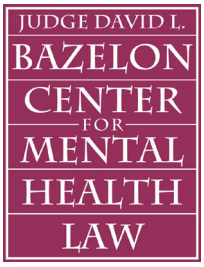
Following the Rules

A Report on Federal Rules and State Actions to Cover Community Mental Health Services under Medicaid

BAZELON CENTER FOR MENTAL HEALTH LAW
1101 Fifteenth Street NW, Suite 1212, Washington DC 20005
202.467.5730 www.bazelon.org



Following the Rules was written by Chris Koyanagi, policy director for the Bazelon Center, with assistance by deputy policy director Elaine Alfano and policy intern Lee Stein, and designed by publications director Lee Carty. Its development was supported in part by the UPENN Collaborative on Community Integration of Individuals with Psychiatric Disabilities (www.upennrrtc.org) The report is available for download at www.bazelon.org/pdf/followingrules.pdf

Following the Rules

A Report on Federal Rules and State Actions to Cover Community Mental Health Services under Medicaid

Introduction

Medicaid is the single most important funding stream for the community mental health services of public mental health systems. Understanding how the program can be used to support a range of community services that aid people in their recovery is therefore critical.

Over the past 15 to 20 years, state and local mental health systems have actively pursued policies to cover public-sector community mental health services under Medicaid.[1] As a result, services that were previously 100 percent state-funded are now jointly funded by the federal and state governments through Medicaid. This is an effective state strategy because Medicaid pays for a broad array of services and covers low-income populations and people with disabilities—groups that often rely on public-sector services.

Medicaid state plans have therefore become the blueprint for the financing of community mental health services through the public mental health system.

Federal policy on Medicaid is set by the law and by the regulations and policy memos issued by the Centers for Medicare and Medicaid Services (CMS), which administers the program. The most recent amendments to the law were made by the Deficit Reduction Act (DRA) of 2005 (PL 109-171). The DRA made a number of changes to Medicaid, giving states greater flexibility in some areas, but also limiting when states may, or may not, use Medicaid targeted case management for children in the foster care system.

In 2007, CMS issued two important regulations: an Interim Final Rule on targeted case management and a proposed regulation defining rehabilitation services. States began to change their programs to accommodate the new policies. However, the two rules were controversial and in mid-2008 Congress halted their implementation. The moratorium runs until April 2009 and effectively returns federal Medicaid policy to that in place in 2006, immediately following enactment of the DRA.

This report presents a summary of federal Medicaid policy as of November 2008 with respect to community mental health services

covered under the Clinic, Rehabilitation and Home and Community Based Services (Section 1915(i)) categories of the law. It also presents the results of a review of official state Medicaid policies with respect to these service categories. The report focuses on community-based services and does not discuss institutional services, such as services of hospitals, residential treatment centers for children, group homes or other congregate-care settings.

The summary is based on official policy documents (the law, regulations that are in effect and various policy memoranda from CMS). Policies were confirmed in personal communication with agency staff. States or advocates with questions about the details of Medicaid coverage should check with CMS regional offices or with the CMS central office in Baltimore to obtain up-to-date information.

Overview of Medicaid

Medicaid is a joint federal-state program that provides health care coverage for low-income people. Approximately 50 million people are covered by Medicaid and many of them are children or adults with serious mental disorders. In fiscal year 2008, the federal government contributed $207 billion toward the costs of Medicaid; other funds came from the states that must provide matching funds (in a few states, localities supply the match). Match funds are based on a formula linked to per capita state income and state rates vary from 50 to 78 percent of the cost of a service.

Federal Medicaid law provides broad national guidelines on eligibility and definitions of covered services. It establishes the basic rules for the program that all states must follow, though states have considerable flexibility. States set the rules for day-to-day operation of the program as they design the specifics of the benefit package, determine which groups of potentially eligible individuals will qualify, who may furnish services and what rates providers will be paid.

Medicaid covers children and groups of low-income parents based on family income; individuals with disabilities and the elderly must meet both financial and other criteria. The array of services covered is broad and more extensive than the benefit packages in a typical insurance plan. Medicaid provides significant coverage of long-term services, such as nursing home care, and specialized services, such as intensive community mental health services, for adults and children who have disabilities or chronic illnesses.

All those eligible for Medicaid in a particular state have an entitlement to the services listed in the state's Medicaid plan. This plan must be submitted to and approved by CMS. The range of mental health services covered for adults largely depends on decisions made by the state as to services to include in its state plan. That is because most of the important

community mental health services are covered only at state option. Of the services mandated by federal law, only inpatient care in a general or community hospital, outpatient hospital services and physician services are relevant for mental health care.

Children, on the other hand, have an entitlement to more than just the services in the state plan. Children are entitled to all services listed in Medicaid law, including those that are optional for adults. Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate, children on Medicaid are entitled to any federally authorized Medicaid service. All states must screen Medicaid-eligible children periodically, diagnose any conditions found through a screen and furnish appropriate, medically necessary treatment to "correct or ameliorate deficits and physical and mental illness and conditions discovered by the screening services."

Medicaid law generally does not permit discrimination by diagnosis, unless the state has special rules. This means mental health services must be covered to the same degree as equivalent health services. All individuals who meet the eligibility criteria and need a particular service covered in the state plan are entitled to receive it (in Medicaid parlance, this is known as "comparability"). Generally, services must also be covered statewide and cannot be limited to a specific geographic area.

States also have options with regard to eligibility rules. Certain groups of people must be covered (the mandatory-eligibility groups). However, states may also include additional optional-eligibility groups. Within federal guidelines, states set the income levels for optional-eligibility groups and these vary significantly across the states. A further requirement for Medicaid eligibility is that the individual be a U.S. citizen, and applicants must produce evidence to that effect. States are not permitted to set any additional residency requirements.

As a result of the state flexibility built into the law with respect to services covered and individuals who are eligible, every state's Medicaid program is different. The added flexibility granted to states under the DRA has created even greater differences between the states than existed before.

Services Covered

Federal definitions of Medicaid services are included in the law and the formal regulations issued by CMS and in guidance that is provided to the states through a Medicaid Manual, letters to state Medicaid agency directors and other policy issuances.

Services that may be covered under Medicaid are listed in several sections of the federal law. Under Section 1905(a), basic state Medicaid

plan services are listed. In addition, states may opt for Home- and Community-Based Services under Section 1915(i) and choose to provide Targeted Case Management services described in Section 1915(g). The federal rules are slightly different in each of these sections.

Section 1905(a) lists both mandatory and optional Medicaid services.[a] These include Clinic Services (including those of community mental health agencies) and Rehabilitation Services (including psychiatric rehabilitation for adults and children). Services under Section 1905(a) must meet the requirements described above regarding statewideness, comparability and non-discrimination.

Section 1915(i) covers a list of home- and community-based services, including psychosocial rehabilitation, case management, respite care, homemaker/home health aide and personal care services. Section 1915(i) services can be limited to a specific number of individuals specified by the state (creating what are known as "slots") and can be available only to individuals with incomes at or below 150 percent of the federal poverty level, which is a lower income threshold than for Section 1905(a) services.

Targeted Case Management under Section 1915(g) can be furnished to groups of individuals specified by the state. These groups can, and often do, include adults with serious mental illnesses or children with serious emotional or mental disorders. Targeted Case Management can also be limited to a specified geographic area and need not be offered statewide.

This basic pattern is made still more complicated by additional state choices. For example, states can apply for waivers of the federal rules in order to:

- Furnish services through managed care arrangements that limit freedom of choice of provider (Section 1915(b); Section 1115);
- Provide a wider range of home- and community-based services for people with disabilities than is permitted under either Section 1905(a) or 1915(i), limiting access to a certain number of slots but including individuals with incomes higher than allowed under Section 1915(i). Very few of these waivers cover adults with mental illnesses and only a limited number cover children with mental or emotional disorders (Section 1915(c));
- Engage in demonstrations that often include expansion of eligibility, allowing individuals to access services either through regular Medicaid, through special, less generous, health plans or through plans in the private market (Section 1115).

States can also create different benefit packages for different groups of Medicaid-eligible individuals under new authority granted to them in

a Some services are optional for adults but, as explained above, under EPSDT all services are mandatory for children.

2006 through the Deficit Reduction Act. These packages can be modeled on private insurance plans or be unique designs drawn up by the state and approved by the federal government. Although only a few states have taken this path, these options generally provide a far more limited array of mental health services than does traditional Medicaid.[2]

Public Mental Health Systems and Medicaid

Combined federal and state Medicaid revenues to public mental health systems are now over $12 billion a year. Medicaid provides over 40 percent of all state mental health authority-controlled spending and fully half of all spending by public systems on community mental health services.[3] In recent years, Medicaid revenue for these state and local mental health systems has increased by 10 percent a year, and most new funds now come from Medicaid.[4]

Despite its importance to public mental health systems, states cannot use Medicaid to cover every service that individuals with mental disorders need, nor is everyone who needs such services eligible for Medicaid. Public mental health systems cannot meet their mandates through Medicaid expansions alone, but must also have significant non-Medicaid resources. Moreover, Medicaid policy is not made by state mental health authorities, even though many of these agencies play a considerable role in defining the services in their state's Medicaid plan through interagency agreements with Medicaid or informal working arrangements with those agencies. In all states, the ultimate responsibility for Medicaid rests with the Medicaid agency.

Unfortunately, state Medicaid agencies are under intense pressure to hold down costs because of the program's overall growth. Medicaid now represents half of the dollars that states receive from the federal government[5] and every change in Medicaid has a significant impact on state expenditures. As a result, governors, legislatures and Medicaid agencies often resist expanding services or eligibility.[6]

Another problem is policymakers' tendencies to focus on one aspect of a budget at a time. This means that state Medicaid policy and funding are often considered in isolation. State officials and legislators focused on rising Medicaid costs may not consider the connection between the availability of certain services and the use of resources in other arms of state government. For example, there is a correlation between investment in community mental health services and rates of incarceration of adults with serious mental illness.[7] This cost-shifting hides the real fiscal impact of decisions that might exclude some individuals or some services from Medicaid coverage.

These issues present challenges to state mental health authorities seeking Medicaid policies that fund the most effective community mental

health services in a comprehensive manner. As states struggle with this, it is often helpful for them to know how other states cover mental health services. It is particularly helpful to know what has been specifically allowed by the federal agency, CMS. This information can also be valuable for mental health advocates seeking to improve their state's Medicaid program.

The study reported on here is designed to facilitate this understanding.

Bazelon Center Study

In the summer and early fall of 2007, the Bazelon Center for Mental Health Law reviewed states' written policies for their Medicaid programs. This was prior to state plan changes stemming from publication of the Targeted Case Management and Rehabilitation regulations that ultimately did not take effect. Accordingly, data from this study indicate the degree to which states have been able to include in their Medicaid programs the range of effective interventions covered under federal policy in force today.

We examined state descriptions of the coverage of mental health services under the Clinic,[8] Rehabilitation[9] and Home- and Community-Based State Plan[10] service categories and their definitions of eligibility groups under Targeted Case Management.[11]

Where these regulations provided insufficient information, we supplemented the data by reviewing other Medicaid policy issuances, such as Medicaid provider manuals and other official documents and, in some cases, contracts between the state Medicaid agency and a managed care entity. The information we extracted from these documents represents a snapshot of Medicaid community mental health coverage under these service categories as of summer/fall of 2007.

We then organized the information into a set of tables. Each state mental health authority was contacted and sent a copy of the data for its state and asked to confirm or correct it. Officials in 46 states responded and confirmed adult service coverage and officials in 45 states responded with respect to children's services.

Changes made by the states were included in the data after follow-up research confirmed that this was written state policy. The purpose of limiting this study to an examination of written rules was to ensure that services listed represent federally approved coverage of mental health care. However, there are exceptions. For example, in some states, assurances from state officials that a particular evidence-based practice is reimbursed were accepted, even if Medicaid rules define only the component parts and do not reference the specific practice. State policies on payment rules also reflect both official Medicaid documents and information from state contacts.

Readers should be aware that other resources are being tapped for the non-Medicaid components of some evidence-based and other services under Section 1905(a). These are services which incorporate elements that are not billable to Medicaid (such as job training, supported employment or the housing cost under supported housing). This study indicates merely that Medicaid is paying for the covered Medicaid services that are components of that evidence-based practice.

The final data are presented in Tables 1-8, attached. All the tables

include the 50 states and the District of Columbia and all totals exclude duplications, such as where a particular service is referenced under two Medicaid categories.

Summary of Findings

1) Clinic Services

Clinic services include mental health treatment furnished by or under the direction of a physician and provided in a clinic setting. Services can be furnished outside the clinic only for individuals who are homeless (defined as people who do not reside in a permanent dwelling or do not have a fixed home or mailing address).

Clinical services can also be covered as Medicaid Rehabilitation services or as part of a Home- and Community-Based Services state plan option. When states include clinical services under Rehabilitation or Home- and Community-Based Services, the service can be furnished not only in a clinic but also in the person's home, on the street or any other place in the community.

Tables 1 and 2 provide data on coverage of clinical services in state Medicaid rules. The tables do not, however, include certain basic services that are routinely covered in all states. All states cover therapy/counseling, almost always specifically stating this can be individual, group and family, and often referring to multi-family groups or co-joint therapy. Some states are also referencing functional family therapy. All states also cover medication administration and management as well as assessments, evaluations and tests and treatment planning. All states also provide access to care in emergencies—either through specific mental health crisis services (as listed in the tables) or through emergency services in a hospital. None of these services are listed in the attached tables because they are available in all states.

Although not all states cover all the services listed in Tables 1 and 2, it is noteworthy that a majority do. The following Clinic Services are included in Tables 1 and 2:

- Crisis intervention: listed as a separate, distinct service; this list includes states that report covering mobile crisis services.
- Mobile crisis services: mobile crisis teams or units available 24 hours a day, seven days a week to address a mental health crisis situation.
- Crisis stabilization: services furnished following crisis intervention to stabilize the individual in the community.
- Partial hospitalization: day programs that provide an alternative to

inpatient hospital services, generally with similar services to those provided in hospital settings.

- Day treatment for mental health: a day program that is generally less medical than partial hospitalization but that provides a structured day (or half-day) program with various therapies and activities and, for children, education.
- Substance abuse outpatient treatment: Coverage for substance abuse counseling, even if of limited duration.
- Substance abuse intensive outpatient services: More intensive services beyond standard therapy or counseling.
- Substance abuse day treatment: a structured day program providing a range of services for part or all of a day.
- Ambulatory detox: detoxification services provided on an outpatient basis.
- Methadone maintenance therapy.

Clinic Services*

Service	For Adults	For Children
Crisis intervention	49 states	50 states
Mobile crisis 24/7	19 states	22 states
Crisis stabilization	34 states	32 states
Partial hospitalization	30 states	25 states
Day treatment for mental health	31 states	40 states
Substance abuse outpatient	40 states	41 states
Substance abuse intensive outpatient	24 states	24 states
Day treatment for substance abuse	14 states	9 states
Ambulatory detoxification	13 states	8 states
Methadone maintenance	16 states	11 states

* Data includes the 50 states and the District of Columbia and each state is counted only once.

2) Psychiatric Rehabilitation

Medicaid law authorizes states to cover "other diagnostic, screening, preventive and rehabilitative services, including any medical or remedial services…recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." Rehabilitation services can be furnished in a facility, a home or other community setting.

The Rehabilitation Services category can include both traditional clinical treatment (that is, the services listed above as clinic services) and rehabilitative recovery-oriented services. The deciding factor on whether a service is considered a Medicaid-covered rehabilitation service is its goal.

CMS policy guidance emphasizes that location is not the issue, the goal of the service is the key determining factor as to whether it is covered by Medicaid. This policy was restated in the now-withdrawn proposed regulation on Rehabilitation Services and CMS will allow such services as long as the individual's plan of care indicates that it is necessary and relates to the person's goals. The service itself, however, must be a covered service, such as skills training or counseling.

The advantage of using the Rehabilitation Services category is that services can be furnished in any setting and can be authorized by any licensed professional. Federal guidance on psychiatric rehabilitation issued in 1992 is still the most comprehensive written federal policy on this category.[12] That guidance specifically states that the following interventions are considered rehabilitation under federal Medicaid:

- Basic living-skills training that focuses on ensuring independent functioning in the community, such as food planning and preparation, maintenance of living environment, community awareness and mobility skills.
- Social-skills training such as communication and socialization skills;
- Counseling and therapy.
- Services to families or significant others when directed exclusively to the needs of the recipient.

With respect to the last item, Medicaid allows services for family members, provided the focus of the service is on the eligible individual's mental health. Family members may be taught to understand the person's disorder or taught strategies for how to handle situations that arise as a result of that disorder and when to call for professional help. Medicaid will not, however, pay for direct services to family members (unless they themselves are eligible for the program). Teaching basic parenting skills that do not relate to the special needs of a child is also unallowable.

Additional guidance from CMS has come from several letters to State Medicaid Directors. Among the many SMD letters the following are the most relevant for coverage of community mental health services:

- Letter clarifying that Assertive Community Treatment is a covered Medicaid service;[13]
- Letter clarifying Medicaid coverage of school-based services;[14]
- Letter defining how and when CMS will reimburse for services of peer specialists.[15]

States also include a number of evidence-based practices in their Medicaid rehabilitation services rules. In addition, they often specify the settings in which some or all of these services may be provided.

As with Clinic Services, some items that are universally included in state rules are not listed in the attached tables. These include all basic clinical treatment (addressed in the Clinic Services tables), skills training services and the fact that services can be furnished in the person's home or another community location.

A. Skills Training

By far the most common reference in state rules for psychiatric rehabilitation is to skills training to restore or maintain an individual's ability to function. All states cover these interventions and some provide detailed lists of the types of skills that can be the focus of such training. Some states separately describe skills training for adults and children; in other states one set of rules applies to both populations.

Since all states provide this service, it is not included in any of the attached tables. Additionally, since most states listing specific skills use them only as examples (and states that do not list them do not necessarily deny payment for them), data on specific skills cited in each state's rules are not all that relevant and are also not included in the tables.

However, states may find it helpful to know what specific skills are referenced in other states' rules. The following table therefore shows the specific types of skills training which states commonly reference.

Skills Training Categories in State Rules

Skill	Adult Rules	Child Rules
Social skills/interpersonal skills	44 states	39 states
Basic living skills	44 states	33 states
Independent living/self care	33 states	20 states
Personal hygiene/grooming/dressing	25 states	16 states
Money management	24 states	13 states
Communication	24 states	22 states
Coping skills	21 states	17 states
Accessing community resources	21 states	13 states
Problem solving	20 states	16 states
Shopping/meal prep/nutrition	20 states	12 states
Social networking	17 states	11 states
Using transportation	17 states	8 states
Engagement in leisure activities	16 states	11 states
Behavior management	13 states	18 states
Cognitive	11 states	7 states
Conflict and anger management	9 states	12 states
Time management/task completion/organizational skills	7 states	6 states
Self-help	7 states	5 states
Adaptive skills	6 states	4 states
Assertiveness	4 states	1 states
Community living/integration	4 states	6 states

Some other categories used in very few states are: self-advocacy

skills, age-appropriate education and emotional adjustment; adult role competencies; functional skills, skills to promote positive growth, transitional living skills, motor skills and coordination, safety skills, self-management skills, lifestyle changes, alcohol and drug-related skills, self-esteem, parent-child interaction skills, physical health/health maintenance skills and educational development.

B. Targeted Skills Training

In addition to describing the functional skill for which training is available, some states also specify coverage of a range of skills training in terms of skills with a specific goal, such as helping the individual stay in school or obtain and maintain a job or housing in the community. Other states describe paying for coaching in various natural environments to apply skills that are being taught.

In some states, such activities may be subsumed under specific evidence-based practices (see below). Other states, however, while not referencing evidence-based practices, do cover certain targeted skills training. States offering targeted skills training are listed in Tables 3 and 4. A significant number of states offer such training in relation to employment for adults, about one third offer education skills training to both children and adults or housing skills training for adults.

Targeted Skills Training*

Skills	For Adults	For Children
Employment skills training	31 states	19 states
Education skills training	17 states	17 states
Housing skills training	16 states	3 states

* Data include the 50 states and the District of Columbia and each state is counted only once.

C. Skills Training and Other Services in Situ

An important aspect of skills training is location. Individuals with serious mental illnesses have been found to often have difficulty transferring a skill from one setting to another. All states allow psychiatric rehabilitation services to be furnished in the home, including various skills related to independent living, personal care, social skills related to housing issues, etc.

In addition, states are covering skills training in community locations where the individual may have difficulties in functioning. For adults, this might include the work site and for children, school.

Tables 3 and 4, attached, list states that cover services in these various settings.

Very few states have specifically stated that providers may furnish a

covered service, such as skills training or counseling, at the job site. On the other hand, states have more readily recognized that children may need supports in school. Federal rules permit states to furnish appropriate covered services in those settings.

It is also important for individuals to be able to receive services during their leisure hours, particularly when they are participating in activities in the community. Yet even fewer states specifically authorize that psychiatric rehabilitation services can be furnished in community settings that are primary recreational or social. (Again, these situations are specifically allowable under federal rules, as described above.)

Services Furnished On-Site*

Service Setting	For Adults	For Children
Services in school	-----	40 states
Employment skills training on the job site	9 states	9 states
Recreation-based setting	8 states	8 states
Socialization setting	8 states	5 states

* Data include the 50 states and the District of Columbia and each state is counted only once.

D. Transition Services

Smooth transitions from one level of service to another is a critical aspect of continuity of care. For youth and young adults, transition from the services they receive from the children's system to the services they may need from adult mental health providers is frequently problematic. Services designed to ensure smooth transitions can be covered under Medicaid and a number of states emphasize their importance by specifically referencing them in their rules and requiring that providers address transition issues.

Transition Services*

Service	States
Transition from one level of care to another	21 states
Transition from child to adult services	6 states

* Data include the 50 states and the District of Columbia and each state is counted only once.

E. Site-Based Rehabilitation Programs

Psychiatric rehabilitation services can be furnished through organized programs as well as in various community locations. Most states define site-based psychiatric or psychosocial rehabilitation programs in their rules, while only a very few cite drop-in centers or club houses as being covered providers.

Site-based programs have generally been paid based on a daily rate. For a while, states were changing this to arrangements that relied on

individual billing of each service in 15-minute increments. However, this is no longer a federal requirement. Daily rates, or weekly rates, are allowable if appropriately calculated and approved by CMS. States taking this approach are expected to require reporting by the provider of encounter data (that is, specific services to specific individuals) and CMS may require future rates to be revised, based on experience as documented by this data.

For children, school-based day treatment is sometimes cited. Other states that describe day treatment programs in their rules (see Clinic Services section) may also include day treatment that is school-based, but have not specifically stated this. CMS has comprehensive rules regarding school-based services and Medicaid will not reimburse schools for services they provide to non-Medicaid children free of charge (other than services of a school health clinic) or for services of providers who are not qualified Medicaid providers in the state. However, community mental health agency personnel who furnish services in a school are covered, regardless of these factors, if they are qualified Medicaid providers and furnish a Medicaid-covered service to a Medicaid-eligible child.

Site-based rehabilitation settings in the various states are listed in Tables 3 and 4.

Site-Based Programs*

Setting	For Adults	For Children
Psychiatric rehabilitation program facilities	35 states	
Club houses	6 states	
Drop-in centers	2 states	
Day treatment programs in schools		7 states

* Data include the 50 states and the District of Columbia and each state is counted only once.

F. Additional Children's Services

States with specific rules on Rehabilitation Services for children often describe services that are unique for this age group. Several of those services are primarily related to the location of the service, with interventions being similar to other rehabilitative interventions. Some of these services offer children a normalizing experience, even if in a segregated setting. For example, the services provided in an after-school or summer camp program may be essentially similar to day treatment services. However, furnishing the service in a type of program that many children experience gives the youngster with serious emotional disorders a sense of belonging in the community and removes a certain stigma.

However, although these settings are allowable under federal rules, only a small handful of states have specifically authorized that they be covered under their Medicaid program. Data on states that cover these services are presented in Table 4.

Other Settings for Child Rehabilitation Services*

Service	States
After-school programs	5 states
Summer programs	3 states
Therapeutic nursery programs	4 states

* Data include the 50 states and the District of Columbia and each state is counted only once.

Other specialized programming for children is aimed at a specific age group, very young children ages zero to three or zero to five. These programs include therapeutic nurseries (see above) and comprehensive early intervention programs. Services for very young children are a little different than rehabilitation for older children in that there must be a significant emphasis on working with the family.

Early Intervention Services*

Service	States
Early intervention programs	11 states

* Data include the 50 states an the District of Columbia and each state is counted only once.

3) Home- and Community-Based State Plan Services

Home- and community-based state plan services authorized by the DRA are covered at this time only in two states (Iowa and Nevada) although other states have state plan amendments pending. Services under this option overlap with services covered under Rehabilitation Services to a considerable degree.

Specifically allowable services for people with mental disorders under 1915(i) of federal law are: case management, personal care, respite, homemaker services, day treatment, partial hospitalization, psychosocial rehabilitation and clinic services in any community setting.

Iowa has chosen not to limit service availability geographically, but it has set enrollment caps and there will be a waiting list for the HCBS. (The state plans to serve 3,700 people in the first year, with the number of participants increasing to nearly 4,500 in the fifth year.) Nevada has set no limits on the availability of the covered services and expects to serve almost 5,000 people in the first year.

In Iowa, the needs-based criteria for eligibility are restrictive and will limit services to those with a history of mental illness. In addition, the functional eligibility criteria are more restrictive than eligibility criteria states generally use for rehabilitation or clinic services. In Nevada, the needs-based criteria are more general and include functional deficits secondary to cognitive and/or behavioral impairments, risk of harm and need for supervision. Iowa will therefore cover only people with serious mental illnesses, while Nevada will cover people with a range of disabilities.

Iowa has elected to offer case management and habilitation. Habilitation includes home-based habilitation, day habilitation, pre-vocational habilitation and supported employment. In Nevada, services provided are: adult day health, habilitation, partial hospitalization and medical-model day treatment, and other services for individuals with severe mental illnesses.

Services covered by these two states under this Medicaid option are listed in Tables 1-6 (Clinic, Rehabilitation and Evidence-Based Practices for adults and children) but on a separate row so that they can be readily identified.

4) Use of Evidence-Based Practices

States are now covering several specific evidence-based practices under Medicaid, either in their Rehabilitation rules or under the new Section 1915(i) home- and community-based services option. States cover these practices in different ways. A number of states have described the practice in detail, clearly intending to ensure that it is practiced at fidelity to the model. When they do this, the state most often then reimburses the providers through a single, comprehensive rate for that service.

Other states describe the components of an evidence-based practice as being covered, but do not specifically mention the practice in their rules. State officials in these states informed the Bazelon Center that they do, in fact, cover the evidence-based practice. However, these states are more often paying providers for each component, not through a single rate.

Paying providers separately for each component is not as effective in ensuring full fidelity to the model as paying a single rate. CMS is encouraging states to cover these evidence-based practices and will allow a single rate (paid for any period of time up to one week). States now have the opportunity to move their community mental health systems forward in terms of quality of care by expanding coverage of comprehensive evidence-based practices..

The rate must be based entirely on the costs of Medicaid-covered services that are part of the practice. Evidence-based practices, such as supported employment, which include components that cannot be covered as rehabilitation services under 1905(a) (job training, etc.) require that the state have other resources to pay for the non-covered activities.

The exception to this rule is the Home- and Community-Based Services state plan option (see above). Some evidence-based practices can be covered in their entirety under this option. To date, Iowa has taken advantage of this rule to cover all components of supported employment.

As is the case for all other Medicaid services, any evidence-based practice covered by the state must be available to all Medicaid beneficiaries

who need the service. This means, for example, that Therapeutic Foster Care cannot be limited only to children in the child welfare/foster care system. It must be available to all children with serious mental disorders who require the service.

Tables 5 and 6 list states covering the various evidence-based practices either as a specific service or through coverage of the component parts (if state officials confirmed that the practice is indeed reimbursed). These data therefore provide a comprehensive picture of how well these most effective services are being paid for through Medicaid in the states.

Evidence-Based Practices*

EBP	For Adults	For Children
Assertive community treatment	33 states	8 states
Integrated MH and SA Treatment	19 states	14 states
Illness/disability Self-Management	19 states	8 states
Supported employment	15 states	5 states
Family psychosocial education	13 states	31 states
Supported housing	9 states	3 states
Supported education	1 state	0 states
Intensive in-home services	----	34 states
Therapeutic foster care	----	31 states
Multi-systemic Therapy	----	17 states
Wraparound services	----	13 states

* Data includes the 50 states and the District of Columbia and each state is counted only once.

5) Recovery Orientation

Certain aspects of a recovery- and wellness-focused system are now being emphasized in some state rules. The proposed regulation on Rehabilitation Services also referenced several important aspects of recovery. While CMS is not enforcing that regulation because it is currently under the moratorium, the agency is strongly encouraging states to adopt procedures that relate to recovery. This would include, for example, that there be a written rehabilitation plan that specifies individualized recovery goals and the services to achieve those goals. The individual (or individual's family or authorized decision maker and others of the individual's choosing) should actively participate in the development, review and modification of goals and services in that plan. The plan should also have a timeline, and should be reevaluated at least annually and revised as necessary. Individuals should also indicate consent by signing their rehabilitation plan.

Over half the states refer to recovery for adults, but very few states are allowing consumers to self-direct their services. For children, very few states reference resiliency, while many more refer to strengths-based, child-centered or family-driven services.

Philosophical Approach of State Medicaid Plans*

Approach	Adults	Children
Recovery	27 states	---------
Resiliency	9 states	6 states
Strengths-based	16 states	21 states
Child-centered	-----	10 states
Family-driven	-----	17 states
Self-directed	9 states	3 states

* Data include the 50 states and the District of Columbia.

Another way a recovery-focused approach is reflected in state Medicaid rules is through recognition of the important role of natural supports in supporting adults and children in the community. Identification of these natural supports, generally as part of treatment planning or case management, is referenced in five state rules see (Tables 3 and 4).

Also relevant is the degree to which services can be furnished by peers. As referenced in the next section, inclusion of peer specialists as Medicaid providers is growing in acceptance. Several states also reference that youth can serve as peer providers for other youngsters. However, CMS requires that peer specialists be old enough to be employed full or part-time. States may find that the agency will not approve youth under the age of 18 as peer specialists.

6) Payment Rules

Several aspects of Medicaid payment rules are extremely important for community mental health services. Table 7 provides information on payment rules. (These rules are not different for adults and children.)

Mental health services furnished to individuals with serious mental disorders are often delivered through a team approach. As a result, payment for providers to consult with each other on a specific case and payment for several providers to participate in team planning is important.

Medicaid does not directly reimburse for these activities. However, consultation time can be estimated and included in provider rates. This is the case whether the consultation is between two individuals or a team. States will need to assess how much time is likely to be spent in those activities and CMS will accept those calculations when considering and approving a state's rate structure. States that pay for such activities often make that explicitly clear to providers by listing the activities in their rules.

Contacting other individuals who interact with the consumer can also be critical and coverage of collateral contacts is often referenced in state rules. And because Rehabilitation Services can be furnished in any location in the community, travel time for providers can also be an issue. Again, these activities can be covered by building their costs into the rates.

In today's electronic world, it is important for providers to be able to contact and work with individuals under their care in various ways. Medicaid rules now allow this and permit providers to be paid for their time in telephone contact and for telepsychiatry.

Payment Rules*

Rule	States
Payment for consultation between two professionals	30 states
Payment for team consultation	9 states
Payment for collateral contacts	31 states
Payment for time spent in transit	8 states
Payment for telephone contacts with client	22 states
Payment for telepsychiatry	20 states

* Data include the 50 states and the District of Columbia.

7) Provider Qualifications

Federal Medicaid provides considerable flexibility regarding the qualifications of the individuals who may furnish or supervise community services. This is particularly true under the Rehabilitation Services category. Provided a service is appropriately supervised by a licensed professional, it may be delivered by any individual who meets the state's standards. Federal approval of state provider-qualification standards is necessary, but states have broad authority in this area.

CMS has issued specific guidance on how states can cover the services of peer specialists. Peer-support providers must be self-identified consumers in recovery, supervised by a mental health professional and must furnish services that are coordinated in the context of a comprehensive, individualized written plan of care with specific goals. States are encouraged to use person-centered planning processes to promote participant ownership of the plan. Peer-support providers must complete training and certification as defined by the state. Ongoing continuing education requirements must also be in place.[16]

For children, states have covered the services of behavioral aides—paraprofessionals who work individually with a child who has a serious mental or emotional disorder. These individuals are employed by mental health programs and must meet state standards. However, behavioral aides must be mental health workers; for example, CMS will not pay for services of school-employed teacher aides as behavioral aides under Medicaid.

Payment for Non-Traditional Providers*

Providers	States
Peer specialists	22 states
Children's behavioral aides	18 states

* Data include the 50 states and the District of Columbia.

8) Targeted Case Management

Targeted case management is a Medicaid service, but it is unusual in that states need not provide it to all Medicaid recipients. Instead, states may target the service to certain groups defined by geography, age, illness or disability. Table 8, attached, lists, by state, the populations eligible for targeted case management and who might be expected to need mental health services. When states pay for targeted case management for these groups they generally do not add additional restrictions, such as limiting coverage to recipients in a specific geographic area.

Most states include as target groups adults and children with serious mental disorders, although they use differing terms to describe the population. Terms used include "serious mental illness," "severe and persistent mental illness," "chronic mental illness," "serious emotional disturbance" and "seriously emotionally handicapped." Many states have lengthy definitions of the terms they use, and these are often similar to the federal definitions of serious mental illness and serious emotional disturbance issued by the Center for Mental Health Services.

Other relevant groups include adults and children in need of protective services, in guardianship, in foster care or receiving child welfare services, and children at risk of contact with the juvenile justice system or already referred to or under supervision of juvenile justice. Some states cover adults and children with substance use disorders, including those with co-occurring mental illness and substance abuse.

Very young children with developmental delays or special needs are also often a target group. In some states, children at risk of developmental delay are targeted. Eligibility for targeted case management is often linked to eligibility for services under the Individuals with Disabilities Education Act (IDEA).

Other adult categories include the geographically targeted, families of certain children and those transitioning from residential placements. A few states list specific mental disorders as the eligibility criteria. Other children's categories include geographic targeting, those at risk of out-of-home placements, those transitioning from residential placements, children at risk of failing in education or in special education programs, and children eligible for home- and community-based waiver services.

Targeted Case Management-Eligible Groups*

Target Group	States
Adults with serious/severe/chronic mental illness	26 states
Children with serious emotional disturbance/handicap	21 states
Children in foster care/child welfare	11 states
Adults with substance use disorders	8 states
Groups of very young children with developmental delay	7 states
Children with substance use disorders	6 states
Children in, or at risk of, juvenile justice supervision	5 states
Groups of very young children with IFSP/special needs:	5 states
Adults in need of guardianship or protective services	2 states

* Data include the 50 states and the District of Columbia.

9) Services Not Covered

In order to ensure that providers fully understand Medicaid rules, and to assuage any doubts that the federal agency may have about a state plan, many states incorporate in their plans a list of the services and activities that are not allowable under their Medicaid program. In some states, this list is quite extensive. Commonly excluded items, none of which can be billed to Medicaid under federal rules for community-based services, are as follows. Phrasing in this list comes from the states' Medicaid rules.

- Room and board
- Vocational issues: job training, job coaching, job development, training for specific job, job task-oriented activities, employment counseling, sheltered workshops
- Education issues: academic education, remedial education, tutoring, tuition, education component of day treatment, college preparation
- Personal care: homemaking services, housekeeping, household tasks performed by staff, provider performance of daily living activities
- Financial: financial services.
- Socialization: services that are primarily social, solely social activities.
- Recreation: services that are solely recreational, recreational outings, routine recreation activities, leisure activities
- Services to others: services not directed to meeting the individual's needs, or not primarily for the consumer's wellbeing, treatment of individuals other than client, services for primary benefit of individual other than recipient
- Convenience: services for convenience of client or provider, individual convenience services, patient convenience

- Experimental services: investigational or experimental drugs or procedures
- Day care
- Respite care
- Custodial care
- Missed appointments

Conclusion

As this report shows, states continue to rely on Medicaid to fund many of the essential community services needed by adults with serious mental illnesses and children with serious mental, emotional or behavioral disorders. However, while the more traditional mental health services are very well covered in state plans, there is less coverage for the newer evidence-based practices. Furthermore, states are not taking full advantage of the flexibility permitted by the federal government for provision of Rehabilitation Services in any appropriate location. In other ways, also, states could make adjustments to their rules to improve their programs.

While some states may, in fact, be paying for things that are not fully defined in their rules, it is advisable for states to ensure that they have CMS approval for all of their Medicaid services. It may not be necessary to provide lengthy details, but each service needs to be clearly defined so that federal approval can be obtained and so providers understand what can be billed, and how. This is particularly true for children's services, which in many states are not separately defined. Children's services are not exactly the same as adult services and, while providers might manage to fit children's services into the adult categories, this is not the best way to proceed.

Overall, however, this report is encouraging, in that most states have at least been able to cover basic treatment and rehabilitation services under Medicaid, and quite a number of them are paying for the most effective interventions.

This document is intended to be a "live" document. The Bazelon Center encourages states to assist us in making it as accurate as possible and in keeping it up-to-date. We welcome further additions or amendments. (To propose changes, please contact Lee Carty at the Bazelon Center, leec@bazelon.org.)

Notes

1 Smith, Vernon, & Ellis, Eileen. (2002), *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Years 2000, 2001, and 2002.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

2 For more details on state coverage options under the DRA, see the Bazelon Center's Report on Implementation of the Deficit Reduction Act, at: www.bazelon.org.

3 Data from author's conversation with Ted Lutterman, National Association of State Mental Health Program Directors Research Institute, February, 2008.

4 National Association of State Mental Health Program Directors Research Institute (November, 2007). State Profile Highlights: FY 2005 State Mental Health Revenue and Expenditure Study Results. At www.nri-inc.org.

5 Kaiser Commission on Medicaid and the Uninsured. (2001). *The Role of Medicaid in State Budgets*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

6 Rosenbaum, Sara. (2002). Health Policy Report: Medicaid. *New England Journal of Medicine*, 346:8, 635–640.

7 A review of mental health utilization and incarceration rates in 14 states shows that those with the highest mental health utilization rate generally have the lowest rate of incarceration and vice versa. Vermont Mental Health Performance Indicator Project, Vermont Department of Developmental and Mental Health. (2002). *Incarceration Rates and Community Mental Health Utilization Rates in Fourteen States*. Waterbury, VT.

8 Social Security Act, Section 1905(a)(9).

9 Social Security Act, Section 1905(a)(13).

10 Social Security Act, 1915(i).

11 Social Security Act, Section 1915(g).

12 Rehabilitation Services for the Mentally Ill – INFORMATION. Memorandum (FME-42) from Director, Medicaid Bureau, Health Care Financing Administration, U.S. Department of health and Human Services to All Regional Administrators, June 1, 1992. (Available upon request from the Bazelon Center.)

13 Letter to State Medicaid Directors from Sally K. Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, Baltimore MD. June 7, 1999.

14 Letter to State Medicaid Directors from Sally K. Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, Baltimore MD. May 21, 1999.

15 Letter to State Medicaid Directors from Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, SMDL # 07-011, August 15, 2007.

16 See State Medicaid Director letter, SMDL #07-011.

Table 1: Clinic Services for Adults

State	Crisis Intervention	Mobile Crisis Response	Crisis Stabilization	SA Outpatient	SA Intensive Outpatient	SA Ambulatory Detox	Methadone Maintenance	Partial Hospitalization	Day Treatment: MH	Day Treatment: SA
Alabama	✓		✓	✓	✓		✓	✓	✓	✓
Alaska	✓		✓	✓	✓		✓		✓	✓
Arizona	✓	✓	✓	✓			✓	✓	✓	
Arkansas	✓								✓	
California	✓		✓	✓	✓				✓	
Colorado	✓							✓		
Connecticut	✓			✓	✓		✓	✓	✓	
Delaware	✓									
District of Columbia	✓		✓						✓	
Florida	✓		✓	✓			✓	✓		✓
Georgia	✓		✓	✓	✓	✓		✓		✓
Hawaii	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Idaho	✓		✓					✓		
Illinois	✓			✓		✓				✓
Indiana	✓		✓	✓	✓	✓		✓		
Iowa		✓		✓	✓			✓	✓	✓
Iowa -1915(i)	✓							✓	✓	
Kansas	✓		✓	✓						
Kentucky	✓			✓				✓	✓	
Louisiana			✓	✓						
Maine	✓	✓	✓	✓	✓		✓		✓	
Maryland	✓	✓	✓	✓			✓	✓	✓	
Massachusets	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓		✓	✓	✓	✓	✓	✓	✓	
Minnesota	✓	✓	✓	✓	✓			✓	✓	
Mississippi	✓							✓	✓	
Missouri	✓		✓	✓					✓	
Montana	✓			✓	✓	✓		✓	✓	✓
Nebraska	✓		✓	✓						
Nevada	✓	✓	✓	✓				✓	✓	
Nevada -1915(I)								✓	✓	✓
New Hampshire	✓							✓		
New Jersy	✓			✓				✓		
New Mexico	✓		✓	✓				✓		
New York	✓			✓				✓	✓	
North Carolina		✓	✓	✓	✓	✓		✓		
North Dakota	✓		✓	✓					✓	✓
Ohio	✓	✓	✓	✓	✓	✓	✓	✓		
Oklahoma	✓	✓	✓	✓	✓					
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Pennsylvania	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island	✓	✓		✓	✓	✓	✓	✓		✓
South Carolina	✓		✓						✓	
South Dakota	✓									
Tennessee	✓	✓	✓	✓	✓	✓		✓	✓	
Texas	✓	✓							✓	
Utah	✓		✓	✓					✓	
Vermont	✓	✓	✓	✓	✓			✓		
Virginia	✓	✓	✓	✓	✓			✓	✓	✓
Washington	✓			✓			✓		✓	
West Virginia	✓		✓							
Wisconsin	✓	✓		✓			✓		✓	✓
Wyoming	✓		✓	✓	✓				✓	
Total:	**49**	**19**	**34**	**40**	**23**	**13**	**16**	**30**	**31**	**14**

Table 2: Clinic Services for Children

State	Crisis Intervention	Mobile Crisis Response	Crisis Stabilization	SA Outpatient	SA Intensive Outpatient	SA Ambulatory Detox	Methadone Maintenance	Partial Hospitalization	Day Treatment: MH	Day Treatment: SA
Alabama	✓			✓			✓		✓	
Alaska	✓		✓	✓	✓			✓	✓	
Arizona	✓	✓	✓	✓					✓	
Arkansas	✓		✓						✓	
California	✓		✓	✓	✓				✓	
Colorado	✓							✓		
Connecticut	✓	✓	✓	✓	✓		✓	✓	✓	
Delaware	✓	✓	✓	✓	✓			✓	✓	✓
District of Columbia	✓		✓						✓	
Florida	✓			✓			✓		✓	
Georgia	✓			✓	✓	✓	✓		✓	✓
Hawaii	✓	✓	✓	✓	✓	✓		✓	✓	
Idaho	✓		✓					✓		
Illinois	✓		✓	✓	✓					✓
Indiana	✓		✓	✓	✓			✓	✓	
Iowa	✓	✓		✓	✓				✓	
Kansas	✓			✓						
Kentucky	✓		✓	✓	✓				✓	
Louisiana	✓			✓						
Maine	✓	✓	✓	✓	✓		✓		✓	
Maryland	✓	✓	✓	✓	✓		✓	✓	✓	
Massachusetts	✓	✓	✓	✓	✓			✓	✓	✓
Michigan	✓		✓	✓	✓		✓	✓	✓	
Minnesota	✓	✓	✓	✓				✓	✓	
Mississippi	✓							✓	✓	
Missouri	✓		✓	✓					✓	
Montana	✓			✓	✓	✓		✓	✓	
Nebraska	✓	✓	✓	✓	✓				✓	✓
Nevada	✓	✓	✓	✓				✓	✓	
Nevada -1915(i)										
New Hampshire	✓							✓	✓	
New Jersey	✓	✓	✓	✓				✓	✓	✓
New Mexico	✓		✓	✓				✓	✓	✓
New York	✓			✓				✓	✓	
North Carolina		✓	✓	✓	✓	✓		✓	✓	
North Dakota	✓		✓	✓						
Ohio	✓	✓	✓	✓	✓	✓	✓	✓		
Oklahoma	✓	✓	✓	✓	✓					
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Pennsylvania	✓	✓	✓	✓	✓	✓		✓	✓	
Rhode Island	✓	✓		✓				✓	✓	
South Carolina	✓		✓						✓	
South Dakota	✓									
Tennessee	✓	✓		✓	✓	✓	✓	✓	✓	
Texas	✓	✓								
Utah	✓			✓					✓	
Vermont	✓		✓	✓					✓	
Virginia	✓	✓	✓	✓	✓			✓	✓	✓
Washington	✓			✓					✓	
West Virginia	✓									
Wisconsin	✓	✓		✓			✓		✓	✓
Wyoming	✓		✓	✓	✓				✓	
Total:	**50**	**22**	**32**	**41**	**24**	**8**	**11**	**25**	**40**	**9**

Table 3: Rehabilitation Services for Adults

State	Site-based Rehabilitation	Drop-in Centers	Club Houses	Employment Skills	Services at Job Site	Housing Skills	Education Skills	Recreation-Based Services	Socialization	Natural Supports
Alabama	✓			✓			✓	✓		
Alaska										
Arizona				✓			✓			
Arkansas										
California	✓									
Colorado				✓						
Connecticut				✓		✓	✓			
Delaware	✓					✓				
District of Columbia										
Florida	✓		✓							
Georgia	✓			✓		✓				
Hawaii	✓		✓	✓	✓		✓	✓	✓	
Idaho	✓			✓		✓	✓			
Illinois										✓
Indiana										
Iowa	✓									
Iowa -1915(i)				✓			✓			
Kansas	✓				✓		✓			
Kentucky	✓			✓						
Louisiana	✓			✓						
Maine				✓			✓			
Maryland	✓					✓				
Massachusetts	✓			✓						
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota	✓	✓	✓	✓	✓	✓				
Mississippi	✓									
Missouri	✓			✓		✓				
Montana	✓			✓	✓		✓			
Nebraska	✓			✓				✓	✓	
Nevada								✓	✓	
Nevada -1915(i)	✓									
New Hampshire										✓
New Jersey				✓						
New Mexico	✓					✓	✓			
New York	✓			✓	✓	✓	✓			✓
North Carolina	✓			✓			✓			
North Dakota	✓			✓						
Ohio				✓		✓		✓	✓	
Oklahoma	✓								✓	✓
Oregon				✓		✓	✓			
Pennsylvania	✓		✓	✓						
Rhode Island	✓									
South Carolina	✓			✓		✓				
South Dakota										
Tennessee	✓		✓	✓	✓	✓	✓			✓
Texas	✓			✓		✓				
Utah	✓									
Vermont	✓			✓	✓	✓	✓	✓	✓	
Virginia	✓									
Washington				✓						
West Virginia				✓			✓			
Wisconsin	✓			✓	✓			✓	✓	
Wyoming	✓									
Total:	**35**	**2**	**6**	**31**	**9**	**16**	**17**	**8**	**8**	**6**

Table 4: Rehabilitation Services for Children

State	Natural Supports	Employment Skills	Education Skills	Services in Schools	School Day Treatment	Afterschool	Summer Programs	Recreation-Based Services	Socialization	Housing Skills	Therapeutic Nursery	Early Intervention Services (0-3)	Transition Services (Child to Adult)
Alabama				✓	✓								
Alaska			✓	✓									
Arizona		✓		✓		✓					✓		
Arkansas													
California													
Colorado		✓		✓									
Connecticut	✓	✓	✓	✓		✓	✓	✓		✓			
Delaware				✓	✓							✓	✓
District of Columbia				✓									
Florida				✓								✓	
Georgia		✓	✓	✓									
Hawaii	✓	✓	✓	✓				✓	✓				
Idaho		✓	✓	✓									
Illinois				✓									✓
Indiana													
Iowa													
Kansas				✓									✓
Kentucky						✓	✓					✓	✓
Louisiana		✓		✓									
Maine				✓	✓							✓	
Maryland						✓				✓	✓		
Massachusetts		✓		✓									✓
Michigan	✓			✓								✓	
Minnesota		✓		✓									
Mississippi				✓	✓								
Missouri		✓		✓									
Montana		✓	✓	✓									
Nebraska		✓		✓				✓			✓		
Nevada			✓	✓				✓	✓				
Nevada -1915(i)			✓										
New Hampshire				✓									
New Jersey			✓	✓									
New Mexico	✓	✓	✓	✓	✓							✓	
New York				✓									
North Carolina		✓	✓	✓								✓	
North Dakota		✓		✓									
Ohio		✓		✓				✓	✓				
Oklahoma			✓	✓								✓	
Oregon		✓	✓	✓				✓		✓			
Pennsylvania	✓			✓	✓	✓	✓	✓	✓		✓		
Rhode Island												✓	
South Carolina			✓	✓								✓	
South Dakota													
Tennessee													✓
Texas			✓	✓									
Utah				✓									
Vermont		✓	✓	✓									
Virginia				✓	✓							✓	
Washington			✓	✓									
West Virginia			✓										
Wisconsin		✓		✓				✓	✓				
Wyoming													
Total:	**5**	**19**	**17**	**40**	**7**	**5**	**3**	**8**	**5**	**3**	**4**	**11**	**6**

Table 5: Evidence-Based Practices for Adults

State	Supported Employment	Supported Housing	Supported Education	Family Psychoeducation	Illness/Disability Self-Management	Integrated MH-SA Treatment	Assertive Community Treatment
Alabama					✓		✓
Alaska					✓		
Arizona	✓						
Arkansas						✓	
California						✓	
Colorado							
Connecticut					✓		✓
Delaware				✓			✓
District of Columbia					✓	✓	✓
Florida							✓
Georgia	✓	✓		✓		✓	✓
Hawaii					✓		✓
Idaho				✓			
Illinois	✓	✓			✓	✓	✓
Indiana							✓
Iowa						✓	✓
Iowa -1915(i)	✓						
Kansas					✓		
Kentucky							
Louisiana							
Maine	✓			✓	✓	✓	✓
Maryland	✓	✓			✓	✓	✓
Massachusets				✓		✓	✓
Michigan	✓	✓		✓		✓	✓
Minnesota					✓		✓
Mississippi							
Missouri							
Montana							✓
Nebraska							✓
Nevada							✓
Nevada -1915(i)							
New Hampshire	✓						
New Jersy							✓
New Mexico					✓		✓
New York	✓	✓		✓	✓	✓	✓
North Carolina				✓			✓
North Dakota						✓	
Ohio				✓			
Oklahoma				✓	✓		✓
Oregon	✓	✓			✓	✓	✓
Pennsylvania	✓		✓	✓	✓	✓	✓
Rhode Island	✓	✓					✓
South Carolina							
South Dakota							✓
Tennessee	✓	✓			✓	✓	✓
Texas							
Utah							
Vermont	✓	✓		✓	✓	✓	✓
Virginia	✓				✓	✓	✓
Washington							✓
West Virginia							✓
Wisconsin				✓		✓	✓
Wyoming					✓	✓	
Total:	**15**	**9**	**1**	**13**	**19**	**19**	**33**

Table 6: Evidence-Based Practices for Children

State	Intensive In-home Services	Therapeutic Foster Care	Multi-systemic Therapy	Wraparound	Family Psychoeducation	Integrated MH-SA Treatment	Illness/Disability Self-management	Supported Education	Supported Employment	Supported Housing	Assertive Community Treatment
Alabama	✓				✓		✓				
Alaska		✓			✓						
Arizona	✓	✓	✓		✓						
Arkansas	✓	✓									
California			✓								
Colorado	✓										
Connecticut	✓	✓	✓	✓	✓	✓	✓			✓	✓
Delaware	✓	✓			✓						
District of Columbia	✓		✓		✓	✓					
Florida	✓	✓			✓						
Georgia	✓	✓		✓	✓	✓					
Hawaii	✓	✓	✓		✓	✓					
Idaho											
Illinois	✓	✓					✓				
Indiana			✓								
Iowa					✓						
Kansas	✓	✓			✓						
Kentucky	✓	✓	✓								
Louisiana	✓										
Maine	✓	✓	✓	✓	✓						✓
Maryland	✓	✓	✓			✓	✓		✓	✓	
Massachusets	✓				✓	✓					✓
Michigan	✓		✓	✓	✓						
Minnesota		✓									
Mississippi	✓			✓							
Missouri	✓	✓		✓	✓						
Montana		✓									
Nebraska	✓	✓			✓	✓					
Nevada	✓	✓	✓	✓	✓						
Nevada -1915(i)		✓									
New Hampshire									✓		
New Jersy		✓	✓	✓	✓	✓	✓				
New Mexico	✓	✓	✓		✓		✓				✓
New York											
North Carolina	✓	✓	✓		✓						
North Dakota	✓	✓									
Ohio	✓				✓						
Oklahoma		✓			✓						
Oregon	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Pennsylvania	✓	✓	✓	✓	✓	✓					
Rhode Island		✓									
South Carolina	✓	✓			✓						
South Dakota	✓				✓						
Tennessee	✓				✓	✓			✓		✓
Texas				✓	✓						
Utah		✓			✓						
Vermont	✓	✓			✓	✓					
Virginia	✓	✓	✓	✓			✓		✓		✓
Washington											
West Virginia											
Wisconsin	✓				✓	✓					✓
Wyoming		✓		✓		✓					
Total:	**34**	**31**	**17**	**13**	**31**	**14**	**8**	**0**	**5**	**3**	**8**

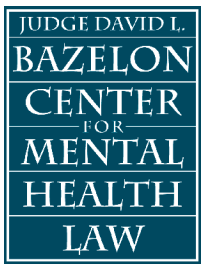
Table 7: Payment Rules

State	Transition Services (one level of care to another)	Consultation (Two Professionals Paid)	Team Consultation	Collateral Contracts	Telepsychiatry	Telephone Contacts with Client Paid	Provider Time in Transit	Peer Specialists	Behavioral Aides
Alabama		✓							
Alaska					✓				
Arizona		✓	✓		✓	✓		✓	
Arkansas				✓	✓				
California				✓		✓			
Colorado		✓							
Connecticut	✓	✓	✓	✓		✓	✓	✓	✓
Delaware	✓	✓				✓	✓		✓
District of Columbia	✓	✓				✓			
Florida	✓	✓							
Georgia	✓							✓	
Hawaii		✓		✓		✓		✓	
Idaho	✓			✓					
Illinois	✓	✓		✓				✓	
Indiana				✓					
Iowa		✓		✓					
Kansas		✓			✓			✓	
Kentucky	✓	✓		✓	✓				
Louisiana									
Maine				✓	✓			✓	
Maryland	✓	✓	✓						✓
Massachusets	✓	✓		✓		✓		✓	
Michigan	✓		✓	✓	✓			✓	✓
Minnesota	✓	✓			✓	✓			✓
Mississippi	✓	✓		✓					✓
Missouri	✓	✓		✓		✓			✓
Montana		✓		✓					
Nebraska	✓	✓	✓	✓		✓	✓	✓	✓
Nevada	✓						✓	✓	✓
New Hampshire									
New Jersy				✓		✓			✓
New Mexico		✓	✓	✓	✓	✓		✓	✓
New York				✓					
North Carolina	✓	✓				✓			
North Dakota		✓		✓	✓	✓			✓
Ohio				✓	✓	✓			
Oklahoma		✓			✓	✓	✓	✓	✓
Oregon		✓		✓	✓	✓	✓	✓	✓
Pennsylvania			✓	✓	✓	✓	✓	✓	✓
Rhode Island			✓	✓			✓		
South Carolina	✓			✓	✓	✓		✓	
South Dakota		✓							
Tennessee	✓			✓	✓			✓	
Texas				✓	✓			✓	
Utah				✓					
Vermont	✓	✓	✓	✓	✓	✓	✓	✓	
Virginia		✓		✓	✓	✓		✓	✓
Washington		✓						✓	
West Virginia		✓							✓
Wisconsin									
Wyoming	✓	✓		✓	✓	✓		✓	✓
Total:	**21**	**30**	**9**	**31**	**20**	**22**	**9**	**22**	**18**

Table 8: States with Carve-Out Managed Care Arrangements for Mental Health Services

States	Adults on SSI*	Children on SSI*	Low-Income Adults	Low-Income Children	Foster Care Children	Uninsured/Expansion Populations
Arizona	yes	yes	yes	yes	yes	yes
California	yes	yes	yes	yes	yes	yes (includes SCHIP)
Colorado	yes	yes	yes	yes	yes	no
Connecticut	no	yes	yes	yes	yes	yes
Delaware	no	yes	no	no	no	no
Florida	yes	yes	yes	yes	yes	no
Hawaii	yes (for SMI)	yes (for SED)	yes (for SMI)	no	no	no
Iowa	yes	yes	yes	yes	yes	SCHIP
Kansas	yes	yes	yes	yes	no	no
Massachusetts	yes	yes	yes	yes	yes	yes (includes SCHIP)
Michigan	yes	yes	yes	yes	no	no
Missouri	no	no	yes	yes	yes	SCHIP
Nebraska	yes	yes	yes	yes	yes	yes
New Mexico	yes	yes	yes	yes	yes	SCHIP
North Carolina	yes	yes	yes	yes	yes	no
Oregon	yes	yes	yes	yes	yes	yes (includes SCHIP)
Pennsylvania	yes	yes	yes	yes	yes	no
Tennessee	yes	yes	yes	yes	yes	yes (includes SCHIP)
Texas	yes	yes	yes	yes	no	yes
Utah	yes	yes	yes	yes	yes (inpatient)	primary care only
Vermont	yes	yes	yes	yes	yes	yes
Washington	yes	yes	yes	yes	yes	yes

* In states that do not use SSI as eligibility for Medicaid, includes individuals who are aged, blind and disabled.


JUDGE DAVID L.
BAZELON
CENTER
FOR
MENTAL
HEALTH
LAW