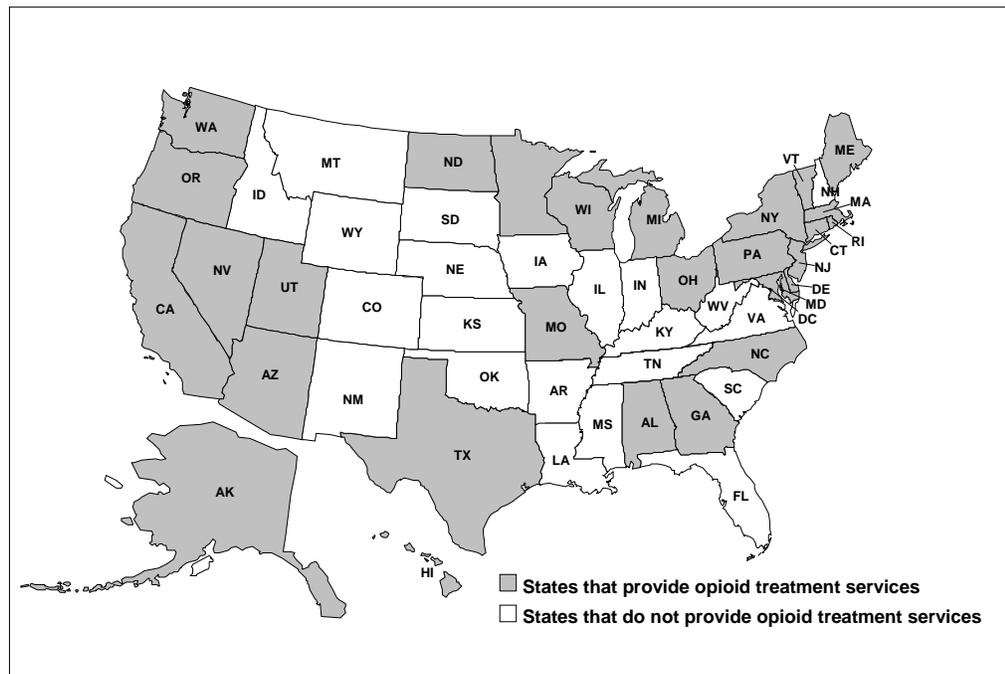


Figure 12. 27 Medicaid plans established an opioid treatment service.

Among the 51 Medicaid programs profiled, 28 (55 percent) covered opioid treatments as of July 2003 (Figure 12).

What Delivery Systems (Managed Care and Fee-for-Service) Do Medicaid Programs Use To Deliver Mental Health and Substance Abuse Services?

As previously discussed, States may deliver services, including mental health and substance abuse services, through a fee-for-service system or through one of four types of managed care. (These are defined in the section *Introduction to Medicaid*.)

1. Comprehensive Managed Care Organization (MCO)
2. Prepaid Inpatient Health Plan (PIHP)
3. Prepaid Ambulatory Health Plan (PAHP)
4. Primary Care Case Management (PCCM)

Agencies can (and in the study, almost all did) use more than one of these five types of delivery systems (the four managed care systems and fee-for-service). For example, some used an MCO to deliver care to people who qualified for Medicaid because they were part of a low-income family, and they delivered care to people who qualified because of age or disability through a fee-for-service system. Individual beneficiaries could also obtain care from more than one delivery system. For example, in Massachusetts, those beneficiaries who were enrolled in the PCCM program received their physical health care through that system but received their behavioral health services from a PIHP.

The issue of delivery systems is important because it can determine how behavioral health care is delivered to Medicaid beneficiaries. If a beneficiary is enrolled in an MCO that covers behavioral health care, that beneficiary may only obtain behavioral health services from providers authorized by the MCO to deliver that care. There may also be prior authorization requirements that are different from the fee-for-service system, and if permission is needed before obtaining a service, the beneficiary would need to get that permission from the MCO. In other words, it is the MCO that determines which providers the individual may use, and whether a service is medically (or therapeutically) necessary. However, States have established mechanisms that enrollees can use to appeal their health plan's decisions.

Finally, actions taken to promote physical health can have an effect on behavioral health, and vice versa, so it is important to coordinate both types of health care. Receipt of different services from different delivery systems can create barriers to coordination if providers belong to different systems and are unable to exchange information for patient confidentiality reasons. Although most States with this type of delivery system structure have taken steps to facilitate coordination across delivery systems (Kaye, 2001) the issue remains an important consideration in the delivery of behavioral health services.

Delivery Systems Used in Medicaid

As of July 1, 2003, 16 Medicaid agencies¹⁷ (31 percent of the 51 Medicaid agencies examined) delivered all behavioral health care through the fee-for-service system. Among these 16 agencies—

- Five (Alaska, Georgia, Mississippi, New Hampshire, and Wyoming) did not use a managed care system to deliver any services.
- Ten (Alabama, Arkansas, Indiana, Kansas, Kentucky, Louisiana, Maine, Montana, North Carolina, and West Virginia) used one or more managed care delivery systems but did not deliver any behavioral health services through managed care.

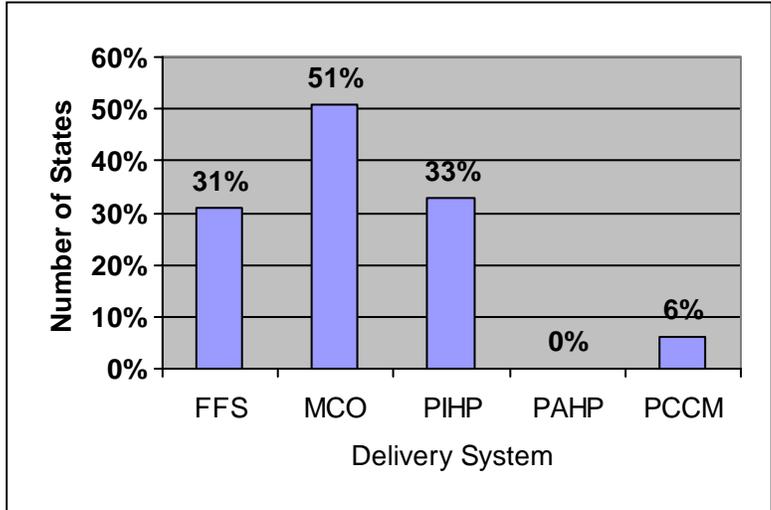


Figure 13. Medicaid often delivers behavioral health services through managed care.

- Nebraska used managed care to deliver physical health services and contracted with an “administrative services–only” contractor to manage the delivery of mental health and substance abuse services to all beneficiaries. While this contractor was not a managed care contractor, it served many of the same functions.

Thirty-four States and the District of Columbia (69 percent of Medicaid agencies) delivered some or all mental health or substance abuse services through a managed care delivery system. Among these 35 States (some used more than one system)—

- 26 States (51 percent of the 51 agencies) delivered some or all behavioral health services through comprehensive MCOs.
- 17 States (33 percent of 51) delivered behavioral health services through a PIHP. Most of these PIHPs delivered all mental health and substance abuse services, but in Hawaii and Texas the PIHP delivered only a limited set of mental health and substance abuse services.
- Three States (6 percent) (Idaho, South Dakota, and Vermont) required all or most beneficiaries who participated in the PCCM program to obtain their PCCM provider’s authorization for seeking mental health and/or substance abuse services.
- No States delivered any mental health or substance abuse benefits through a PAHP.
- Two States delivered few mental health and substance abuse services through managed care, while fee-for-service was the dominant delivery system for these services.
 - Florida used managed care to deliver mental health and substance abuse services in the Tampa area only (through a PIHP). All other mental health and substance abuse services in the State were available through fee-for-service.

- New Jersey excluded most mental health and substance abuse services from delivery through its MCO, and all other services were delivered through fee-for-service.

As noted above, the number of States using each type of delivery system totaled more than 35. This is because 12 States (Arizona, California, Delaware, Hawaii, Massachusetts, Michigan, Oregon, Texas, Utah, Vermont, Washington, and Wisconsin) used more than one managed care delivery system to deliver mental health or substance abuse services. In six of these States (Arizona, California, Delaware, Michigan, Oregon, and Washington), a comprehensive MCO delivered a limited set of mental health or substance abuse services, and a PIHP delivered the remaining Medicaid-covered behavioral health services. (In Oregon, all substance abuse services were covered by the MCO, while mental health services were excluded and covered by a PIHP.) However, the six remaining States (Hawaii, Massachusetts, Texas, Utah, Vermont, and Wisconsin) combined delivery systems in other ways. Two examples illustrate these arrangements.

- In Massachusetts, beneficiaries enrolled in the comprehensive MCO program received all mental health and substance abuse services from their MCO. Those enrolled in the PCCM program received all mental health and substance abuse services from the PIHP.
- In Utah, all beneficiaries (except some who only qualified for Medicaid under a §1115 waiver) were enrolled in a PIHP that delivered all mental health services. Most beneficiaries who lived in an urban area were required to join an MCO that delivered inpatient detoxification services. (Other substance abuse services were delivered through the fee-for-service system.)

that allowed under Medicaid. For example, instead of specifying mandatory and optional service categories, Federal law simply required SCHIP programs to provide coverage that met one of four possible benchmarks or that was approved by the Secretary of the Federal Department of Health and Human Services.

The remainder of this section examines policies in the 36 States with separate SCHIP programs (including separate programs in States that also operated a Medicaid expansion program). This discussion excludes Medicaid expansion SCHIP programs because, as previously mentioned, all the State-specific policies discussed in the previous section on Medicaid also apply to children enrolled in a SCHIP Medicaid expansion program. As a result, there is no need to repeat that information here.

The relationship between Medicaid and SCHIP is very close, even among those States with separate SCHIP programs. Federal law promotes this congruency. For example, SCHIP programs cannot serve children who qualify for the Medicaid program; however, other similarities have been created as State initiatives. For example, among the 36 States with separate SCHIP programs, 16 modeled their separate SCHIP program service package on Medicaid. Two of these offered a package that was a minor modification of the Medicaid package, and the remainder offered a package identical to Medicaid.

Who Can Participate in Separate SCHIP Programs?

States can cover all uninsured children with a family income up to 200 percent FPL. There are few classes of children that States are prohibited from covering. Most of these prohibitions were established to ensure that the new program (with its enhanced Federal funding) created new coverage for children and did not simply supplant existing State coverage. The groups of children States may not cover under SCHIP are—

- Children who qualify for the State’s Medicaid program
- Inmates of public institutions
- Patients in an institution for mental disease (IMD)
- Children of State employees who are eligible for the State employee benefit plan¹⁸
- Children who could be covered by a State program in operation prior to July 1, 1997, that received no Federal funds

As in Medicaid, there are mechanisms that allow States to cover additional people. For example, States have full flexibility to determine how they will calculate a family’s income.

- States may disregard specified amounts of income when calculating family income, such as all income between 200 and 250 percent FPL—effectively increasing the upper income limit to 250 percent FPL.
- States can use §1115 waivers in SCHIP; three States (Arizona, Minnesota, and New Jersey) have used §1115 waiver authority to expand separate SCHIP eligibility to include adult populations.

Because SCHIP excludes all children who qualify for the State’s Medicaid program, separate SCHIP programs commonly describe their eligibility floor as “those not eligible for Medicaid.” Further, when they provide specific information about the lower income limit for participating in SCHIP, they must use the same age ranges as their Medicaid program to show that SCHIP eligibility starts where Medicaid eligibility ends. For example, if a Medicaid program covers “all children under age 1 with family incomes up to 185 percent FPL,” the SCHIP program must describe eligibility for that group as “all children under age 1 with family incomes of 185 percent FPL up to....”

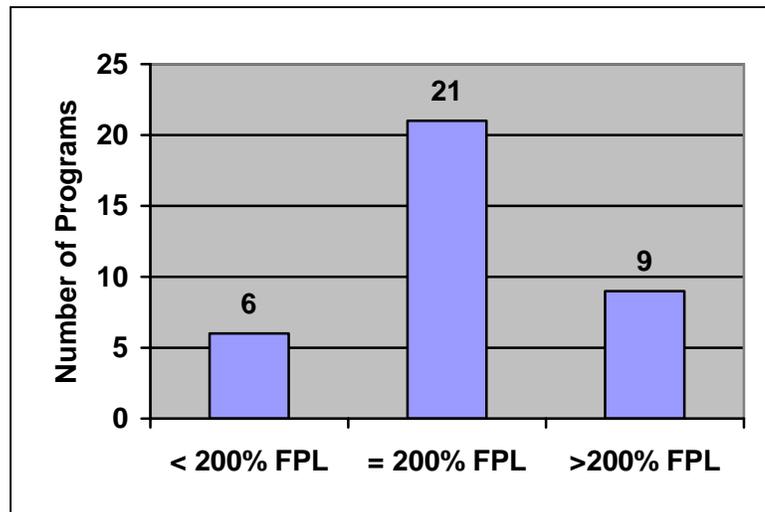


Figure 15. Most separate SCHIP programs had an upper income limit of 200 percent FPL.

SCHIP upper income limits, however, are most often set as a single limit for all age groups. Specifically, among the 36 States with separate SCHIP programs, only Delaware set different income limits for older and younger children—children through age 5 have an income limit of 200 percent FPL, while children ages 6–18 had a limit of 150 percent FPL. This limit was also often well above the highest optional Medicaid limit (Figure L). Wisconsin, meanwhile, required new enrollees to be in families with incomes less than 185 percent FPL, but allowed those with incomes up to 200 percent FPL to remain in the program. Among the 36 separate SCHIP programs—

- 21 programs had an upper income limit of 200 percent FPL for all children, and Delaware established that limit for children through age 5.
- Nine programs had an upper income limit higher than 200 percent FPL.
- Six States had an upper income limit of less than 200 percent FPL for all children, and Delaware had a limit lower than 200 percent FPL for children ages 6–18.

What Services Are Covered in Separate SCHIP Programs?

Federal minimum coverage requirements are expressed in SCHIP programs as coverage that meets a certain benchmark, not as a series of mandatory and optional services. Most separate SCHIP programs have established benchmark coverage that relates to commercial coverage

within the State. As a result, mental health and substance abuse coverage is often not described as specifically in separate SCHIP programs as it is in Medicaid. Table 9 in Appendix A is not intended to be definitive, but rather illustrative of broad categories of services that can be covered by SCHIP. Of the 36 States that have a separate SCHIP program—

- With minor variances, 16 States provided the mental health benefit that was available through Medicaid.
- 20 States provided a non-Medicaid benefit for separate SCHIP participants; all these programs covered both inpatient and outpatient mental health and substance abuse services. Most often, there was a single benefit limit towards which mental health and substance abuse services counted.

Concerning other services—

- Five States specifically mentioned coverage of opioid treatments, such as methadone maintenance and/or LAAM.
- Seven States covered residential services, such as those in a residential treatment facility (RTF), though one limited residential services to mental health conditions.
- Alabama and California had special services that were available to children with severe emotional disturbance, and Connecticut provided an expanded range of services to children with special needs.

Finally, among the States that had obtained a §1115 waiver that allowed them to enroll adults into their separate SCHIP program, two offered different benefit packages to children and adults. In both States, children received the full Medicaid mental health benefit; however—

In Oregon, adults eligible for SCHIP received no mental health benefit, while in Minnesota, the adult inpatient benefit was capped, and the outpatient benefit excluded most mental health services

What Delivery Systems Do States Use in Separate SCHIP Programs?

Unlike Medicaid, no federally defined terminology exists for the delivery systems used by separate SCHIP programs.¹⁹ However, as previously discussed, a number of separate SCHIP programs use their State’s Medicaid delivery system to also deliver SCHIP services. Therefore, this report uses the same delivery system typology to analyze separate SCHIP program data as used to analyze Medicaid delivery system data. These are—

1. Comprehensive MCO (or HMO)
2. Prepaid Inpatient Health Plan (PIHP)
3. Prepaid Ambulatory Health Plan (PAHP)
4. Primary Care Case Management (PCCM)

As for Medicaid programs, it is important to examine delivery system type because it affects how beneficiaries obtain care (and from whom they obtain it), as well as the ease of coordination between physical and behavioral health services.

Fee-for-Service and Managed Care Delivery Systems in Separate SCHIP Programs

As in Medicaid, most separate SCHIP programs delivered all or some behavioral health services through a managed care delivery system. Specifically, among the 36 separate SCHIP programs, 10 (28 percent) delivered behavioral health services only through a fee-for-service (FFS) system. Of the 12 State SCHIP programs—

- Seven States (Georgia, Mississippi, Montana, North Carolina, North Dakota, West Virginia, and Wyoming) did not deliver any services through managed care.
- Three States (Indiana, Kentucky, and Maine) delivered some services (usually physical health) through one or more managed care delivery systems, but did not deliver mental health or substance abuse services through a managed care system.

The 26 remaining separate State SCHIP programs delivered some or all behavioral health care through a managed care system. Specifically—

- 21 State SCHIP programs (58 percent) of the 36 programs delivered behavioral health care through comprehensive MCOs (HMOs).

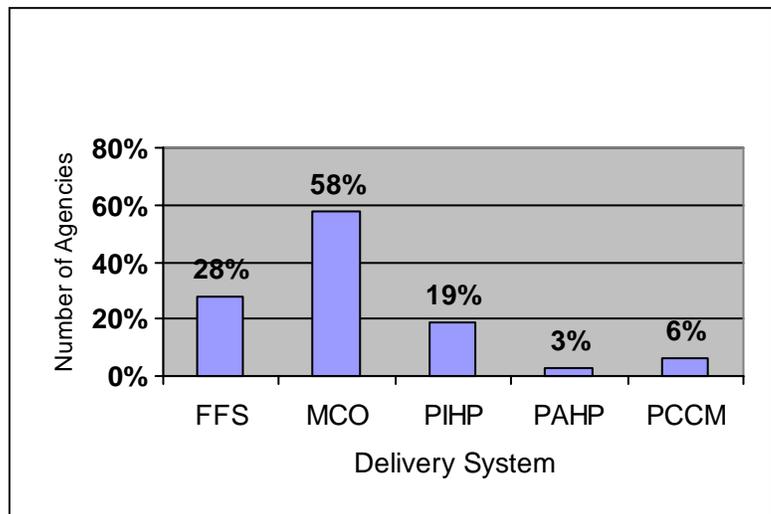


Figure 16. SCHIP programs usually delivered behavioral health through managed care (data as of July 1, 2003).

- Seven State SCHIP programs (19 percent) delivered behavioral health care through PIHPs.
- Alabama (3 percent) of the 36 State SCHIP programs delivered some outpatient behavioral health services through a capitated arrangement (PAHP).
- South Dakota and Vermont (6 percent) included behavioral health care within the PCCM provider's scope of authority.

Five States delivered behavioral health services through more than one delivery system. In three of these States (Delaware, Michigan and Washington), a comprehensive MCO delivered a limited set of mental health or substance abuse services, and a PIHP delivered the remaining Medicaid-covered behavioral health services.

Regarding the two other States—

- In California, comprehensive MCOs (HMOs) provided basic mental health services and medically necessary treatment of severe mental illness when there was no dual diagnosis of

severe emotional disturbance (SED) and either developmental disability or substance abuse disorder. However, if a child was thought to have SED, the child was referred to the county mental health department for an SED evaluation. If the mental health department determined that the child met SED criteria, it assumed responsibility for the provision of the treatment of SED condition(s) with the exception of the first 30 days of inpatient services per benefit year, which remained the responsibility of the MCO.

- In Massachusetts, beneficiaries enrolled in the comprehensive MCO program received all mental health and substance abuse services from their MCO. Those enrolled in the PCCM program received all mental health and substance abuse services from the PIHP. (This is the same delivery system as that used to deliver behavioral health services to Medicaid beneficiaries.)

VII. LIMITS ON MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN MEDICAID AND SCHIP

In both Medicaid²⁰ and SCHIP, States have established limits on the kinds and amounts of services that they cover. Like eligibility limits, service limits help States to manage costs of their health care programs in part by discouraging the use of more expensive services, and making less expensive preventive and anticipatory services more accessible. The service limits used by States come in a variety of forms, though they tend to follow common patterns and are based on a relatively small number of criteria.

Although the service limits in Medicaid and SCHIP collectively produce very different programs across States, there are relatively few criteria around which limits are likely to be different. These include age, number of units of service, locus of care, type of service, and kind of diagnosis. In Medicaid, for example, services often differ on the two ages of 21 and 65. The former is the upper age limit for children identified through EPSDT, and the latter is the minimum age at which individuals are eligible for Medicare. In either case, when used in conjunction with the other types of limits, they collectively express State funding priorities concerning those who should receive services and the kinds of services they are entitled to.

The different choices States make about limits contribute to the wide variety of packages available throughout the country. This general discussion of limits applies to both Medicaid and SCHIP programs and to both the inpatient and outpatient services available through each program. The discussion of limits in Medicaid programs begins below.

How Are Medicaid Services Limited?

There are generally three categories of restrictions that Federal regulations place on the application of State limits:

1. Those concerning “amount, duration, and scope”
2. “Comparability”
3. “Statewideness”

For a more detailed discussion of how Federal regulations constrain State limits in Medicaid, see Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*.

Discussion here will address the most pertinent Federal guidelines concerning service limits used by State Medicaid plans. These regulations stipulate that services must be adequate in “amount, duration, and scope” to achieve their intended purpose. Within these constraints, for example, States have limited the number of inpatient hospital stays or the number of yearly outpatient physician visits. The lone exception to this rule is EPSDT services to children under 21 where the scope of services available includes all those necessary to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screen.” EPSDT services will be discussed further below.

One of the more common limits used by State Medicaid programs is more akin to a check on the delivery of services. As mentioned earlier, Medicaid, unlike SCHIP, is an entitlement program, meaning that the State is obligated to pay for services as specified in its approved State plan for all covered individuals. Because States are prohibited from denying coverage of legitimate services, yet desirous of constraining unnecessary access to some services, many have introduced systems to preapprove or preauthorize services beyond a certain level. More of a management tool than a strict limit, prior authorization²¹ allows States to retain ultimate authority on the appropriateness of some kinds of care.

Concerning mental health services, many States have an explicit exemption from prior authorization for certain diagnoses, such as those that qualify an individual as having a serious mental illness, or a serious and persistent mental illness. Limits such as this allow individuals with serious mental illnesses to continue to receive the services they need, while helping to limit access services to those for whom they may not be appropriate.

It is important to note that unless granted a waiver, States are prohibited by Federal statute from providing services to individuals in an institution for mental disease, or IMD. Known as the IMD exclusion, this provision was originally intended to indemnify the Federal government from providing Medicaid coverage to individuals with mental illness receiving long-term, inpatient services in

An institution for mental disease, or IMD, is defined as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”

psychiatric hospitals—services that were already fully funded by States and counties when Medicaid was created. While States may cover individuals in inpatient settings to stabilize their condition caused by a mental illness or for substance abuse detoxification, IMDs are facilities that are geared towards the long-term care and maintenance of individuals with mental illness (Rosenbaum, et al., 2002).

Some populations are not bound by the IMD exclusion. These include children under age 22 who may be covered as an optional category (see section on Optional Groups), and adults over age 65. States are required to cover those children identified through an EPSDT screen (see below).

Limits on Inpatient Services in Medicaid

As noted above, limits come in a variety of forms, and they commonly concern locus of care, units of care, diagnosis requirements, kinds of services, and the use of prior authorization or preapproval. For most inpatient services for mental health issues, States differentiate between acute or emergency services and other kinds of inpatient care. Wyoming, for example, goes even further and notes that—

To qualify as an acute care admission, the beneficiary must have one or more of the following conditions: suicide attempt, homicidal threats, or other assaultive behavior indicating a threat to others, gross dysfunction, and/or child exhibiting bizarre or psychotic behaviors that cannot be contained or treated in an outpatient setting.

Inpatient limits in most States can be exceeded under certain circumstances that include diagnosis, approval of the Medicaid agency and/or its agent, or pending reporting by the attending physician.

Inpatient Length of Stay

Eighteen (35 percent) of 51 States provided an explicit limit on adult inpatient days for mental health problems in an acute care facility (either a mental health ward of a general hospital or a designated psychiatric hospital), with most limits in the 20–30 day range per year.

- Nevada established the fewest number of inpatient mental health days—at 5 days.
- The highest number of inpatient mental health days was available in Maine and Massachusetts; in Massachusetts, the limit was per member per year (30 days per admission, 60 days per year) and was only available for adults in an institute for mental disease.
- 21 (41 percent) of 51 States specifically mentioned coverage of or coverage limits for inpatient substance abuse services.
- 8 (47 percent) of the 17 States that specifically covered substance abuse services merely noted that the established coverage limits referred to both inpatient mental health and substance abuse services.
- 9 (18 percent) of 51 States only covered detoxification services in an inpatient setting. These had a variety of limits, including the location—typically requiring services in a general hospital or an acute hospital—and number of days.

Prior Authorization or Preapproval

A handful of States required some kind of prior authorization, concurrent review, and/or authorization by the attending physician. Many States that required prior authorization for emergency care allowed approval to be granted retroactively.

Limits on Outpatient Medicaid Services

The research revealed that outpatient mental health and substance abuse services covered a wide range of services. The limits discussed in this section are those that were compiled from every State plan category except those concerning the mandatory category “Inpatient Hospital Services,” and the optional category “Inpatient Psychiatric Services (for persons under age 22).”

It is important to note that the information contained in Table 5 and discussed in this section is not exhaustive in the description of limits.

At times, States described in greater detail the kinds of services that were limited or only provided to a constrained target population. For example, Colorado covered some substance abuse services but only for pregnant women at risk of poor birth outcomes, and only in agency-approved programs. Including this level of detail on a program-by-program, State-by-State basis would produce an unwieldy document and make it difficult to extract generalizations on service limits. Accordingly, the tables and the descriptive passages included in this section are merely intended to provide examples and elucidate common themes about limits on outpatient mental health and substance abuse services in Medicaid. The individual profiles prepared for each State detail these and other limits imposed by States.

In most cases, States provided a single limit for mental health and substance abuse office visits. Those States that identified limits almost always covered additional visits with prior authorization.

Common limits—

- Many States limited the number of visits, while others limited the number of hours.
- Most States used the time period of a year—either fiscal or calendar—over which a defined limit of benefits could be used; for example, California covered no more than eight visits in a 120-day period; Pennsylvania covered 7 hours in 30 consecutive days.
- The two services that were most often given separate limits were evaluation and/or assessment and medication management.²²

Substance abuse services also varied by service, such as—

- Detoxification
- Opioid treatment such as LAAM or methadone maintenance

Only a few States, such as Alaska, provided limits on substance abuse office visits that were different from other mental health concerns. Again, it is important to note that the information concerning substance abuse services is only intended to illustrate limits specifically mentioned in State profiles.

How Are Separate SCHIP Program Services Limited?

As noted in the introductory section on SCHIP, States choosing to operate separate SCHIP programs must provide coverage that is based on a benchmark benefit package or approved by the Secretary of DHHS. Accordingly, the limits in State SCHIP programs tend to mirror those in other health insurance programs in their States.

In general, service limits in SCHIP programs tend to be simpler than those found in Medicaid programs. In part, this is because of the different nature of each program: whereas Medicaid is an

entitlement program obligating States to pay for care for all enrolled and eligible individuals, separate SCHIP programs are allowed to be both more selective and more restrictive.

Operating more like private insurance, separate SCHIP programs have much more flexibility than Medicaid programs. For example, they are not obligated to cover all individuals meeting the eligibility requirements, but they can limit enrollment to a specific number. Separate SCHIP programs are under no obligation to provide coverage beyond the limits specified in their coverage packages. Often separate SCHIP programs will require enrollment in an MCO with no option to move into a fee-for-service delivery system. Medicaid, meanwhile, must abide by the “amount, duration, and scope” requirement, which effectively requires the use of limits that can be exceeded under certain circumstances.

Many of the limits common in Medicaid are also found in separate SCHIP programs. These include, among others, limits that vary by diagnosis, units of services, and locus of care. Some States offer different plans with different service limits to beneficiaries. In some cases, such as Iowa, the limit differences were based on a beneficiary’s choice of MCO. Connecticut, meanwhile, had a more generous benefit for children with special needs.

Finally, as noted in a previous section, SCHIP programs have the option of charging premiums and copays. Although not a strict service limit, copays make the acquisition of services more burdensome to beneficiaries. In this way, they serve a function that is analogous to prior authorization in Medicaid.

The limits reported in this section concern those found in Table 9.

- 16 (44 percent) of the 36 States with separate SCHIP programs chose to offer the same benefit package in their separate SCHIP as was available in Medicaid.
 - Oregon’s §1115 waiver allowed the provision of Medicaid benefits to adults with the exception of mental health and substance abuse services.
 - Minnesota, which otherwise provided Medicaid coverage, covered mothers of unborn children for prenatal care only. Minnesota also limited its coverage of SCHIP §1115 waiver participants to an annual expenditure of \$10,000.
- 6 (30 percent) of the 20 States with separate SCHIP programs that did not offer the Medicaid benefit package combined limits for both mental health and substance abuse services; for example, the State expressed the limit as “10 inpatient days for treatment of mental health and/or substance abuse conditions.” Pennsylvania and Connecticut were special cases:
 - Pennsylvania used the same limits for both but provided a specific limit on inpatient detoxification services.
 - Connecticut provided a combined benefit for mental health and substance abuse inpatient services for children with special needs, but otherwise had separate mental health and substance abuse limits.

Inpatient Mental Health Limits in Separate SCHIP Programs

- 16 (80 percent) of the 20 States with separate SCHIP benefits that were different from Medicaid benefits limited the number of inpatient days that were covered. The most common limit was 30 days.
 - Two States—Iowa (for one of their MCO plans) and North Dakota—provided 60 days for mental health services alone.
 - Pennsylvania provided up to 90 inpatient days, but these were split between mental health and substance abuse admissions.
 - Wyoming’s 21-day limit on inpatient services could be exceeded but only for children with a diagnosis of one of the five most severe mental illnesses or autism.
- 4 (25 percent) of the 16 States with limits on inpatient days allowed them to be converted into outpatient services. The most common conversion rate was 1 inpatient day for two outpatient visits.
- 4 (20 percent) of the 20 States with separate SCHIP benefits that were different from Medicaid required some other form of oversight, such as prior authorization or a requirement of medical necessity.

Inpatient Substance Abuse Limits in Separate SCHIP programs

It is slightly more difficult to generalize about the kinds of inpatient service limits on substance abuse services because services tended to be broken out even further than those for mental health. For example, limits for inpatient substance abuse services often differentiated between detoxification, acute hospital stay, and stays in a residential treatment facility (RTF). Of those States that specified a limit, the largest number of any kind of substance abuse inpatient stay was the 90 days per year provided by Pennsylvania—which, as mentioned above, had to be shared with inpatient mental health stays. Alternatively, Virginia also provided a 90-day limit, but this was a lifetime benefit.

Two States—Iowa (through one of its MCOs) and Mississippi—provided a dollar amount cap on inpatient substance abuse services.

Outpatient Mental Health Limits in Separate SCHIP programs

Much like inpatient mental health limits, those on outpatient services commonly concerned the number of visits. As noted above, 16 States provided coverage limits that were the same or similar to Medicaid. Two waiver States (Oregon and Minnesota) are also included here as the Medicaid limits were mostly applicable to their separate SCHIP programs. Oregon did not cover substance abuse services for adults but otherwise used the Medicaid limits. Minnesota provided the Medicaid limits in its separate SCHIP program with three additions: SCHIP funding was used to cover only prenatal care for pregnant women and some mental health services for homeless children and children in the court system.

- 9 (45 percent) of the 20 States providing a benefit different from the Medicaid benefit provided a single benefit that applied to both mental health and substance abuse services in their separate SCHIP programs.
 - Pennsylvania, which used a blended model, limited services to 50 outpatient visits that must be shared among mental health and substance abuse services; however, substance abuse services could not exceed 30 visits per year. Pennsylvania also established a lifetime maximum of 120 days for substance abuse.
 - Connecticut, which otherwise provided different coverage limits for mental health and substance abuse services, had a combined benefit for children with special needs.
- 17 (85 percent) of 20 States providing a benefit different from Medicaid established limits on the number of outpatient visits in their separate SCHIP programs.
 - The highest number of visits—60 visits—were allowed by Mississippi, New York, and North Carolina.
 - The fewest visits—20 visits—were allowed by six States.
- North Carolina and Utah both allowed inpatient days to be exchanged for outpatient services.
- California, Colorado, Kansas, Utah, and Wyoming all had diagnostic criteria for limits and some specific services.

Outpatient Substance Abuse Services in Separate SCHIP Programs

As in Medicaid, the limits on substance abuse services in separate SCHIP programs is slightly different from those for mental health. Covered or excluded services were rarely given much detail. Methadone maintenance and/or LAAM, mentioned by Florida and Kansas, were the only specific substance abuse services that were excluded by any State. Most commonly, when detoxification services were mentioned, they were exempt from limits.

Eleven States provided a substance abuse benefit different from that for mental health. Of these programs, 16 separate SCHIP programs described a specific limit on the number of outpatient services that could be received. Alabama, California, and Colorado each provided 20 outpatient visits per year, while Connecticut and New York each provided up to 60. Instead of a visit limit, Iowa, Mississippi, Montana, and Wyoming all provides a dollar limit on substance abuse services covered by their separate SCHIP programs. Kansas allowed outpatient days to be exchanged for inpatient days.

VIII. WAIVERS

As discussed in the introduction, Medicaid and SCHIP programs can make use of three types of waivers to establish programs that deviate from standard Medicaid rules: §1915(c) home- and community-based service program waivers; §1915(b) freedom-of-choice waivers; and §1115 Research and Demonstration Waivers.²³

Section 1915(c) Home- and community-based service program waivers are used to operate home- and community-based services programs for beneficiaries who qualify for long-term care services. All States now operate one or more of these waivers but only four reported operating a program specifically targeted to beneficiaries with mental health needs: Colorado, Kansas, New York, and Vermont.

Section 1915(b) freedom-of-choice waivers can be used primarily to require beneficiaries to enroll in managed care programs that do not meet §1931 requirements. As previously reported, 35 States and the District of Columbia delivered some or all mental health or substance abuse services through a managed care delivery system. Almost half (17 of 35) of these agencies operated one or more managed care programs under a §1915(b) waiver (CMS, June 2003).

Section 1115 research and demonstration waivers can be used to waive almost any Federal Medicaid or SCHIP law. For example, a State may—

- Offer a benefit package with services it could not otherwise offer.
- Exclude services that it must otherwise offer.
- Cover groups of people it could not otherwise cover.
- Exclude groups it would otherwise be required to cover.

The Federal *Health Insurance Flexibility and Accountability (HIFA) Initiative* provides for an expedited review of §1115 waivers that expand coverage, are Statewide, and coordinate with private sector coverage.

The study indicated that there were 31 States using §1115 waivers. Seventeen States had just one waiver that affected the delivery of mental health and substance abuse services, while five States had two §1115 waivers. New Jersey's waiver was still active, but the State had stopped accepting new applicants in June 2002. New Mexico was granted a waiver, but as of July 2003, the State had not implemented a program. Among the 31 States with §1115 waivers—

- Twenty-six (84 percent) had waivers that expanded the eligible population.
- Nine (30 percent) had waivers that did not affect the delivery of mental health or substance abuse services.
- Five (16 percent) had waivers that required enrollment in managed care.
- Four (13 percent) had waivers that both required enrollment in managed care and expanded the eligible population.

IX. CONCLUSIONS

Given the variety of health care services that are available through Medicaid and the State Child Health Insurance Program (SCHIP), details of mental health and substance abuse services can be subsumed in generalized discussions of specialty care. However, behavioral health services and information on their delivery are vitally important to States.

This report examines approved State Medicaid and SCHIP plans as of July 2003 to identify important comparative information on the design and delivery of behavioral health services. The 50 States and the District of Columbia had used all the flexibility available within Medicaid and SCHIP to align eligibility and service standards to reflect their priorities. Consequently, no two State Medicaid plans were the same. But within these sometimes substantial differences, evidence can be found that States were engaging many similar activities that nonetheless produced disparate outcomes.

Among these activities, States—

- Used many optional State plan categories to define behavioral health services in Medicaid
- Used common criteria—such as units of service, prior approval, and diagnosis—to promote and limit access to services for various categories of individuals
- Authorized the same or similar services in Medicaid through multiple pathways made available through State plan categories
- Made care available through combinations of managed care and fee-for-service delivery systems
- Used Federal flexibility to increase access to Medicaid and SCHIP for families and individuals with disabilities

GLOSSARY

ABD	Aged, blind, and disabled
BBA	Balanced Budget Act
CASAC	Certified alcohol and substance abuse counselor
CMO	Care management organization
CMS	Centers for Medicare & Medicaid Services
EPSDT	Early periodic screening, diagnosis, and treatment
FPL	Federal poverty level
HCBO	Home- and community-based organization (waiver)
HIFA	Health Insurance Flexibility and Accountability
IMD	Institution for mental disease
LAAM	Levo-alpha-acetyl-methadol, a synthetic opioid used for opiate addiction
MCO	Managed care organization
Medicaid	State-run programs that help many people who cannot afford medical care pay for some or all of their medical bills
NASHP	National Academy for State Health Policy
PAHP	Prepaid ambulatory health plan
PCCM	Primary care case management
PIHP	Prepaid inpatient health plan
RTF	Residential treatment facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SED	Severe emotional disturbance
SSI	Social Security income

SSP

State Supplemental Payment

REFERENCES

- Buck, J.A., et al. (2003, September). Mental health and substance abuse services in Ten State Medicaid programs. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMSHA), National Mental Health Information Center. Retrieved January 19, 2005, from <http://mentalhealth.samhsa.gov/cmhs/ManagedCare/Resource/Articles/medicaidprograms.asp>
- CMS (Centers for Medicare & Medicaid Services). (2004, January 8). Health care spending reaches \$1.6 trillion in 2002. Retrieved January 19, 2005, from www.cms.hhs.gov/media/press/release.asp?Counter=935
- CMS (Centers for Medicare & Medicaid Services). (2004) *2003 Medicaid managed care enrollment report*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/managedcare/mmcss03.asp
- CMS (Centers for Medicare & Medicaid Services). (2003, June 30). *Breakout of managed care entities by State*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/managedcare/mctype03.pdf
- CMS (Centers for Medicare & Medicaid Services). *2003 SSI FBR, Resource limits, 300% cap, break-even points, spousal impoverishment standards*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/eligibility/ssi0103.asp
- CMS (Centers for Medicare & Medicaid Services). *Work incentives eligibility groups*. Retrieved January 19, 2005, www.cms.hhs.gov/twwiia/Statemap
- CMS (Centers for Medicare & Medicaid Services). (2003, November). *Medicaid eligibility*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/eligibility/criteria.asp
- CMS (Centers for Medicare & Medicaid Services). *National summary of state Medicaid managed care programs: Program descriptions as of June 30, 2003*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/managedcare/mmcons603.asp
- CMS (Centers for Medicare & Medicaid Services). *State Children's Health Insurance Program approved plan files*. Retrieved January 19, 2005, from www.cms.hhs.gov/schip/chpa-map.asp
- CMS (Centers for Medicare & Medicaid Services). *State Medicaid plan search application*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/Stateplans/map.asp
- CMS (Centers for Medicare & Medicaid Services). *State waiver programs and demonstrations*. Retrieved January 19, 2005, from www.cms.hhs.gov/medicaid/waivers/waivermap.asp

Henry J. Kaiser Family Foundation. (2004, July). www.statehealthfacts.kff.org/

Henry J. Kaiser Family Foundation Kaiser. Medicaid Resource Book. Retrieved January 19, 2005, from www.kff.org/medicaid/2236-index.cfm

Kaye, N. (2001) *Medicaid managed care: A guide for States, 5th edition*. Portland: ME: National Academy for State Health Policy (48).

Mark, T. L., et al. Spending on mental health and substance abuse treatment, 1987–1997. *Health Affairs*. (19(4), pp.108–120).

National Academy for State Health Policy (NASHP). (2003, July). Income eligibility levels for children in Medicaid and SCHIP and cost sharing. Retrieved from, www.nashp.org/Files/Eligibility_and_cost_sharing_chart_July_2003_f.PDF

Pernice, C., et al. (2001, July). *Charting SCHIP: Report of the second national survey of the State Children's Health Insurance Program*. Portland, ME: National Academy for State Health Policy.

Rosenbaum, S., Teitelbaum, J., Mauery, D.R. (2002, December) *An analysis of the Medicaid IMD exclusion* (9). Washington, DC: Center for Health Services Research and Policy, George Washington University School of Public Health and Health Services.

Medicaid Web Sites

Alabama Medicaid Agency, www.medicaid.State.al.us

Alaska Health and Social Services, www.hss.State.ak.us

Arizona Health Care Cost Containment System, www.ahcccs.State.az.us

Arkansas Medicaid, www.medicaid.State.ar.us/

California Medi-Cal, <http://files.medi-cal.ca.gov>

Colorado Medical Assistance Program Information Center, www.chcpf.State.co.us

Connecticut Department of Social Services, www.dss.State.ct.us/svcs/medical/index.htm

Delaware Health and Social Services, www.State.de.us/dhss/dss/medicaid.html

District of Columbia Department of Health, http://dchealth.dc.gov/information/maa_outline.shtm

Florida Agency for Health Care Administration, www.fdhc.State.fl.us

Georgia Department of Community Health, www.communityhealth.State.ga.us/

Hawaii State Med-Quest, www.med-quest.us

Idaho Department of Health & Welfare, www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3348/DesktopDefault.aspx

Illinois Department of Public Assistance, www.dpaininois.com/medical/medicaid.html

Indiana Family and Social Services Administration, www.State.in.us/fssa/servicedisabl/medicaid/index.html

Iowa Department of Human Services, www.dhs.State.ia.us/MedicalServices/MedicalServices.asp

Kansas Department of Social and Rehabilitation Services, www.srskansas.org/services/HCP_index.htm

Kentucky Department for Medicaid Services, www.chfs.ky.gov/dms/

Louisiana Medicaid, Bureau of Health Services Financing, www.dhh.State.la.us/offices/?ID=92

Maine Bureau of Medical Services, www.maine.gov/bms/

Maryland Specialty Mental Health Services, www.dhmmh.State.md.us/mma/smhs/

Massachusetts Health and Human Services, www.mass.gov/portal/index.jsp?pageID=eohhs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2

Michigan Department of Community Health, www.mdch.State.mi.us/msa/mdch_msa/msahome.HTM

Minnesota Department of Human Services, www.dhs.State.mn.us/main/groups/healthcare/documents/pub/DHS_id_006254.hcsp

Mississippi Division of Medicaid, www.dom.State.ms.us/

Missouri Department of Social Services, <http://www.dss.State.mo.us/dms/>

Montana Medicaid, www.dphhs.State.mt.us/hpsd/medicaid/index.htm

Nebraska Health and Human Services, www.hhs.State.ne.us/med/medindex.htm

Nevada Division of Health Care Financing & Policy, <http://dhcftp.State.nv.us/>

New Hampshire Department of Health & Human Services, www.dhhs.State.nh.us/DHHS/MEDICAIDPROGRAM/default.htm

New Jersey Department of Human Services, www.state.nj.us/humanservices/dmahs/dhsmed.html

New Mexico Human Services Department, www.State.nm.us/hsd/mad/Index.html

New York State Department of Health, www.health.State.ny.us/health_care/medicaid/index.htm

North Carolina Division of Medical Assistance, www.dhhs.State.nc.us/dma/

North Dakota Department of Human Services, www.State.nd.us/humanservices/services/medicalserv/medicaid/

Ohio Medicaid, <http://jfs.ohio.gov/ohp/>

Oklahoma Health Care Authority, www.ohca.State.ok.us/

Oregon Department of Human Services, www.dhs.State.or.us/

Pennsylvania Department of Public Welfare, www.dpw.State.pa.us/omap/dpwomap.asp

Rhode Island Department of Human Services, www.dhs.State.ri.us/dhs/dheacre.htm

South Carolina Department of Health and Human Services, www.dhhs.State.sc.us/Default.htm

South Dakota Department of Social Services, www.State.sd.us/social/medical/index.htm

Tennessee, www.State.tn.us/tenncare/

Texas Health and Human Services Commission, www.hhsc.State.tx.us/medicaid/

Utah Medicaid Program, <http://hlunix.hl.State.ut.us/medicaid/>

Vermont Health Access, www.ovha.State.vt.us/

Virginia Department of Medical Assistance Services, www.dmas.virginia.gov/

Washington State Department of Social & Health Services, <http://fortress.wa.gov/dshs/maa/>

West Virginia Bureau for Medical Services, www.wvdhhr.org/bms/

Wisconsin Medicaid, www.dhfs.State.wi.us/medicaid/

Wyoming Medicaid, <http://wyequalitycare.acs-inc.com/>

ENDNOTES

¹ Within this document, use of the word “State” refers to the 50 States and the District of Columbia.

² Information in this report about Medicaid and SCHIP is current as of the time of writing.

³ Because Medicaid coverage rules have grown over time, many of these groups overlap or have been subsumed into another group.

⁴ Because States always cover children from families with higher income limits than provided for under §1931, the remainder of this report describes this group as “parents.”

⁵ SSI is a federally administered cash payment to individuals meeting Federal definitions of aged, blind, or disabled and who have incomes and resources below federally established limits. In CY 2003, those limits were monthly income, \$552/individual, \$829/couple; assets, \$2,000/individual, \$3,000/couple. Source: CMS, *2003 SSI FBR, Resource Limits, 300% Cap, Break-Even Points, Spousal Impoverishment Standards*, www.cms.hhs.gov/medicaid/eligibility/ssi0103.asp.

⁶ Prior authorization is an administrative check on the delivery of services that allows States to ensure that services are necessary for the diagnosis and appropriate in duration.

⁷ The following definitions are based on those found in the *CMS 2003 Medicaid Managed Care Enrollment Report*.

⁸ 1903(m)(2)(a) of the Act defines a comprehensive contract as one covering inpatient hospital services and any of the following services, or any three or more of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) FQHC services; (4) other laboratory and X-ray services; (5) nursing facility services; (6) EPSDT services; (7) family planning; services; (8) physician services; or (9) home health services.

⁹ Budget neutral means that no more Federal Medicaid funds may be spent under the waiver than would have been spent without the waiver.

¹⁰ State supplemental payments are payments that States make to ABD populations to supplement Federal SSI cash payments. These payments are 100 percent State-funded, and States are not required to have a supplemental program. If they operate a supplemental program, they are not required to provide Medicaid to that group.

¹¹ A number of States identify “detoxification” as the only substance abuse service they cover for adults. However, Federal EPSDT regulations require full coverage for children when a substance abuse need is identified in an EPSDT screen.

¹² The profiles were prepared mainly from information contained in each State’s Medicaid plan, but State Web sites were also checked for additional information about people covered and services provided. The amount of information available from this second data source varied widely. Some State Web sites contained only basic information about their Medicaid programs, while others included detailed documents such as provider manuals.

¹³ The Ages and Stages Questionnaire: Social-Emotional is a screening tool that helps to identify concerns in the social and emotional development of children.

¹⁴ The 11 States that do not cover inpatient hospitalization for substance abuse are Arkansas, California, and the District.

¹⁵ Wyoming and New Mexico cover this service as a specific EPSDT service instead of through the optional Medicaid service category that allows coverage of these services for children.

¹⁶ Decomensation describes the process whereby an individual with a mental illness moves from psychiatric stability to psychiatric instability.

¹⁷ This number increased to 17 on December 31, 2003, when Oklahoma ended its comprehensive MCO program. This State still uses a PAHP, but the PAHP delivers only primary care services.

¹⁸ At the time SCHIP was created, Mississippi and North Carolina contributed less than a nominal amount (defined as \$10 per month) to the coverage of dependents of State employees. As a result, they are the only two States that are allowed to enroll dependents of State employees who are eligible for the State benefit plan in their SCHIP programs.

¹⁹ SCHIP programs that are expansions of Medicaid use the same delivery systems as the Medicaid program.

²⁰ Medicaid here is inclusive of Medicaid Expansion SCHIP programs, which are required to follow the same limits as Medicaid.

²¹ For simplification, the term “prior authorization” used throughout this document is inclusive of prior authorization and preapproval.

²² Evaluation and/or treatment concerns visits where the primary activity is the measurement of the kind and degree of illness; medication management concerns people with mental illness in particular. Many medications, particularly those for people with serious mental illness, require a careful fine-tuning to maximize efficacy and minimize side effects. Often these visits are less intensive and more perfunctory than full clinic visits, so States may provide a lower reimbursement rate for medication management than for a full clinic visit. Similarly, so that visits for the express purpose of managing medications do not count against the overall limit for outpatient visits, States established a different category for medication management.

²³ See section III for a more detailed discussion of Federal policies governing the use of waivers.