MAKING SENSE OF MEDICAID

FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

A review of how states provide access to the most effective community-based services for children on Medicaid who need mental health care.

BAZELON CENTER FOR MENTAL HEALTH LAW

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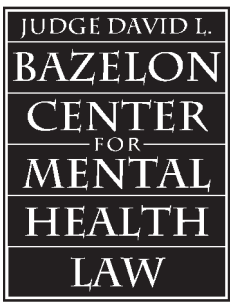
September 1999



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The Bazelon Center is the leading national legal advocacy organization representing low-income adults and children with mental disabilities. We work for their full integration into the community by protecting their rights to choice and dignity and expanding their access to health and mental health care, housing, employment and income-support. Our strategies include system-reform litigation, legislative and policy advocacy, public education and constituency-building. The center publishes materials interpreting major federal laws and regulations; staff attorneys provide training and technical assistance to lawyers, protection and advocacy agencies and other advocates for low-income individuals and families.

Additional copies of ***Making Sense of Medicaid*** and its companion booklet, ***Where to Turn: Confusion in Medicaid Policies on Screening Children for Mental Health Needs***, may be ordered from the Bazelon Center's online store via a link from www.bazelon.org, or with a copy of the form on page 90.

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FOREWORD

Children with mental health needs are much in the news these days. It is more vital than ever that public systems be able to provide the services these children need to live safely and grow up in families. The federal-state Medicaid program should be a principal avenue of access to the kinds of community mental health services these children require, yet, as a result of deficient state policies, it remains underused for their benefit.

It is alarming that, 10 years after the passage of federal legislation requiring Medicaid-eligible children to have access to all medically necessary services to treat any physical *and mental* conditions, many states have less-than-adequate definitions of covered services. Although, under Medicaid law, children are eligible for *all* appropriate care, the lack of specificity in many state rules makes it very hard for families to access many critical services, or even to know that their child has such coverage.

The Bazelon Center has produced this report with the goal of encouraging states to improve their Medicaid policies so as to expand and ensure children's access to appropriate community mental health services—especially services for children with serious mental or emotional disorders.

In the three chapters of Part I we offer background on state-of-the art child mental health services, summarize current law and assess the meaning of our study's results. The meat of the study is Part II, explaining how the states we reviewed are making use of Medicaid for children's mental health care, and the tables showing the states' current definitions of covered services.

Medicaid funding is now the backbone of state mental health systems. It is therefore crucial for state Medicaid rules to reflect current knowledge on what services work best for children with mental and emotional disorders. We urge state policymakers in mental health, child welfare, education and other child-serving agencies, as well as officials in Medicaid, to review this study, their own state's rules and the examples of state definitions

that are summarized in Chapter 5, and consider whether—and what—changes should be made to their own state's rules and/or managed care contracts.

We also hope this report will assist advocates for children in pressing for policy improvements in their state and, most importantly, informing families of their child's rights. To assist advocates further in their work with families—and to further inspire state officials toward policy improvement—we have produced a coordinated publication on the issue of identifying children who need mental health services. Titled ***Where to Turn: Confusion in Medicaid Policies for Screening Children for Mental Health Needs***, this much shorter report can be ordered via the form on page 90.

Acknowledgments

Both publications, ***Making Sense of Medicaid*** and ***Where to Turn***, were written by Chris Koyanagi, the Bazelon Center's policy director, in consultation with legal director Ira Burnim and staff attorney Mary Giliberti. The analysis is based on research directed by Rafael Semansky, assisted by interns Lindsay Dutton, Heidi Lifson and Jennifer Kettren, with support from Gwen Ewing. Communications director Lee Carty edited and designed both.

We are profoundly grateful to the Annie E. Casey Foundation for supporting the writing and production of these reports, and to the Center for Mental Health Services and project officer Judith Katz-Leavy, for funding the study reported in Chapters 4 and 5. Others contributing to this work are also acknowledged with deep appreciation: the Nathan Cummings Foundation, Freddie Mac Foundation and David and Lucile Packard Foundation, for their support of our work on behalf of children, and the John D. and Catherine T. MacArthur Foundation and Public Welfare Foundation, which provide generous core support for the Bazelon Center's overall advocacy program.

Robert Bernstein, Executive Director
September 30, 1999

MAKING SENSE OF MEDICAID
FOR CHILDREN WITH
SERIOUS EMOTIONAL DISTURBANCE

PART I

CHAPTER 1
PURPOSE OF THIS REPORT

This is a report on how well states provide access to the most effective community-based services for youngsters on Medicaid who need mental health care. The Bazelon Center has prepared it to help policymakers, families and advocates understand the federal rules concerning child mental health services and compare their state's Medicaid rules against those of other states. We describe in detail how Medicaid law is being implemented by states, offering data on all covered mental health services but focusing particularly on the complex array of services needed by children with serious emotional disturbance and their families. This report reviews service definitions in fee-for-service Medicaid, specialized mental health managed care plans and selected managed health care plans, such as health maintenance organizations.

What's in This Report

This report offers information:

- on the arrangements each state uses for the provision of child mental health services—integrated managed health care entities (HMOs or other MCOs), behavioral health carve-out managed care entities and fee-for-service;
- on the state rules and managed care contracts that define the specific services in the state, with a particular emphasis on community-based wraparound services;
- comparing rules for coverage in traditional fee-for-service Medicaid, HMOs/MCOs and managed care organizations that

provide extended benefits (these are primarily the mental health care carve-out plans, but in some states they are HMOs/MCOs);

- on the most comprehensive definitions of certain community-based wraparound services;
- summarizing particularly innovative approaches in specific states using Medicaid resources under managed care and fee-for-service to finance wraparound services.

We hope that, armed with this information, state policymakers and advocates will work together to improve their state's definitions for the various mental health services for which children are eligible and to develop those services in all parts of the state so they will be accessible to all children and families in need.

Overall, there is much room for improvement in state Medicaid policies governing services for children who need mental health care. This is especially true for children who need extended services because they have serious emotional disorders. Despite a federal mandate that Medicaid children receive all medically necessary services authorized by federal law, many states have policies that prevent children from receiving services that would enable them to avoid residential or inpatient hospital placement and to do well in their home, school and community. The barriers raised by some state policies are especially high for intensive community-based services, such as in-home services, family support, family respite, independent-living skills training, summer programs and services for very young children.

BACKGROUND

About one in five children suffers from a diagnosable mental, emotional or behavioral disorder,[1] and a significant proportion of these children have disorders that have a substantial impact on their ability to function. According to recent estimates, 9-13% of children aged 9-17 have a serious emotional disturbance which causes a "substantial functional impairment;" 5-9% have a serious emotional disturbance which causes "extreme functional impairment."[2]

Recent studies confirm that substantial numbers of children with mental disorders do not receive the services they need.[3] Some 75-80% of children with serious emotional disturbance fail to receive

specialty services, and most receive no mental health services at all. These studies are consistent with an earlier finding that two thirds of all children who need mental health care go without treatment.[4]

There is evidence that mental and emotional disorders in children are growing more pervasive, that children are showing signs of very significant distress while still toddlers and preschoolers,[5] and that childhood disorders are far more significant and serious than policymakers have previously assumed. Recent and tragic schoolhouse shootings dramatize how young boys may externalize their distress, but many other boys and girls suffer more quietly from equally serious disruptive mental disorders.

Children enrolled in Medicaid have been found to have significant rates of mental disorder and relatively high rates of service utilization. More than 200,000 children with serious emotional disturbance are categorically eligible for Medicaid by virtue of their eligibility for federal Supplemental Security Income (SSI) disability benefits; they represent about 24% of children on SSI.[6] By definition, these children have very significant functional impairments. Other low-income children who are Medicaid-eligible also have significant rates of mental disorder and high utilization of mental health services. A study of two state Medicaid programs in 1996, found that 5-7% of all nondisabled children used mental health care.[7] Between 8% and 11% of them had a psychiatric hospital stay, and their stays were much longer than for the general child population. About 20% of them also had a re-admission. Importantly, this study also found that the percentage of total expenditures for all health services to these recipients was at least three times higher than the level suggested by their proportion in the general Medicaid population (although they represented only 5% of the children, they accounted for 17% of expenditures). These children represent significant costs to Medicaid, particularly with respect to their inpatient psychiatric care.

Another significant group of Medicaid-eligible children are those in the custody of child welfare. These children have high rates of mental disorders. Studies have found anywhere from 32-72% of children in foster care exhibit profiles of severe emo-

Which Children Are Eligible for Medicaid?

Medicaid is a federal-state program to provide health care to low-income individuals. Children whose families receive welfare benefits and children in families whose economic circumstances are similar to welfare families' are eligible.

Also eligible are children in families whose income level meets certain criteria—for children under 6, if family income is below 133% of the federal poverty level and, for children 6-14, when family income is below 100% of poverty. States can expand Medicaid beyond these federal minimum requirements, and 44 states have done so—some setting the family-income limit as high as 250% of poverty.

In addition, all children in the child welfare system are covered. And in most states, children who receive federal Supplemental Security Income (SSI) disability benefits can qualify for Medicaid.

For more details on Medicaid eligibility, see Appendix III.

tional disturbance.[8] These children are at high risk for developing maladaptive outcomes, including socio-emotional, behavioral and psychiatric problems that require mental health treatment.[9]

Accordingly, non-disabled children on Medicaid need significant mental health services. In addition, significant numbers of Medicaid-eligible children who have disabilities have serious emotional disturbance. Adequate access to effective child mental health care through Medicaid is therefore critically important.

COMPREHENSIVE COMMUNITY SERVICES

A full array of services is required to meet the needs of Medicaid-eligible children. This should include 24-hour inpatient care; crisis services; short-term, acute office-based therapy and medication services, and a wide range of intensive community services to assist the child and support the family in keeping the child at home. Generally speaking, the more traditional mental health services of inpatient and outpatient hospital care, office-based services and medications are the most widely available in communities and the most thoroughly defined under Medicaid. The intensive community services— which many families report are the most helpful to them—are the least available, and the least well-defined.

THE "WRAPAROUND" APPROACH

For the array of community-based services children need, mental health policymakers promote "wraparound." Wraparound is both a philosophical approach and a set of specific services for children who have serious mental or emotional disorders. Many of the children have multiple problems and use the services of more than one public child-serving entity, such as mental health, child welfare, special education and/or juvenile justice.

Wraparound has emerged as an effective service strategy. Moreover, families and children find it supportive and helpful.[10] Local demonstrations, statewide initiatives and a significant federal categorical program now support the approach in communities all across the nation.[11] A high percentage of Medicaid children who need mental health care will need wraparound services.

The concept of wraparound grew out of a nationwide effort

to reform children's mental health services. Wraparound was a response to a delivery system seen as being too inflexible, too restrictive, inefficient and insensitive to the needs of children and their families.[12] Wraparound services are community-based. Services and supports are individualized to meet the child and family's needs. Families are engaged in every step of the process and the nature of the supports changes to meet changing needs in the family situation.[13] The approach is culturally sensitive to the unique needs of the child and family. Services are based on the child's and family's strengths and are unconditional; families are not rejected from services when difficulties arise.

The wraparound approach has been found effective for diverse youth in a wide range of settings. It has worked for children and youth with severe disorders[14] and those at risk for serious emotional disturbance.[15] Wraparound can be applied to children of different ages, from as young as 5[16] to as old as 21.[17] Wraparound has been used for youth at risk of out-of-home placement,[18] for children in foster care,[19] children in institutions[20] and children returning from out-of-state placement.[21] The approach is effective for all cultural groups, including Caucasian, African American, Native American, Hispanic/Latino and Asian cultures.[22] Wraparound has been used successfully in both rural and urban communities.[23]

Wraparound requires interagency collaboration and an interdisciplinary approach, in which providers have access to flexible, noncategorical funding. Medicaid is not generally considered a flexible funding stream. However, under capitated managed care arrangements, states can provide for significant flexibility, allowing use of a wraparound approach. Even in fee-for-service, some states have clarified how Medicaid can fund a significant portion of a wraparound program and, if supplemented by other more flexible resources, Medicaid can clearly contribute significantly to the delivery of an appropriate and effective plan of care.

Since wraparound is a concept that emphasizes the provision of flexible services to meet the specific needs of an individual family, there is no definitive list of services which together comprise a wraparound program. However, some elements are common. They include:

Wraparound Works

A number of important sudies have evaluated the wraparound approach. Overall, it has reduced children's out-of-home placements and improved their functioning and symptoms. Highlights of a few studies are summarized here:

- A controlled evaluation of wraparound for children in foster care who had experienced multiple placements found that children who received wraparound services had significantly fewer placement changes, spent significantly fewer days as runaways and were more often permanently placed and less likely to be incarcerated.[24]
- Among children randomly assigned either to a treatment foster care program or to wraparound services, the wraparound group showed significant improvement in behavior, mood, emotions, symptoms and role performance at the end of a year, while the control group did not.[25]
- A study of youth being returned or diverted from out-of-state residential placement compared those with and without wraparound services. The wraparound group had higher ratings of community adjustment.[26]
- Outcome data for 40 youths in substitute care or at-risk of home removal found that after 12 months of wraparound services, the youth were living in significantly less restrictive settings and displaying significantly fewer problem behaviors than at baseline.[27]

- case management— coordination of care and advocacy to enable the child and family to access other services and benefits to which they may be entitled;
- individualized service plans— generally developed with interdisciplinary, interagency teams;
- an array of home-based and community-based mental health services and supports;
- school-based services—including afterschool and summer services;
- 24-hour crisis response;
- parent education and training—on the child's disorder and its management, parenting skills, family counseling, etc; and
- family support services—including respite care.

Each of these services is included in this study, to provide a picture of how well the wraparound approach can be supported with Medicaid resources. Since the federal government and many states promote interagency systems of care furnishing comprehensive wraparound community services, this report can assist policymakers, families and advocates in understanding how Medicaid policy can support the goals of current state and federal initiatives.

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CHAPTER 2

CHILD MENTAL HEALTH SERVICES UNDER MEDICAID

HOW CHILDREN ARE ENTITLED TO SERVICES

Children who are eligible for Medicaid are entitled to any federally authorized Medicaid service. Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate, all states must screen eligible children, diagnose any conditions found through a screen and then furnish appropriate medically necessary treatment to "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services."[1] A screen can be a formal checkup, covering both physical and mental health issues, or it can be any contact with a health care professional for assessment of a potential problem. Thus, children who need mental health care can be assessed by a community mental health provider and this assessment then entitles the child to any services necessary to treat the diagnosed condition.

Children have a broader entitlement than adults who qualify for Medicaid. For adults, some services are mandatory, but some need only be provided at a state's option. A state will list its "optional" services in its Medicaid plan, but must make available to children all services listed in the federal Medicaid law "whether or not such services are covered under the state plan."[2] However, a child is eligible only for services determined medically necessary.

This broad entitlement is now 10 years old. A 1989 law[3] created this *mandate* for children to receive a full array of necessary services.

WHAT MEDICAID SERVICES ARE COVERED IN FEDERAL LAW

Access to all federally authorized Medicaid services means that children are entitled to the following services, when the services are determined to be medically necessary:

24-Hour Services

- Inpatient hospital services for children under 21—includes inpatient services in a general hospital or psychiatric hospital or in a psychiatric facility accredited by the Joint Commission on Accreditation of Health Care Organizations, the Council on Accreditation of Services for Families and Children or the Commis-

sion on Accreditation of Rehabilitation Facilities. This category includes residential treatment centers.[4]

- Services in group homes of 16 or fewer beds.

Ambulatory Services

- Clinic option—assessment, diagnosis, crisis services, individual, group or family therapy, medication management, substance abuse counseling, family education and similar services when furnished on-site in the clinic by or under the direction of a physician.[5]
- Outpatient hospital services—clinical services furnished to outpatients.
- Physician services—services of licenced physicians, including psychiatrists.
- Services of other licensed professionals—states use this category to reimburse clinical psychologists and psychiatric social workers.
- Prescription drugs.

Intensive Outpatient Services

- Rehabilitation services—any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.[6]
- Targeted case management—assistance to gain access to needed medical, social, educational and other services.[7]

Waivers (require approval by the federal government)

- Home- and community-based services, including a full array of services furnished in place of institutional care.

This list represents a broad array, but federal definitions of these services are short and nonspecific. Some services in particular are not fully explained, such as those covered under "rehabilitation." As a result, states have discretion to define these terms further and to clarify the standards for providers wishing to bill for services.

States may define covered services "as long as the definition comports with the requirements of the statute in that all services included in...the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening process are provided."[8] However, states

The Services to Which Children Are Entitled

- Inpatient hospital care, residential treatment centers or group homes
- Clinic services by a physician or under a physician's direction
- Outpatient hospital services
- Physician services and services by other licensed professionals
- Prescription drugs
- Rehabilitation services
- Targeted case management
- When the state has obtained a federal waiver, home- and community-based services in place of institutional care

have used this authority in widely varying degrees. States do not define all services, and when there are no definitions, it is very hard for families to be sure what services their child is entitled to.

Insufficiently defined state rules also create problems for providers, who often do not know how to bill Medicaid for a service. Thus, although children in all states have the same entitlement to a full array of medically necessary services, the degree to which the state clearly defines those services and sets standards for providers to furnish them can have a major impact on the availability of a particular service for a child.

As a result, the mental health services actually provided to children—particularly community-based wraparound services—vary among states. Complicating the picture further is states' use of different terms to describe the same service or different definitions for similar terms. This makes cross-state comparisons even more difficult. For this report we have tried to assess and unify the terms in order to compare states' programs.

MANAGED CARE

In recent years, states have been shifting their Medicaid programs to managed care arrangements, significantly compounding the programs' complexity. States use different types of managed care in Medicaid for children who need mental health services. The most important are:

- managed health care organizations (MCOs) that are responsible for physical and some or all Medicaid-covered mental health services; often these are health-maintenance organizations (HMOs) and
- specialized managed behavioral health care organizations (MBHOs), known as "carve-out" plans, which provide mental health and sometimes also substance abuse services to a defined group of Medicaid consumers.

Then there is also traditional fee-for-service Medicaid, which still operates in most states, often alongside managed care.

THE IMPORTANCE OF MEDICAID

Despite problems discussed in more detail below, Medicaid is an enormously important funding source for wraparound and other mental health services to low-income children:

- States with fully defined community services under Medicaid

can obtain federal matching funds for a comprehensive array of intensive community services using the wraparound approach for children of all ages with serious emotional disturbance.

- Through capitated managed care arrangements (a federal waiver is required),[9] states can authorize a wider array of wraparound, even services not normally covered under fee-for-service Medicaid.
- Some states have addressed specific problem areas in Medicaid; their innovations expand the value of Medicaid in ensuring that children have easy access to the services to which they are entitled.

CHIP—INCREASING THE IMPORTANCE OF MEDICAID

Enactment of the federal Child Health Insurance Program (CHIP) has made Medicaid an even more important and valuable resource for meeting the needs of low-income children.[10] CHIP provides federal funds to ensure health care coverage for uninsured children in families with incomes up to 200% of the federal poverty level (in a very few states, up to 250% of poverty). States have the option of enrolling these children in Medicaid, thus expanding the Medicaid rolls significantly. CHIP makes it all the more important to have a clear understanding of what mental health services for children are accessible in a state's Medicaid program. See also the summary of eligibility rules in Appendix III.

NOTES

1. 42 U.S.C. §1396d(a).
2. Social Security Act, Section 1905(r)(5).
3. Omnibus Budget Reconciliation Act, 1989, Public Law 101-239, mandates that states provide the full array of federally authorized services to children, whether or not services are part of the state's Medicaid plan.
4. 42 C.F.R. §440.160 and §441.151
5. 42 C.F.R. §440.90.
6. 42 C.F.R. §440.130(d).
7. 42 C.F.R. §440.169, §431.51, §431.54 and §440.250.
8. State Medicaid Manual: Part 5, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Transmittal Notice No. 3, April 1990. Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C.
9. In capitated managed care arrangements, the state, county or other public entity pays a set amount to a managed care organization (MCO) for each person enrolled in the managed care plan. The MCO then has the responsibility to provide all necessary care to plan members when they need services. There are advantages on both sides: the public agency knows what its costs will be and the MCO can use its resources as it sees fit to meet enrollees' needs.
10. State Children's Health Insurance Programs, part of the Balanced Budget Act of 1997. Public Law 105-33, 105th Cong. 1st Sess.

Judge David L.
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Update on Medicaid for Children

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

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

- ***Eligibility***

  - ✓ Medicaid eligibility is expanded to require coverage of all children with family incomes at or below 133% of the federal poverty level (as of 2010, $29,400 for a family of 4, or $14,400 for an individual). States must maintain Medicaid eligibility rules for children that were in place early in 2010 for children until 2019. (Affordable Care Act).

  - ✓ At the state's option, certain families of children with disabilities may buy into the Medicaid program (this provision is from the Family Opportunity Act). Specifically, Medicaid coverage can be purchased by parents with family incomes of up to 300% of the federal poverty level for children under age 19 whose disabilities meet Supplemental Security Income (SSI) eligibility standards (Deficit Reduction Act).

  - ✓ States will have the option starting in 2014 to extend Medicaid coverage—including all benefits and EPSDT—to former foster children who have aged out of the system, up to age 26 (Affordable Care Act).

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

- ***Benefits***

  - ✓ States have new authority to limit benefits for certain groups of children on Medicaid by enrolling them in a "benchmark" plan modeled on private insurance benefit packages. However, all children up to age 19 are still entitled to any necessary Medicaid-covered service because the Early and Periodic Screening, Diagnosis and Treatment provision (EPSDT) still applies to them. However, in states that take this option, the Medicaid

benefit is bifurcated —children have certain benefits under their benchmark plan and only if they seek additional services based on the EPSDT mandate will those services be furnished. Very few states chose this option, and not all of those that initially used it still do. There are significant limits on which groups of children states may *require* to enroll in a benchmark plan. However, states may *offer* these benefits to any child enrolled on Medicaid (Deficit Reduction Act).

- ✓ The definition of targeted case management is clarified, as is when other programs must pay for case management because Medicaid is the last payer. The new legislative definition is essentially the same as the definition that has been in regulation for some years. The clarification regarding other programs' responsibility for case management focuses particularly on child welfare systems and also is not significantly different from prior administrative rules. General language about other programs' responsibility is of concern, but has not been clarified in the final federal regulations (Deficit Reduction Act).

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

- ***Demonstration Projects***

  - ✓ A five-year demonstration project has been established to test the feasibility and cost of home- and community-based waivers (1915(c)) for children who would otherwise be placed in psychiatric residential treatment centers. Ten states were selected for participation and the project is authorized until FY 2011. Under Medicaid law, to be eligible for a home- and community-based waiver, the child would otherwise need to be placed in a hospital, nursing home or ICF-MR (Deficit Reduction Act).

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

  - ✓ States may now impose premiums, deductions and co-payments for groups of Medicaid-covered individuals. Medicaid beneficiaries can also now be denied coverage for failure to pay their premium within 60 days and denied a service if they fail to pay co-payments. Allowable levels for state-imposed premiums and cost-sharing vary by family income. Although most children are exempt, those in families with incomes between 100% and 150% of poverty who qualify through a Medicaid optional eligibility group can be charged. Children whose family income is above 150% of FPL are also not exempt. There are limits on total cost-sharing, by service and/or income (Deficit Reduction Act).

- ***Other Provisions***

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

  - ✓ To assist states with the increased costs of the Medicaid expansion, the Affordable Care Act provides for an increase in the federal share of Medicaid costs for the newly enrolled children and adults (Affordable Care Act).

Children's Health Insurance Program (CHIP)

In addition to changes to Medicaid, Congress has continued the State Children's Health Insurance Program (CHIP) and extended the current authorization (through FY 2013) for two additional years (to 2015), providing funding through September 2015 with an increase in the federal share.

States must maintain current CHIP eligibility standards at least until September 30, 2019 (Affordable Care Act). Another law enacted in 2009 amended the rules on benefits to require parity for mental health benefits so that they are comparable to benefits for medical/surgical services (Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3).

7/10

CHAPTER 3

PROBLEMS IN MEDICAID IMPLEMENTATION

Problems with Medicaid-funded child mental health services stem both from the federal law and from issues that arise in the states. These problems include:

- confusion about a child's entitlement;
- accessing an effective EPSDT screen;
- division of responsibility between different health plans;
- limits in managed care benefit packages;
- incomplete or missing definitions;
- the limitations of federal definitions;
- other problems in federal rules; and
- services not covered by Medicaid.

This section discusses these problems. Parts IV and V describe how some states have dealt with them.

CONFUSION ABOUT A CHILD'S ENTITLEMENT

Some states operate Medicaid as if EPSDT were a special service, rather than an entitlement. As a result, services that children are entitled to under federal law can be inaccessible because they are not among those listed in the state's Medicaid plan. A 1993 study found that only 25 states' Medicaid manuals for providers gave clear information on the specific services children could receive, and 15 of those states required providers to seek prior authorization for services that are not listed in the state plan.[1] While prior-authorization requirements are legal and may be appropriate for services that are needed only rarely, a number of states have them for many more routine services.

Even today, some state officials report that certain services are available only to "EPSDT children"—a meaningless term, since every Medicaid-eligible child is entitled to EPSDT services.

PROBLEMS IN OBTAINING EPSDT SCREENS

Longstanding problems with EPSDT screens impede access to services by children who need mental health care. Many mental health problems go unidentified because states have not conducted aggressive outreach to find children who need assessments.[2] Even

if they receive screens, many children are not referred for needed mental health services. Most children on Medicaid receive their EPSDT screens from a pediatrician as part of a regularly scheduled physical health care checkup. Since pediatricians often do not identify mental health problems and few states have screening tools designed to identify mental health issues, many children fall through the cracks.

Children often miss out on mental health services when they are screened by managed health care plans, which fail to assess adequately for mental health issues.

Children enrolled in managed care may miss out on mental health screening—and needed services—for another complex set of reasons. Many states now require a child's managed health care plan to conduct the screen. When the health plan fails to assess adequately for mental health issues, the child will not receive necessary mental health services. This occurs even when the state has a specialized managed mental health care plan for Medicaid-eligible children, because the child's health plan is generally the entity responsible for screening and identifying mental health problems. A Bazelon Center study found that only a quarter of the specialized managed mental health care plans are given the responsibility for EPSDT screens.[3]

Even though Medicaid law allows any qualified provider to assess a Medicaid-eligible child and bill that assessment as a screen, families may not seek specialized assessments if their health care plan has indicated the child has no mental health condition. And in states that use a mix of financing mechanisms (such as a health plan and a managed mental health plan, or fee-for-service Medicaid), families may not even know where the responsibility for an EPSDT screen lies, or how to access one.[4]

DIVISION OF RESPONSIBILITY FOR TREATMENT

The proliferation of managed care arrangements in Medicaid has created confusion about who is responsible for mental health care. The division of responsibility between funding streams is confusing for families and certainly hampers continuity of care.

Often a child who is enrolled for physical health care in an HMO receives mental health care through fee-for-service Medicaid or a specialized carve-out mental health managed care plan. Some children receive basic mental health services through their HMO, but only until a limit is reached; at that point the child can be

considered for an extended-services package provided through either fee-for-service Medicaid or a specialized carve-out plan. Continuity of care in these situations is a serious problem.

LIMITED BENEFIT PACKAGES

Most managed health care plans, such as HMOs, contract to provide only a short-term acute mental health benefit. However, the state remains responsible under the law for providing care to children who have serious disorders and who require services the HMO does not provide. States should inform families of their child's right to all medically necessary services, but few provide clear explanations. As a result, families, unaware that their child has such a right, do not know how to claim additional services if the HMO benefit is inadequate.

Some states have avoided this situation by covering all children who need mental health services under a specialized carve-out managed care plan that provides a full array of acute and long-term Medicaid services. Other states, however, limit access to such a plan to children in defined categories, such as children with disabilities, children with a serious emotional disturbance, children in the care of child welfare agencies, etc. As a result, some children who need more services than their limited health plan offers have great difficulty accessing them.

INCOMPLETE OR MISSING DEFINITIONS

As illustrated by the data in this report, a number of states fail to provide specific definitions of certain Medicaid services, particularly services authorized through the rehabilitation option. Without an adequate definition, providers worry that the state will not accept their service as appropriate. Further, they have trouble getting paid for the service, because it has no billing code and no published payment rate.[5]

As a result, providers often assume that an undefined service is not part of the Medicaid benefit. Families are then left to fight, service by service, treatment by treatment, for the care their child needs. Even if they understand a child's right to the service under Medicaid—and frequently they do not—this is a difficult, time-consuming and costly battle, sometimes requiring legal assistance.

LIMITATIONS OF THE FEDERAL DEFINITIONS

The federal law also lacks clear definitions of many important community-based services. This is especially true of community services using a wraparound approach to meet family crises and overcome barriers to the child's remaining at home. On the one hand, this lack of detail in the federal definitions gives states the flexibility to set their own standards. Several states have used this flexibility to describe an expansive array of services in detail. Other states have been more conservative, however, often leaving children and families without ready access to effective services that are covered under federal law.

Medicaid has also been criticized as being too medical and, especially, too clinical. Yet this is more a result of how Medicaid has been interpreted and defined by states than an outcome of the federal law, which provides much broader coverage for both physical and mental health care than the standard clinical approach of private insurance. As illustrated later in this report, this aspect of Medicaid is gradually being addressed state-by-state.

Kansas, New York and Vermont have found that Medicaid Home- and Community-Based Care waivers under Section 1915(c) enable them to provide a broader, more flexible service array than described in federal law. Maryland and Ohio have also requested home- and community-based waivers or have an application in the development stage. Still other states (e.g., North Dakota) use research and demonstration waivers under Section 1115 to expand services through capitated managed care arrangements.

OTHER PROBLEMS IN FEDERAL RULES

Medicaid's rules are based on health insurance principles and therefore require a focus on the "patient" child. For the Medicaid program to be billed for a service, the child, in addition to being eligible for Medicaid, must have a diagnosis and must be the recipient of the service. These requirements can challenge states seeking to provide services that will allow early intervention or improve the child's environment. For example, for family-support services to be reimbursable, the state must define them in a way that clearly shows a direct, positive effect on the individual child.

The rule can be especially problematic when a child is in a vulnerable situation—with a substance abusing parent, for instance—and

could benefit from mental health services to avoid developing a mental health or substance abuse disorder later in life. Yet it is difficult, though not impossible, for states to cover these early intervention services.

This rule also makes it difficult for states to fund mental health consultation services to other agencies, such as schools or child care providers. However, some states use the Administrative Costs line (not discussed in any detail in this report) to fund such consultation activities. For example, a therapist may work with individual children (and bill for services) but also provide information to the caregivers about how to identify children with mental or emotional disorders and how to change the environment to be more conducive to accommodating children with mental health problems.

Federal Medicaid also creates problems for the wraparound concept of interagency collaboration and a team approach to care. It has proven difficult to pay for professional consultation with others, including other members of a child's treatment team. A few states now have rules allowing the wraparound team to bill time for all participants, although this is generally found in managed care plans. However, some states bill under fee-for-service for more than one team member.

SERVICES MEDICAID DOES NOT COVER

Certain types of services are quite specifically prohibited under federal Medicaid rules. Medicaid funds may not be used to pay for education or vocational services, including job training. Medicaid also does not pay for recreation or social services with no therapeutic value.

IMPACT

This study found an enormous discrepancy between the level of definition in state rules for traditional medical and clinical care (e.g., inpatient hospital services and psychotherapy) and for the intensive community services required by children with serious disorders. Traditional services are almost universally described in detail in state Medicaid rules, while many community-based services using the wraparound approach are defined in fewer than a third of the states.

For lack of community services, many parents have had to give up custody of their children to the child welfare system in order to access Medicaid-funded residential mental health care.

Families report that community-based wraparound services are the critical missing component in their communities. Yet because most states still fail to use Medicaid to clearly define the needed array of community-based services, the state is not able to claim the federal reimbursement that would allow these services to be more widely available.

The combination of narrow eligibility rules and difficult reimbursement policies has created a major problem for parents and robbed children of their rights. A disturbingly large number of parents give up custody of their children to the child welfare system in order to access Medicaid-funded mental health residential care. This is a direct result of the lack of community services (as well as a lack of access to the services that do exist for families who are not eligible for Medicaid). A recent study[6] found this problem pervasive in approximately half the states, and a survey of parents[7] found that nearly one fourth had been told by public officials that they needed to relinquish custody to get needed services for their children. Fear of coerced relinquishment of custody is so widespread that it is the top policy priority of the Federation of Families for Children's Mental Health, the leading national group of families concerned with children's mental health.

NOTES

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4. *Ibid*.
5. Conversation with Don Kates, Director of Financing Projects, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, Washington D.C., June 1999.
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PART II

CHAPTER 4

FINANCING MECHANISMS AND SERVICE DEFINITIONS

Reviewing Medicaid programs in all 50 states and the District of Columbia, the Bazelon Center identified mental health services definitions in 68 programs. Unlike many studies that rely on expert opinion alone, we based this review on actual regulations and contract language as well as expert opinion. We examined state Medicaid regulations, provider manuals, state plans, managed care requests for proposals and contracts to identify the Medicaid-defined services. Then we sent a summary of the defined services we had identified to the state Medicaid agency and the Children, Youth and Family Division Representative of the National Association of State Mental Health Program Directors. We received responses from all but four programs in four states—a 96% response rate. For one third of the programs, we received responses from both entities queried.

ANALYSIS OF DELIVERY AND FINANCING MECHANISMS

We found that:

- Medicaid fee-for-service remains by far the most prevalent aspect of Medicaid for financing the intensive services required for children with serious emotional disturbance.
- Managed care arrangements, in contrast, are often limited to children with less significant mental health needs or are available only in a limited geographic area.
- Few states are currently contracting with for-profit private companies when they set up managed care arrangements to provide intensive community-based services for children.
- Managed *health* care (HMO/MCO) entities are widely used for Medicaid physical health care delivery and limited acute mental health care. In these situations, fee-for-service or other specialized managed care arrangements often supplement the HMO/MCO benefit for children who need extended mental health services.
- Some states have enrolled populations with significant mental

health needs, such as children in child welfare and children on SSI, in the integrated (HMO/MCO) plans. This raises the question whether, in fact, these children can easily access mental health services beyond the limited benefit of their plan—services that should be available to them through fee-for-service Medicaid.

- A significant number of states that use managed care are providing such arrangements:
  - through counties or regional bodies such as community mental health boards (in these states, there may be different approaches in different counties or the basic benefit package may be state-defined);
  - by managing the care themselves; or
  - by organizing managed care through traditional public-sector providers.

The vast majority of children whose condition suggests they would turn to the public mental health system for their care are not assigned to managed care for their mental health needs.

In other words, despite much recent attention to managed care under Medicaid, the vast majority of children whose condition suggests they would turn to the public mental health system for care are not assigned to managed care for their mental health needs. Although 54% of all Medicaid beneficiaries are enrolled in managed care programs[1] and 97 managed care programs in 47 states provide some form of mental health and/or substance abuse care,[2] children with significant mental health needs generally do not receive services to address their significant needs through these plans.

Many of the children who are so assigned are enrolled in specialized managed mental health care programs designed to meet their needs. Some of these programs are still organized, managed and furnished through traditional public mental health systems and may, therefore, not be very different (in terms of services they furnish) than the previous fee-for-service system. Nonetheless, some children with extended mental health care needs are in HMOs, which generally have limited benefits. This raises some concerns.

An important study of child mental health managed care reforms, conducted by the University of South Florida, has found stability in most of these arrangements. States reportedly are not changing the types of managed care they are using.[3] Accordingly, the information presented in this report probably does not represent transient trends.

The Medicaid arrangements examined for this study vary by state. We attempted to analyze the most significant arrangement in each state, whether fee-for-service or some form of managed care. In several states, we reviewed more than one financing mechanism (although sometimes these have the same benefit packages).[4] This report provides information on:

- traditional, fee-for-service Medicaid (39 states);
- managed mental health care carve-out programs that are either statewide or at least cover a significant proportion of the state (19 plans); and
- integrated managed health care entities, such as HMOs (12 plans).[5]

Differences Among States

Since only a few states have statewide managed mental health care arrangements, a great many children remain in fee-for-service. Most are children who live in rural areas and children who need extended-care services. Only 13 states have reached the stage where their fee-for-service rules have little or no applicability because managed care has been implemented for the public mental health system. For this reason, fee-for-service Medicaid rules were the primary arrangement we analyzed.

In only 15 states are children with extended mental health care needs enrolled through Medicaid contracts with private companies. However, many of these contracts do not cover all parts of the state or all children in the state. Colorado covers only one region; Florida has only a pilot project; Maryland covers only administrative services; California, Massachusetts, Oklahoma, Pennsylvania and Texas cover only some counties. Each of the plans in these states was analyzed, either in addition to or instead of fee-for-service rules.

Nine states have organized managed mental health care without using private companies. These plans were also analyzed.

Three states have contracts for integrated health and mental health services through managed health care entities. Oklahoma's plan operates only in parts of the state; Massachusetts' integrated plan is only for children who elect to enroll in an HMO. In these

Which States?

- Thirteen states use only managed care for the public mental health system (making fee-for-service no longer relevant): Arizona, California, Colorado, Delaware, Iowa, Maryland, Massachusetts, Michigan, New Mexico, Oregon, Tennessee, Utah and Washington.
- Fifteen states enroll children with extended mental health care needs in managed care using contracts with private companies: Arizona, Arkansas, California, Colorado, Florida, Iowa, Maryland, Massachusetts, Nebraska, New Mexico, Oklahoma, Oregon, Pennsylvania, Tennessee and Texas.
- Nine states organize managed care without using private companies: parts of California and most of Colorado, Delaware, Kentucky, Michigan, Pennsylvania (Philadelphia and Pittsburgh), Utah, Washington and parts of Wisconsin.
- Three states have contracts for integrated health and acute *and* extended mental health services through managed health care entities: New Mexico, Oklahoma and Massachusetts.

two states, we reviewed two financing arrangements. New Mexico's managed care plan operates statewide and the state no longer provides easy access to fee-for-service. However, for purposes of comparison, we also analyzed New Mexico's fee-for-service rules.

This analysis does not review all of the numerous Medicaid HMO/MCO plans, but includes a sampling of these benefit packages. Additional data from other studies indicate that the packages in the analyzed plans are generally similar to those in other states.[6]

A few states have developed unique financing approaches. Four examples are described in Part 5: Milwaukee, Wisconsin (Milwaukee Wraparound managed care); Delaware (public-sector managed care); Kansas (home- and community-based care waiver); and Florida, (blending of Medicaid and juvenile justice).

MANAGED CARE ARRANGEMENTS

Table 1 (page 76) explains the nature of the various managed care arrangements studied and the populations enrolled in them. As shown there, these plans are either carve-out specialized managed mental health care plans or integrated HMO/MCO plans. They are generally available across a significant geographic area, and 70% are statewide.

Table 1 also clarifies the population of children the plan is expected to serve, either through an acute benefit (such as inpatient services and outpatient clinical treatment) or by providing services for children with extended mental health care needs. Generally speaking, only plans serving the latter group include intensive community-based services, using the wraparound approach.

Enrollment information shows that nearly all (97%) of the managed health care plans cover children enrolled through the welfare system (AFDC/TANF); 80% of these plans also enroll children who receive supplemental security income (SSI). About two thirds of the plans (63%) are responsible for children in the custody of the state child welfare agency. Accordingly, both HMO/MCOs and specialized managed mental health carve-out arrangements have significant responsibility for providing mental health services to children who might have serious mental health service needs.

There is some evidence that states are increasingly moving

children who are more likely to be high utilizers of mental health services, such as those receiving SSI disability benefits or children in the child welfare system, into managed care arrangements of various kinds, including HMO/MCOs.[7]

Generally speaking, of the managed care programs, the specialized mental health managed care plans have the most expansive benefit, with the broadest array of services, and enroll the broadest population of children. Children on SSI and other children with serious emotional disturbance are often in these carve-out plans. In several states, other children with acute mental health needs are also enrolled in the specialized carve-out.

This study confirmed findings from the Health Care Tracking Project of the University of South Florida, that many carve-out plans have more expansive lists of covered-services.[8] This may reflect several factors. First, several states shifted to managed care arrangements specifically to create more expansive and flexible benefits, while constraining costs through a defined capitation payment.[9] Since the state pays a predetermined rate per person enrolled, flexibility in benefit structure does not raise concerns about runaway costs. Second, state policymakers may feel a need to mandate explicit inclusion of all necessary services in the plan's benefit package, out of concern that unlisted benefits might be denied. Public-sector programs operating in a fee-for-service environment are more likely to interpret policy broadly and to provide the fullest possible array of services.

Which Medicaid-eligible children are covered by integrated managed health care plans?

- ***97% of HMO/MCOs cover AFDC/TANF children.***
- ***80% cover SSI children.***
- ***63% cover children in the child welfare system.***

Both this study and the Health Care Tracking Project found that integrated managed care designs were more likely to be limited to traditional services typically included in commercial insurance plans, while carve-outs were more likely to include additional home- and community-based services.[10]

Some managed care contracts also list optional services, which the plan is not required to furnish but may make available to certain children if it chooses to do so. This flexibility is part of the attraction of contracting with managed care entities. However, we did not include these optional services in our analysis because 1) we were unable to identify the optional services available through many of the plans and 2) we lacked data to confirm that children

in these plans actually access these services.

For an explanation of the method used to include a service definition in this report, refer to the technical notes on page 64.

ANALYSIS OF STATE SERVICE LISTINGS

Our review found that:

- Traditional medical and clinical treatments for mental disorders are by far the most likely services to be defined in state Medicaid rules. Services that fall under the Medicaid categories of targeted case management or rehabilitation are far less often defined.
- When the state does define its community-based rehabilitative services, certain services are very often included: day treatment in schools and other settings, targeted case management, intensive home-based services and independent-living skills training.
- In contrast, a group of community-based rehabilitative services listed in far fewer states includes therapeutic foster care, respite and family support.
- Some community-based rehabilitative services are extremely rare, particularly summer camps and other summer programs, recreational services, therapeutic nurseries and therapeutic preschools.

The information below describes the child mental health services listed and detailed in state Medicaid rules. These services fall into three categories:

1. Intensive Community-Based Services

This category includes community-based wraparound services for children and youth with serious emotional disturbance. Children with less serious disorders will rarely need these services. In this category are the Medicaid services of targeted case management and rehabilitation.

2. Traditional Medical/Clinical Services

This category includes traditional outpatient mental health services, similar to the types of services normally covered under a private insurance plan or a Medicaid HMO/MCO. Included are the Medicaid categories of clinic services, physician services, services of mental health professionals and outpatient hospital services.

3. Residential Services

This category includes inpatient hospital care and other 24-hour-a-day facilities for children, such as residential treatment centers,

crisis residential programs and services for a child as well as room-and-board costs of caregivers in group homes.

We identified the most commonly listed mental health services in each of the categories. For clinic services and residential settings, we reviewed differences between services listed in the 39 fee-for-service programs and the 29 managed care programs. For the intensive community-based services, we compared fee-for-service programs with the 23 managed care programs that provide intensive community services to children with extensive mental health care needs (77% of all the managed care programs reviewed).[11] The other seven managed care programs were HMO/MCO plans and provide only acute mental health benefits. In these states, fee-for-service Medicaid offers the intensive community service benefit for children with serious emotional disturbance.

INTENSIVE COMMUNITY-BASED SERVICES

This is the most significant group of Medicaid-funded community-based services for children with serious emotional disturbance. Included are all of the less traditional mental health services, ranging from family respite and summer camp activities through transitional living services for older adolescents. These services are usually covered through the Medicaid service categories of targeted case management and rehabilitation. Not included are traditional psychiatric and clinical treatment, reviewed beginning on page 28.

Generally speaking, the fee-for-service Medicaid programs list more intensive community-based services than do managed care arrangements. Nonetheless, other than the HMO/MCO plans which are designed to provide only acute care, a high proportion of all Medicaid programs covered significant intensive community services for children with serious emotional disturbance.

The following intensive community-based services are the most often covered (see Part V for definitions of many of them).

- day treatment furnished in settings other than schools (defined in 74% of programs and 42 states);
- targeted case management (72% of programs and 43 states); and

- intensive home-based services (59% of all programs and 35 states).

These three services are prevalent in both the fee-for-service Medicaid programs and in managed care arrangements for children with extended needs. These managed care arrangements are more likely than fee-for-service Medicaid to list other day-treatment programs and intensive home-based services.

Some states bill for team care, either using Medicaid administrative funds or defining the activity as a service for a particular child.

The next most widely listed services are:

- school-based day treatment (50% of all programs and 30 states);
- independent-living skills training (53% of all programs and 30 states); and
- therapeutic foster care (37% of all programs and 20 states).

In addition, a significant number of states now define various services to support families so that children may continue to live at home:

- family support, sometimes labeled wraparound, (approximately one third of all programs and 19 states); and
- child respite (16% of all programs and 11 states).

Other services that can be part of a wraparound continuum were far less well covered. Few programs list summer camps/summer programs, recreational services, therapeutic nurseries or therapeutic preschools. Fee-for-service Medicaid programs are more likely to list these services.

A team approach to care is an important aspect of the wraparound approach. However, only five programs reimburse clinicians for attendance at team meetings. Medicaid rules make it difficult to bill for more than one professional to provide services related to a particular child at the same time. Nonetheless, some states have managed to do this, either using Medicaid administrative funds or defining the activity as a service for a particular child. States that bill for this as a service have authorized it either under rehabilitation services or under clinic or hospital service definitions. The number of clinicians may still be restricted (such as to two).

Part V of this report includes sample definitions of many of the above services, taken from both fee-for-service Medicaid and managed care arrangements in states that have relatively detailed rules.

The sample definitions are for wraparound services, wraparound team meetings, family support services, respite care, summer camps/afterschool/recreational services, use of parents as case managers/service providers, mentoring programs, intensive in-home services, early intervention services, services for very young children, and independent living skills programming.

Comparing Fee-for-Service and Managed Care

The following summary explains the degree to which each of the intensive community-based services studied for this report is defined in fee-for-service Medicaid and in managed care programs responsible for providing care to children with extended mental health care needs (in this section, referred to simply as "managed care programs"). Table 2 (page 80) is a full list of these services, by state and plan, for fee-for-service Medicaid programs; Table 3 (page 81) provides the same information for the managed care contracts.

- Targeted case management: Approximately three quarters of fee-for-service programs (80%) and managed care programs (73%) list this service.
- Intensive home-based services: Managed care arrangements (82%) are much more likely to list this service, while just over half of the fee-for-service programs (56%) list this service.
- School-based day treatment: More than half of fee-for-service (56%) and managed care arrangements (55%).
- Other day treatment: This service is more frequently listed in managed care arrangements (91%) than in fee-for-service (74%).
- Summer camps/summer programs: Few Medicaid programs (seven in all—five fee-for-service and two managed care) list this service through either arrangement.
- Afterschool activities: Few Medicaid programs (10 in all, six fee-for-service and four managed care) list this service through either arrangement.
- Family support/wraparound: One third of all Medicaid programs (36% fee-for-service, 36% managed care arrangements) list this service.

Covered Services

The intensive community-based services most often covered are:

- day treatment other than in schools (74% of programs, 42 states)
- targeted case management (72% of programs, 43 states)
- intensive home-based services (59% of programs, 35 states)
- school-based day treatment (50% of programs, 30 states)
- independent-living skills training (53% of programs, 30 states)
- therepeutic foster care (37% of programs, 20 states)
- family support/wraparound (32% of programs, 19 states)
- child respite care (16% of programs, 11 states)

Covered by just a few programs—and then primarily by fee-for-service Medicaid programs—are:

- after-school activities
- summer camps/summer programs
- therapeutic nurseries
- therapeutic preschool
- other independent living programs

- Child respite care: About one quarter of managed care arrangements (23%) and Medicaid fee-for-service programs (15%) list this service.
- Therapeutic foster care: three fee-for-service programs and one managed care program provide reimbursement for all costs of therapeutic foster care, including room-and-board; 10 managed care programs (45%) and 15 fee-for-service (39%) reimburse therapeutic foster care services but not room and board.
- Therapeutic nurseries: Few Medicaid programs (seven in all, three fee-for-service and four managed care) list therapeutic nurseries.
- Therapeutic preschool: Only three Medicaid programs (two fee-for-service and one managed care) list therapeutic preschools.
- Independent-living skills training: More than half of the fee-for service programs (59%) and the managed care arrangements (59%) list this service.
- Other independent living programs: A few programs (four in all—two fee-for-service and two managed care) list other independent living programs.

In addition to these specific service definitions, some states list wraparound services as a single service that includes in its definition components of wraparound such as those described above.

Another broad category of service definition is psychosocial rehabilitation services, listed in 31% of fee-for-service arrangements and 23% of managed care programs. This may include several of the services listed above, but state rules do not provide sufficient detail to assess the extent to which each component studied for this report is defined. The psychosocial rehabilitation definitions are frequently based on the rehabilitative service definitions for adults; as a result, often they are not as relevant for children.

MEDICAL AND CLINICAL SERVICES

This category includes the Medicaid service categories of clinic, physician, other licensed professionals and hospital outpatient services. These four Medicaid categories cover basic medical and therapeutic services, including assessments and diagnosis, crisis services, psychotherapy, medication management and partial hospitalization.

This analysis reviews the definitions in fee-for-service programs and all managed care arrangements (both those with acute-care benefits and those serving children who need extended care).

Medication management and individual, family and group therapy are the most widely listed services in this category, specified by nearly all Medicaid fee-for-service and managed care programs. Crisis intervention is the next most widely listed service. Nearly all managed care arrangements list it; fee-for-service Medicaid programs specify it to a lesser extent.

Also explicitly listed in a significant number of Medicaid programs are substance abuse counseling (listed by 72% of programs in 38 states) and partial hospitalization (listed by 65% of programs in 36 states). Managed care contracts are slightly more likely to list substance abuse counseling and also more likely to specify partial hospitalization services than the fee-for-service Medicaid rules.

Few Medicaid programs list any specific clinic services other than the study categories (see Table 3).

States have used the flexibility in federal law to authorize psychologists to bill Medicaid directly on a fee-for-service basis, but only a few states authorize billing by any other non-physician mental health practitioners. Some allow social workers to bill independently, but almost no other mental health professionals are able to do so. For this analysis, only fee-for-service Medicaid programs could be reviewed, since the contracted managed care plans are responsible for developing their own networks and for credentialing their providers. It is very possible that managed care arrangements enable a wider range of professionals to provide services independent of physician supervision, because MCOs may view this as cost-effective.

Physician services, including psychiatrists', and hospital outpatient services for mental health conditions are mandatory Medicaid services for adults. As a result, all states have clear guidance on these service categories. All fee-for-service programs list both services, but fewer managed care arrangements list these services specifically. For hospital services, this appears to be because states may choose to reimburse hospital services through their fee-for-service program.

Which mental health professionals can bill Medicaid directly? In fee-for service programs:

- ***psychiatrists,***
- ***psychologists, for testing, in 36 states***
- ***psychologists, for treatment, in 28 states***
- ***social workers, in 15 states***

Specifically, states cover the following medical and clinical services:

- Individual psychotherapy is listed in 100% of fee-for-service and 100 % of managed care arrangements.
- Family therapy is covered by 95% of fee-for-service programs and 97% of managed care arrangements.
- Group psychotherapy is listed in 100% of fee-for-service and 100% of managed care arrangements.
- Crisis intervention is commonly listed as a specific service in both managed care arrangements (97 %) and fee-for service (85%).
- Family education regarding the child's disorder is listed in nearly half (49%) of fee-for-service programs compared to about one third (31%) of managed care arrangements.
- Physician services, including the services of psychiatrists, a mandatory Medicaid service for adults, are listed by all 39 fee-for-service programs and nearly all managed care arrangements.
- Other licensed mental health professionals (listed in fee-for-service arrangements only):
  - 36 states (92%) allow psychologists to bill independently for psychological testing;
  - 28 states (72%) allow psychologists to bill independently for treatment;
  - social workers, with different licensure requirements depending on the state, are allowed to bill independently in 15 states (39%);
  - other mental health professionals (licensed professional counselors, advanced nurse practitioners, and marriage and family therapists) can bill independently in nine states (23%).
- Medication management is listed by all the fee-for-service programs and managed care arrangements.
- Partial hospitalization is more likely to be listed in managed care arrangements (69%) than fee-for service arrangements (62%).
- Hospital outpatient mental health services are a mandatory Medicaid service for adults and, as could be expected, are listed by all but one fee-for-service program (Alaska has no hospitals providing outpatient mental health services). Managed care arrangements (69%) are less likely to list this.

RESIDENTIAL SERVICES

This category of services, listed in Table 4, includes hospital inpatient services, residential treatment centers, group homes and crisis residential services. Not included is therapeutic foster care (see the first section above) or any service (including group homes or residential treatment centers) where the room-and-board costs are not paid for by Medicaid.

This analysis includes all fee-for-service programs and all managed care arrangements, both acute plans and plans for children with extended needs.

General hospital inpatient services for mental disorders and inpatient psychiatric hospital services are the most common residential services, listed in nearly 90% of all programs. General hospital inpatient services for mental disorders are more commonly listed in fee-for-service programs.

The next most common residential service for children is care in an accredited residential treatment center, listed in 56% of programs in 31 states.

Both psychiatric hospital inpatient services for mental disorders and residential treatment center services are more likely to be listed in managed care arrangements than fee-for-service.

Therapeutic group homes, small institutional settings of 16 beds or fewer, are listed by approximately one third of all programs in 20 states. Medicaid covers the costs of services and room-and-board costs for caregivers.

We also attempted to identify whether the state has specifically established residential crisis programs in accredited facilities as alternatives to hospital placement in time of crisis. This service is now quite commonly offered for adults, but was identifiable for children in only 40% of all Medicaid programs.

Specifically:

- General hospital inpatient services for mental disorders are much more often listed in fee-for-service programs (100%) than in managed care arrangements (76%).
- Inpatient psychiatric services are slightly more likely to be listed in a managed care arrangement (93%) than in a fee-for-service program (85%).
- Residential treatment centers are much more likely to be listed in

managed care arrangements (66%) than fee-for service (49%).

- Therapeutic group homes are listed by a third of all the programs (38% fee-for-service arrangement, 28% managed care).
- Residential crisis intervention is listed in 38% of managed care arrangements and 41% of fee-for-service arrangements.

NOTES

1. *Medicaid Managed Care Enrollment Report* (Baltimore: Health Care Financing Administration, 1998).
2. *State Profiles on Public Sector Managed Behavioral Healthcare and Other Reforms* (Rockville, MD: SAMHSA Managed Care Tracking System, 1998).
3. Pires, S., Armstrong, M., and Stroul, B. A., *Health Care Reform Tracking Project: 1997-1998 State Survey*. Tampa FL:Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Florida Mental Health Institute, University of South Florida. 1999.
4. Where the same benefit package is mandated but the organizational arrangements are different (such as when two separately operating county managed care plans exist but both must have a state-defined benefit), the benefit is counted as a single arrangement for purposes of this report.
5. Massachusetts and Oregon have both a specialized carve-out mental health managed care arrangement and integrated HMO/MCO plans. In this list, each is counted, making a total of 31 plans examined. However, in the charts on covered services, the plans in these two states are combined because the state requires both to meet a single defined benefit package. Thus, 31 plans were reviewed, but only 29 benefit packages.
6. *Assessing Approaches to Medicaid Managed Behavioral Health Care*, Bazelon Center for Mental Health Law, Washington D.C. February 1997.
7 *1997-1998 State Survey*, note 1.
8. *Ibid.;* also Pires, S., Armstrong, M., & Stroul, B. A, *Health Care Reform Tracking Project: 1997 Impact Analysis*. Tampa: FL:Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Florida Mental Health Institute, University of South Florida. 1999.
9. Stevenson, J., Bevilacqua, J. & Koyanagi, C., *Behavioral Health Managed Care: Survey of States (II)*, Bazelon Center for Mental Health Law, Washington D.C. 1997.
10. *1997-1998 State Survey,* note 1.
11. All carve-out managed mental health plans were in this category, as were four integrated plans HMO/MCO (New Mexico, Massachusetts, Oklahoma and Oregon).

CHAPTER 5

MEDICAID RULES AND PROGRAM INNOVATIONS IN SELECTED STATES

As states have moved to more clearly define in their Medicaid rules the various services available to children who need mental health care, new innovations have emerged. Service definitions have become clearer and more specific, making it easier for families and providers alike to understand what is an allowable Medicaid expense.

This section of the report offers examples of state rules and state innovations for aspects of community-based wraparound services. We provide these examples to stimulate further innovation and encourage replication in states where such services are either not clearly and easily billable or not definitively defined.

Information is provided on the following:

Wraparound Package of Services, p. 34

- Nebraska (managed care)
- Michigan (managed care)

Team Meetings, p. 36

- Kansas (fee-for-service)
- Minnesota (fee-for-service)

Family Support Services, p. 37

- Kentucky (managed care)
- Pennsylvania (fee-for-service)
- Maine (fee-for-service)

Respite Services, p. 38

- Vermont (home and community-based waiver)
- New York (fee-for-service)
- Texas (managed care, NorthSTAR)

Summer Camps/After-School/Recreation Programs, p. 39

- Kentucky (managed care)
- South Carolina (fee-for-service)
- Pennsylvania (fee-for-service and managed care)

Parents as Case Managers/Service Providers, p. 40

- Maine (fee-for-service)
- Kansas (fee-for-service and home- and community-based waiver)
- Kansas (fee-for-service credentialing rules)

Mentoring, p. 41

- Kentucky (managed care)

Home-Based Services, p. 42

- Michigan (managed care)

Early Intervention Services, p. 43

- South Carolina (fee-for-service)

Meeting the Needs of Very Young Children, p. 44

- South Carolina (fee-for-service)
- West Virginia (fee-for-service)
- South Carolina (fee-for-service)

Independent Living Skills Program, p. 48

- South Carolina (fee-for-service)

Financing Innovations, p. 49

- Kansas home- and community-based waiver
- Milwaukee Wraparound: public-sector system (managed care)
- Delaware public-sector managed care (managed care)
- Florida: services in juvenile justice residential programs (fee-for-service)

WRAPAROUND PACKAGE OF SERVICES

Nebraska (managed care)

Nebraska requires its contractor to provide wraparound mental health and substance abuse services for individuals and families with serious, multiple or complex illness, disease or disorder. "Parents and/or guardians must be integral in each step of the development of wraparound services for children and adolescents." According to the contract, the wraparound process is based on the following precepts:

"1) services are based in the community with the purpose of reintegrating the client into the home community as appropriate,
2) strategies are individualized in that they are tailored to the unique needs and strengths of the child,

3) services and supports are culturally competent,
4) the process is strength-based rather than deficit-based,
5) professionals work in partnership with the individual/family to promote the individual/family ownership of the plan,
6) collaboration across agencies creates an integrated system of care,
7) use of informal community supports as the primary strategy to assist individuals/families, and
8) unconditional care (not rejecting individuals/families from services because they are too difficult to serve)."

Wraparound services are to include care coordination, including meetings of the multidisciplinary team (see "team meetings," below), coordinating formal and informal services/supports/resources, monitoring service delivery and implementation of the treatment plan, and monitoring outcomes.

"Services which may be provided under the Wraparound category include: outpatient, inpatient, day treatment, treatment foster care, respite care, and intensive home-based services as well as resources and community supports tailored to the unique needs, strengths and priorities of the individual/family. The purpose of these services is to assist the individual/family to develop a natural support system to support them when formal or publicly funded services are terminated.

"The wraparound process must be integrated with the comprehensive community-based system of care for individuals/families that includes local health and human service system (e.g., education, child welfare, adult and juvenile justice, vocational rehabilitation, development disabilities, health care, mental health, substance abuse) as well as consumers and community leaders."

Collaboration across agencies creates an integrated system of care in Nebraska.

Michigan (managed care)

In Michigan, wraparound services are defined as "...an individually designed set of services provided to minors with serious emotional disturbance or serious mental illness and their families that includes treatment services and personal support services or any other supports necessary to maintain the child in the family home. Wraparound services are to be developed through an in-

teragency collaborative approach and a minor's parent or guardian and a minor age 14 or older are to collaborate in planning the services."

Wraparound may include "substitute activities that meet the essential treatments/support functions, service objectives and intended outcomes of a covered service. Wraparound service arrangements are the result of a collaborative planning process that focuses on the unique strengths, values, norms, and preferences of the child/adolescent and family, and that is developed in partnership with other community agencies."

TEAM MEETINGS

Kansas (fee-for-service)

Kansas defines a case conference as "a scheduled face to face meeting between two or more individuals to discuss problems associated with the beneficiary's treatment. The conference may include treatment staff, collateral contact, or the consumer's other agency representatives, not including court appearances and/or testimony."

Minnesota (fee-for-service)

Minnesota permits a team approach to care "[i]f the service is provided by a team which includes contracted vendors and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team case management and a description of the roles of the team members."

Nebraska (managed care)

The definition of wraparound services specifies a multidisciplinary team that includes the individual and/or parent or guardian, the care coordinator, informal supports such as relatives, neighbors and community members who know the individual/family, mental health/substance abuse professional/staff involved in services to the

individual/family, and other professionals such as probation officers, teachers, clergy, etc. involved with the individual or family.

Kentucky (managed care)

In Kentucky's managed care rules, family support services are defined as services "...to prevent unnecessary hospitalization or psychiatric distress and decompensation that may lead to hospitalization...must be in the scope of medical necessity and must facilitate the prevention or relief of psychiatric distress or prevention of decompensation."

- Family support or self-help groups are services which, "whether provided singly, or in combination with other family members or parents, assist the child and family in understanding and coping with the family stressors associated with the child's disability. These services may include, but are not limited to, parenting skills training and the forming and leading of support groups."
- Wraparound supports: "in the form of material goods and assistance to the child and his or her family. These supports facilitate stability of placement and functioning for the child. These supports may include, but are not limited to, the purchase of medicine, food, clothing and transportation assistance; the purchase of vocational, recreational, and educational items not covered under law by the Local Education Authority (LEA) and the purchase of behavioral incentives for the child."

Pennsylvania (fee-for-service)

As part of its psychosocial rehabilitation services definition, Pennsylvania includes services to develop interpersonal, and when appropriate, community living skills. These services can include:

"Family support and training services which, for example, assist the parents of the child to identify social-emotional needs, and develop family interpersonal relationships which will allow the child to return to the child's family if this has been identified as a goal of the rehabilitative program."

FAMILY SUPPORT SERVICES

Kentucky covers self-help groups' activities, including "the forming and leading of support groups."

Maine (fee-for-service)

Maine defines family and community support services for children to include services provided to those under 21 years of age which provide family support (if appropriate), promote community integration and continuity of care, reduce symptomatology, and maintain quality of life and family intactness among children and adolescents who have emotional disturbance.

Services include: supportive counseling for guidance of the child and, if appropriate, family members; outreach; reunification and mediation; crisis management planning; ensuring continuity and consistency of such activities across school, home and community settings and other services. Services must be appropriate to the developmental level of the child.

CHILD RESPITE SERVICES

Vermont (home and community-based waiver)

Child respite care is provided in the recipient's home, place of residence or in the home of a respite provider, or foster home. Respite services are provided on a short-term basis "because of the absence of need for relief of those persons normally providing the care." Respite care must be "provided in accordance with the recipient's plan of care."

Reimbursement for the cost of room and board is only available when "provided as part of respite care in a facility approved by the state that is not a private residence."

New York (fee-for-service)

Child respite care in New York is defined as "activities that provide a needed break for the family and the child to ease the stress at home and improve family harmony. These activities include aid in the home, getting a child to school or program, aid after school, aid at night or any combination of these activities. It may be provided on a planned or emergency basis either in-home or out-of-home by trained respite workers."

Texas (managed care, NorthSTAR)

"Services provided to family members of an individual in services, based on their identified needs, for purposes of allowing the indi-

vidual to function as independently as possible. Respite services are those services provided for temporary residential placement outside the usual living situation. Community-based respite services involve introducing respite staff into the usual living situation, providing a place for the individual to go during the day/evening, or other services considered to provide a respite."

Kentucky (managed care)

SUMMER CAMPS/ AFTER SCHOOL/ RECREATIONAL PROGRAMS

This is a "structured program to bridge the school and home environments for children with severe emotional disabilities." Services "shall be provided in accordance with an individual treatment plan and may include:

- group activities that promote developmentally appropriate social skills with the child and with the family;
- daily clinical monitoring and intervention;
- individual, group, or family therapy;
- coordination with teachers, parents, or caregivers;
- scheduled activities that promote family involvement and empower the family to meet the child's needs;
- recreation therapy; and
- an individualized behavioral management plan developed by a clinical services provider.

The program must have continuing on-site supervision by a Clinical Services Provider. The following services can be furnished, as appropriate through a structured program:

- tutoring and special education;
- social skill building instruction; and
- recreation therapy.

South Carolina (fee-for-service)

As part of its service of "Wrap-Around," South Carolina defines "recreation therapy" as: "Structured, goal-oriented activities, both physically active and passive in nature, designed to assist children in self-expression, social interaction, self-esteem enhancement and entertainment as well as to develop skills and interests leading to enjoyable and constructive use of leisure time. Activities are

planned and therapeutically benefit the children referred."

Services must be furnished as part of a wraparound plan of care under the supervision of a physician and are available only to children who meet the state's definition of eligibility.

Pennsylvania (managed care and fee-for-service)

Under HealthPass, health maintenance organizations (HMOs) are responsible for providing summer therapeutic activities programs to children enrolled in those organizations.

These services are defined through Pennsylvania's fee-for-service regulations. They are to provide "a range of age appropriate specialized therapies (art, music, dance and movement, play, recreational or occupational therapies)...to aid in the development of interpersonal relationship, daily living, decision-making, problem-solving and coping skills. These services are generally provided in an outdoor environment for the purpose of furthering individualized therapeutic goals as described in the individualized treatment plan. Summer therapeutic activities programs are expected to be integrated into the overall mental health treatment of the child."

To participate in a summer therapeutic activities program, a child must have a documented need for the program, which must be prescribed or recommended as medically necessary by a licensed physician or licensed psychologist.

PARENTS AS CASE MANAGERS

Maine (fee-for-service)

Maine has issued a proposed regulation authorizing parents to qualify as case managers and furnish case management services for children with serious emotional disturbance and their families. Maine's system has three levels of case management; the parent-case manager is level one. The proposed regulation was effective February 1999, and includes the following language:

"Case managers provide resource coordination, information, and referrals... Case managers may be either a professional position or *may be performed by agency staff who have parented a child or adolescent with special needs*. For staff who perform (case management) services, the designated provider shall specify staff qualification,

training, and ongoing supervision, which must be approved by the Department of Mental Health, Mental Retardation, and Substance Abuse Services." (emphasis added)

Kansas (fee-for-service)

Kansas fee-for service Medicaid also utilizes parents as case managers, under its broad definition of case management providers: "Targeted case management services are provided by at least a BA/BS degree person, or one equivalently qualified by work experience or a combination of work experience and schooling with one year of experience substituting for one year of schooling. No formal education requirements are specified, but the staff member shall possess demonstrated interpersonal skills, ability to work with the mentally ill, and the ability to react effectively in a wide variety of human service situations...

"The case manager is supervised by an MSW (Master's Level Social Worker), RMLP (Registered Master's Level Psychologist), licensed psychologist or master's degree psychiatric nurse within the agency delivering targeted case management services."

Kansas defines case managers broadly, emphasizing experience and interpersonal skills.

Kansas (fee-for-service; credentialing rules)

Kansas' Medicaid fee-for-service program has expanded covered providers through less stringent credentialing of personnel who provide mental health attendant care and behavior management services. These services are available statewide.

Requirements for these staff include completion of a 40-hour basic training program, having a basic knowledge of normal and abnormal behavior, and showing an ability to relate to an emotionally disturbed child.

Kentucky (managed care)

MENTORING

In Kentucky, a child's treatment plan may include the following supports and services to prevent unnecessary hospitalization or psychiatric distress and decompensation that may lead to hospitalization. These services and supports must be in the scope of medical necessity and must facilitate the prevention or relief of

psychiatric distress or the prevention of decompensation:

- Mentoring: "social skills training and modeling for the child... may include, but is not limited to, the further development of social skills strengths held by the child, as well as focusing on the child's social skills deficits."
- Behavior management skills training: "instruction and training with the child and his or her family regarding behavior management techniques and interventions...may include, but is not limited to, assisting the parents or guardians in designing and implementing a behavior management plan for the child...(and) individual instruction with the child to enable (him/her) to recognize...maladaptive behavioral patterns and the rehearsal of more adaptive and appropriate behaviors."

HOME-BASED SERVICES

Michigan (managed care)

Mental health home-based service programs are designed to provide intensive services to individuals and families with multiple service needs who require access to an array of mental health services. Primary program goals are to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce usage of or shorten the length of stay in psychiatric hospitals and other substitute-care settings. The family unit is the focus of treatment.

The service style must support a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers. Services are provided in the family home or community.

"The degree of intensity will vary to meet the needs of families. The home-based services worker to family ratio should be established to accommodate the levels of intensity that may vary from 2 to 20 hours per week based on individual family needs. The worker to family ratio should not exceed 1:15 for a full-time equivalent position.

"Responsibility for directing, coordinating, and supervising the program shall be assigned to a specific staff position. The supervisor of the program shall meet the qualifications of a child mental health professional with 3 years of clinical experience.

"There shall be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the individual's and family's needs.

"Mental health home-based services shall be provided in accordance with a family focused plan of service. The family plan of service is a comprehensive plan that identifies child and family strengths and needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies, through a person-centered planning process.

"Mental health home-based services programs combine individual therapy, family therapy, group therapy, crisis intervention, service coordination, and family collateral contacts. The family is defined as immediate or extended family or an individual acting in the role of family.

"Services provided in a home-based services program range from assisting clients in meeting basic needs such as food, housing, and medical care, to more therapeutic interventions such family therapy or individual therapy."

The family unit is the focus of treatment in Michigan.

South Carolina (fee-for-service)

South Carolina's "High Risk Intervention" is "targeted to youth under age 21 who have early symptoms or are considered at risk of developing symptoms of mental health, substance abuse or developmental problems...This service also includes education/ training of caregivers, service providers and others who have a legitimate role in addressing the needs identified the needs in the service plan (non-agency staff)."

Activities billable under this definition include:

- group and individual counseling,
- staff support for client directed and managed activities,
- mentors,
- adaptive skill training in all functional domains (vocational, educational, personal care, domestic, social, communication, leisure, problem solving, etc.),

EARLY INTERVENTION SERVICES

- behavioral interventions (token/level systems, contracts, structured behavior programs, etc.),
- community integration activities,
- modeling, positive reinforcement, redirection, de-escalation, anticipatory guidance, etc.,
- providing training to caregivers, service providers and others who have a legitimate role in addressing the needs identified in the service plan (non-agency staff).
- additional staff to work with the child in the schools, home, community, residential settings, mainstream day programs, vocational settings, etc.,
- recreational activities when used as a strategy to meet clinical goals (e.g. exceptional equestrians, occupational therapy activities, therapeutic camping),
- telephone contact with the client or caretaker, and
- psycho-educational activities.

Modeling and recreational activities are among billable early intervention activities for high-risk children in South Carolina.

Non-billable activities include participating in treatment team meetings, writing treatment plans and progress notes, meeting without the client or relevant others present, and staff travel time.

MEETING THE NEEDS OF VERY YOUNG CHILDREN

South Carolina (fee-for-service)

South Carolina provides a therapeutic child care program for children from birth through age 6 providing "a psychosocial and developmental system of services...whose goal is to cultivate the psychological and emotional well-being of children and to promote their developing competencies."

To be eligible, the child must "show significant problem indicators in any one or more of the following developmental areas: attachment, emotional, social, cognitive, self-concept, self-help, behavioral, receptive/expressive language, and physical." And, "in the absence of focused, individualized interventions, these children and their families will be at high risk for more serious emotional/social problems."

Services are provided to both child and family and include "a well structured treatment program for young children provided in a

safe, nurturing, stimulating environment; monitored interactions of child and family; individual, group and family therapy; and in-home observation and intervention modalities."

Outcomes are expected to include "the prevention of child maltreatment, the mitigation of the affects [sic] of abuse and neglect, and the empowerment of families as skilled caregivers."

Services must be medically necessary and "recommended by a physician or other licensed Practitioner of the Healing Arts, within the scope of his/her practice under state law." A current DSM diagnosis, including certain conditions from the V Codes Section, will substantiate the medical-necessity determination.

Assessments involve professional determination of the child/family problems, factors contributing to them, and the family's strengths and resources. At a minimum, assessment services include "an age appropriate evaluation of the child's developmental as well as emotional/behavioral domains; a family history and assessment of problems and strengths, using an environmental assessment as part of this process. Results of observations of child, parent, and parent-child interactions (are also) documented."

An eligible child "has a substantiated case of abuse and/or neglect," or "has been removed from the home of the primary caregiver due to maltreatment/abandonment or other specified reason, and shows delay or deviation in *two or more*...domains (language, fine and gross motor, attachment, cognitive, behavioral, self concept, social/emotional, physical health)."

Children at high risk of abuse or neglect are also eligible. Environmental factors that put a child at risk are defined to include: "evidence of substance abuse in the home environment, previous or current violence in home, social isolation, social/health/education/vocational service inaccessibility..."

The program provides care at least four hours each day, and should be offered five days per week. A therapeutic schedule must be in place, documenting the activities that constitute the program day. A child may stay in the program as long as the medical-necessity criteria apply.

South Carolina's program for children up to age 6 and their families seeks "the prevention of child maltreatment, the mitigation of the effects of abuse and neglect, and the empowerment of families as skilled caregivers."

West Virginia (fee-for-service)

Early intervention services are available to all children from birth to age 3 who have a handicapping condition or are at significant risk for such conditions if they do not receive early intervention services. This includes children who have significant delays in any developmental area or a medical diagnosis such as Down syndrome, fetal alcohol syndrome, spina bifida, etc., or other combinations of factors that have been determined to place the child at risk of having delays if early intervention services are not provided.

"Services are provided at a level of intensity/frequency and in settings determined by the treatment team to ensure that children and their families have access to needed services and resources. Due particularly to the young age of the children and to promote efficiency and effectiveness, services are to be designed and delivered in a collaborative team approach. Necessary evaluations and services are conducted in natural environments to the extent possible and treatment plans are developed and implemented by the family and/or professionals as a team. The review of a child's/family's needs occurs on an ongoing basis and at regularly scheduled 90 day intervals to facilitate developmental progress."

West Virginia takes a team approach to care, involving families with professionals on the team.

All covered services can be utilized only by children determined through the Office of Maternal and Child Health as eligible for early intervention services under Part C of the IDEA.

Services include screening, "a face-to-face meeting of the child and/or care giver with professional staff to gather information necessary to complete the evaluation process."

Following screening, an assessment is made by a professional or therapist to make a determination of "a child's and family's strengths, resources, and basic needs." This shall include "evaluating the child's level of functioning in the following developmental areas: cognitive abilities, physical functioning, including vision, hearing and nutrition, language and speech, psychosocial/emotional, social/adaptive skills, gross and fine motor skills." It also includes "identifying services appropriate to meeting identified child and family needs; determining strengths, resources, and needs of the family related to enhancing the development of the child; and documentation of the assessment activity."

Intervention services can be provided to a child, caregiver or both by professional staff to promote the child's developmental progress. These services can be provided individually or in groups and may include:

- "Assistance with activities, equipment and learning environments that promote the child's acquisition of skills.
- "Working with the child to enhance the child's development.
- "Providing families or caregivers with information, skills, and support related to enhancing the development of the child.
- "Providing families or caregivers with the information, skills, and support to enable and empower the family."

South Carolina preschool program (fee-for-service)

South Carolina's preschool program offers "individual, family, and group services for children with emotional, behavioral, and/or developmental disturbances (in) a time-limited, intensive, coordinated structured milieu." The expected duration of the service is six months. The program's goals are to ensure that the child and family will "develop clinically adaptive behavior, with the ultimate goal of producing sufficient change so that the child will not require restrictive and intensive treatment in the future."

The ultimate goal of South Carolina's preschool program is to avoid restrictive placements.

The preschool program "is designed to serve young children (ages 2-5) within the least restrictive therapeutically appropriate context, to comprehensively evaluate children and their families, develop effective intervention strategies for caretakers and community agents, and assist in the implementation of these intervention strategies." Services include "accessing needed medical, psychiatric, social, educational and other support services essential to meeting the child's identified needs."

As a result, children should show a significant reduction in disruptive and problem behaviors and develop age-appropriate social and behavioral competencies, resulting in enhanced coping, self-control and more successful interactions with others. They should also show significant improvements in mood, accompanied by positive changes in self-worth and greater confidence.

Parents will "learn new strategies for managing problem behaviors and interfacing effectively with their children and identify

and reduce maladaptive patterns and stresses in the home which compound the participating child's emotional problems."

Services must be authorized and directed by a physician, who, "within the scope of medical practice, will decide if the service is therapeutic, ameliorative, and is expected to improve and preserve the health of the patient." The physician is "required to establish the diagnosis, treatment goals, and frequency of care" and to "evaluate the...need for continued service...(and participate as) a member of the multi-disciplinary treatment team..."

The preschool program is to be "included in the treatment plan for patients who the physician believes would benefit through reduction of a handicap and/or maintenance of role function." In addition, "a treatment goal shall be written that is outcome oriented and individualized. It shall be based on an assessment of the patient's current level of functioning and needs."

The preschool program includes "planned interactions between the staff, the child, the child's family and /or significant others." Interactions with the family and/or caretakers are intended "to promote the child's social and behavioral competencies and are directed towards enhancing family functioning." Treatment strategies are developed to assist the family/caretakers in promoting positive behaviors in the child.

The programs provide coordination and linkage with needed community services and resources.

Parents of participants will "learn new strategies for managing problem behaviors and interfacing effectively with their children and identify and reduce maladaptive patterns and stresses in the home which compound the participating child's emotional problems."

INDEPENDENT-LIVING SKILLS PROGRAMS

South Carolina (fee-for-service)

Supervised Independent Living involves a range of rehabilitative services for adolescents from 16 to 21, "designed to improve the quality of life for adolescents by assisting them to assume responsibility over their lives and to function as actively and independently in the community as possible. Supervised Independent Living is designed to both strengthen the adolescent's [sic] skills and develop environmental supports necessary to enable them to function independently in the community."

Services "are restricted to adolescents who have completed an intensive, out-of-home therapeutic placement or who have been

incarcerated in the Juvenile Justice System and who are in need of continued treatment services in a less intensive therapeutic environment which offers independent living skills." They "are intended to enable the adolescent to transition to a less intensive environment while encouraging the adolescent to maintain community tenure, obtain all necessary treatment services, access services from a variety of community programs, and improve his/her capacity for independent living. Services are provided in the context of a supportive, non-institutional environment[1] in the community and should be offered in a manner that maximizes the adolescent's responsibility, control and feelings of self worth, and encourages ownership in the rehabilitation process."

Two types of supervised independent living services are available in South Carolina:

- Level 1 services are available to adolescents "who need independent living skills provided in a structured environment. This level provides services in a therapeutic foster home, designated cottage on a residential group care campus, or a separate group care facility, in conjunction with 24-hour supervision by staff who have separate quarters within the foster home, cottage or facility.... These services are used to initiate independent living concepts and teach basic skills under immediate supervision."
- Level 2 services are provided in a structured environment with 24-hour on-site monitoring to adolescents at least 18 years old "who have demonstrated readiness to practice independent living skills with supervision" and who are employed or actively pursuing some type of educational and/or vocational program.

Level 2 services offer the opportunity for independent living "through the availability of an apartment or other living arrangement which is separate from, but supervised by on-site staff (e.g. adolescents share apartments and staff have a separate apartment in the same building). The adolescent assumes primary responsibility for daily living (e.g. cooking, shopping, money management,....). Staff supervision is supportive, less intensive, and available on a 24-hour basis."

The goals of supervised independent living are "to reduce problem areas which prevent successful independent living,

South Carolina's supervised independent living services "are designed to improve the quality of life for adolescents by assisting them to assume responsibility over their lives and to function as actively and independently in the community as possible."

implement an independent living plan, develop or increase skills in stress management, decision making, problem solving, coping skills and, if appropriate, to develop parenting skills, develop or increase basic life skills that contribute to successful independent living, reduce barriers to independence within the community by creating realistic opportunities for the adolescent to practice/apply skills learned and to develop a protected living environment for the adolescent requiring long-term protected care."

FINANCING INNOVATIONS

Several states have devised innovative approaches to funding community-based wraparound services for children with serious emotional disturbance, as summarized below.

Kansas Home- and Community-Based Waiver

Only three states operate home- and community-based Medicaid waivers for children with serious emotional disturbance (SED). Kansas operates one of the largest programs. As of January 5, 1999, 530 children and adolescents have been served (452 active plans of care and 78 terminated plans of care). For FY 1999, the program aims to serve 775 children and adolescents.

The waiver was designed to provide the following four additional services to children whom the state identified through its Children's Initiative project.

- Family training and support—These activities include coaching and assisting the family in increasing their knowledge and awareness of their child's needs, the process of interpreting choice offered by service providers, explanations and interpretations of policies and procedures and regulations that affect children living in the community.
- Wraparound facilitation/community support—This service involves assessment of the child's and family's/caretaker's strengths and needs for community relationships and involvement. It also produces an individualized community-based plan to access and be part of informal community resources and develop relationships to help the child succeed in the community.
- Independent-living skills—These services are designed to assist

children and adolescents in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home- and community-based settings. This service includes budgeting, shopping and working, engaging in recreational activities with peers, peer-to-peer support and appropriate social and work skills to remain in the community.

- Respite care—This service provides short-term and temporary direct care and supervision for youth. The primary purpose is relief to families/caretakers of a child with a severe emotional disturbance. Activities include aid in the home, getting a child to school or program and aid after school or at night, and/or any combination of the above. Respite care providers are required to complete an approved mental health and developmental disabilities training program.

The Medicaid program implemented the waiver through contracts with local mental health authorities. Parts of the state that were federal demonstration sites had developed an extensive array of services and eagerly sought waiver slots. Some areas had difficulties hiring attendant care and respite workers. Other jurisdictions were not as interested in the program and did not seek many slots. Due in part to these difficulties, the full array of services is not always available throughout the state.

Kansas has an extensive data-collection system to measure the outcomes of the waiver program. Although a larger percentage of the waiver children had a clinically significant Child Behavior Check List score, indicating more severe illnesses, they generally had better outcomes than children who were receiving regular case management services. For the last quarter of FY 1998, waiver children excelled on all other measures. For the first quarter of 1999, waiver children did better than their comparison group on all measures except the Child Behavior Check List score and contact with law enforcement. The difference between the groups in the law enforcement measure was a few percentage points. Considering the greater severity of the waiver children's disabilities, the waiver program has achieved excellent results. In addition, most families were very happy with the waiver services that they had received.

Four key services are covered under Kansas' waiver:
- ***family training and support;***
- ***wraparound facilitation/community support;***
- ***independent-living skills; and***
- ***respite care.***

Milwaukee Wraparound: Public Managed Care System

Milwaukee Wraparound provides services through an innovative public-sector managed care system exclusively to children at risk of residential treatment. Children are identified as high risk through their involvement in the juvenile justice and child welfare systems. Milwaukee County acts as an managed care organization providing a specialized behavioral carve out. The Medicaid capitation rate ($1,478 per child per month) follows the child through the system. Additional funds are then provided by child welfare, juvenile justice and other sources.

Milwaukee Wraparound's benefit package includes 60 services and supports under a capitated public-sector managed care arrangement.

Services are individualized for each child's situation. Service goals are to minimize out-of-home placements, support families and deliver services in the most effective manner. Milwaukee Wraparound provides a benefit package with no limits, covering 60 services and supports including: individual and family therapy, mentors, therapeutic camps, family foster care, day treatment, intense home therapy and respite. The managed care approach creates a seamless system offering services and supports through a provider network of 160 agencies. The array of providers is deliberately broad. Care coordinators are the key for arranging access and coordinating services in the system.

Lead care coordination agencies are selected through a request for proposals process and contracts are negotiated. Other services providers apply to be part of the network and are paid on a fee-for-service basis, based on negotiated fees.

The program began in 1994 and was initiated through a five-year grant from the Center for Mental Health Services for developing a system of care for children with serious emotional disturbance. Since 1994, the program has been significantly expanded. During the first two years, 175 children were served; to date, more than 650 children have been served by the program.

The program has resolved issues around multiple-agency funding by blending funds from three county systems: Medicaid, child welfare and juvenile justice. Medicaid's level of funding is based on two actuarial studies, through which the capitation rate was developed. One was a study of the 175 youngsters initially seen by the program. In addition, the costs of some mental health services

were calculated from experience in Dane County, which has the same benefit under a managed care program.

The impact of the program has been twofold: financial savings and improved outcomes. Milwaukee Wraparound has thus achieved the goals many state managed care programs seek. It has improved quality for children while controlling the costs of Medicaid. Results include:

- reduction in the residential treatment population in the child welfare and juvenile justice systems from 360 to 190 children;
- reduction in the number of inpatient days per year from 24,000 to 10,000 days for Medicaid-eligible children served;
- significant improvement in children's functioning and more children living in less restrictive environments.

The savings are being reinvested to serve additional youngsters and to develop a fuller array of services and supports.

Milwaukee Wraparound has developed a flexible managed care program using Medicaid funds blended with funds of other agencies, and has achieved cost-savings that also ensure good outcomes for the children served.

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Delaware: Public-Sector Managed Care

Delaware has established a managed care system, run by the Division of Child Mental Health Services, for children under 18 with moderate and severe disorders who need mental health and/or substance abuse services. The system is funded by both Medicaid and non-Medicaid revenue and serves children without insurance as well as Medicaid children. State general-fund dollars are the more significant portion of funding, contributing $19 million in FY 1999 compared to $8.4 million from Medicaid. About 1% of Medicaid children at any one time and about 3.6% of Medicaid children in a year receive services through this program.

Delaware's Medicaid agency has established a managed care system using several managed care organizations (MCOs) to provide physical health care and a limited mental health benefit to Delaware's Medicaid children and families. The MCOs' mental health/substance abuse benefit is up to 30 hours of outpatient service per year.

Under a Section 1115 waiver, the Medicaid agency has delegated to the Division of Child Mental Health Services the authority to be a public managed care organization to provide mental health and substance abuse services beyond the basic MCO benefit. Services that exceed the MCO benefit, either in extent or intensity/restrictiveness, are provided by the division. This arrangement eliminates the Medicaid office's role as a direct payor for child mental health services; only the MCOs and the Division of Child Services are payors.

A Section 1115 waiver allows the Delaware mental health agency for children to act as the Medicaid managed care entity.

Under the financing agreement, Medicaid bears the risk for the number of youth served, but the division bears the risk for the cost of services provided to the children. Medicaid contributes directly to the division a case rate for each eligible child served each month. In 1998, this case rate was $4,329 per child/per month.[2]

Delaware is one of the states with a child agency. The Delaware Department of Services for Children, Youth and Their Families includes mental health, family services (child welfare), youth rehabilitative services (juvenile justice) and a division of management support. This agency operates all public child mental health and substance abuse treatment services in Delaware, including services for both Medicaid-eligible and non-Medicaid eligible children.

This design has enabled smooth integration of Medicaid and non-Medicaid funding streams. It also recognizes MCOs' limitations. Delaware, like other states, found the concept of MCOs' providing behavioral health care as part of primary care unworkable. The limited MCO benefit is effective, especially since the MCOs have contracted with public-sector community providers.

Behavioral health services offered through the public-sector carve-out are very specialized, especially for low-income and culturally diverse populations. There is a strong focus on continuity of care, family-focused care and individualized services. Services the division offers through its carve-out include: crisis services, outpatient services, intensive outpatient services, wraparound services, in-home services, day treatment, residential treatment and psychiatric hospital care. There are no benefit limits.

The program has a strong emphasis on client rights and a clearly delineated system of appeals.

The division attributes its ability to run this program in part to several years of experience building a continuum of services, improving clinical management, developing skill in contracting and developing a strong information system and data infrastructure.

The division manages care for Delaware's children through a clinical services management model, in which teams led by a licensed behavioral health care professional certify clinical necessity and plan, authorize, coordinate and monitor and evaluate treatment services of all clients in the system.

As part of the initiative, the division has established a sophisticated data system and family and child tracking system. A comprehensive database covers child welfare, juvenile justice, child mental health and substance abuse through the integrated Department of Services for Children, Youth and Their Families. This data system is funded in part through the Statewide Automated Child Welfare Information System, and the total investment in the data system to date is $14 million. The state utilizes the data system for contracts, licensing, management of client services, prevention tracking and the interstate compact. It is available statewide and can be accessed 24 hours a day/seven days a week.

The division has been able to exert clear control on hospital use, which contributed to a positive review by the Medicaid agency.

In FY 1995, some of the savings under Medicaid were allocated back to the division for expanding specific community-based, family-focused services, including day treatment for mental health and substance abuse, wraparound services (average cost per client $4,400) and early intervention (through consultation and staff training of community child care center and HeadStart personnel). The division has been able to increase significantly its capacity to provide intensive outpatient services.

The division collects data on several performance measures, including percentages of children showing progress on various goals, child and family satisfaction with their role in planning of care, accessibility of services and interaction with staff. Data show satisfaction and increased utilization of intensive outpatient services and reduced use of deep-end services, such as residential care.

What a public MCO can offer:

Delaware's public agency for children's mental health and substance abuse services, operating as a public managed care organization, lists what it offers:

- ◆ statewide access;
- ◆ appropriate services drawn from a full continuum, including extensive flexible wraparound options;
- ◆ monitored effectiveness of services;
- ◆ system efficiency without stockholder costs, so that maximum numbers can be served;
- ◆ growing capacity to accommodate eligible youth;
- ◆ limitless coverage—youth are not dumped or dropped because of benefit exhaustion.

Florida: Services in Juvenile Justice Residential Programs (fee-for-service)

A significant percentage of children and youth in Florida's juvenile justice facilities have serious mental and emotional disorders. Conservative estimates suggest that 50% have conduct disorder, 25-50% have substance abuse disorders, up to 46% have attention-deficit/hyperactivity disorder and between 32% and 78% have affective disorders. However, only about 20% of youth in the state's corrections facilities are specifically identified as seriously emotionally disturbed, suggesting significant under-identification.[3]

To improve the provision of mental health and substance abuse services to juveniles in the corrections systems, Florida has created a financing mechanism and developed an array of services that can be reimbursed through Medicaid. These services are specifically designed to prevent transfer to higher levels of care of youth in custody of juvenile justice who have been placed in group homes. These facilities receive a bundled payment rate to provide an array of mental health and substance abuse services.

Florida's fee-for-service plan finances mental health and substance abuse services for youth in the custody of juvenile justice who have been placed in group homes and is designed to prevent their transfer to higher levels of care.

Juvenile justice residential programs in Florida must enroll as Medicaid providers in order to secure funding to provide certain mental health and substance abuse services. These services are provided in addition to, and overlay, services already provided by the Department of Juvenile Justice—room and board, 24-hour supervision and educational and vocational services. The state worked with the Florida Mental Health Institute to develop programmatic requirements for the behavioral health overlay services.

The goal of the overlay services is to improve the mental status, emotional and social adjustment of children so as to avoid a more intensive level of care. Services are individualized and child-specific, and include medically necessary mental health and substance abuse treatment.

The specific mental health services provided under the bundled rate include: crisis management, individual, group and family therapy, social rehabilitation and counseling, basic living skills training, behavioral programming, counseling towards reunification with family, supportive counseling during transitions, transition planning, and, if developmentally appropriate, services for

increased capacity for independent living. In addition, providers may bill fee-for-service for other Medicaid services, such as evaluation and testing, treatment planning and review, and medical and psychiatric services.

The long-term goals of the program are: improved emotional, mental and functional status, reduction in unplanned placement changes, increased ability to live safely, attending school and being a productive member of the community, increased likelihood of successful return to family and increased capacity among youth for independent living.

The services are funded through a bundled per diem rate, reimbursed by Medicaid. To participate, a program must enroll as a Medicaid provider, be designated an essential provider by the Department of Juvenile Justice and certified by the Department of Children and Families, Office of Children's Mental Health and/or Substance Abuse. Providers are responsible for effectively addressing behavioral health needs, managing the clinical behavioral health risks, providing clinical services, documenting and monitoring the processes and outcomes for children and providing linkages to other necessary components of a comprehensive system of care.

An evaluation of this initiative found that most of the children needed and received similar services: home-based rehabilitation, counseling and day treatment provided in group sessions around the school day and medication management. Family therapy was also offered, but on a less frequent basis. The cases were complicated, and the children had multiple diagnoses, multiple risk behaviors and significant co-morbidities.

Hawaii Early Intervention Carve-Out Agreement

Under a Section 1115 Medicaid waiver, Hawaii has created a statewide carve-out program of early intervention services for very young children, run by the Department of Health. The carve-out provides services covered under Medicaid and the Individuals with Disabilities Education Act (IDEA) to children from birth to age 3 who are enrolled in Hawaii's managed care plans (known as QUEST) and who meet eligibility requirements under Part C of

Services for Juveniles

Mental health services provided under Florida's financing scheme to improve care for youth in the corrections system include:

- ◆ crisis management;
- ◆ individual, group and family therapy;
- ◆ social rehabilitation and counseling;
- ◆ basic living-skills training;
- ◆ behavioral programming;
- ◆ counseling toward reunification with family;
- ◆ transition planning and supportive counseling during transitions; and
- ◆ services to increase capacity for independent living.

Providers are responsible for linking juveniles to other components of a comprehensive system of care.

the IDEA. Funds are provided on a capitated basis to prevent or reduce the need for more costly health care for children who are medically fragile or developmentally delayed or who have significant biological risk factors. Also covered are services for children at risk for abuse and neglect, in order to reduce future cost for child protective services and mental health.

The carve-out addresses an inherent conflict between the managed health care plans—each with its own policies and standards for determining medical necessity—and an early intervention system that stresses family-centered, community-based services. The carve-out eliminates this barrier, removing from the managed care plans the responsibility for providing services with which they are less familiar. At the same time it enables the state to maximize federal matching funds to enhance and support its existing child-abuse prevention and early intervention service system.

The carve-out addresses an inherent conflict between the managed health care plans—each with its own policies and standards for determining medical necessity—and an early intervention system that stresses family-centered, community-based services.

The state's Medicaid match funds are provided by the Department of Health (DOH) and the Med-QUEST Division of Medicaid. Medicaid pays DOH a capitated amount, $325 per member per month, for each Medicaid-eligible infant and toddler served by DOH under Part C of the IDEA. For the Medicaid agency, billing a single entity on a capitated rate is far more cost-effective than contracting with and billing multiple health plans. The capitation rate was calculated based on actual costs of early intervention services to very young children in Hawaii.

Total costs under the carve-out agreement between DOH and Medicaid are limited to $5 million in state and federal funds each fiscal year. There is a total cap of $2.5 million for the federal share for the duration of the waiver or until an adjustment can be made to the budget-neutrality baseline for Hawaii's Section 1115 managed care waiver.

The early intervention services provided are those that can be funded by Medicaid and Part C of the IDEA. These carve-out services are excluded from the QUEST plan benefits.

Early intervention services under the carve-out are defined as: "services designed to meet the developmental needs of each child eligible under Part C, and the needs of the family; (which are) selected in collaboration with the parents; provided...in conformity

with an individualized family support plan (IFSP), and (provided) at no cost to families except where policies permit a sliding fee schedule; and which meet the standards of the state."

Specifically, these services include:

- Screening Services:
  - hospital-based chart review to identify children at-risk for abuse and neglect;
  - developmental screening, including social-emotional screening to determine need for early intervention services; and
  - information and referral services to provide a centralized point-of-contract and assignment of an interim care coordinator.
- Care Coordination Services:
  - IDEA case management services;
  - development and periodic review of an IFSP for each family; and
  - activities to assure that services included in the child's IFSP are being provided on a timely basis.
- Early Intervention Services:
  - defined under Part C of the IDEA, include family training, counseling and home visits, psychological services, service coordination, social work services and transportation and related costs.

Early intervention services include family training, counseling and home visits, psychological services, service coordination, social work services, and transportation and related costs.

Family training includes services provided to help the family understand the child's special needs and how to enhance the child's development. Social work services include preparing a social or emotional developmental assessment of the child in a family context, providing individual and family group counseling with parents and other family members, and appropriate skill-building activities with the child and parents.

Under a memorandum of understanding between Medicaid and the Department of Health, DOH makes training available to all primary care providers regarding screening tools for identifying infants and toddlers with developmental delays, including social-emotional delays. Following a screen, or when there is an obvious need for services, any primary care provider or QUEST plan can refer an infant or toddler to DOH.

Eligibility criteria for Part C services in Hawaii include children with developmental delay or at "environment risk." Environment risk is defined as having one or more of the following conditions:

- physical, developmental, emotional, or psychiatric disability in primary care giver;
- abuse of any legal or illegal substance by a primary caregiver;
- child abuse and neglect of target child or siblings;
- presence of physical, developmental, emotional, emotional, or psychiatric disability in a sibling or any other family member in the home.

Hawaii used current funds to pay for these early intervention services. Use of the Medicaid carve-out approach made federal matching funds available for Medicaid-covered services, allowing for the reinvestment of state funds in long-range funding for prevention and early intervention programs. This arrangement also provides an opportunity for DOH and DHS to address prevention issues of mutual concern collaboratively.

NOTES

1. Supervised independent living may be rendered in a licensed residential group-care facility or licensed child-placing agency with a therapeutic foster home component. These licensed facilities or agencies must have a separate and identifiable service established for the sole purpose of providing supervised independent living and offer the appropriate clinical oversight.
2. Case rates represent standard payment amount for each child who actually uses services; a capitation rate would be a rate per child covered under a plan, whether or not the child uses any services. Thus case rates must be considerably higher than capitation payments.
3. Medicaid Program Development Unit, Agency for Health Care Administration. *Behavioral Health Overlay Services in Department of Juvenile Justice Residential Facilities*. Tallahassee FL, February 18, 1998.

CONCLUSION

The purpose of this report is to describe state Medicaid programs for children with mental health needs, especially children with serious emotional disorders, and show advocates and policymakers how their state's program compares with others'.

As our study reveals, Medicaid programming for children with serious emotional disorders remains somewhat traditional. Most of these children are still in a fee-for-service plan. Furthermore, the range of services for which the state has clear and specific definitions is generally limited to the most traditional forms of treatment, especially 24-hour facilities and clinical services.

At the same time, however, some states have made innovations, either in organization and financing or in the range of community services for which they provide detailed definitions. Accordingly, it remains true that where a Medicaid child lives has a significant impact on the type of services to which he or she has access.

Although many states define certain activities in Medicaid's Rehabilitation category, these definitions are often limited to day treatment and in-home care. Few states include descriptions of a broad array of wraparound services, even though the research shows their effectiveness for children of all ages and all cultures. By contrast, a few states have defined in detail a significantly wider array of services. This re-emphasizes that Medicaid can be used—but often is not—to finance the services that are most effective for children with serious emotional disorders.

The definition of services is generally more complete and expansive in fee-for-service Medicaid than in managed care, although some public managed care arrangements offer a detailed list of available services. The clearer and more specific the definitions of covered services, the easier it is for both providers and Medicaid enrollees to know what services are available to a child. There is a lot of room for improvement in many of the contracts, particularly those with integrated managed health care entities.

The study's findings re-emphasize that Medicaid can be used—but often is not—to finance the wraparound services that are most effective for children with serious emotional disorders.

A second issue we studied is the degree to which mental health services are now furnished to Medicaid children through managed care. This report and others have found extensive use of integrated managed health care plans for the Medicaid population, and our study reveals that these plans tend to have very limited mental health benefits. Children who need more than a minimum benefit will not receive the federally mandated entitlement to all medically necessary care through these plans. It is therefore critical for states to have explicit policies on how children in integrated health care plans can access additional care through fee-for-service or a specialized carve-out managed mental health care plan. Unless these children can move into alternative funding systems giving them access to full Medicaid benefits, the state will be out of compliance with federal law. Because many integrated managed health care plans have responsibility for groups of children with a high need for mental health services (children on SSI or in child welfare), states have some serious policy questions to resolve.

The law requires that all Medicaid children have access to any covered service when it is medically necessary. However, in states that do not have specific definitions of all covered services, it is extremely unlikely that children can access these services.

The carve-out managed mental health care plans, we found, are generally required to provide a much wider range of community-based services. A few states use private, for-profit companies to manage their carve-out plans for children who need extended mental health services. Other states with carve-out arrangements have organized them through nonprofit networks, run them directly or limited the company's role to administrative activities only. Even where private companies are utilized, many states limit them to pilot projects. As a result, the traditional system and the traditional providers are generally still in charge of mental health care for children with serious disorders.

In sum, the law requires that all Medicaid children have access to any covered service when it is medically necessary. However, in states that do not have specific definitions of all covered services, it is extremely unlikely that children can access these services.

We hope this report will help to improve state Medicaid definitions. Only thus will all states comply with the EPSDT mandate, enabling children with serious emotional disorders, no matter where they live, to access the services required to provide an effective, wraparound approach to their care.

APPENDIX I

METHODOLOGY AND TECHNICAL NOTES

METHODOLOGY

Medicaid fee-for-service and managed care programs were identified in all 50 states and the District of Columbia. We checked the managed care programs identified for study against programs listed in *State Profiles on Public Sector Managed Behavioral Health Care and Other Reform.*[1] Our study includes 39 fee-for-service Medicaid programs, except for programs that exclude children with SED, 22 of the larger Medicaid managed care programs that provide benefits for children with extensive mental health needs and seven managed care plans that provide acute mental health care benefits.

Through a two-part review, we identified mental health services listed in 68 Medicaid programs. First, we examined state Medicaid regulations, provider manuals, state plans, managed care requests for proposals and contracts to identify the Medicaid-listed services. Unlike other studies, which generally rely on expert opinion alone, we based our report on actual Medicaid regulations and contract language as well as expert opinion.

For the second level of review, we sent a summary of the service definitions we had identified to the state Medicaid agency and the Children, Youth and Family Division Representative of the National Association of State Mental Health Program Directors (Appendix II is a sample summary).

For one third of the programs, we received responses from both the Medicaid program and the Children, Youth and Family Representative, submitted jointly or independently. For all but four of the remaining programs, we received one response from either the Medicaid program or the Children, Youth and Family Representative. Multiple follow-up mailings, faxes and phone calls were made to contacts in four states with four programs (Hawaii fee-for service, TennCare, Virginia fee-for-service and Arkansas

Managed Care), but these four chose not respond. Accordingly, we recommend viewing the summaries for these programs with caution.

TECHNICAL NOTES

The intent of this survey was to identify services that are specifically defined under Medicaid regulations, state or county requests for proposals and state or county contracts for managed care. As a result, our findings may differ from other studies that relied solely on expert opinion. A recent study by Pires, Armstrong and Stroul identified services provided through public-sector managed care reforms that include but were not limited to Medicaid-funded services.[2] Other studies, such as the *State Profiles on Public Sector Managed Behavioral Health Care and Other Reform,*[3] include broader service categories (inpatient, outpatient, crisis, mental health support, and rehabilitation).

Services were counted for the study only if language in a Medicaid regulation, contract or RFP identified it as a defined service. Medicaid regulations often had the most complete documentation, including a description of the service, the larger program of which the service is part, staffing requirements and the payment rate. Some Medicaid programs pay for a service by billing it as another service. We did not count services billed as a general clinic visit. For instance, we would not count a day treatment program that was billed as outpatient therapy.

To increase comparability across programs, the number of study categories was limited to commonly provided mental health services. Programs and broad services were broken down into components to fit into the categories, particularly those in psychiatric/psychosocial rehabilitation services. For instance, if a state provides a community support program that includes family support, independent living skills and day treatment programs, then all four services were counted as listed services. Services not listed in the study categories are included in the "other" category. Please refer to the notes, below, for descriptions of specific services.

Managed care arrangements raised different concerns from Medicaid fee-for-service. Some states, such as Colorado, require managed care contractors to provide flexible, individualized optional

services, leaving the contractor free to determine the exact nature of those services. This made it difficult to identify the specific services selected by each contractor. Accordingly, optional services are not counted as a defined service, but are indicated in the option column on the chart and described in the notes.

Some state Medicaid programs require the contractor to provide a range of service rather than specific ones. For example, a contract could require community-based alternatives to institutional long-term care without specifying whether it should be residential treatment centers and/or group homes. In these cases, we included the services most often provided by the managed care organization. Some managed care organizations also provide services not required by the contract. We did not count those services in this study.

Some Medicaid managed care programs, such as Oklahoma, limit the availability of some services to people with more severe illnesses. In such cases, the limited services are counted as defined. Please refer to Table 8 for the limitations.

NOTES ON SPECIFIC SERVICES

Residential services

- Residential treatment centers and residential crisis intervention were counted as a defined service only if room, board and treatment are paid for by Medicaid. Group homes were counted only if room-and-board costs for caregivers were paid by Medicaid.
- Residential crisis intervention was included as a defined service if it pays for an out-of-home, non-hospital placement during a crisis. Some Medicaid programs pay for the treatment only.

Medicaid programs that provide intensive services in the home instead of another home-like setting were not counted as defining residential crisis intervention.

Clinic services

- Substance abuse counseling clinic services were considered a defined service if substance abuse is an approved diagnosis for outpatient psychotherapy services.

Case management

- Case management was counted only if the state has defined Medicaid's case management option for children with SED.

Though managed care plans often provide case management for serious illnesses, it was only counted if it was for children with SED.

Case management was excluded if there were no specific billing codes or regulations describing this service.

Psychiatric/psychosocial rehabilitation

- Day treatment/school-based services were counted if provided through a structured program emphasizing rehabilitation and/or skills building.

Family support/wraparound

Due to the overlap of services in these two categories, they were combined in this study.

NOTES

1. *State Profiles on Public Sector Managed Behavioral Health Care and Other Reform*. (Rockville, MD: The Substance Abuse and Mental Health Administration, July 1998).
2. Pires, S., Armstrong, M. I., & Stroul, B.A. *Health care reform tracking project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families--1997-98 State Survey.* Tampa FL: Louis de la Parte Florida Mental Health Institute, 1999.
3. *State Profiles*, 1998, op cit.

APPENDIX II

SAMPLE STATE SUMMARY

[Insert State] FFS/MC Medicaid Child Mental Health Services

Reviewer Instructions

1. Key Reviewer's Name: _____ Phone number: _____

2. Date: _____

3. Are the sources listed in the first footnote up to date?
   ____ Yes
   ____ No If not, please send us current sources.

4. We have this question (these questions) regarding service coverage:

5. Please review the following tables of covered services. Please keep in mind the following:

   - "Covered" refers to whether or not a service is covered. We have only indicated a "Y" for "Yes" for those services that are covered.

   - The "Other" category includes additional information regarding the coverage limitations or descriptions of selected services. "DK" indicates "Don't know".

If you have any questions, please don't hesitate to contact Rafael Semansky, Policy Research Analyst, at the Bazelon Center for Mental Health Law.

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1) Mandatory Services

	Covered	Other	Documentation
General hospital in-patient care		Additional authorization:	
General hospital out-patient care			
Physician services			

Services that Are Optional for Adults (under EPSDT all services are mandatory for children)

	Covered	Other	Documentation
Psychiatric hospital			
Residential treatment centers		Prior authorization: Limit on LOS:	
Group homes		Size limit:	
Residential crisis intervention			

Clinic Services:

	Covered	Other	Documentation
Individual psychotherapy			
Family psychotherapy			
Group psychotherapy			
Family education re: child disorder			
SA counseling			
Crisis intervention			
Partial hospitalization			
Medication management			

Services of Other Licensed Mental Health Professionals (Independent Billing Authority):

	Covered	Documentation
Psychologists: testing (Psychological evaluation)		
Psychologists: services		
Social Workers (MSWs)		
Other: _____		

Targeted Case Management

	Covered	Documentation
Targeted case management which specifically includes children and youth with SED		

Psychiatric/Psychosocial Rehabilitation Services

	Covered		Documentation
Psychiatric/Psychosocial rehabilitation services	Yes ____ No ____	Indicate which of the following services listed below are **specifically covered** by state Medicaid regulations or managed care contracts.	
	Covered	**Other**	**Documentation**
Intensive home-based services		Limits per episode:	
School-based day treatment		Limits:	
Other day treatment		Limits:	
Therapeutic nurseries			
Therapeutic preschool			
Summer camps/summer programs		Describe:	
Afterschool activities		Describe:	
Family support services		Describe:	
Family respite care		Limits:	
Independent living skills training			
Other independent living programs _____			
Other: _____			

Thank you for your assistance.

APPENDIX III

WHICH CHILDREN ARE ELIGIBLE FOR MEDICAID?

Federal law requires states to provide Medicaid to certain groups of children and authorizes states to include other groups. Clearly, the eligibility standards are as critical as the array of services to a state's ability to assure children of access to needed mental health services.

Federal law requires that Medicaid coverage by provided for certain "categorically needy" groups, including children who meet the welfare law standards (ADFC/TANF children), SSI recipients (in most states), children in foster care/adoption in the child welfare system, children under age 6 in families with incomes at or below 133% of poverty, children under age 16 in families with incomes at or below 100% of poverty, and certain other groups.

Other groups of children may be covered at a state's option. One of the most important optional categories is new. Low-income children not previously eligible for Medicaid can now be covered through the State Children's Health Insurance Program (CHIP), authorized in 1997 as Title XXI of the Social Security Act.[1] CHIP provides $24 billion over five years for states to ensure health care coverage for uninsured children in low-income families who were not eligible for Medicaid under state rules in place at the time of CHIP's enactment.

States can choose between two ways to accomplish this goal: 1) they can expand Medicaid eligibility to cover some or all of these children, or 2) they can create a separate health insurance program for them.[2] These are not exclusive options; states may choose to cover some CHIP children under Medicaid and provide a separate health plan to others. As of June 1999, 21 states and two territories have CHIP Medicaid expansion programs,[3] 15 have separate state-designed CHIP programs[4] and 13 have a combination of Medicaid expansion and a state-designed program.[5]

Under CHIP law, states can cover children up to age 19 in families with incomes below 200% of the federal poverty level (FPL). States that had previously covered low-income children up to 200% of FPL

under Medicaid were permitted to expand coverage to higher income levels (up to 250% of FPL).

States covering CHIP children under Medicaid must also determine how services will be furnished to them. In most states, CHIP children are grouped with other low-income children, such as children in TANF-eligible families. They are not grouped with children who have serious emotional disturbance. As a result, CHIP children with Medicaid eligibility are most often enrolled in a managed health care plan, usually an HMO. As documented by data in this report, these plans have limited mental health benefits. As a result, although a child with SED is *entitled* to more services, the family may have a hard time accessing them. In some states, however, CHIP children are eligible for a managed mental health program that provides extended benefits, including, in some states, wraparound services.

CHIP-eligble children with Medicaid coverage have the same entitlements as all othert Mediaid children.

Most important, all CHIP-eligible children provided with Medicaid coverage have the same entitlements as any other Medicaid child, including the entitlement to screening and to all medically necessary services, as required under EPSDT.

In addition, states may select other groups for coverage under their Medicaid program, and several of these optional eligibility categories are significant for children with mental health needs. Relevant groups of children which states may elect to cover are:

- infants up to age 1 and pregnant women with family incomes no more than 185% of poverty;
- children between 1 and 6 years old with family income no more than 185% of poverty;
- children born after September 1983 with family income up to 100% of poverty;
- children in institutions under an income level, set by the state, up to 300% of the SSI benefit rate;
- children who would be eligible if institutionalized, but who receive care under home- and community-based waivers;
- medically needy adults and children who would be eligible under one of the mandatory or optional groups except for their expenses that reduce their income to the state's mdically needy income level. In 1996, 42 states had medically needy categories for Medicaid eligibility.
- children with disabilities under age 18 who live at home but who

would be eligible for SSI if they were hospitalized. In this instance, only the child's income and resources, and not the parents', are counted when determining financial eligibility. A child must require the level of care provided in an institution, but it must be appropriate to provide such care outside the institution and the cost of home care cannot exceed what Medicaid would pay for the institutional care.

NOTES

1. Title XXI, Social Security Act. Enacted under Balanced Budget Act of 1997, Public Law 105-33, 105th Cong., 1st sess.
2. States may also use a limited amount of CHIP funds to pay directly for health care services to eligible children, but this is a very minor provision in terms of the number of children effected and the range of services such children receive.
3. Alaska, Arkansas (plan not yet submitted, using a Medicaid waiver), District of Columbia, Hawaii, Idaho, Indiana, Iowa, Louisiana, Maryland, Minnesota, Missouri, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Virgin Island and Puerto Rico.
4. Arizona, Colorado, Delaware, Georgia, Kansas, Mississippi, Montana, North Carolina, New York, Nevada, Oregon, Pennsylvania, Utah, Vermont and Wyoming.
5. Alabama, California, Connecticut, Florida, Illinois, Kentucky, Massachusetts, Maine, Michigan, New Hampshire, New Jersey, Texas and West Virginia.

TABLES

TABLE 1 OVERVIEW OF MANAGED CARE AND CARVE-OUT PROGRAMS DESCRIBED IN PART II

State	Program Name	Behavioral Health Carve-Out (CO) Integrated MCO	Area State Region or Pilot	Benefit Acute or Extended	Eligibility			
					AFDC/ TANF*	SSI or ABD*	Child Welfare	CHIP*
Arizona	Arizona Behavioral Health Health Care Cost-Containment System	CO	Region	Extended	√	√	√	
Arkansas[1]	Benefit Arkansas	CO	State	Extended	√		√	
California	Medi-Cal Specialty Mental Health Services-Consolidation Program	CO	State[2]	Extended	√	√		√ (voluntary)
Colorado	Colorado Medicaid Mental Health Capitation and Managed Care Program	CO	State	Extended	√	√	√	
Connecticut	Connecticut Accesss	MCO	State	Acute	√	√	√	√
Delaware	Diamond State Health Plan HMO	MCO	State	Acute	√	√	√	
	Diamond State Health Plan Public Managed Care Organization	CO	State	Extended	√	√	√	
Florida	PrePaid Mental Health Plan	CO	Pilot	Extended	√	√	√ [3]	√

1 Arkansas is awaiting federal approval of a waiver to implement its managed care program.

2 Except for pilot programs in Solano and San Mateo Counties.

3 Unless the child is in a residential group home or therapeutic foster care .

TABLE 1 OVERVIEW OF MANAGED CARE AND CARVE-OUT PROGRAMS DESCRIBED IN PART II

State	Program Name	Behavioral Health Carve-Out (CO) Integrated MCO	Area State Region or Pilot	Benefit Acute or Extended	Eligibility			
					AFDC/ TANF*	SSI or ABD*	Child Welfare	CHIP*
Hawaii	QUEST	MCO	State	Acute	√			√ (non-disabled)
Iowa	Mental Health Access Plan	CO	State	Extended	√	√	√	
Kentucky	Access[4]	CO	Region[5]	Extended	√	√	√	
Maryland	Specialty Mental Health System	CO	State	Extended	√	√	√	
Massachusetts	MassHealth	MCO	State	Extended	√	√		√
	MassHealth	CO	State	Extended	√	√	√	√
Michigan	Managed Specialty Services Program	CO	State	Extended	√	√	√	
Minnesota	Prepaid Medical Assistance Program	MCO	State	Extended[6]	√		√ [7]	√
Missouri	Managed Care+	MCO	Region	Acute	√	√		√

4 Program has received HCFA approval and is accepting proposals.

5 Will be phased in statewide.

6 The extended benefits are for children who are not on SSI, therefore they are less comprehensive than the extensive benefits in states where SSI children are included.

7 Unless prior to Medicaid eligibility, child was receiving an adoption subsidy or was in a foster care placement.

TABLE 1 OVERVIEW OF MANAGED CARE AND CARVE-OUT PROGRAMS DESCRIBED IN PART II

State	Program Name	Behavioral Health Carve-Out (CO) Integrated MCO	Area State Region or Pilot	Benefit Acute or Extended	Eligibility			
					AFDC/ TANF*	SSI or ABD*	Child Welfare	CHIP*
Nebraska	Nebraska Health Connection Mental Health Substance Abuse	CO	State	Extended	√	√	√	
New Mexico	Salud!	MCO	State	Extended	√	√	√	√
Oklahoma	SoonerCare Plus	MCO[8]	Region	Extended[9]	√			√
Oregon	Oregon Health Plan	MCO CO[10]	State	Extended	√	√	√	
Pennsylvania	Health Choices Behavioral Health Services	CO	Region	Extended	√	√	√	
Rhode Island	RIte Care	MCO	State	Acute	√			√
Tennessee	TennCare Partners	CO	State	Extended	√	√	√	
Texas	NorthSTAR	CO	Pilot	Extended	√	√		
	STAR Health Plan	MCO	Region	Acute	√	√		√
Utah	Prepaid Mental Health Plan	CO	State[11]	Extended	√	√		

8 The ABD population began enrolling in the plan on July 1, 1999.

9 Targeted case management and other day treatment are available only to children meeting the state's definition of Serious Behavioral Health Needs.

10 Fully integrated managed care organizations are replacing the behavioral carve out.

11 Excluding 4 rural counties.

TABLE 1 OVERVIEW OF MANAGED CARE AND CARVE-OUT PROGRAMS DESCRIBED IN PART II

State	Program Name	Behavioral Health Carve-Out (CO) Integrated MCO	Area State Region or Pilot	Benefit Acute or Extended	Eligibility			
					AFDC/ TANF*	SSI or ABD*	Child Welfare	CHIP*
Vermont	Vermont Health Access Plan	MCO	State	Acute	√	√	√[12]	
Washington	Integrated Community Mental Health Program	CO	State	Extended	√	√		
Wisconsin	Children Come First WrapAround Milwaukee	CO	Pilot	Extended	[13]	[13]	[13]	[13]

* Sources: AFDC/TANF and SSI or ABD eligibility from *State Profiles on Public Sector Managed Behavioral Healthcare and Other Reforms* (Rockville, MD: SAMHSA Managed Care Tracking System, 1998) and *1998 National Summary of State Medicaid Managed Care Programs*, (Baltimore, MD: Health Care Financing Administration, 1998). CHIP eligibility from "CHIP State Plan Summaries" *HCFA Summary* (Baltimore, MD: Health Care Financing Administration, 1998).

12 Mandatory enrollment proceeding by age group.

13 Child must be in Juvenile Justice to be eligible.

TABLE 3 COMMUNITY-BASED SERVICES IN MANAGED CARE

States	Optional services	Note	Targeted case management	Intensive home-based services	School-based day treatment	Day treatment (Excluding school-based	Summer camps/summer programs	Afterschool activities	Family support/wraparound	Child respite care	Therapeutic foster care	Therapeutic nurseries	Therapeutic preschool	Independent living skills training	Other independent living programs	Other psychosocial rehabilitation
Arizona			+	+	+	+			+		+			+	+	
Arkansas			+	+	+	+		+		+	+	+	+	+		
California			+	+		+										
Colorado	+		+			+			+					+		
Connecticut			+													
Delaware (MC)																
Delaware (Public MC)				+		+					+			+		
Florida	+		+			+										
Hawaii		+	+													+
Iowa				+	+	+				+						
Kentucky				+		+	+	+	+		+					
Maryland			+	+	+	+						+		+		
Massachusetts				+		+										
Michigan	+		+	+		+			+	+	+					
Minnesota				+	+	+			+		+			+		
Missouri																
Nebraska		+		+	+				+		+					+
New Mexico	+	+	+		+	+					+			+		+
Oklahoma		+	+	+		+					+			+		
Oregon			+	+	+	+		+	+	+	+	+				
Pennsylvania		+	+	+	+	+	+	+	+					+		+
Rhode Island						+										
Tennessee		+	+	+	+	+						+		+	+	
Texas(NorthSTAR)		+	+	+	+	+				+				+		+
Texas(STAR)																
Utah		+	+													+
Vermont																
Washington			+	+		+								+		
Wisconsin			+	+	+	+								+		

TABLE 3 COMMUNITY-BASED SERVICES IN MANAGED CARE

States	Optional services	Note	Targeted case management	Intensive home-based services	School-based day treatment	Day treatment (Excluding school-based	Summer camps/summer programs	Afterschool activities	Family support/wraparound	Child respite care	Therapeutic foster care	Therapeutic nurseries	Therapeutic preschool	Independent living skills training	Other independent living programs	Other psychosocial rehabilitation
Arizona			+	+	+	+			+		+			+	+	
Arkansas			+	+	+	+		+		+	+	+	+	+		
California			+	+		+										
Colorado	+		+			+			+					+		
Connecticut			+													
Delaware (MC)																
Delaware (Public MC)				+		+					+			+		
Florida	+		+			+										
Hawaii		+	+													+
Iowa				+	+	+				+						
Kentucky				+		+	+	+	+		+					
Maryland			+	+	+	+						+		+		
Massachusetts				+		+										
Michigan	+		+	+		+			+	+	+					
Minnesota				+	+	+			+		+			+		
Missouri																
Nebraska		+		+	+				+		+					+
New Mexico	+	+	+		+	+					+			+		+
Oklahoma		+	+	+		+					+			+		
Oregon			+	+	+	+		+	+	+	+	+				
Pennsylvania		+	+	+	+	+	+	+	+					+		+
Rhode Island						+										
Tennessee		+	+	+	+	+						+		+	+	
Texas(NorthSTAR)		+	+	+	+	+				+				+		+
Texas(STAR)																
Utah		+	+													+
Vermont																
Washington			+	+		+								+		
Wisconsin			+	+	+	+								+		

TABLE 5 CLINIC SERVICES IN MANAGED CARE

States	Optional services	Note	Individual psychotherapy	Family psychotherapy	Group psychotherapy	Family education re: child disorder	SA counseling	Crisis intervention	Partial hospitalization	Medication management	Other clinic services	Psychologists: testing	Psychologists: services	Social workers	Other psychology professionals	General hospital outpatient care	Physician services
Arizona			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Arkansas			+	+	+		+	+	+	+		/	/	/	/		
California		+	+	+	+			+		+		/	/	/	/	+	+
Colorado	+		+		+			+	+	+		/	/	/	/	+	+
Connecticut			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Delaware (MC)			+	+	+		+	+		+		/	/	/	/		
Delaware (Public MC)		+	+	+	+		+	+	+	+	+	/	/	/	/		
Florida	+		+	+	+			+		+		/	/	/	/	+	+
Hawaii			+	+	+		+	+	+	+		/	/	/	/	+	+
Iowa			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Kentucky			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Maryland			+	+	+			+	+	+		/	/	/	/	+	+
Massachusetts		+	+	+	+		+	+	+	+	+	/	/	/	/		
Michigan	+		+	+	+		+	+	+	+		/	/	/	/	+	+
Minnesota			+	+	+		+	+	+	+		/	/	/	/	+	+
Missouri			+	+	+			+		+		/	/	/	/	+	+
Nebraska			+	+	+	+	+	+		+		/	/	/	/	+	+
New Mexico			+	+	+		+	+	+	+		/	/	/	/	+	+
Oklahoma			+	+	+		+	+	+	+		/	/	/	/	+	+
Oregon			+	+	+			+	+	+		/	/	/	/		
Pennsylvania		+	+	+	+	+	+	+	+	+	+	/	/	/	/	+	+
Rhode Island			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Tennessee			+	+	+		+	+		+		/	/	/	/		+
Texas(NorthSTAR)			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Texas(STAR)	+		+	+	+		+	+		+		/	/	/	/	+	+
Utah			+	+	+	+		+	+	+		/	/	/	/		
Vermont			+	+	+			+	+	+		/	/	/	/	+	+
Washington	+		+	+	+			+		+		/	/	/	/		
Wisconsin			+	+	+		+			+		/	/	/	/		+

/ Coverage of specific practitioners is not included in managed care contracts but is left to the discretion of the plan.

TABLE 5 CLINIC SERVICES IN MANAGED CARE

States	Optional services	Note	Individual psychotherapy	Family psychotherapy	Group psychotherapy	Family education re: child disorder	SA counseling	Crisis intervention	Partial hospitalization	Medication management	Other clinic services	Psychologists: testing	Psychologists: services	Social workers	Other psychology professionals	General hospital outpatient care	Physician services
Arizona			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Arkansas			+	+	+		+	+	+	+		/	/	/	/		
California		+	+	+	+			+		+		/	/	/	/	+	+
Colorado	+		+		+			+	+	+		/	/	/	/	+	+
Connecticut			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Delaware (MC)			+	+	+		+	+		+		/	/	/	/		
Delaware (Public MC)		+	+	+	+		+	+	+	+	+	/	/	/	/		
Florida	+		+	+	+			+		+		/	/	/	/	+	+
Hawaii			+	+	+		+	+	+	+		/	/	/	/	+	+
Iowa			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Kentucky			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Maryland			+	+	+			+	+	+		/	/	/	/	+	+
Massachusetts		+	+	+	+		+	+	+	+	+	/	/	/	/		
Michigan	+		+	+	+		+	+	+	+		/	/	/	/	+	+
Minnesota			+	+	+		+	+	+	+		/	/	/	/	+	+
Missouri			+	+	+			+		+		/	/	/	/	+	+
Nebraska			+	+	+	+	+	+		+		/	/	/	/	+	+
New Mexico			+	+	+		+	+	+	+		/	/	/	/	+	+
Oklahoma			+	+	+		+	+	+	+		/	/	/	/	+	+
Oregon			+	+	+			+	+	+		/	/	/	/		
Pennsylvania		+	+	+	+	+	+	+	+	+	+	/	/	/	/	+	+
Rhode Island			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Tennessee			+	+	+		+	+		+		/	/	/	/		+
Texas(NorthSTAR)			+	+	+	+	+	+	+	+		/	/	/	/	+	+
Texas(STAR)	+		+	+	+		+	+		+		/	/	/	/	+	+
Utah			+	+	+	+		+	+	+		/	/	/	/		
Vermont			+	+	+			+	+	+		/	/	/	/	+	+
Washington	+		+	+	+			+		+		/	/	/	/		
Wisconsin			+	+	+		+			+		/	/	/	/		+

/ Coverage of specific practitioners is not included in managed care contracts but is left to the discretion of the plan.

TABLE 6 INSTITUTIONAL CARE IN FEE-FOR-SERVICE

States	Optional services	Note	General hospital inpatient care	Psychiatric hospital	Residential treatment centers	Group homes	Residential crisis intervention
Alabama			+	+			+
Alaska			+	+	+		
Arkansas			+				
Connecticut			+	+	+		
DC			+	+	+	+	
Florida		+	+			+	+
Georgia			+				+
Hawaii		+	+	+	+		
Idaho			+	+			+
Illinois			+	+			
Indiana			+	+			
Kansas		+	+	+	+		+
Kentucky			+	+	+	+	+
Louisiana			+	+			
Maine			+	+			
Minnesota			+	+			
Mississippi			+	+	+		
Missouri			+	+			
Montana			+	+	+	+	+
Nebraska			+	+	+	+	+
Nevada			+	+		+	+
New Hampshire			+	+			+
New Jersey			+	+	+		
New Mexico			+	+	+	+	
New York			+	+	+	+	
North Carolina			+		+	+	+
North Dakota			+	+	+	+	+
Ohio			+	+			
Oklahoma			+	+	+	+	
Pennsylvania			+	+	+	+	
Rhode Island			+		+	+	+
South Carolina			+	+	+	+	+
South Dakota			+	+			
Texas			+	+			
Vermont			+				
Virginia			+	+			
West Virginia			+	+	+	+	+
Wisconsin		+	+	+			+
Wyoming			+	+			

TABLE 7 INSTITUTIONAL CARE IN MANAGED CARE

States	Optional services	Note	General hospital inpatient care	Psychiatric hospital	Residential treatment centers	Group homes	Residential crisis intervention
Arizona			+	+	+		
Arkansas				+	+	+	+
California			+	+			+
Colorado		+	+	+			
Connecticut			+	+	+		
Delaware (MC)							
Delaware (Public MC)				+	+		+
Florida			+	+	+		
Hawaii			+	+			
Iowa			+	+	+		
Kentucky			+	+	+		
Maryland			+	+	+		
Massachusetts				+	+	+	+
Michigan			+	+			+
Minnesota			+	+			
Missouri			+	+	+	+	
Nebraska			+	+	+	+	+
New Mexico			+	+	+	+	+
Oklahoma			+	+	+		
Oregon				+	+	+	
Pennsylvania			+	+	+	+	
Rhode Island			+	+	+		
Tennessee				+	+	+	+
Texas(NorthSTAR)			+	+	+		+
Texas(STAR)	+	+	+	+			
Utah			+				
Vermont			+	+			
Washington				+	+		+
Wisconsin			+	+			+

TABLE 8 EXPLANATION OF INFORMATION IN TABLES 2-7.

Tables 2-7 includes notations for items that require more explanation. The following chart presents information on the optional services included in some managed care contracts (see second column of tables 3, 5 and 7), along with details on services listed in state rules and service definitions that did not fit easily into the categories of tables 2-7.

State Medicaid Program	*Optional Services in Managed Care Contracts*	*Explanations of notes (see tables 2-7)*
California MC		Clinic services are provided and paid for through the psychosocial rehabilitation option.
Colorado MC	Community-based services: Respite care, family support (family preservation services), home-based services, wraparound services, warm lines, early intervention services, and vocational and pre-vocational services are optional services. Clinic services: Family education and training services are optional services.	Other institutional services: The RFP requires that residential services should be available in varying degrees based on the needs of the population in the contract's service area.
Delaware Public MC		Other clinic services: Clinic team coordination.
Florida FFS		Institutional services: Residential crisis intervention is provided through specialized therapeutic foster care. Clinic services: Crisis intervention is provided through specialized therapeutic foster care. Other psychosocial rehabilitation: Public school program and behavioral health overlay for children in juvenile justice providing clinic services, intensive therapy and home- and community-based services at a bundled rate.
Florida MC	Clinic services: Partial hospitalization is a optional service. Community-based services: Respite, supported employment and specialized therapeutic foster care are optional services.	

State Medicaid Program	*Optional Services in Managed Care Contracts*	*Explanations of notes (see tables 2-7)*
Hawaii FFS		Institutional services: Coverage of care in a residential treatment center is limited to out-of-state placements. Other psychosocial rehabilitation: Psychosocial rehabilitation.
Hawaii MC		Other psychosocial rehabilitation: Through a subcapitation arrangement, Medicaid will provide funds to the Department of Mental Health for a range of community-based services for children with SED.
Kansas FFS		Institutional services: Residential crisis intervention is provided through foster care. Other psychological professionals: Licensed marriage and family therapists. Other psychosocial rehabilitation: Mental health attendant and mental health attendant care.
Kentucky FFS		Other psychosocial rehabilitation: Early intervention (0-3) and wilderness camp.
Maine FFS		Other psychosocial rehabilitation: Infant mental health services.
Massachusetts MC		Other clinic services: Bridge consultation pays for outpatient staff to be part of team meeting at hospital.
Michigan MC	Clinic services: Family education is an optional service.	
Minnesota FFS		Other psychology professional: Clinical nurse specialist in mental health. Community-based services: Independent living-skills training is a time-limited, crisis-oriented service.
Missouri FFS		Other psychology professional: Licensed professional counselors. Other independent living programs: Community support.
Montana FFS		Other psychology professional: Nurse practitioners, advanced practice nurses, physicians assistants, and licensed professional counselors.

State Medicaid Program	*Optional Services in Managed Care Contracts*	*Explanations of notes (see tables 2-7)*
Nebraska FFS		Other psychosocial rehabilitation services: Community treatment aide and respite for foster parents.
Nebraska MC		Other psychosocial rehabilitation services: Community treatment aide and respite for foster parents.
New Hampshire FFS		Other psychology professional: Advanced registered nurse practitioners.
New Mexico FFS		Other psychology professionals: Licensed drug and alcohol abuse counselors. Other psychosocial rehabilitation services: Early intervention therapy services, early intervention/developmental services and behavior management skills-development services.
New Mexico MC	Community-based services: Respite care for caregivers is an optional service.	Other psychosocial rehabilitation: Behavior management skills-development.
New York FFS		Other psychosocial rehabilitation: Teaching family homes (community residences providing psychoeducational services for a small number of children, usually four).
North Carolina FFS		Other psychosocial rehabilitation: Recreation activities, child care facilities and early intervention for children 0-6.
Oklahoma FFS		Other psychosocial services: Rehabilitative treatment services.
Oklahoma MC		Targeted case management for children who meet the state's definition of SBHN. Some, but not all, SED children will fit into the category. Community-based services: Intensive home-based services, independent living and therapeutic foster care are for children who meet the state's definition of SBHN.
Pennsylvania FFS and MC		Other clinic services: Interagency team meeting. Other psychosocial rehabilitation: Therapeutic staff support and behavioral specialist consultant.
Rhode Island FFS		Other psychology professional: Licensed nurse. Other clinic services: Multidisciplinary team meeting.
South Carolina FFS		Other independent living programs: Supervised independent living.

State Medicaid Program	*Optional Services in Managed Care Contracts*	*Explanations of notes (see tables 2-7)*
Tennessee MC		Other independent living skills: Leisure education, and prevocational activities.
Texas FFS		Other psychology professional: Licensed professional counselors.
Texas MC NorthSTAR		Other psychosocial rehabilitation: Early intervention.
Texas MC STAR	Clinic services: Partial hospitalization is an optional service. Institutional care: Residential treatment center is an optional services.	
Utah MC		Other psychosocial rehabilitation: Skills- development services can be provided in any appropriate setting.
Vermont FFS		Community-based services: Intensive home-based services are paid through SRS child welfare. Child respite care is available only to children in the home- and community based waiver.
Virginia FFS		Other psychology professionals: Clinical nurse specialists in psychiatry and professional counselors.
Washington MC	Clinic services: Under the MC contract, the plans can provide any optional clinic service that meets the needs of the recipient.	
West Virginia FFS		Other psychosocial rehabilitation: Behavioral management and early intervention services.
Wisconsin FFS		Institutional services: Residential crisis intervention is provided at foster homes, group homes and community-based residential facilities.