Office for Treatment Improvement

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Medicaid Financing for Mental Health and Substance Abuse Services for Children and Adolescents

Technical Assistance Publication Series Number 2

Financing Subseries, Volume I

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Foreword

The last decade has been marked by significant expansion in the Medicaid program in terms of both eligibility and the scope of available benefits. These changes offer new opportunities to finance mental health and substance abuse services for low-income children and adolescents in communities throughout the United States.

Increasingly, States and localities have expressed an interest in obtaining detailed information about how Medicaid can be used to cover a wider array of services, providers, and settings. They have also requested information on innovative Medicaid financing strategies used by States to pay for the full continuum of mental health and substance abuse prevention, intervention, and treatment programs.

In response, the Alcohol, Drug Abuse, and Mental Health Administration requested Fox Health Policy Consultants and McManus Health Policy, Inc., to prepare this technical assistance report, which provides an overview of Medicaid coverage policies for mental health and substance abuse services. This report contains background information on the Medicaid child and adolescent population, explains key components of the Medicaid program, and also includes a status report on States' current Medicaid eligibility and service coverage policies. Perhaps most important, the report offers guidance on all of the Medicaid financing opportunities available to States to meet their mental health and substance abuse treatment objectives.

I hope that this report will stimulate greater understanding and coordination among State alcohol, drug abuse, mental health, and Medicaid programs. I believe that, as these agencies develop greater knowledge of one another's program requirements, significant improvements can be made in financing needed services for our Nation's greatest resource—its youth.

Beny J. Primm, M.D.
Associate Administrator
for Treatment Improvement

Executive Summary

States, in recent years, have focused increasing attention on ways to expand and improve services for youth who have, or are at risk for, emotional or substance abuse problems. As part of this effort, State mental health and substance abuse programs are seeking approaches to maximize available sources of financing to support evolving prevention and treatment service systems for children.

State Medicaid programs, at the same time, have demonstrated an increased willingness to broaden the scope of services they reimburse and to play the primary role in financing health care services for poor children. Congress, through recently enacted changes in the Federal Medicaid statute, has strengthened this role by extending Medicaid eligibility to greater numbers of young, poor children and mandating that all these eligible children have access to a wider range of benefits for medically necessary services.

This report provides State alcohol, drug abuse, and mental health program administrators and other policymakers with an explanation of the basic structure of the Federal Medicaid program and current information on the availability of Medicaid coverage for mental health and substance abuse prevention and treatment services across States. The report places special emphasis on innovative approaches that either have been or could be used by States to improve Medicaid coverage of needed services. In reviewing gaps and opportunities in Medicaid reimbursement for children's mental health and substance abuse treatment services, the report examines the following questions:

1. What are the characteristics and service needs of children receiving Medicaid?
2. How do children become eligible for Medicaid benefits?
3. What types of services can State Medicaid programs reimburse?
4. How are State Medicaid programs financed and administered?
5. What Medicaid services are federally mandated and how do States use them to serve children with mental health and substance abuse problems?
6. What services may States cover at their own option and to what extent are these benefits available to children with mental health and substance abuse problems?
7. How might State Medicaid reimbursement of mental health and substance abuse treatment services for children be improved?

Data for this report come primarily from a telephone survey of State Medicaid agency staff conducted by Fox Health Policy Consultants and McManus Health Policy, Inc., in the spring and summer of 1989. All State Medicaid survey data are current as of June 1989. Data from the March 1989 Current Population Survey also are used to estimate the number and characteristics of children with Medicaid coverage.

Because major changes in the Federal Medicaid statute were made by the Omnibus Budget Reconciliation Act of 1989 after our survey was completed, we also describe and evaluate its impact on State Medicaid coverage policies with respect to mental health and substance abuse services for children. We focus in particular on the expanded benefits required as part of States' Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT).

What Are the Characteristics and Service Needs of Children Receiving Medicaid?

Nearly 11 million youths under age 21 were enrolled in the Medicaid program in 1988. Very young (under age 5), very poor (under 50 percent of the Federal poverty level), minority, and rural children, those in single-parent households, those whose parents have not completed high school, those living in the Northcentral or Northeast regions, and those with health problems are most likely to be Medicaid recipients.

Medicaid-enrolled children who manifest or are at risk for mental health or substance abuse problems require a range of parallel services,

from assessment and short-term counseling to residential treatment (see table 4). Services may be needed in a variety of settings, including the home, and may need to be furnished by a range of providers.

How Do Children Become Eligible for Medicaid Benefits?

Medicaid eligibility policies, which are quite complex, essentially provide three avenues to Medicaid benefits. Children can qualify as categorically needy recipients, as recipients not linked to a cash assistance program, and as medically needy recipients.

The categorically needy program is made up primarily of individuals who receive cash assistance under the Aid to Families with Dependent Children (AFDC) program. Also included are individuals receiving cash benefits under the Supplemental Security Income (SSI) program, children for whom payments are being made under the Federal foster care or adoption assistance programs, and children aged 6 who meet the financial, but not the categorical, criteria for AFDC payments. Other categorically related groups may be covered at a State's option.

Certain additional groups of infants and children who are not related to any cash assistance program can qualify for Medicaid as a result of legislation enacted by Congress over the past several years. Mandatory coverage now exists for all children up to age 6 with family incomes up to 133 percent of the Federal poverty level. Coverage is optional for all children up to age 7 with family incomes up to 100 percent of the poverty level and to infants with family incomes above 133 percent, but at or below 185 percent of the poverty level.

The medically needy program, an optional program operated by 36 States, extends eligibility to low-income individuals who meet the categorical, but not the financial, criteria for cash assistance. A State may include individuals with incomes up to 133 1/3 percent of the AFDC eligibility cutoff for a similarly sized family and also other individuals if their medical expenses are high enough to reduce their countable income below the medically needy standard.

What Types of Services Can State Medicaid Programs Reimburse?

Federal Medicaid law establishes a core of seven benefits (such as inpatient services and physician services) that States are *required* to provide and more than a dozen other benefits (such as clinic services, independent practitioner services, rehabilitative services, and case management) that States *may* provide at their option. Through these benefit categories, Medicaid offers significant flexibility in the types of services that may be reimbursed, the settings in which they may be furnished, and the types of providers who may furnish them.

States are free, within broad Federal guidelines, to establish the amount, duration, and scope of services they will cover under a benefit category. In addition, they may impose prior authorization or other utilization review requirements.

State Medicaid programs also may establish provider qualifications for each service they reimburse. Federal law requires, however, that the qualifications be reasonably related to the ability to furnish the particular service.

Further, States are permitted, with some exceptions, to determine the reimbursement methodologies their Medicaid programs will use, as long as three basic requirements are met. First, providers must accept the Medicaid payment as payment in full. Second, Medicaid must be the payer of last resort. Third, Medicaid payments must be adequate to assure economical, efficient, and quality care.

How Are State Medicaid Programs Financed and Administered?

Medicaid is financed and administered jointly by Federal and State governments. Federal law basically dictates how the program is financed, but States enjoy significant authority in its administration.

The formula used to calculate the Federal share of State Medicaid program costs is based on a State's per capita income and ranges from 50 to 80 percent. The Federal share of State administrative costs is the same across all States—generally 50 percent.

State administration of the Medicaid program is the responsibility of a single designated agency. Each State also has a Medicaid medical advisory group that includes provider and consumer representatives. Each State develops a State Medicaid plan, describing eligibility, benefits, reimbursement, and administrative policies. The plan must be approved by the Health Care Financing Administration (HCFA) and can be revised at any time with HCFA approval.

How Do States Use Federally Mandated Services To Serve Children?

The benefits States are federally required to provide under Medicaid include four of particular

importance for children with mental health and substance abuse problems: outpatient hospital services, inpatient hospital services, physician services, and EPSDT. Our survey revealed the following characteristics of State coverage policies under each of these benefits:

- Outpatient hospital services for both mental health and substance abuse treatment are provided without limits in about half the States. Coverage includes partial hospitalization services for emotionally disturbed children in over a dozen States and for substance-abusing children in five States.
- Inpatient hospital services are provided without limits in about half the States. Coverage in nearly all States includes mental health and substance abuse treatment in inpatient units, although reimbursement of substance abuse treatment in most States is limited to detoxification.
- Physician services are provided without limits in nearly two-thirds of States, which, however, sometimes place greater restrictions on psychiatrists' services than on the services of other physicians. Benefits in over half the States include services furnished by practitioners working autonomously but supervised by physicians, such as nurse practitioners and clinical social workers.
- States, for the most part, have not used the EPSDT program's potential for providing specialized screening or augmented diagnostic and treatment benefits to children with mental health or substance abuse problems.

What Optional Benefits Are Available?

The benefits States may cover at their option include several that are needed to treat children with emotional or substance abuse problems: clinic services, rehabilitative services, other licensed practitioner services, personal care services, inpatient psychiatric facility services for persons up to age 22, and targeted case management services. States have structured coverage of children's mental health and substance abuse treatment services under these benefit categories in the following ways:

- States use the clinic services benefit to reimburse services furnished by mental health clinics, substance abuse clinics, and school clinics, among others. Mental health clinic services are reimbursed in over three-fourths of all States. Over half of these States do so potentially without limits, and more than two-thirds include coverage for day treatment. Substance abuse clinic services are covered in less than a quarter of States. While all but one of the States provide potentially unlimited coverage, only about half reimburse alcohol abuse treatment. School clinics are directly reimbursed for services in only two States, although additional States reimburse these clinics indirectly by reimbursing another provider type that operates the clinic, such as a community health center, or the individual practitioners who furnish the services.
- The rehabilitative services benefit is used in only a dozen States to reimburse mental health services and in even fewer to reimburse substance abuse treatment services. Mental health rehabilitative services are available on an unlimited basis in three-fourths of the States with coverage, and the benefit generally includes day treatment. Substance abuse rehabilitative services are unlimited in over half the States, but only half provide day treatment.
- The other licensed practitioner services benefit can be used to reimburse services furnished by licensed psychologists and clinical social workers, among others. Psychologists are reimbursed in half the States, but clinical social workers are reimbursed in only two. Half the States covering each type of practitioner, however, do so without limits.
- The personal care services benefit is used to pay for services to persons with mental health problems in only a few States. The benefit is used in a limited way by these States to augment payment for services furnished to persons in foster care, supervised living arrangements, or board and care homes.
- The inpatient psychiatric services benefit for individuals under age 21 is provided by almost three-quarters of States, usually without limits. Most of these States reimburse only traditional freestanding psychiatric hospitals, but only slightly more than a quarter reimburse other types of facilities, such as small residential treatment centers. Treatment of substance abuse problems is included in the coverage in nearly all States when it is the secondary diagnosis and in over one-third when it is the primary diagnosis.
- The targeted case management benefit is used in fewer than a dozen States to serve children with emotional problems. Only a handful of States use the benefit to serve children with substance abuse problems.

How Might Medicaid Reimbursement Be Improved?

States, overall, have not made optimal use of Medicaid as a financer of mental health and

substance abuse services for children. Although a number of States have structured their Medicaid benefits to allow reimbursement of innovative services delivered in a child's home, school, or other nonclinic site, many others still emphasize traditional inpatient and clinic-based services in their coverage policies.

State program administrators should examine Medicaid mandatory and optional benefit policies carefully to understand how they can be used in various combinations to provide coverage for a full continuum of services in a variety of settings. States should focus on the mandatory EPSDT benefit, in particular, as a means of supporting prevention, early intervention, and treatment activities. Given recent Federal mandates that require increased screening under the program and greater coverage of diagnostic and treatment services, the EPSDT program should increase greatly in usefulness.

The key to making necessary changes in a State's Medicaid coverage policies is collaboration among State Medicaid, mental health, and substance abuse program staffs. Once programs understand one another's requirements, a number of improvements in service delivery and financing are possible, including cooperation in developing screening and referral protocols, designating case management responsibility, establishing provider qualifications, and operating prior authorization programs.

Introduction

This report presents a detailed analysis of Medicaid financing of mental health and substance abuse[1] prevention and treatment services for children.[2] State Medicaid program staff in each of the 50 States and the District of Columbia[3] were interviewed by telephone in 1989 by Fox Health Policy Consultants and McManus Health Policy, Inc.[4] Although we provide background information on eligibility, reimbursement, financing, and administration, this report focuses primarily on Medicaid benefit policies.

A previous study on Medicaid eligibility and benefits for severely emotionally disturbed children, entitled *An Explanation of Medicaid and Its Role in Financing Treatment for Severely Emotionally Disturbed Children and Adolescents*,[5] was prepared in 1987 by Fox Health Policy Consultants for the Georgetown University Child Development Center with funding from the Child and Adolescent Service System Program (CASSP), National Institute of Mental Health. Fox and Yoshpe surveyed each State's Medicaid agency to determine coverage of numerous Medicaid benefits. These included four mandatory services (hospital outpatient services, hospital inpatient services, physician services, and the Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] program) and five optional services (clinic services, medical or other remedial care provided by licensed practitioners, case management services, prescription drugs, and psychiatric facility services) for individuals under 21. The analysis was supplemented in 1989 with a report on mental health rehabilitative services.[6]

This report updates information from the earlier reports and includes benefits for out-of-State inpatient psychiatric placements. It also considers the needs of a broader population of children, including groups at risk for mental health and substance abuse problems.

Since our survey was completed, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) was enacted. This historic law mandates significant expansions in both Medicaid eligibility and benefits affecting children. As a result, State Medicaid programs may be in the process of expanding their coverage policies for children under the EPSDT benefit. We have incorporated relevant OBRA '89 changes and their implications in the text.

This report is intended to assist primarily State, but also Federal and local, substance abuse and mental health agency staff in their efforts to use Medicaid more effectively as a source of payment for services to low-income children. Readers should be cautioned, however, that Medicaid, like private insurance, will seldom serve as the sole source of payment for all mental health and substance abuse services delivered to poor children because certain nontherapeutic interventions (such as educational or vocational services) and certain unlicensed providers with no relationship to a clinic or other organized setting cannot be reimbursed. Multiple funding sources will continue to be essential for providing a full range of mental health and substance abuse prevention and treatment services.

This report is organized into three chapters.

- Chapter 1 provides basic information on the characteristics of Medicaid-enrolled children, the mental health and substance abuse service needs for youth, and the requirements and operation of the Medicaid program.
- Chapter 2 presents background material on the ways in which Medicaid's mandatory and optional benefits can be and are used by States to reimburse prevention and treatment services for children with mental health or substance abuse problems.
- Chapter 3 assesses the significance of the State Medicaid survey results and presents recommendations for improved use of State Medicaid benefits as a financing mechanism for children's mental health and substance abuse services.

The report also includes two appendixes. Appendix A contains tables presenting the results of our 50-State survey of Medicaid coverage policies for children's mental health and substance abuse services, and Appendix B contains two glossaries—one of common Medicaid terms and one of abbreviations used in this report.

Chapter 1—Background on the Medicaid Child and Adolescent Population and Key Components of the Medicaid Program

Efforts to improve Medicaid's role in financing mental health and substance abuse treatment services for children are aided by a basic understanding of the Medicaid program and the children it covers. Mental health and substance abuse program administrators, for example, need to know what proportion of the child population is apt to be enrolled in Medicaid and what Federal or State policies limit the types of services that Medicaid can reimburse.

This chapter attempts to provide answers to these and other basic questions. It begins with an examination of the characteristics of children covered by Medicaid and the nature of the comprehensive service systems that treat these children when they develop emotional or substance abuse problems. The chapter continues with a description of the Medicaid eligibility, benefit, and reimbursement policies that determine the extent to which coverage for particular services will be available, and it concludes with an overview of how the Medicaid program is financed and administered.

Characteristics and Service Needs of Recipients

Only 53.5 percent of children under age 21 and below the poverty level were enrolled in Medicaid in 1988.[7] The children most likely to be covered by Medicaid were ages 5 and under, the very poor (those with family incomes below 50 percent of the Federal poverty level), those residing in single-parent households, minorities, those whose parents have not graduated from high school, those living in the Northeast or Northcentral regions, and those from rural areas. Research on Medicaid recipient characteristics has revealed also that children with health problems are more likely to be covered by Medicaid than those without health problems.[8]

Despite Medicaid's failure to cover all poor children, nearly 11 million youth ages 21 and under were covered by this important health care financing mechanism in 1988.[9] They accounted for as many as half of all Medicaid recipients, but because of their relatively low service costs, represented only 20 percent of all Medicaid vendor payments. The average per-child expenditure in 1988 was $865, compared with $3,658 per adult. Medicaid represents an extremely important source of financing for low-income children, but only a small portion of Medicaid child recipients rely on costly health services, such as hospital care or long-term institutional services.

Medicaid-enrolled children who manifest or are at risk for mental health or substance abuse problems need various and parallel services for which Medicaid can provide reimbursement. These treatment services span a full continuum of care and include assessment and short-term counseling at one end and residential treatment at the other. In the middle are a variety of intensive therapeutic interventions that may be furnished in traditional settings such as clinics, hospital outpatient departments, or individual practitioners' offices. For some children, therapeutic interventions may also be offered in the child's home or through specialized foster care, family preservation programs, group living arrangements, day treatment programs, and after-school programs.[10]

Because the Health Care Financing Administration (HCFA) analyzes Medicaid service data according to benefit categories and not diagnostic codes, national utilization and expenditure information on services to Medicaid-enrolled children with mental health and substance abuse problems is not available.[11] A number of States, however, are beginning to collect data on the use and cost of mental health and substance abuse services for their own purposes.

Medicaid's Eligibility, Benefit, and Reimbursement Policies

Federal law has established requirements and policies that set

the parameters for who can receive Medicaid benefits, what those benefits can be, and how benefits can be reimbursed. Within these broad Federal guidelines, however, States have significant flexibility in establishing additional policies and requirements that may substantially narrow the availability of Medicaid reimbursement for specific groups and services.

The following sections set forth basic Federal requirements and State options in the areas of Medicaid eligibility, benefits, and reimbursement. With respect to eligibility and reimbursement, these sections also provide some information on actual State practices. Detailed information on State practices in the area of benefits is provided in chapter 2.

Eligibility

Eligibility policy under Medicaid is exceedingly complex, particularly with respect to a State's income and resource standards. The following discussion provides a brief overview of the three ways in which children can qualify for Medicaid coverage: as categorically needy recipients, as recipients not linked to a cash program, and as medically needy recipients. Chart 1 presents this information graphically.

The Categorically Needy Program

The categorically needy program is composed largely of individuals who either receive Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) or who are categorically related to one of the cash assistance programs. The categorically related groups may be mandatory (required by Federal law) or optional (covered at the discretion of the State). Approximately 16.5 million individuals were enrolled in Medicaid as categorically needy cash-assistance-linked in 1988, according to HCFA data.[12]

The AFDC Groups. Children who must be provided Medicaid coverage as AFDC-linked categorically needy recipients fall into one of three groups. These include

- all children receiving cash benefits under the AFDC program (Title IV, Part A of the Social Security Act)—those under 18 who live in a family in which one parent is dead, incapacitated, or absent (or, as of October 1, 1990, a family in which the principal wage-earner is unemployed)[13] and who meet the income and resource standards specified in the State's AFDC plan;
- all children for whom payments are being made under the foster care or adoption assistance program (Title IV, Part E of the Social Security Act)—those in a family foster home or child care institution who otherwise would be eligible for AFDC payments and those adopted who have special needs and who either meet the requirements for SSI or otherwise would be eligible for AFDC; and
- all children aged 6 who meet the State's financial criteria for AFDC, but not the definition of "dependent child."[14]

At State discretion, Medicaid benefits also may be extended to certain other AFDC-related groups of children. The most significant of the State options is the ability to extend Medicaid eligibility to all the so-called "Ribicoff children"—those who meet the State's financial criteria for AFDC but live in two-parent families[15] or are not otherwise considered dependent. States may cover either all financially eligible children from age 7 to age 18, 19, 20, or 21 *or* one or more reasonable classifications of financially eligible children up to age 18, 19, 20, or 21, such as those in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities, as shown in table 1.

The other major optional groups of AFDC-related children are these:

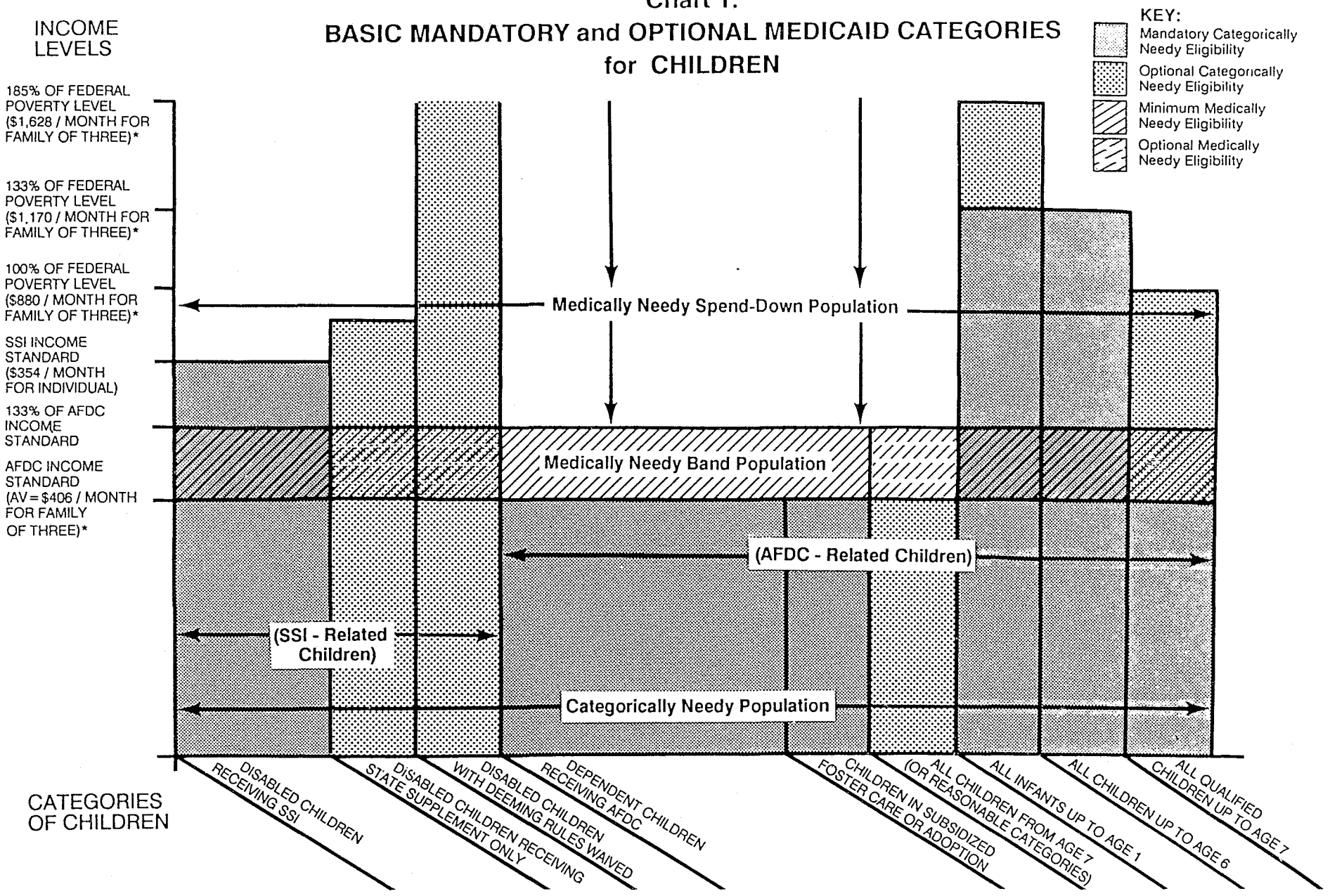
- all children who are eligible for, but whose families have not applied for, AFDC benefits;
- all children who are eligible under the AFDC program except for their institutional status;
- all children who would be eligible for AFDC payments if the State's program were as broad as Federal law allows (that is, if it included children aged 18 who regularly attend school); and
- as of September 30, 1990, all children aged 7 who meet the State's financial criteria for AFDC but not the definition of "dependent child."

In addition to State differences in categorical Medicaid policies, there is wide variation in the income and resource standards that States use. Income eligibility for Medicaid typically is determined by a State's AFDC payment level. (Individuals are not eligible for AFDC benefits unless their countable income falls below the amount that may be paid to them.) Since the AFDC payment level across States averages less than 50 percent of the Federal poverty level, a substantial proportion of poor children and adolescents are excluded from Medicaid. As table 2 shows, 48 States set their AFDC payment level at or below 75 percent of the Federal poverty level, 34 States at or below 50 percent of the poverty level, and 4 States at or below 25 percent of the poverty level.

The SSI Groups. Children receiving SSI benefits, unlike those receiving AFDC, are not granted mandatory eligibility status for Medicaid. Federal law permits States to select one of two Medicaid coverage options with regard to SSI recipients:

- they may make all SSI recipients eligible and, at their discretion, also provide Medicaid benefits to individuals receiving only optional State supplementary SSI payments, or
- they may limit Medicaid eligibility to individuals who meet

Chart 1:
BASIC MANDATORY and OPTIONAL MEDICAID CATEGORIES for CHILDREN



*CURRENT AS OF JUNE 1990

Prepared by: FOX HEALTH POLICY CONSULTANTS, JULY 1990

Table 1
Coverage of Optional Child Categories[1,2]

State	All Children to Age 18, 19, 20, or 21	Reasonable Categories to Age 18, 19, 20, or 21				
		Psychiatric Institution	ICF/MR*	Foster Care	Adoption	Other
Alabama	—	18	—	18	—	—
Alaska	21	—	—	—	—	—
Arizona	N/A	N/A	N/A	N/A	N/A	N/A
Arkansas	18	21	—	21	—	—
California	21	—	—	—	—	—
Colorado	—	21	21	21	—	—
Connecticut	21	—	—	—	—	—
Delaware	—	—	—	21	21	—
District of Columbia**	21	—	—	—	—	—
Florida	21	—	—	—	—	—
Georgia	18	—	—	—	—	—
Hawaii	18	—	19	21	21	—
Idaho	—	—	—	21	21	—
Illinois	18	—	—	—	—	—
Indiana	—	21	—	—	—	20[3]
Iowa	21	—	—	—	—	—
Kansas	18	21	21	21	21	—
Kentucky	18	21[4]	—	19[5]	—	—
Louisiana	—	—	—	18	—	—
Maine	21	—	—	—	—	—
Maryland	21	—	—	—	—	—
Massachusetts	21	—	—	—	—	—
Michigan	21	—	—	—	—	—
Minnesota	21	—	—	—	—	—
Mississippi	18	—	—	21	21	—
Missouri	21	—	—	—	—	—
Montana	—	—	—	21	—	—
Nebraska	21	—	—	—	—	—
Nevada	—	—	19	19	19	—
New Hampshire	—	—	—	19[5]	19[5]	—
New Jersey	21	—	—	—	—	—
New Mexico	—	—	—	18	18	—
New York	21	—	—	—	—	—
North Carolina	21	—	—	—	—	—

Table 1 (Cont.)
Coverage of Optional Child Categories[1,2]

State	All Children to Age 18, 19, 20, or 21	Reasonable Categories to Age 18, 19, 20, or 21				
		Psychiatric Institution	ICF/MR*	Foster Care	Adoption	Other
North Dakota	21	—	—	—	—	—
Ohio	21	—	—	—	—	—
Oklahoma	21	—	—	—	—	—
Oregon	—	21	21	21	21	—
Pennsylvania	21	—	—	—	—	—
Rhode Island	—	—	19	19[5]	—	—
South Carolina	18	—	—	21	—	—
South Dakota	—	—	—	18	18	—
Tennessee	21	—	—	—	—	—
Texas	19	—	—	—	—	—
Utah	18	21	—	—	—	—
Vermont	21	—	—	—	—	—
Virginia	21	—	—	—	—	—
Washington	—	21	21	21	21	—
West Virginia	—	21	—	18	18	—
Wisconsin	18	21	—	—	—	21[6]
Wyoming	—	—	—	19[5]	19[5]	—

* Intermediate Care Facility for the Mentally Retarded

** The District of Columbia was considered a State for purposes of this report.

— = option not used

[1] These are made up of so-called "Ribicoff children"—those whose family income meets AFDC standards but whose family composition does not.

[2] All States except the following extend AFDC eligibility to children up to age 18 if they still are in school, making Medicaid eligibility for such children mandatory: Alabama, Alaska, Arkansas, Delaware, Florida, Georgia, Indiana, Mississippi, and Tennessee.

[3] Indiana extends eligibility to children up to age 20 who meet all AFDC requirements except age and children up to age 18 who are in the legal custody of county child welfare agencies.

[4] Kentucky extends eligibility to children in psychiatric facilities up to age 21 if they were admitted on or before their 18th birthday.

[5] Kentucky, New Hampshire, Rhode Island, and Wyoming extend eligibility to children in foster care up to age 19 if they are still enrolled in high school. New Hampshire and Wyoming also extend eligibility to children up to age 19 in an adoption assistance program if they are still enrolled in high school.

[6] Wisconsin extends eligibility to children up to age 21 who are in skilled nursing facilities or intermediate care facilities.

SOURCE: Information obtained by Fox Health Policy Consultants and McManus Health Policy, Inc., through telephone interviews with State Medicaid agency staff during the spring and summer of 1990.

Table 2
Annualized Medicaid Income Standards for Recipients Eligible Under the AFDC Program

State	Current Medicaid Eligibility (AFDC—Family of Three)[1] ($)	Current Medicaid Eligibility as a Percentage of the Poverty Level[2] (%)
Alabama	1,416	13.4
Alaska	10,152	76.9[3]
Arizona	3,516	33.3
Arkansas	2,448	23.2
California	8,328	78.9
Colorado	5,052	47.8
Connecticut	6,660	63.1
Delaware	3,996	37.8
District of Columbia	4,908	46.5
Florida	3,528	33.4
Georgia	4,968	47.0
Hawaii	7,224	59.5[3]
Idaho	3,780	35.8
Illinois	4,404	41.7
Indiana	3,456	32.7
Iowa	4,920	46.6
Kansas	4,596	43.5
Kentucky	6,312	59.8
Louisiana	2,280	21.6
Maine	7,824	74.1
Maryland	4,752	45.0
Massachusetts	6,468	61.3
Michigan	6,900	65.3
Minnesota	6,384	60.5
Mississippi	4,416	41.8
Missouri	3,468	32.8
Montana	4,308	40.8
Nebraska	4,368	41.4
Nevada	3,960	37.5
New Hampshire	7,116	67.4
New Jersey	5,088	48.2
New Mexico	3,168	30.0
New York	7,476	70.8
North Carolina	3,324	31.5
North Dakota	4,632	43.9
Ohio	3,852	36.5
Oklahoma	5,652	53.5

Table 2 (Cont.)
Annualized Medicaid Income Standards for Recipients Eligible Under the AFDC Program

State	Current Medicaid Eligibility (AFDC—Family of Three)[1] ($)	Current Medicaid Eligibility as a Percentage of the Poverty Level[2] (%)
Oregon	5,184	49.1
Pennsylvania	5,052	47.8
Rhode Island	6,516	61.7
South Carolina	5,028	47.6
South Dakota	4,524	42.8
Tennessee	4,644	44.0
Texas	2,208	20.9
Utah	6,192	58.6
Vermont	7,944	75.2
Virginia	3,492	33.1
Washington	6,012	56.9
West Virginia	2,988	28.3
Wisconsin	6,204	58.8
Wyoming	4,320	40.9

[1] These figures are current as of January 1990. Several States use two or more eligibility levels to reflect regional differences, seasonal differences, or differences in whether applicants have earned or unearned income. The eligibility figures presented in this table are considered the most representative for these States.

[2] The 1990 Federal poverty guideline for a family of three is $10,560 per year.

[3] Poverty guidelines for Alaska and Hawaii differ from other States. The poverty guideline for a family of three is $13,200 in Alaska and $12,150 in Hawaii.

SOURCE: Information obtained from State Medicaid agency staff by the National Governors' Association in January 1990.

categorical or financial requirements more restrictive than those established under SSI.

SSI is a Federal program that provides cash assistance to low-income persons who are aged, blind, or disabled. To receive benefits, a child qualifying as disabled must be under the age of 18 and suffer from a physical or mental impairment that has lasted, or is expected to last, for a continuous period of 12 months and compares in severity to an impairment that would make an adult unable to engage in substantial gainful activity. In addition, parental income deemed available to the child, after allowable family expense deductions, must not exceed the monthly maximum, which is $386 (plus $20 of excluded income).

States that choose to apply more restrictive eligibility criteria than those used under the Federal program are known as 209(b) States, a reference to the provision in the 1972 bill that established the option. The eligibility criteria they select may be more restrictive with respect to either the disability definition or the income and resource standards, or both. As of January 1, 1990, 41 States covered all disabled children who receive Federal SSI cash assistance.[16] Of these, 19 also provided eligibility to disabled children who receive State supplements but have incomes that make them ineligible for Federal benefits. The remaining 10 States failed to provide Medicaid benefits to all SSI children, and one of them (New Hampshire) did not cover SSI children at all.

States have the option to cover certain additional groups of SSI-related recipients as well, regardless of which of the basic SSI coverage options they select. The most significant for children is the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) amendment option to provide eligibility to all noninstitutionalized children 18 years of age or younger who qualify as disabled but otherwise would meet the financial criteria for SSI only if they were in a medical institution where their parents' income would not be deemed available to them. To be

eligible under this category, children must require the level of care provided in a hospital or nursing home, and the estimated cost of their care to the Medicaid program must be less than it would be for institutional care.

Other groups of children that may be covered as SSI-related categorically needy recipients include

- disabled individuals eligible for, but not receiving, SSI payments;
- disabled individuals who would be financially eligible for SSI or an optional State supplement if they were not in a medical institution;[17] and
- disabled individuals in institutions who are eligible under a special income level.

Children Not Linked to a Cash Assistance Program

In recent years, Congress has enacted several pieces of legislation that have extended mandatory or optional Medicaid eligibility to groups of infants and young children not eligible for any of the cash assistance programs. HCFA data indicate that in 1988, approximately 3.2 million individuals were enrolled in Medicaid as categorically needy but were not eligible for any cash assistance program.[18] The new groups of categorically needy noncash recipients are covered in the following ways:

- all States are *mandated* to cover children up to age 6 whose family income is no greater than 133 percent of the Federal poverty level;
- States have the *option* of covering children aged 6 (and, as of October 1, 1990, aged 7) whose family income is no greater than 100 percent of the Federal poverty level; and
- States also have the *option* of covering infants (and pregnant women) whose family income is above 133 percent but at or below 185 percent of the Federal poverty level.

Resource and asset testing for these groups may be omitted entirely but if tests are used for infants and children, they may be no more restrictive than those applied under AFDC. Infants and children eligible under these provisions are entitled to the same benefit package as cash assistance recipients.

These provisions have significantly increased younger children's access to Medicaid benefits by breaking the link to the cash assistance programs. Most children aged 7 or older, however, still must qualify for AFDC or SSI to be eligible for Medicaid, as shown in table 3; this stipulation leaves large numbers of poor older children and adolescents without coverage.

The Medically Needy Program

The medically needy program is a State option designed to permit Medicaid coverage of low-income individuals who meet the categorical, but not the financial, criteria for cash-assistance-related Medicaid eligibility. States can set medically needy income standards at levels up to 133 1/3 percent of the maximum AFDC payment standard[19] for similarly sized families. Individuals who meet this income standard are referred to as the "band" population (see chart 1). Through a spend-down provision, individuals with incomes above the medically needy standard also may become eligible if their medical expenses are high enough to reduce their countable income below their medically needy maximum. These individuals are referred to as the "spend-down" population (see chart 1). Approximately 3.6 million individuals were enrolled in Medicaid through medically needy programs in 1989, according to HCFA data.[20]

States that choose the medically needy program option are required at a minimum to extend eligibility for ambulatory services to certain categories of children who meet their income and resource standards as medically needy.[21] These may include children up to the age of 18 who are financially ineligible for cash assistance, but who meet the categorical requirements for inclusion in one of the programs.

Thirty-six States, as well as the District of Columbia, currently operate medically needy programs.[22] Because most States' AFDC payment level is significantly below the Federal poverty level, however, the medically needy band population in these States is composed largely, if not exclusively, of AFDC-type individuals whose countable income, after child care and other allowable deductions, still exceeds the payment level. SSI-type individuals in these States are not likely to be included in the band at all, because raising the AFDC payment level by 133 1/3 percent generally does not bring the medically needy into a standard above the SSI income standards.

Benefit Design and Provider Options

Medicaid can play a major role in financing the wide range of services needed by children with emotional or substance abuse problems. Many of the services can be covered in different settings, including children's homes or foster homes, schools, and an array of small residential treatment settings, as well as more traditional clinic and psychiatric facility sites, as shown in table 4.

Moreover, Medicaid offers significant flexibility in terms of who may provide mental health and substance abuse services. Broad categories of services may be reimbursed, regardless of whether they are furnished by licensed professionals or by unlicensed or paraprofessional providers. Generally, though, reimbursement for the services of unlicensed providers is available only

Table 3
Medicaid Income Eligibility for Children and Adolescents as a Percentage of Poverty, as of April 1, 1990[1]

State	Children, Newborn Through Age 6 (%)	Children Aged 1 to 6 (%)	Children Aged 6 (%)	Children Aged 7 and over (%)
Alabama	133.0	133.0	14.1	14.1
Alaska	133.0	133.0	77.2	77.2
Arizona	133.0	133.0	35.0	35.0
Arkansas	133.0	133.0	24.3	24.3
California	185.0	133.0	79.1	79.1
Colorado	133.0	133.0	50.2	50.2
Connecticut	185.0	133.0	63.7	63.7
Delaware	133.0	133.0	39.7	39.7
District of Columbia	133.0	133.0	46.9	46.9
Florida	150.0	133.0	100.0	34.2
Georgia	133.0	133.0	44.9	44.9
Hawaii	185.0	133.0	57.8	57.8
Idaho	133.0	133.0	36.3	36.3
Illinois	133.0	133.0	40.8	40.8
Indiana	133.0	133.0	34.4	34.4
Iowa	185.0	133.0	100.0	47.0
Kansas	150.0	133.0	47.8	47.8
Kentucky	133.0	133.0	26.0	26.0
Louisiana	133.0	133.0	100.0	22.7
Maine	185.0	133.0	75.4	75.4
Maryland	185.0	133.0	45.0	45.0
Massachusetts	185.0	133.0	69.1	69.1
Michigan	185.0	133.0	68.2	68.2
Minnesota	185.0	133.0	63.5	63.5
Mississippi	185.0	133.0	43.9	43.9
Missouri	133.0	133.0	34.0	34.0
Montana	133.0	133.0	42.8	42.8
Nebraska	133.0	133.0	43.4	43.4
Nevada	133.0	133.0	100.0	39.4
New Hampshire	133.0	133.0	59.2	59.2
New Jersey	133.0	133.0	50.6	50.6
New Mexico	133.0	133.0	31.5	31.5
New York	185.0	133.0	64.3	64.3
North Carolina	150.0	133.0	100.0	31.7
North Dakota	133.0	133.0	46.0	46.0
Ohio	133.0	133.0	38.3	38.3
Oklahoma	133.0	133.0	56.2	56.2

Table 3 (Cont.)
Medicaid Income Eligibility for Children and Adolescents as a Percentage of Poverty, as of April 1, 1990[1]

State	Children, Newborn Through Age 6 (%)	Children Aged 1 to 6 (%)	Children Aged 6 (%)	Children Aged 7 and over (%)
Oregon	133.0	133.0	49.1	49.1
Pennsylvania	133.0	133.0	45.8	45.8
Rhode Island	185.0	133.0	100.0	61.7
South Carolina	185.0	133.0	48.1	48.1
South Dakota	133.0	133.0	43.7	43.7
Tennessee	133.0	133.0	43.5	43.5
Texas	133.0	133.0	21.9	21.9
Utah	133.0	133.0	59.9	59.9
Vermont	185.0	133.0	100.0	75.0
Virginia	133.0	133.0	34.7	34.7
Washington	185.0	133.0	100.0	58.7
West Virginia	150.0	133.0	100.0	29.7
Wisconsin	133.0	133.0	61.7	61.7
Wyoming	133.0	133.0	42.9	42.9

[1] The 1990 Federal poverty guideline for a family of three is $10,560 per year.

SOURCE: Fox Health Policy Consultants, including data provided by the Children's Defense Fund, April 1990.

indirectly, that is, available only to a facility or organization that contracts with or employs the practitioner.

Federal law establishes both mandatory and optional Medicaid services, many of which are important for financing mental health and substance abuse services to children. Those that States are required to offer include inpatient and outpatient hospital services, laboratory and radiology services, physician services, nurse practitioner services, family planning services and supplies, and EPSDT services for persons under age 21. Among the optional services that States may reimburse are clinic services, physical therapy, occupational therapy, speech pathology and audiology services (referred to in this report as speech therapy), rehabilitative services, case management, inpatient psychiatric services for persons under age 21, other licensed practitioner services (such as those of psychologists and social workers), personal care services, transportation, and prescription drugs.

States can structure benefits to provide coverage for various types of services and interventions. The hospital outpatient benefit category, for example, could be used to reimburse comprehensive assessments and testing; the clinic services benefit category could be used to pay for day treatment services; and the rehabilitative services benefit category could be used to reimburse the therapeutic service component of specialized foster care.

As a result of OBRA '89, States now are required to reimburse *all* federally allowable mandatory and optional diagnostic and treatment services needed to ameliorate or correct a physical or mental problem discovered during an EPSDT screening examination. Thus, although a State's Medicaid plan may not include coverage for inpatient substance abuse treatment for adolescents, for example, it would be obligated to reimburse the service for an adolescent whose screening examination uncovered a substance abuse problem for which inpatient detoxification was medically necessary.

With respect to all regular Medicaid services, however, States are free, within broad guidelines, to establish the amount, duration, and scope of services that they will cover—both mandatory and optional services. They may place restrictions on the number of visits, number of days, length of time, and exact type of services for which reimbursement will be provided. In addition, they may impose prior

Table 4
Potential for Financing Mental Health and Substance Abuse Prevention and Treatment Services for Children and Adolescents

Service or Intervention	Medicaid Benefit Category	
	Mandatory Regular Medicaid Service (and Mandatory EPSDT Treatment Service)[1]	**Optional Regular Medicaid Service (and Mandatory EPSDT Treatment Service)[1]**
Early identification	Outpatient hospital, physician and physician-supervised, and EPSDT screening services	Clinic, rehabilitative, licensed psychologist and social worker, and screening services
Assessment and diagnosis	EPSDT diagnostic services	Diagnostic services
Case management	None	Targeted case management
Outpatient treatment	Outpatient hospital and physician and physician-supervised services	Clinic, rehabilitative, and licensed psychologist and social worker services
Day treatment	Outpatient hospital services (and some components under physician and physician-supervised services)	Clinic and rehabilitative services (and some components under licensed psychologist and social worker services)
Home-based services	Physician and physician-supervised services	Rehabilitative, licensed psychologist and social worker services (and some components under personal care services)
Therapeutic foster care	None	Rehabilitative services (and some components under personal care services)
Therapeutic group care	None	Rehabilitative services (and some components under personal care and licensed psychologist and social worker services)
Therapeutic after-school care	None	Rehabilitative services (and some components under personal care services)
Therapeutic camp services	None	Rehabilitative services (and some components under personal care and licensed psychologist and social worker services)
Respite care—residential (not in a hospital)	None	Psychiatric facilities for individuals under 21 and rehabilitative services (and some components under personal care services)
Respite care—home-based and outpatient (not in a hospital)	None	Rehabilitative and personal care services

Table 4 (Cont.)
Potential for Financing Mental Health and Substance Abuse Prevention and Treatment Services for Children and Adolescents

Service or Intervention	Medicaid Benefit Category	
	Mandatory Regular Medicaid Service (and Mandatory EPSDT Treatment Service)[1]	Optional Regular Medicaid Service (and Mandatory EPSDT Treatment Service)[1]
Residential treatment services (excluding room and board)	(Some components under physician and physician-supervised services)	Rehabilitative services (and some components under clinic, personal care and licensed psychologist and social worker services)
Inpatient hospital	Inpatient hospital services (and some components under physician services)	Psychiatric facilities for individuals under 21
Detoxification	Inpatient hospital, outpatient hospital, and physician and physician-supervised services	Psychiatric facilities for individuals under 21 and rehabilitative services
Crisis stabilization—residential (not in a hospital)	(Some components under physician and physician-supervised services)	Rehabilitative services (and some components under personal care and licensed psychologist and social worker services)
Crisis stabilization—home-based and outpatient	Outpatient hospital and physician and physician-supervised services	Clinic, rehabilitative, and licensed psychologist and social worker services
Independent living services	Physician-supervised services	Rehabilitative services (and some components under licensed psychologist and social worker services)
Prescription drugs	None	Prescribed drugs

[1] OBRA '89 made all federally allowable services mandatory when medically necessary to correct or ameliorate a physical or mental problem discovered during an EPSDT screening examination.

SOURCE: Fox Health Policy Consultants, April 1990.

authorization or utilization control measures to ensure that overutilized or very expensive services are medically necessary.[23]

In addition, States have broad discretion in defining the nature of all optional services. Coverage of mental health clinic services, for example, may be less than sufficient to meet the needs of a drug-dependent or emotionally disturbed child who requires intensive individual therapy, as long as the State has specified in its plan that clinic services are intended for crisis intervention only.

State Medicaid programs also may establish provider qualifications or standards for each of the services they reimburse. Federal regulations require, however, that the standards be reasonably related to the provider's ability to furnish the particular service. Reasonable requirements might relate to training and education, years of experience in providing the service, supervisory and training capacity, existence of coordination and referral agreements with other relevant types of providers, and familiarity with program benefits.

Reimbursement Policies

States have considerable latitude in determining both the rates and methods of Medicaid reimbursement. Several Federal requirements, however, must be met.

- Providers must accept Medicaid payment in full, without any

cost-sharing from recipients. The only cost-sharing allowed would be that related to a medically needy recipient's spend-down liability.

- If a recipient is insured through another party, Medicaid must be the payer of last resort.
- Medicaid payments must be adequate to assure economical, efficient, and quality care.[24]

The Federal Government dictates reimbursement policies only for certain types of providers. Rural health clinics, ambulatory services provided by community health centers, migrant health centers, and health care for the homeless programs, for example, must be reimbursed an amount that reflects 100 percent of reasonable costs. There is no comparable requirement for reimbursement of community mental health centers (CMHC's).

For all services, Medicaid payment rates must be adequate to assure that Medicaid recipients' access to services is equivalent to that of the general population. Low reimbursement rates are known to affect a provider's decision to participate in the Medicaid program and also the extent to which a participating provider will actually serve Medicaid patients. Congress recently incorporated this longstanding regulatory requirement for adequate payment rates into the Medicaid statute, but it provided no objective standard against which existing reimbursement policies could be measured. In addition, it established State reporting requirements applicable only to obstetric and pediatric services.[25]

Medicaid reimbursement rates in general are low compared with private-sector rates, as well as Medicare rates, and they vary significantly across States. In our survey, for example, we found that the mean rate of reimbursement for a psychiatric diagnostic interview examination in 1989 was $58, with a high of $95 in South Carolina and a low of $26 in New Jersey. Data on comparable private market fees were not collected.

Medicaid Financing and State Administration

Medicaid was designed to be financed and administered jointly by Federal and State governments. Matters of program financing are largely dictated by Federal law. In the area of administration, however, States are permitted to determine many aspects of program operation, although there are broad Federal requirements that must be met in this area as well.

The following section begins by briefly reviewing the methodologies used to determine Federal and State responsibilities in meeting the costs of Medicaid programs. It concludes with a discussion of the Federal requirements and State discretionary authority relating to program administration, including information about steps some States have taken to address an administrative issue of special concern for adolescents—confidentiality of claims.

Financing

The Medicaid program is financed jointly by Federal and State governments. Each year the Federal Government calculates its share of payment to States based on the Federal Medical Assistance Percentage (FMAP). The following formula is used to calculate the FMAP:[26]

$$\text{FMAP} = 100 \text{ Percent} - \text{State Share}$$

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 45 \text{ percent}$$

In 1989, the FMAP ranged from a low of 50 percent in 12 States to a high of 80 percent in Mississippi. Thus, in the State of Mississippi, the Federal Government would contribute 80 cents for every dollar spent on covered Medicaid benefits. The mean FMAP was 60.72 percent in 1989.

The Federal Government also pays 50 percent of administrative costs for State Medicaid services. Higher rates, however, are available for certain administrative services, such as the operation of automated claims processing systems (75 percent) or administrative activities that must be performed by skilled professional staff (75 percent).

State governments must pay at least 40 percent of the non-Federal share, with local governments in some States contributing the remainder. In 1986, only 14 States required local funding.[27] Medicaid rules also allow for private funds to be contributed toward the non-Federal share as long as the funds come under the administrative control of the State's Medicaid agency. If a hospital, for example, were to donate funds, it could play no role in determining which services or populations the funds would be used to support.

State Administration

Each State has a single agency—most often the welfare or social services department (25 States) or a combination of health and social services departments (15 States)—charged with administering the State Medicaid program. The agency has responsibility for determining eligibility, certifying providers, developing coverage policies, processing claims, and reviewing health services. Each State also has a Medicaid medical advisory group, which must include both provider and recipient representatives.

Each State develops a Medicaid State plan describing its eligibility, benefits, reimbursement, and administrative policies. The plan must be approved by HCFA but

can be revised at any time. Amendment requests go to the appropriate HCFA regional office, which has 90 days to approve the amendment, reject it, or request additional information. Regional offices do not have the authority to reject a State plan amendment; formal rejections must be determined by the HCFA central office. If HCFA has not responded to the request at the end of the 90-day period, the amendment is deemed to be approved.

When individuals or families apply for Medicaid, they must be notified of their eligibility determination within 60 days if applying as disabled and 45 days otherwise, except for pregnant women presumed to be eligible. Retroactive eligibility also may be granted for up to 3 months prior to application. Eligibility usually is redetermined at 6-month intervals for AFDC recipients and at less frequent intervals for other recipient groups. Of course, individuals must report changes in income or family composition that may affect eligibility in accordance with State requirements.

Individuals deemed eligible receive a Medicaid card that entitles them to all services covered under the State plan. The general practice is for States to give the parent/guardian one Medicaid card that lists all eligible family members. Only five States—California, Kansas, Maryland, New Hampshire, and New York—allow teens to obtain their own Medicaid cards in an effort to protect their privacy. All but seven States, however, have elected not to send Medicaid service reports home to recipients on a regular basis.[28]

Medicaid recipients, except under an approved waiver, must be allowed to obtain covered services from any provider certified by the Medicaid program as able to furnish them. States establish provider standards, but then must allow any provider that meets the standards to enroll in the program.

Chapter 2—State Analysis of Selected Medicaid Benefits Related to Alcohol, Drug Abuse, and Mental Health Prevention and Treatment

Given the broad discretion States have in structuring Medicaid benefits, it is not surprising that benefit packages vary significantly among States. Because States may provide reimbursement for many services under a number of different categories, assessing the adequacy of a State's coverage of mental health and substance abuse treatment services for children requires a review of its full Medicaid benefits plan. Both mental health and substance abuse treatment services, for example, can be covered as physician-supervised services, hospital outpatient services, clinic services, licensed practitioners' services, or rehabilitative services.

Fox Health Policy Consultants and McManus Health Policy, Inc., jointly surveyed Medicaid agency staff in 50 States during the spring and summer of 1989.[29] The survey questionnaire was designed to elicit detailed information on the extent of coverage for selected mandatory and optional services critical to meeting the needs of children who have manifested or are at risk for mental health and substance abuse problems. The questionnaire was pretested and administered by telephone. An attempt was made to speak to the head of coverage policy in each State. Draft tables detailing individual State coverage policies were mailed to the State Medicaid directors for review, and revisions were made as appropriate.

Each of the benefits most important in financing mental health and substance abuse prevention and treatment services for children is described below,[30] along with information on coverage patterns across States. Detailed State information also is presented in appendix tables 1 through 13. For each category, we define the benefit, discuss why it is important, and then describe how States use it to reimburse mental health and substance abuse services.

Mandatory Benefit Categories

The mandatory Medicaid services most important to children with emotional or substance abuse problems are outpatient hospital services, including partial hospitalization; inpatient hospital services; physician services; and EPSDT. About half of all States provide potentially unlimited coverage of mental health and substance abuse treatment services in hospital outpatient units. Over a third also include coverage for partial hospitalization for up to 5 or 7 days per week. Perhaps surprisingly, nearly half of all States reimburse inpatient hospital stays in psychiatric and substance abuse units potentially without limit. Coverage of physician services, including those of psychiatrists, in most States also is unlimited, and over half of the States reimburse services furnished by physician-supervised personnel as well as those rendered directly by the physician.

States have not made extensive use of the EPSDT benefit to meet children's mental health and substance abuse treatment needs, however. In only a few States have EPSDT screening examinations been directed explicitly at detecting emotional or substance abuse problems in children. Moreover, no State has established referral protocols for further diagnosis and treatment of children in whom these problems are suspected. As a result of OBRA '89, however, EPSDT services should improve significantly for children with mental health or substance abuse treatment needs.

Early and Periodic Screening, Diagnosis, and Treatment for Children Aged 21 and Under

The EPSDT program is a mandatory Medicaid benefit for all recipients under the age of 21, except those who are medically needy.[31] Its purpose is to provide screening and diagnostic services to detect physical or mental defects and to furnish health care, treatment, and other measures to correct or ameliorate any defects or chronic conditions discovered.[32] The requirement to provide EPSDT services is different from the requirement to offer other mandatory services in that it obligates States to inform families of children about the benefits of

prevention and the availability of EPSDT services, to assist with referrals and transportation to providers, and to followup to ensure that necessary diagnostic and treatment services are provided. Taken together, the components of the EPSDT benefit make possible the financing of a comprehensive child health services system.

According to Federal regulations, the EPSDT program consists of four basic activities:

- identifying and informing eligible children and their parents of the benefits of prevention and the type of assistance available;[33]
- assessing a child's health needs through initial and periodic examinations and evaluations (screenings) of physical and mental health and development, vision, dental health, and hearing;
- ensuring that health problems detected are diagnosed and treated fully and in a timely manner; and
- helping families use available health resources.[34]

Although EPSDT has always been an important preventive benefit for children and adolescents at risk of mental health and substance abuse problems, it has the potential to play an even more important role in financing diagnosis and treatment as well as preventive interventions as a result of changes made to the benefit by OBRA '89. EPSDT now constitutes the most comprehensive child preventive care and treatment package in any private or public financing plan. The critical changes made by OBRA '89 are these:

- Distinct periodicity schedules must be established for health screens, vision services, dental services, and hearing services, and the intervals at which screenings are required must meet reasonable standards of practice.[35]
- States must reimburse providers for health screenings and for vision, dental, and hearing services whenever they are medically necessary, regardless of whether the service is due under the State's periodicity schedules.[36,37]
- States must provide all health care, diagnostic services, and treatment services that are federally allowable under section 1905(a) of the Social Security Act and needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered as a result of the screening services, whether or not such services are covered under the State plan.[38]

Historically, most States have failed to take advantage of EPSDT's flexibility for financing comprehensive screening and followup treatment services to children with any physical health or mental health problem. The discretionary authority previously granted the States has not been widely used, nor have States taken the initiative to develop effective screening and referral protocols for children with special health care needs, including those with mental health and substance abuse problems.

The number of preventive screening examinations States cover for children ages newborn to 21 under their periodicity schedules ranges from as few as 4 in Idaho to as many as 30 in Ohio, as shown in appendix table 1. Only 19 States meet the American Academy of Pediatrics' (AAP) overall recommendations for children's preventive health examinations.[39]

Moreover, although States have long been allowed to reimburse for "interperiodic" examinations (those that are performed between scheduled examinations because of medical necessity), only half the States have elected to do so. Twelve cover *all* medically necessary screens. Among the others, seven reimburse up to a certain number of interperiodic screens, and six cover interperiodic screens if done for specific reasons (e.g., camp or sports physical) or for children with specified problems (e.g., failure to thrive or severe disability).

The vast majority of States have not developed appropriate policies for EPSDT mental health assessments. Only three States (Massachusetts, Montana, and South Dakota) even prescribe a screening protocol for mental health assessments, and only one of them (Massachusetts) requires the use of a formal tool (a State-developed checklist of questions). The other 47 States do not furnish screening providers any specific guidance about mental health assessments. Further, no State has established protocols for referring children suspected of having emotional problems to specific types of providers for further evaluation and treatment. Thus, mental health assessments and referrals are left almost entirely to the discretion of individual EPSDT providers.

Although no State has prescribed a screening protocol to detect the use of alcohol or drugs, most States (43) will pay for laboratory tests under EPSDT to confirm substance abuse where it is suspected by the screening provider. As is the case for mental health problems, no State has established referral protocols for further evaluation and treatment of children suspected of having a substance abuse problem.

A particular shortcoming of State EPSDT programs has been the lack of specialized qualifications or training for screening providers expected to identify, even in a general way, mental health or substance abuse problems. Virtually all States use the same provider to perform the physical examination and to administer the other components of the screen, except for dental services and, in some cases, hearing and vision services. In almost all instances, these providers include private physicians, local health departments, and other providers

who may have limited experience and training in detecting mental health or substance abuse problems in children.

In addition, a significant majority of States have not used the now mandatory, but previously optional, discretionary services provision enabling them to cover for EPSDT-screened children federally allowable diagnostic and treatment services that are not available to other Medicaid recipients. Our survey found that only 14 States authorized discretionary diagnostic and treatment services, although about half used the option to finance psychologists' or other services needed by children with emotional or substance abuse problems. Half a dozen additional States, though, reported an interest in examining the option as a way to reimburse services to the population of children with emotional disturbances.

The statutory changes enacted by OBRA '89, are likely to increase the availability of reimbursement for comprehensive screening services that include appropriate mental health and developmental assessments, and coverage of diagnostic and treatment services for the mental health and substance abuse problems of children. The potential impact of the OBRA '89 mandates is seen in the following hypothetical case.

> A teacher notices a marked change in the demeanor of one of his 14-year-old pupils. He refers the student to the school health clinic (a Medicaid-certified provider) for an assessment of his physical and mental health. The screening procedures, billed as an interperiodic assessment under EPSDT, indicate that the student is clinically depressed, possibly as a result of his parents' recent divorce. Evidence of regular and current cocaine use also is detected. He is referred to the local community mental health center for outpatient counseling. He shows little progress and, as a result, the staff psychiatrist, in consultation with medical staff, recommends a short-term placement in a small residential treatment center for detoxification and mental health therapy. The State's basic Medicaid plan covers heroin detoxification, but no other drug abuse treatment and no inpatient psychiatric facility services for individuals under age 21. Under the new EPSDT provisions, however, Medicaid would now be required to reimburse all medically necessary detoxification and residential mental health therapy, because the problems requiring treatment were discovered during an EPSDT screening.

Physician Services

Physician services constitutes a mandatory benefit defined to include services provided within the scope of practice of the profession, as defined by State law, and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.[40] Physician services can be provided in any setting—an office, a patient's home, a hospital, a small residential treatment facility,[41] or even a school.

The physician services benefit category is important for several reasons. It permits coverage of medical and psychiatric diagnosis and treatment, including the prescribing of medication. It also may be used to reimburse a physician's basic office staff and other health practitioners who work under his or her supervision. Such practitioners would include psychologists and social workers, for example. This coverage is particularly important in States that do not cover the optional benefit category of "other licensed practitioner services." If, for instance, a psychologist provided individual therapy to a Medicaid-insured youth in a psychiatrist's office, a clinic, or other site, the State may allow the supervising physician to bill this as a physician service.

Two-thirds of States (33) do not set visit or dollar limits on the number of nonpsychiatric physician visits that can be reimbursed, as shown in appendix table 2, and only 6 States require any prior authorization for services. Among the remaining 17 States, 11 (primarily Southern) impose limits on the frequency of visits in a given month or year, ranging from a low of 12 per year in 5 States to a high of 10 visits per month in 1 State. Another 6 States allow 1 or more physician visits per day.

Almost as many States (26) offer psychiatric visits without limits, although a number require prior authorization for at least some services. Where limits on psychiatric services are imposed, they are most likely to be part of an overall limit on all physician services and to fall between 18 and 48 visits per year. In some cases, however, State Medicaid agencies have separate coverage policies for psychiatric services. These limits vary widely but usually are more restrictive than those for other physician services. In six States the limit on reimbursement is part of a broader cap on all outpatient visits, on all outpatient mental health visits, or on all psychiatrist and psychologist visits combined.

In addition to benefit amounts, States may set other policies that affect access to services needed by children with mental health or substance abuse problems. Many States, for example, restrict the type of physician who can use psychiatric billing codes. We found that in 29 States only psychiatrists are allowed to bill for psychiatric services,[42] and in 20 of these States, psychiatrists are required to be board certified or board eligible. In these States, pediatricians and other physicians who specialize in behavioral pediatrics would not be allowed to bill Medicaid for

services related to the evaluation and management of psychiatric problems.

Moreover, two States have no psychiatric billing codes at all. In these States, no independently practicing physician, including a psychiatrist, can bill for psychiatric services. While it might be possible for a physician to submit Medicaid claims under a general medical billing code, reimbursement amounts would likely be inadequate, considering the amount of time spent for psychiatric services. As a result, Medicaid recipients in these States would probably be able to receive outpatient psychiatric services only in clinics and other organized provider settings.

It is important to note, though, that nearly two-thirds of State Medicaid programs include services supervised by a psychiatrist under the physician services benefit. Twenty-nine States cover basic office staff, which might include nurses and psychometrists. Twenty-seven cover the services of licensed practitioners. About half of those allow psychiatrists to bill for any type of licensed mental health practitioner and the others specify only certain licensed practitioners, usually psychologists *or* social workers, but not both.

States vary in the level of supervision they require of psychiatrists. Roughly one-third, for example, stipulate that psychiatrists be in direct contact with the licensed practitioners they supervise, another third require only that psychiatrists be on the premises, and the remaining third use other less restrictive supervisory criteria (such as the psychiatrist's assuming professional responsibility for the care of the patient or writing the treatment plan).

Outpatient Hospital Services

Outpatient hospital services are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a physician or dentist. The services must be provided on an outpatient basis in a facility that meets the Medicaid requirements established for inpatient hospital facilities.[43] The outpatient hospital services benefit may include coverage for a wide range of interventions, including partial hospitalization as well as various types of diagnostic, assessment, and treatment services.

Mental Health Outpatient Hospital Services

Reimbursement for mental health services in an outpatient hospital setting is available in 41 States, as shown in appendix table 3. In all these States, mental health services are covered in general public and private acute care hospital settings, but only in 18 can psychiatric hospital providers be reimbursed.

Fifteen States limit mental health services delivered in hospital outpatient settings. All but one (Idaho) apply the same restriction to both general and psychiatric hospitals. In most States, the level of coverage for outpatient hospital mental health services would be adequate for most youth with emotional problems, although 14 require some prior authorization of services.

A total of 18 States provide coverage for partial hospitalization. Most (16) define this day hospital benefit to include persons with psychiatric disorders, such as children with severe emotional disturbances. In the five that impose limits, the range of coverage is quite dramatic: 24 hours per year in North Carolina to 1,560 hours per year in Kansas. Over half of these 16 States require prior authorization of partial hospitalization services.

Substance Abuse Outpatient Hospital Services

Substance abuse services are less likely to be covered in an outpatient hospital setting than are mental health services. Only 31 States cover outpatient substance abuse services provided by general acute care hospitals, as shown in appendix table 4. Only 14 of these also allow psychiatric hospitals to enroll as providers.

Ten States restrict coverage for substance abuse hospital outpatient services. In five of these States, the limit extends to include all outpatient hospital services and, in several instances, also physicians' and clinic services. In the remaining five States, coverage limits vary from as little as $313 annually to as much as 3 hours per day. In general, limits on substance abuse outpatient services are more restrictive than those applied to mental health hospital outpatient services.

In contrast to States' coverage of mental health services, only six States cover partial hospitalization for the purpose of substance abuse treatment.[44] Two of the States require prior authorization of the service. Only one State, though, imposes a limit on the amount of partial hospitalization (24 hours per year).

Inpatient Hospital Services

Inpatient hospital services (other than services in an institution for mental disease or tuberculosis) constitutes a mandatory benefit that includes services furnished in a hospital for the care and treatment of inpatients and provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by a designated State standard-setting authority, and it must either be qualified to participate under Medicare or have been determined to meet the requirements of participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid

program.[45] Coverage of inpatient hospital services may include treatment in a psychiatric or substance abuse unit of a general acute care hospital.

Mental Health Inpatient Hospital Services

All States, as required by law, reimburse inpatient hospital services, including services provided in psychiatric units. Most (33) do so without limit, although about half the States require prior authorization for the stay, as shown in appendix table 5. Sixteen States impose a limit on the amount of inpatient coverage that applies to stays in a psychiatric unit. In most of these States, the same limit is applied in psychiatric units as in other units in the hospital. Only six States set separate day limits for stays in psychiatric units. Another, more common, way States limit coverage for inpatient stays is through the use of prospective reimbursement methods. Fifteen States, for example, apply a Diagnosis-Related Group (DRG) methodology to inpatient stays in the psychiatric unit of an acute care general hospital.[46]

Substance Abuse Inpatient Hospital Services

All but two States (Delaware and Virginia) cover both alcohol and drug abuse treatment in a general acute care hospital. In half of these States, however, reimbursement is available for detoxification only, as shown in appendix table 5. Of the remaining two States, one covers only methadone maintenance treatment as an inpatient hospital service, and the other does not cover any substance abuse treatment as an inpatient hospital service. Thus, States are much more likely to restrict the type of treatment for inpatient substance abuse services than for inpatient mental health services.

Nearly half the States (22) limit inpatient substance abuse treatment, and they are more likely to impose a separate limit for inpatient substance abuse treatment than for inpatient mental health services. Ten States have separate inpatient substance abuse limits, compared with only six with separate inpatient mental health limits. Fewer State Medicaid programs (19 compared with 22) impose prior authorization requirements on stays for substance abuse treatment than on stays for psychiatric services, however.

Optional Benefit Categories

Many optional Medicaid services—clinic services, rehabilitative services, other licensed practitioners' services, personal care services, inpatient psychiatric services for persons under age 21, and targeted case management—also are part of the continuum of care for children who have manifested or are at risk for emotional or substance abuse problems.

State Medicaid programs, not surprisingly, are more likely to reimburse mental health and substance abuse treatment services in traditional service settings. As a result, they tend to provide better coverage for these services under the clinic and psychiatric hospital benefit categories. Coverage also is frequently available for the services of independently practicing psychologists. It is less prevalent, though, for social worker and other licensed independent practitioner services, for small residential treatment centers that are not based on a medical model of care, and for rehabilitative services that permit reimbursement for therapeutic interventions in nonclinical settings. Coverage of case management services for children with emotional or substance abuse problems also is not widespread.

Clinic Services

Clinic services are defined as any preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients by or under the direction of a physician or dentist in a facility that is not a hospital but is organized and operated to provide medical care to outpatients.[47] Clinic services may be provided in a satellite facility or mobile van but, because of the requirement that clinic services be furnished to outpatients, they may not be provided in a home, school, or other site that is not a part of a clinic facility.

The clinic services benefit category can be used to reimburse a comprehensive range of center-based mental health and substance abuse services, including services furnished by a variety of freestanding health, mental health, and specialty clinic facilities, both public and private. Among the interventions that could be reimbursed are assessment, diagnosis, testing and evaluation, therapy services, medication administra- tion and monitoring, and day treatment for both mental health and substance abuse treatment clients.

All but three States (Mississippi, Rhode Island, and Wisconsin) use the clinic services benefit category to reimburse at least one type of clinic.[48] Five of the States using the clinic services category define the benefit generally and have a single set of coverage policies applicable to all types of clinic providers. These five (Hawaii, Indiana, Iowa, South Dakota, and Washington) provide relatively broad coverage. They may have general State licensure requirements, however, and these could restrict the types of clinics that could actually qualify as Medicaid providers.

Most States (42), though, provide coverage for particular categories of clinic services, such as mental health and substance abuse treatment, and they specify for each kind of clinic service the types of facilities and interventions that may be reimbursed. In these States, mental health and substance abuse

treatment clinics each ideally would be included with appropriate billing codes.

Mental Health Clinics

Thirty-three of the States that use discrete clinic services categories specify coverage for mental health clinic services, as shown in appendix table 6. Thirteen of the States only cover CMHC's under their mental health clinic benefit, while the remaining 20 States cover CMHC's and other freestanding mental health clinics as well.

Just over half the States (17) that cover mental health clinic visits as a discrete clinic services category provide potentially unlimited benefits, although 5 of them require at least some prior authorization. The other States impose some type of visit restrictions. Eight have annual visit limits that vary for each type of mental health intervention and 7 have visit limits that range from as few as 200 during a lifetime to as many as 1 per day. In four States, the clinic visit restriction is part of a broader limit on all outpatient mental health services combined.

Mental health clinic visits in most States are defined to include diagnosis and assessment; individual, group, and family therapy; medication administration and monitoring; and psychological testing. Crisis intervention and collateral contact services are less frequently covered, with fewer than a dozen States reimbursing them.

Coverage for therapeutic day treatment—usually defined as at least 3 hours of multidisciplinary services—is available in 28 States that use discrete clinic service categories, as well as in 3 States that reimburse clinics generically. About two-thirds (18) of the States cover it potentially without limit. Among the remaining third that restrict coverage, the most common limit is about 1,440 hours—the equivalent of 360 days of treatment for 4 hours per day.

The therapeutic day treatment benefit generally is available to Medicaid recipients of all ages, providing they are assessed as needing these services. Two States (Alabama and Vermont) and the District of Columbia, however, define day treatment in such a way that reimbursement would not be available for children's services. Six other States have established medical necessity criteria for day treatment that, while not impossible, would be difficult for children, younger ones in particular, to meet. Five of these States, for example, require patients to be chronically mentally ill and the sixth requires patients to have a mental disorder with psychotic features.

Substance Abuse Clinics

Only 11 of the States that use discrete clinic services categories specify coverage for some form of substance abuse treatment, as shown in appendix table 7. Five cover treatment services only for drug abuse; the others cover both alcohol and drug abuse treatment. All reimburse services to children as well as to adults.

Reimbursement for substance abuse clinic services as a discrete clinic category is available without limits in 10 of the 11 States, although 2 States require that services be prior authorized. The 11th State imposes limits according to the specific intervention; for example, assessments are limited to two per year, and individual therapy is limited to six visits per month.

The kinds of interventions for which reimbursement is available vary considerably; 3 of the 11 States limit coverage of substance abuse treatment clinics to methadone maintenance services. In eight other States, coverage is available for diagnosis and assessment and for individual, group, and family therapy, as well as methadone maintenance services. One of these eight States, Louisiana, reimburses occupational therapy, art therapy, music therapy, recreational therapy, and collateral contacts also. Only 3 of the 11 States cover day treatment services at substance abuse clinics.

School Clinics

School clinics—in which a clinic operated by a school meets the State's clinic provider requirements and bills Medicaid directly—is an allowable clinic category in only two States, Connecticut and Illinois. Although school clinics may be used to provide a full range of mental health and substance abuse treatment services, they are not yet being used in this way. Connecticut is the only State that reimburses school clinics for mental health therapies (individual, group, and family therapy) and for substance abuse counseling. It covers these services without limits.

Schools have not been enrolled in the Medicaid program as clinic providers for a variety of reasons. One is that State licensure is frequently required and licensure laws are not applicable to clinics operated by schools. Another, less common, reason is that school clinics are not in compliance with Medicaid's clinic services requirement for physician direction.

It is possible, however, for services furnished on school sites to be reimbursed by Medicaid in other ways. A number of States pay for services delivered in school-based clinics operated as satellite facilities by Medicaid-certified providers (such as freestanding mental health clinics or hospital outpatient units) able to submit claims. Additionally, in several States reimbursement is provided to schools that serve as billing agents or billing providers for services furnished by salaried or contract staff and covered under Medicaid's physician services or independent practitioner categories.

Rehabilitative Services

Rehabilitative services are any medical or remedial services

recommended by a physician *or* other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level.[49] The regulations establish no restrictions on the setting in which services may be provided and no criteria for the individuals who may deliver the services. They also do not require that the services be furnished under a physician's direction.

The rehabilitative services benefit category offers significant opportunities for financing mental health and substance abuse treatment services to eligible children and their families. These services might include (in addition to the more traditional treatment interventions) home visiting, specialized after-school programs (combining elements of day treatment and recreational therapy), residential and nonresidential crisis services (including telephone hotlines), and the therapeutic components of care in a specialized foster home, camp, group home, or other small residential facility. The services may be delivered by someone who is trained and supervised, but not necessarily licensed.

Over two-thirds of the States (33) cover some type of services under the rehabilitative services category, but only about a fourth use the option to cover mental health services (12 States)[50] or substance abuse treatment services (8 States), as may be seen in appendix tables 8 and 9.[51] For both types of services, States use clinics and other established agencies as rehabilitative services providers.

Mental Health Rehabilitative Services

Half of the 12 States that cover mental health services under the rehabilitative services benefit category have eliminated their mental health clinic benefits and folded them into the rehabilitative services category. These States most often cited the need to reimburse mental health services furnished outside a clinic setting as the reason for using the rehabilitative services category. The other half of the States have elected to use both the clinic and the rehabilitative services categories, in part to ensure appropriate reimbursement for various types of mental health services with different levels of medical supervision.

Of the 12 States that cover mental health services under the rehabilitative services benefit, 11 reimburse CMHC's.[52] Of these, three (Florida, Oregon, and Wyoming) also reimburse other freestanding mental health clinics or agencies,[53] one (Maine) also reimburses freestanding mental health clinics or agencies and private nonmedical institutions, and another (Minnesota) also reimburses school districts, hospital outpatient units, and county-contracted day treatment providers. The remaining State (Connecticut) limits reimbursement to school districts.

In addition to specifying allowable providers for mental health rehabilitative services, States also stipulate the types of mental health interventions that may be reimbursed. While one State covers only the more traditional therapeutic interventions (diagnostic evaluation and assessment, individual and group therapy, and living skills training), the remaining 11 States also cover other mental health services (such as crisis intervention and psychosocial rehabilitation). In addition, all States but one cover services delivered off-site—in settings that may include a home, school, day care facility, small residential treatment center, or inpatient facility—although sometimes this coverage is authorized only under certain circumstances.[54]

Interestingly, the most diverse benefit packages are those offered by the two States (Connecticut and Minnesota) that allow school districts to be providers. These States have used the rehabilitative services option to structure coverage for all health-related services provided to children in special education, pursuant to an Individualized Education Plan (IEP). Rehabilitative services in these two States include physical, occupational, and speech therapy, as well as mental health services.

Criteria for receiving mental health rehabilitation services vary widely across the 12 States. In most, there are no age or diagnostic criteria; the only requirement is that an assessment or evaluation indicating the medical necessity for rehabilitative services be detailed in a treatment plan. One State, however, limits reimbursement for all its mental health rehabilitative services to three groups with complex, long-term mental health needs, one of which is severely emotionally disturbed children. Another State limits coverage of mental health rehabilitative services to children receiving special education services.

Regardless of the providers and services they cover, however, States using the rehabilitative services option for mental health services have been exceptionally generous in the amount of their benefits. All but three permit an unlimited number of annual visits, although prior authorization sometimes is required. Of those that limit visits, two do so according to the specific type of intervention provided, and the third limits visits to one per day.

Ten of the 12 States use the rehabilitative services option to finance day treatment as well as therapeutic visits. Nine States use a distinct "day treatment" benefit, with its own reimbursement rate; the 10th (Maine) permits reimbursement for multiple mental health rehabilitative visits in a single day, thereby providing

financing for extended hours of treatment.[55] None of these States limits the number of reimbursable days. Typically, though, the day treatment benefit is defined as a certain number of hours per day, usually 3 to 5 hours but, in one State (Ohio), as many as 14 hours. States usually chose to finance day treatment services under the rehabilitative services benefit to permit coverage in settings other than clinic or agency sites.[56,57]

Only one State currently uses the rehabilitative services option to cover therapeutic foster care services. Kansas has begun reimbursing caregivers of children with long-term psychiatric problems who reside in group homes or special "family" homes[58] for "behavior management" services provided as part of the child's treatment plan for up to 24 hours per day. Under this arrangement, group homes bill Medicaid directly, while family homes bill through private nonprofit agencies that locate and train the families.

Substance Abuse Rehabilitative Services

Ten States have elected to reimburse some form of substance abuse treatment services under the rehabilitative services benefit, but they vary with regard to the types of facilities that qualify as providers. Six States enroll only freestanding alcohol and drug abuse treatment centers, and two of them restrict coverage even further: one reimburses only CMHC's and the other reimburses only State-operated, county-based substance abuse clinics. Another three States (Florida, Michigan, and Wisconsin) reimburse a combination of outpatient and residential providers: Florida and Wisconsin reimburse both freestanding clinics and residential programs, and Michigan reimburses hospital outpatient units and residential programs. The 10th State (Minnesota) restricts reimbursement to inpatient or residential providers.

The range of services reimbursed under the substance abuse rehabilitative services benefit is fairly consistent across the 10 States. Both alcohol and drug abuse treatment services are reimbursed in all but one State (Minnesota), which reimburses drug abuse treatment services only. All 10 States provide coverage for individual, group, and family counseling; 8 include assessment as well; and 4 include medication administration and monitoring. A few States reimburse additional interventions, such as crisis intervention (Maine, South Carolina, and Wisconsin), detoxification (Maine), and collateral contacts (Florida). Most of the States limit coverage to services furnished at the provider sites, although four (Florida, Oregon, Rhode Island, and South Carolina) offer more expansive coverage, permitting reimbursement for services furnished in settings such as private homes, schools, and other outpatient sites.

The criteria States apply for receiving substance abuse rehabilitative services are more variable. Half the States require only a physician referral for services, while the rest require an assessment or evaluation indicating medical necessity. None of the States has established specific age or diagnostic criteria.

As is the case for mental health rehabilitative services, the amount of State coverage for substance abuse services under the rehabilitative services benefit overall is quite generous. Over half the States (six) will reimburse a potentially unlimited amount of services; the remaining four impose limits according to the specific type of intervention furnished. Just under half the States require prior authorization of substance abuse rehabilitative services.

Only five States (Florida, Illinois, Mississippi, South Carolina, and Wisconsin) use the rehabilitative services option to finance day treatment services for substance abusers, and all have established a distinct day treatment benefit to do so. Four of the States provide potentially unlimited coverage of day treatment services, but one restricts reimbursement to 20 hours per week.

Other Licensed Practitioner Services

This category of practitioners' services refers to any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice defined under State law.[59] Psychologists, clinical social workers, and other professionals, therefore, can be covered as independent practitioners in States that license them. Reimbursement for licensed practitioners' services is important for children with emotional or substance abuse problems because it can be authorized in any setting, including private homes, small residential treatment centers, schools, or health care facilities.

Despite the prevalence of licensure,[60] not many States have elected to reimburse the services of psychologists and clinical social workers. Only half the States (25) cover psychologists' services, and only 2 (Massachusetts and Montana) cover services provided by clinical social workers, as shown in appendix table 10.

Further, half the States that include coverage for these practitioners impose significant limits on the number of reimbursable visits. Twelve of the 25 States that cover psychologist's services have an annual visit limit that ranges from 1 (Washington) to 260 (Maine). One of the two States that cover social worker's services imposes a limit of 22 visits per year. Moreover, psychologists' visits in six of the States and social workers' in the one State are part of an

overall limit for all outpatient mental health services combined; all social worker and psychologist services combined; or all psychologist, speech therapist, and occupational therapist services combined.

The scope of coverage, though, tends to be broad. Most States that cover psychologists' and clinical social workers' services will pay for a range of services, including diagnosis and assessment; testing; and individual, group, and family therapy. Only two States restrict their benefits to psychological evaluations and testing. Most States require only that the services be medically necessary, although a few also demand a physician referral or impose another type of requirement (e.g., the problem must be expected to respond to short-term therapy).

States rarely impose restrictions on the setting in which licensed practitioner services will be reimbursed. Only two States deny reimbursement for psychologists' services provided in a school, although one of these States also denies reimbursement for services in a private home, group home, or residential treatment facility. Neither of the two States reimbursing clinical social workers' services places any restrictions on the service setting.

Personal Care Services

Personal care services are defined as services prescribed by a physician in accordance with a plan of treatment and provided by an individual who is (1) qualified to provide the services, (2) supervised by a registered nurse, and (3) not a member of the recipient's family.[61] Policy guidelines issued by HCFA further define personal care services as medically oriented tasks having to do with a patient's physical requirements, which enable someone to be treated by a physician on an outpatient rather than on an inpatient or institutionalized basis. The guidelines state also that the personal care provider should perform such tasks as assisting the patient with personal hygiene, dressing, feeding, and transfer or ambulatory needs, and that any homemaker tasks (such as shopping, meal preparation, cleaning, and laundry) performed should be purely incidental to the patient's health care needs.[62]

The personal care services benefit can be useful in financing certain services or service components needed by children with mental health or substance abuse problems. Specifically, it can provide reimbursement for the physical tasks provided as part of a residential care program and for family respite services furnished in the recipient's home.

Some basic limitations to using the personal care services benefit, however, in many situations make it more advantageous for States to finance the same services under the rehabilitative services benefit as part of a more comprehensive service package. One is the physically oriented and essentially unskilled nature of the service. Individuals who care for emotionally disturbed or substance-abusing youth often need to provide a broader range of interventions than those authorized as personal care services. Another is the requirement for supervision by a registered nurse. Not all programs have a psychiatric or other registered nurse to provide appropriate supervision.

Although we did not include interview questions on the personal care services option in our 50-State survey, followup telephone calls in March 1990 to a dozen States known to use the benefit confirmed our impression that it generally is used to pay for services provided to frail elderly, mentally retarded, or physically disabled individuals. We found that a few States, however, do use the personal care services benefit category to augment payments for foster care services furnished to the mentally ill (Michigan) or to assist mentally ill clients living alone or in "board and care" homes (West Virginia).

Inpatient Psychiatric Services for Individuals Under 21 Years

Existing Federal regulations define inpatient psychiatric services for individuals under 21[63] as services provided under the direction of a physician in a psychiatric facility or an inpatient program in a psychiatric facility accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).[64] These regulations, however, do not comport with relatively recent statutory changes that have deleted the reference to JCAHO accreditation and substituted the definition of psychiatric hospital under Medicare. Current statutory law defines inpatient psychiatric services for individuals under 21 as services provided in an institution (or a distinct part of an institution) that is a psychiatric hospital as defined in section 1861(f) of the Medicare statute.

Almost three-quarters of the States (36) reimburse inpatient psychiatric services for individuals under 21, as appendix table 11 shows. Of these states, 10 reimburse facilities, such as residential treatment centers or skilled nursing facilities, that are not hospitals and may not meet the Medicare definition of a psychiatric hospital facility.

HCFA staff indicate that the agency would not approve State plan provisions authorizing reimbursement for facilities that meet the regulatory, but not the statutory, requirements for inpatient psychiatric services. In setting policies on the types of facilities in which inpatient psychiatric services are covered, States may rely either on the statutory definition for inpatient psychiatric services alone or on the

statutory definition and other Medicaid statutory and regulatory provisions governing inpatient service coverage. That is, States may include under the inpatient psychiatric services benefit both psychiatric hospitals that meet Medicare standards and nursing homes that are psychiatric facilities with JCAHO accreditation.

States also must comply with Federal statutory and regulatory requirements on criteria for receiving inpatient psychiatric services. For reimbursement to be federally approved, a team of professionals must certify that inpatient care is medically necessary and can reasonably be expected to improve the recipient's condition or prevent further regression. Further, services must involve "active treatment," which means implementation, within 14 days of admission, of a professionally developed individual plan of care designed to achieve the recipient's discharge from inpatient status as soon as possible.[65]

Among the States that currently pay for children's inpatient psychiatric services, relatively few (six) apply criteria for receiving these services in addition to those established by regulation and statute. Those that do, however, usually require only a psychiatric diagnosis.

All but one of the 36 States covering inpatient psychiatric services reimburse substance abuse treatment services provided in these facilities to some degree. Nearly half (14) reimburse services even if alcohol or drug abuse is the primary diagnosis, although more States (21) reimburse inpatient facilities for substance abuse treatment only if it is a secondary diagnosis.[66]

Inpatient psychiatric services for those under age 21 are usually available without limits, although about half the States require prior authorization. Only one State directly limits the amount of coverage. Three others, however, use a reimbursement methodology (e.g., DRG's) that may limit the number of days covered.

Targeted Case Management

Case management services are defined as services that will help eligible individuals gain access to needed medical, social, education, and other services.[67] The benefit is distinct from the generally more narrow case management activities that may be paid for indirectly as part of services under another Medicaid benefit, reimbursed as a discrete item under another Medicaid benefit, offered under a waiver, or financed as a component of overall program administration. Moreover, it permits States to target these services to high-risk geographic areas and population groups.

Children in need of mental health or substance abuse treatment services are ideal target groups to receive specially designated case management services. States covering case management services to severely emotionally disturbed or substance-abusing children are permitted, by specific exception, to designate in their Medicaid plan amendment the particular types of providers that will be permitted to become qualified.[68] A State, for example, may elect to designate certain CMHC's, State-operated agencies, hospital outpatient departments, or schools as the qualified case managers for the families of these children.

HCFA approval of a case management services application requires, however, that Medicaid's usual prohibition on restricting a recipient's free choice among qualified providers remains in effect. This requirement has several implications: it means that children and their families cannot be forced to accept case management services, that they must be free to obtain them from any qualified provider in the State, and that the services may not be used to deny them access to any other services available under the State Medicaid plan.[69]

Overall, 26 States have amended their plans to provide reimbursement for case management to one or more target groups. As shown in appendix table 12, nine States reimburse case management services to severely emotionally disturbed children of all ages, and two of these States reimburse case management services for children with less severe emotional problems as well. An additional two States reimburse case management services only for those severely emotionally disturbed adolescents aged 18 to 21. Four States (Georgia, North Carolina, West Virginia, and Wisconsin) have established coverage for case management services provided to substance abusers of all ages.

All but two of the States covering case management services to these groups of children have designated specific agencies as qualified case management providers. The remaining two have established comprehensive provider standards instead.

Coverage amounts for case management services tend to be very generous. All but two of the States reimbursing services to severely emotionally disturbed children and all of the States covering case management to substance abusers do so without limits. Even the two States that limit reimbursement provide enough coverage for an hour of case management services per week.

Most States reimbursing case management services to one or both groups of children discussed above bill the services on the basis of increments of time (e.g., 30-minute intervals). Several of the States, however, use monthly capitation rates, the validity of which has been seriously questioned both by State agency and HCFA staff.[70]

Out-of-State Inpatient Psychiatric Benefits

Although Medicaid recipients usually receive their Medicaid mental health services from providers and facilities practicing in the same State, in some circumstances the services of an out-of-State facility may be required. Nearly all States (46) permit some psychiatric admissions to out-of-State facilities, as shown in appendix table 13.

States vary somewhat with respect to the types of out-of-State facilities that will be reimbursed. Eighteen States limit coverage only to stays in the psychiatric units of general acute care hospitals, and an equal number limit them to stays in the psychiatric units of both general hospitals and freestanding psychiatric hospitals. In two States (Maryland and New Jersey), reimbursement is available for out-of-State residential treatment centers, as well as the psychiatric units of general and psychiatric hospitals. The remaining eight States cover stays only in freestanding psychiatric hospitals.

States generally are more restrictive in their criteria for admission to out-of-State facilities than to in-State facilities. Only 4 of the 46 States allowing out-of-State placements (Illinois, Mississippi, South Dakota, and Virginia) reported that they impose no special requirements for out-of-State psychiatric admissions. The remaining 42 States, however, limit the circumstances under which Medicaid recipients can receive out-of-State services. Most often, out-of-State psychiatric admissions are permitted only if appropriate and if necessary services are not available in-State (10 States), if services are prior authorized (9 States), or if an emergency exists (8 States). Twelve additional States require that some combination of those three factors exist. The remaining two States reimburse out-of-State admissions only when made to the nearest appropriate facility.

A few States also impose special requirements for out-of-State facilities that can receive reimbursement. One will cover only out-of-State facilities certified by its mental health department; another will reimburse only facilities in bordering States; and a third will reimburse only specialized facilities for youth.

Chapter 3—Conclusions and Recommendations

Medicaid offers opportunities to finance a wide array of mental health and substance abuse prevention and treatment services for over half of all low-income children. In 1988, nearly 11 million children up to age 21 were Medicaid recipients. These children qualified for Medicaid benefits in several ways—some mandatory, some optional. In all States, Medicaid-enrolled children included the mandatory AFDC cash assistance recipients, children age 7 who met the financial criteria for AFDC cash assistance, and children up to age 6 with family incomes up to 133 percent of the Federal poverty level. Children covered under the major optional categories included SSI cash assistance recipients in 49 States, children eligible as medically needy because of extensive medical costs in 36 States, and children aged 6 with incomes up to 100 percent of poverty in 9 States.

In 1989, many States had structured their Medicaid benefits to provide reimbursement for community-based outpatient services, in some cases including services furnished in home and school settings. We found, for instance, that a number of States had used their optional rehabilitative services and clinic services categories to support a continuum of mental health and substance abuse services. Yet, overall, our survey revealed State Medicaid programs' historical bias toward reimbursing mental health and substance abuse services furnished in more traditional hospital, clinic, and office-based settings.

Perhaps not surprisingly, we also discovered that mental health services were more likely to be covered than substance abuse treatment services. Moreover, State Medicaid programs reimbursed a somewhat more expansive range of interventions for treating emotional problems than for treating problems relating to alcohol and drug dependence. For example, under the clinic category, mental health clinics typically could obtain reimbursement for services including diagnosis and assessment; individual, group, and family therapy; medical administration and monitoring; psychological testing; and day treatment. In contrast, substance abuse clinic benefits usually were restricted to provide reimbursement for a more limited range of interventions: diagnosis and assessment; individual, group, and family therapy; and medication administration and monitoring. In only a few States could day treatment services be reimbursed.

This disparity in coverage may be explained by several factors: the qualifications of many substance abuse treatment providers, the use of a more limited range of interventions to treat substance abuse, and the concurrent use of mental health services by many substance-abusing youth. Historically, providers of substance abuse services often have not been linked with the traditional health and mental health services system because many providers are themselves recovering and often are certified through courses outside of the traditional health and mental health training programs. Substance abuse counselors usually are not qualified to bill Medicaid directly because of State licensure and Medicaid independent practitioner qualifications. In addition, the staff of programs through which substance abuse services are delivered—clinics, residential treatment centers, and hotlines—often have not aggressively pursued opportunities for obtaining reimbursement under existing benefit categories, as shown in our survey.

With respect to both mental health and substance abuse services, State Medicaid programs generally provide coverage for most of the services that follow a medical model of care. For the more innovative services directed toward children with emotional disturbances and substance abuse problems, however, benefits are less likely to be available. Overall, we found that States frequently failed to cover: (1) partial or day hospital treatment under the outpatient hospital benefit, (2) clinical social workers under the other licensed practitioner services category, (3) school clinics under the clinic services category, (4) home-based and other off-site therapies as rehabilitative services, and (5) case management for at-risk

as well as severely emotionally disturbed children and substance-abusing youths.

With the passage of OBRA '89, unprecedented authority exists to expand and link the preventive, diagnostic, and treatment components of the EPSDT program for youth who have manifested or are at risk for mental health and substance abuse problems. To date, however, the use of EPSDT for low-income youths at risk for mental health and substance abuse problems has been very limited. According to our 1989 survey, almost all States failed to provide EPSDT screeners with any guidance on mental health or substance abuse assessment tools or to establish protocols for referrals. Moreover, no specialized training was required of EPSDT providers in these complex areas. Another example of EPSDT's limited use has been States' historical reticence to employ their discretionary authority to cover additional diagnostic and treatment services for EPSDT-screened children requiring services not covered under a given State's Medicaid plan.

The key to making necessary changes in a State's Medicaid system is collaboration among State Medicaid, mental health, and substance abuse program staffs. To take advantage of the inherent flexibility in the Medicaid program, however, program staff need to learn about Medicaid's opportunities and requirements. Doing so may require technical assistance from the Alcohol, Drug Abuse, and Mental Health Administration, particularly for State substance abuse program staff who may have had less experience with the Medicaid program. An improved understanding of Medicaid would do much to ensure a productive relationship with State Medicaid staff and enable the agencies to achieve significant improvements in Medicaid financing for children with mental health and substance abuse problems.

State Medicaid, mental health, and substance abuse program administrators, in conjunction with child health advocates, need to promote the adoption of all Federal eligibility options for children. In the last decade, most of Medicaid's optional eligibility expansions have been directed at young children, but not all of these have been used by every State. Moreover, the longstanding medically needy option, the primary means of extending benefits to older children above the AFDC income cutoff, has not been implemented in 14 States. Even when all children's options are enacted in a State, however, mental health and substance abuse program administrators need to ensure that all the potentially Medicaid-eligible children they serve are actually enrolled as Medicaid recipients.

More important still, they need to examine Medicaid mandatory and optional benefit policies carefully to understand how they can be used in various combinations to establish coverage for a full continuum of interventions in a variety of settings. In each State, the process should begin by first identifying the full array of mental health and substance abuse treatment services that need to be covered (see appendix table 4), next ascertaining the extent to which they might be reimbursable under existing benefit policies (see appendix tables 1-13), and then determining the State plan revisions or expansions that would be needed to cover the remainder. Program administrators should find it useful to consult Medicaid and program staff in States that use particular Medicaid benefits to pay for these uncovered services.

Most States will want to give particular consideration to expanding benefits for the services mentioned above as frequently unavailable. For many, significant coverage expansions under the rehabilitative services benefit category, which would permit reimbursement for the broadest range of nontraditional interventions, may prove to have the greatest payoff for financing children's mental health and substance abuse treatment services. The targeted case management benefit undoubtedly will be important as well. For whatever benefit categories a State elects to use for reimbursing mental health and substance abuse treatment services, though, Medicaid policies must be appropriately structured.

- Service definitions should be matched to the mental health or substance abuse service.
- Coverage amounts should be adequate for the child population that will use the particular service.
- Mental health and substance abuse programs should be used to perform prior authorization functions for relevant Medicaid services to child populations[71] or, alternatively, Medicaid agency prior authorization personnel should receive special training on the treatment needs of emotionally disturbed and drug-abusing youth.
- Provider qualifications should be jointly established, ensuring that providers who furnish mental health and substance abuse services to children can easily become Medicaid-certified.

States should focus on EPSDT in particular as a means of supporting prevention, early intervention, and followup treatment. Given the OBRA' 89 mandates requiring increased availability of scheduled and interperiodic screening services and greater coverage of EPSDT diagnostic and treatment services, efforts to improve the quality of mental health and substance abuse assessments and to assure appropriate referrals should have a measurable impact.

- Mental health, substance abuse treatment, and Medicaid programs should develop joint screening and referral protocols,

as well as specialized training, for EPSDT and other mental health- and substance abuse-related services.

- Programs should target EPSDT outreach and case management services not only to children who manifest emotional problems or substance abuse, but to the growing number of children at risk for them. (The EPSDT program's responsibility to arrange transportation, refer to providers, and ensure the provision of followup services could be discharged to the mental health or substance abuse programs, for example, once a child is determined to need such services.)
- Programs should work collaboratively to determine the extent to which new diagnostic and treatment services need to be made available for EPSDT-screened children for whom they are determined to be medically necessary.

State Medicaid agency staff are likely to be more responsive to coverage proposals made by State mental health and substance abuse program administrators than they may have been in the past. For one thing, Medicaid staff will need the assistance of professionals to establish definitions, medical necessity criteria, and reimbursement policies for all the services that they now are required to cover under EPSDT. For another, they are coming to realize that Medicaid, with its substantial Federal match, can play a critical role in financing health-related services that otherwise would be paid for primarily with State funds.

Appendix A

Tables Presenting the Results of a 50-State Survey of State Coverage Policies and Practices

Appendix Table 1
EPSDT Periodicity Schedules in State Medicaid Programs, Compared with the AAP'S Recommended Periodicity Schedule,[1] as of June 30, 1989

State	Scheduled Screenings			
	Ages newborn to 3	Ages 3 to 10	Ages 10 to 21	Ages newborn to 21
	AAP Recommendation 9	AAP Recommendation 5	AAP Recommendation 6	AAP Recommendation 20
Alabama	2	8	6	20
Alaska	8	3	4	15
Arkansas	4	2	3	9
California	10	3	3	16
Colorado	10	4	4	18
Connecticut	9	5	4	18
Delaware	9	5	6	20
District of Columbia	8	3	3	14
Florida	8	5	6	20
Georgia	9	5	6	20
Hawaii	9	5	6	20
Idaho	2	1	1	4
Illinois	9	3	6	18
Indiana	8	5	6	19
Iowa	7	3	3	13
Kansas	7	4	4	15
Kentucky	8	6	4	18
Louisiana	5	3	4	12
Maine	9	5	6	20
Maryland	7	9	11	27
Massachusetts	12	7	6	25
Michigan	3	4	6	13
Minnesota	As many as medically necessary			
Mississippi	6	5	3	14

Appendix Table 1 (Cont.)
EPSDT Periodicity Schedules in State Medicaid Programs, Compared with the AAP'S Recommended Periodicity Schedule, as of June 30, 1989

State	Scheduled Screenings			
	Ages newborn to 3	Ages 3 to 10	Ages 10 to 21	Ages newborn to 21
	AAP Recommendation 9	AAP Recommendation 5	AAP Recommendation 6	AAP Recommendation 20
Missouri	9	5	4	18
Montana	6	3	3	12
Nebraska	3	6	5	14
Nevada	6	3	3	12
New Hampshire	8	4	3	15
New Jersey	7	3	3	13
New Mexico	10	4	3	17
New York	9	5	6	20
North Carolina	8	4	4	16
North Dakota	2	7	11	20
Ohio	10	9	11	30
Oklahoma	1	2	2	5
Oregon	9	5	6	20
Pennsylvania	9	5	6	20
Rhode Island	9	5	6	20
South Carolina	8	4	3	15
South Dakota	9	3	3	15
Tennessee	9	6	3	18
Texas	7	2	2	11
Utah	6	3	3	12
Vermont	9	5	6	20
Virginia	8	3	3	14
Washington	8	7	10	25
West Virginia	8	7	7	22
Wisconsin	9	5	6	20
Wyoming	7	2	3	12
Total number with periodicity schedule equal to or greater than the AAP's	22	26	22	19

[1]Committee on Practice and Ambulatory Medicine, Recommendations for Preventive Health Care, American Academy of Pediatrics, Elk Grove, Illinois, September 1987.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 2
State Restrictions on Physician and Psychiatrist Visits, as of June 30, 1989

State	Basic Physicians' Services				Psychiatrists' Services			
			Physician-Supervised Services				Psychatrist-Supervised Services	
	Visit/Dollar Limits	Prior Authorization Requirement	Practitioner Assisting Physician	Practitioner Working Autonomously	Separate Psychiatrist Visit/Dollar Limits	Prior Authorization Reqirement	Practitioner Assisting Physician	Practitioner Working Autonomously
Alabama	12 visits/year	No	Yes	No	None	No	Yes	Yes
Alaska	None	No	Yes	Yes	None	No	Yes	Yes
Arkansas	12 visits/year	No	Yes	No	None	No	Yes	No
California	None	No	Yes	Yes	None	Yes	No	No
Colorado	None	No	Yes	Yes	None	No	Yes	Yes
Connecticut	None	No	Yes	No	None	Yes	Yes	Yes
Delaware	None	No	Yes	No	None	No	No	No
District of Columbia	None	No	Yes	No	None	Yes	Yes	No
Florida	None	No	Yes	No	None	No	No	No
Georgia	None	Yes	Yes	No	24 hours/year	No	No	Yes
Hawaii	None	No	Yes	No	None	Yes	Yes	No
Idaho	None	No	Yes	Yes	Varies with intervention	No	No	No
Illinois	None	No	Yes	Yes	None	No	No	No
Indiana	None	Yes	Yes	No	None	Yes	Yes	Yes
Iowa	None	No	Yes	No	None	No	Yes	No
Kansas	12 visits/year	No	Yes	Yes	Varies with intervention, 200 visits/ lifetime for all outpatient mental health	No	Yes	Yes
Kentucky	None	No	Yes	Yes	None	No	Yes	Yes
Louisiana	12 visits/year	No	Yes	Yes	None	No	Yes	No
Maine	None	Yes	Yes	Yes	1 hour/day, 5 hours/week	No	No	No
Maryland	1 visit/day	No	Yes	Yes	None	No	Yes	Yes
Massachusetts	1 visit/day	No	No	No	None	Yes	No	No
Michigan	None	No	Yes	Yes	None	No	No	Yes

Appendix Table 2 (Cont.)
State Restrictions on Physician and Psychiatrist Visits, as of June 30, 1989

State	Basic Physicians' Services				Psychiatrists' Services			
			Physician-Supervised Services				Psychatrist-Supervised Services	
	Visit/Dollar Limits	Prior Authorization Requirement	Practitioner Assisting Physician	Practitioner Working Autonomously	Separate Psychiatrist Visit/Dollar Limits	Prior Authorization Reqirement	Practitioner Assisting Physician	Practitioner Working Autonomously
Minnesota	None	No	Yes	Yes	Varies with intervention for all outpatient mental health	No	Yes	Yes
Mississippi	12 visits/year	No	Yes	Yes	Varies with intervention for all outpatient mental health	No	Yes	Yes
Missouri	None	No	Yes	Yes	None	Yes	No	No
Montana	None	No	Yes	No	None	No	Yes	No
Nebraska	None	No	Yes	Yes	None	No	No	Yes
Nevada	None	Yes	No	No	None	Yes	No	Yes
New Hampshire	18 visits/year	No	Yes	Yes	None	No	Yes	Yes
New Jersey	None	No	Yes	No	None	Yes	Yes	Yes
New Mexico	None	No	Yes	Yes	Lifetime limit for all outpatient mental health, varies with diagnosis	No	No	No
New York	None	No	Yes	Yes	None	No	Yes	Yes
North Carolina	24 visits/year for all physician, outpatient hospital, and clinic	No	No	Yes	None	Yes	No	Yes
North Dakota	None	No	Yes	Yes	None	No	Yes	Yes
Ohio	10 visits/month	Yes	Yes	Yes	None	Yes	Yes	Yes
Oklahoma	4 visits/month	No	Yes	No	None	No	No	No
Oregon	2 visits/day	No	Yes	No	None	No	No	No
Pennsylvania	None	No	No	Yes	None	No	No	No
Rhode Island	None	No	Yes	No	None	No	Yes	No

Appendix Table 2 (Cont.)
State Restrictions on Physician and Psychiatrist Visits, as of June 30, 1989

State	Basic Physicians' Services				Psychiatrists' Services			
			Physician-Supervised Services				Psychatrist-Supervised Services	
	Visit/Dollar Limits	Prior Authorization Requirement	Practitioner Assisting Physician	Practitioner Working Autonomously	Separate Psychiatrist Visit/Dollar Limits	Prior Authorization Reqirement	Practitioner Assisting Physician	Practitioner Working Autonomously
South Carolina	18 visits/year	No	No	Yes	Varies with intervention	No	No	No
South Dakota	None	No	Yes	Yes	None	Yes	Yes	Yes
Tennessee	24 visits/year	No	Yes	Yes	None	No	Yes	Yes
Texas	None	No	Yes	Yes	$313/year	No	No	Yes
Utah	1 visit/day	No	Yes	Yes	None	Yes	No	No
Vermont	None	Yes	Yes	No	None	Yes	Yes	No
Virginia	None	No	Yes	Yes	52 visits/1st year, then 26 visits/year for all outpatient mental health	Yes	Yes	Yes
Washington	1 visit/day	No	Yes	Yes	None	Yes	No	No
West Virginia	1 visit/day	No	Yes	No	None	Yes	Yes	Yes
Wisconsin	None	No	Yes	Yes	None	Yes	Yes	Yes
Wyoming	None	No	Yes	Yes	None	No	Yes	Yes
Total	17	6	45	31	10	18	29	27

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 3
State Coverage of Outpatient Mental Health Services in General and Psychiatric Hospitals, as of June 30, 1989

State	Mental Health Visits				Partial Hospitalization		
	General Hospitals	Psychiatric Hospitals	Coverage Limits	Prior Authorization Requirement	Available for Severely Emotionally Disturbed Youth	Coverage Limits	Prior Authorization Requirement
Alaska	Yes	No	None	No	No	NA	NA
Arkansas	Yes	No	12 visits/year	No	No	NA	NA
California	Yes	Yes	None	Yes	Yes	None	Yes
Colorado	Yes	Yes	1 hour/day	No	Yes	None	No
Connecticut	Yes	Yes	None	Yes	Yes	None	Yes
Delaware	Yes	No	None	No	Yes	None	No
District of Columbia	Yes	Yes	2 visits/day	Yes	No	NA	NA
Florida	Yes	No	$1,000/year for all outpatient hospital	No	No	NA	NA
Georgia	Yes	No	None	No	No	NA	NA
Hawaii	Yes	No	None	Yes	No	NA	NA
Idaho	Yes	Yes	45 hours/year for all outpatient mental health	No	No	NA	NA
Illinois	Yes	No	None	No	No	NA	NA
Indiana	No	No	None	No	No	NA	NA
Iowa	Yes	Yes	None	Yes	No	NA	NA
Kansas	Yes	Yes	Varies with intervention plus 200 visits/lifetime for all outpatient mental health	No	Yes	1,560 hours/year	Yes
Kentucky	Yes	No	None	No	No	NA	NA
Louisiana	Yes	No	None	No	No	NA	NA
Maine	Yes	No	None	No	Yes	None	No
Maryland	Yes	Yes	None	No	Yes	None	No
Massachusetts	Yes	Yes	None	Yes	Yes	6 hours/day	No
Michigan	No	No	NA	NA	Yes	None	Yes

Appendix Table 3 (Cont.)
State Coverage of Outpatient Mental Health Services in General and Psychiatric Hospitals, as of June 30, 1989

State	Mental Health Visits				Partial Hospitalization		
	General Hospitals	Psychiatric Hospitals	Coverage Limits	Prior Authorization Requirement	Available for Severely Emotionally Disturbed Youth	Coverage Limits	Prior Authorization Requirement
Minnesota	Yes	No	None	No	Yes	80 days/year	Yes
Misssissippi	Yes	No	6 visits/year for all outpatient hospital	No	No	NA	NA
Missouri	Yes	Yes	None	No	No	NA	NA
Montana	Yes	No	None	No	No	NA	NA
Nebraska	Yes	Yes	None	Yes	Yes	None	No
Nevada	Yes	No	None	Yes	No	NA	NA
New Hampshire	Yes	No	12 visits/year for all outpatient mental health	No	No	NA	NA
New Jersey	Yes	Yes	None	Yes	Yes	None	Yes
New Mexico	Yes	No	Lifetime limit for all outpatient mental health, varies with diagnosis	Yes	No	NA	NA
New York	Yes	Yes	None	No	Yes	None	Yes
North Carolina	Yes	Yes	24 visits/year for all outpatient hospital, clinic, and physician	Yes	Yes	24 visits/year for all outpatient hospital, clinic, and physician	Yes
North Dakota	Yes	Yes	None	No	No	NA	NA
Ohio	Yes	No	10 visits/month	Yes	No	NA	NA
Oklahoma	Yes	No	1 visit/day for all outpatient hospital	No	No	NA	NA
Pennsylvania	Yes	Yes	Varies with intervention	Yes	Yes	720 hours/year	No
Rhode Island	Yes	No	None	No	No	NA	NA

Appendix Table 3 (Cont.)
State Coverage of Outpatient Mental Health Services in General and Psychiatric Hospitals, as of June 30, 1989

State	Mental Health Visits				Partial Hospitalization		
	General Hospitals	Psychiatric Hospitals	Coverage Limits	Prior Authorization Requirement	Available for Severely Emotionally Disturbed Youth	Coverage Limits	Prior Authorization Requirement
South Carolina	Yes	No	None	No	No	NA	NA
South Dakota	Yes	No	None	No	No	NA	NA
Tennessee	Yes	No	30 visits/year for all outpatient hospital	No	No	NA	NA
Texas	Yes	No	$313/year	No	No	NA	NA
Vermont	Yes	Yes	None	No	No	NA	NA
Wisconsin	Yes	Yes	None	Yes	Yes	None	Yes
Total	41	18	15	14	16	5	9

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 4
State Coverage of Outpatient Substance Abuse Treatment Services in General and Psychiatric Hospitals, as of June 30, 1989

State	Substance Abuse Visits				Partial Hospitalization		
	General Hospitals	Psychiatric Hospitals	Coverage Limits	Prior Authorization Requirement	Available for Youth with Substance Abuse Problems	Coverage Limits	Prior Authorization Requirement
Arkansas	Yes	No	12 visits/year for all outpatient hospital	No	No	NA	NA
California	Yes	Yes	None	Yes	No	NA	NA
Colorado	Yes	Yes	None	No	No	NA	NA
Connecticut	Yes	Yes	None	Yes	Yes	None	Yes
Delaware	Yes	No	None	No	Yes	None	No
Georgia	Yes	No	None	No	No	NA	NA
Hawaii	Yes	No	None	Yes	No	NA	NA
Idaho	No	Yes	None	No	No	NA	NA
Illinois	Yes	No	3 hours/day	No	No	NA	NA
Indiana	Yes	Yes	None	Yes	No	NA	NA
Iowa	Yes	Yes	25 visits/year	Yes	No	NA	NA
Kentucky	Yes[1]	No	None	No	No	NA	NA
Louisiana	Yes	No	None	No	No	NA	NA
Maine	Yes	No	None	No	Yes	None	No
Maryland	Yes	Yes	None	No	No	NA	NA
Massachusetts	Yes	Yes	None	No	No	NA	NA
Mississippi	Yes	No	6 visits/year for all outpatient hospital	No	No	NA	NA
Missouri	Yes	Yes	None	No	No	NA	NA
Montana	Yes	No	None	No	No	NA	NA
Nevada	Yes	No	NA	NA	No	NA	NA
New Hampshire	No	No	NA	NA	No	NA	NA
New Jersey	Yes	Yes	None	No	Yes	None	Yes
New York[2]	Yes/Methadone maintenance only	Yes/No	None	No	Yes/No	None	No
North Carolina	Yes	Yes	24 visits/year for all outpatient hospital, clinic, and physician	Yes	Yes	24 visits/year for all outpatient hospital, clinic, and physician	No

Appendix Table 4 (Cont.)
State Coverage of Outpatient Substance Abuse Treatment Services in General and Psychiatric Hospitals, as of June 30, 1989

State	Substance Abuse Visits				Partial Hospitalization		
	General Hospitals	Psychiatric Hospitals	Coverage Limits	Prior Authorization Requirement	Available for Youth with Substance Abuse Problems	Coverage Limits	Prior Authorization Requirement
North Dakota	Yes	Yes	None	No	No	NA	NA
Ohio	Yes	No	10 visits/month	Yes	No	NA	NA
Oklahoma	Yes	No	1 visit/day for all outpatient hospital	No	No	NA	NA
Pennsylvania	Yes	No	Varies with intervention	No	No	NA	NA
Rhode Island	Yes	No	None	No	No	NA	NA
South Carolina	Yes	No	None	No	No	NA	NA
South Dakota	Yes	No	None	No	No	NA	NA
Tennessee	Yes	No	30 visits/year for all outpatient hospital	No	No	NA	NA
Texas	Yes	No	$313/year	No	No	NA	NA
Vermont	No	Yes	None	No	No	NA	NA
Total	31	14	10	7	6	1	2

[1]Substance abuse visits are covered only if another primary diagnosis is present and substance abuse is secondary.
[2]New York has separate policies for alcohol and drug abuse reimbursement. In cases in which both policies apply, the alcohol policy is listed first, followed by the drug policy.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 5
State Coverage of Inpatient Psychiatric and Substance Abuse Services in General Hospitals, as of June 30, 1989

State	Mental Health		Substance Abuse		
	Day Limit for Inpatient Mental Health Services	Prior Authorization Requirement	Includes Substance Abuse Treatment	Day Limit for Inpatient Substance Abuse Services	Prior Authorization Requirement
Alabama	12 days/year	No	Yes	12 days/year	No
Alaska	None	Yes	Detox only	None	Yes
Arkansas	35 days/year	Yes	Yes	35 days/year	Yes
California	None	Yes	Detox only	None	Yes
Colorado	None	Yes	Yes	None	Yes
Connecticut	None	Yes	Yes	None	Yes
Delaware	None	No	No	NA	NA
District of Columbia	None	No	Detox only	21 days/year	No
Florida	45 days/year	No	Detox only	45 days/year	No
Georgia	Varies with diagnosis	No	Detox only	Varies with diagnosis	No
Hawaii	50 days/year	Yes	Detox only	None	Yes
Idaho	None	No	Detox only	None	No
Illinois	None	No	Detox only	5 days/admission	No
Indiana	None	Yes	Detox only	None	Yes
Iowa	None	No	Yes	None	No
Kansas	None	No	Yes	3 admissions/lifetime	Yes
Kentucky	14 days/year	Yes	Detox only	14 days/year	Yes
Louisiana	15 days/year	No	Yes	15 days/year	No
Maine	None	No	Yes	None	No
Maryland	None	No	Detox only	None	No
Massachusetts	None	Yes	Methadone only	28 days/6 months	No
Michigan	None	Yes	Detox only	None	No
Minnesota	None	Yes	Yes	None	Yes
Mississippi	15 days/year	Yes	Yes	15 days/year	Yes
Missouri	Varies with diagnosis	No	Yes	Varies with diagnosis	No
Montana	None	Yes	Detox only	None	Yes
Nebraska	None	Yes	Detox only	5 days/admission	Yes
Nevada	None	Yes	Detox only	4 days/admission	Yes
New Hampshire	None	No	Detox only	None	No
New Jersey	None	No	Detox only	None	No
New Mexico	None	No	Detox only	5 days/admission	No

Appendix Table 5 (Cont.)
State Coverage of Inpatient Psychiatric and Substance Abuse Services in General Hospitals, as of June 30, 1989

State	Mental Health		Substance Abuse		
	Day Limit for Inpatient Mental Health Services	Prior Authorization Requirement	Includes Substance Abuse Treatment	Day Limit for Inpatient Substance Abuse Services	Prior Authorization Requirement
New York [1]	None	No	Detox and rehabilitation/ Detox only	None	No
North Carolina	None	Yes	Yes	None	Yes
North Dakota	None	No	Yes	None	No
Ohio	None	No	Detox only	None	No
Oklahoma	60 days/year	No	Yes	60 days/year	No
Oregon	18 days/year	Yes	Detox only	5 days/admission	Yes
Pennsylvania	48 hours/admission	No	Detox only	None	No
Rhode Island	None	Yes	Yes	None	No
South Carolina	None	No	Detox only	None	No
South Dakota	None	No	Detox only	5 days/admission	No
Tennessee	20 days/year	Yes	Detox only	None	Yes
Texas	30 days/admission	No	Detox only	6 days/admission	No
Utah	None	Yes	Detox only	21 days/admission	No
Vermont	None	No	Yes	None	No
Virginia	21 days/admission	No	No	NA	NA
Washington	None	No	Detox only	3 days/admission	No
West Virginia	15 days/year	No	Detox only	3 days/admission	No
Wisconsin	None	Yes	Yes	None	Yes
Wyoming	None	Yes	Detox only	None	Yes
Total	16	22	48	21	19

[1]New York has separate policies for alcohol and drug abuse reimbursement. In cases in which both policies apply, the alcohol policy is listed first, followed by the drug policy.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 6
State Coverage of Mental Health Clinic Services, as of June 30, 1989

State	Community Mental Health Centers	Private Mental Health Clinics	Day Treatment	Services Other Than Assessment and Therapy[1]	Coverage Limits	Prior Authorization Requirement
Alabama	Yes	No	Yes	Yes	30 visits/year for each type of therapy	No
Alaska	Yes	No	Yes	Yes	None	No
Arkansas	Yes	Yes	Yes	Yes	Varies with intervention	Yes
California	Yes	Yes	Yes	Yes	None	Yes
Colorado	Yes	No	Yes	Yes	1 visit/day	No
Connecticut	Yes	Yes	Yes	Yes	None	Yes
District of Columbia	Yes	Yes	Yes	Yes	None	Yes
Georgia	Yes	Yes	Yes	Yes	Varies with intervention	No
Hawaii[2]	Yes	Yes	No	No	48 visits/year, 1 visit/day	No
Idaho	Yes	Yes	Yes	Yes	45 visits/year for all outpatient mental health	No
Indiana[2]	Yes	Yes	No	Yes	Varies with intervention	Yes
Iowa[2]	Yes	Yes	Yes	Yes	Varies with intervention	Yes
Kansas	Yes	No	Yes	Yes	Varies with intervention 200 visits/lifetime for all outpatient mental health	No
Louisiana	Yes	Yes	No	Yes	None	No
Maryland	Yes	Yes	Yes	Yes	1 visit/day	No
Massachusetts	Yes	Yes	Yes	Yes	None	Yes
Michigan	Yes	No	Yes	No	1 visit/day, plus annual limit that varies with service	No
Minnesota	Yes	No	No	Yes	Varies with intervention for all outpatient mental health	No

Appendix Table 6 (Cont.)
State Coverage of Mental Health Clinic Services, as of June 30, 1989

State	Community Mental Health Centers	Private Mental Health Clinics	Day Treatment	Services Other Than Assessment and Therapy[1]	Coverage Limits	Prior Authorization Requirement
Missouri	Yes	No	No	Yes	None	No
Montana	Yes	Yes	Yes	Yes	None	No
Nebraska	Yes	Yes	Yes	Yes	None	Yes
Nevada	Yes	No	No	Yes	None	No
New Jersey	Yes	Yes	Yes	Yes	1 visit/day	Yes
New York	Yes	Yes	Yes	Yes	None	No
North Carolina	Yes	Yes	Yes	Yes	None	No
North Dakota	Yes	Yes	Yes	Yes	Varies with intervention	No
Ohio	Yes	No	Yes	Yes	None	No
Oklahoma	Yes	Yes	Yes	Yes	Varies with intervention	No
Pennsylvania	Yes	Yes	Yes	Yes	1 visit/day, plus annual limit that varies with intervention	No
South Carolina	Yes	No	Yes	Yes	None	No
South Dakota[2]	Yes	Yes	Yes	Yes	None	No
Tennessee	Yes	No	Yes	Yes	None	No
Utah	Yes	No	Yes	Yes	Varies with intervention	No
Vermont	Yes	Yes	Yes	Yes	Varies with intervention	Yes
Virginia	Yes	No	No	Yes	52 visits/1st year, 26 visits following years for all outpatient mental health	Yes
Washington[2]	Yes	No	Yes	Yes	None	No
West Virginia	Yes	Yes	Yes	Yes	Varies with intervention	Yes
Wyoming	Yes	Yes	Yes	Yes	None	No
Total	38	24	31	36	20	13

[1]"Other services" include medication management and collateral contacts. All States include individual, group, and family therapy.

[2]Clinic services benefits in these States apply to all clinic services generally; they are not specific to mental health clinics.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 7
State Coverage of Substance Abuse Clinic Services, as of June 30, 1989

State	Assessment	Individual, Group, and Family Therapy	Day Treatment	Other Services[1]	Coverage Limits	Prior Authorization Requirement
California	Yes	Yes	No	Yes	None	No
Connecticut	Yes	Yes	No	Yes	None	Yes
Delaware	No	No	No	Yes	None	No
Hawaii[2]	Yes	Yes	No	Yes	None	Yes
Illinois	Yes	Yes[3]	Yes	No	None	No
Indiana[2]	Yes	Yes	No	Yes	None	Yes
Iowa[2]	Yes	Yes	Yes	Yes	None	No
Louisiana	Yes	Yes	No	Yes	None	No
Maryland	Yes	Yes	No	Yes	None	No
Nevada	No	No	No	Yes	None	Yes
New Jersey	Yes	Yes	No	Yes	None	No
New York[4]	Yes	Yes/No	Yes/No	Yes	None	No
Pennsylvania	Yes	Yes	No	Yes	Varies with intervention	No
Utah	No	No	No	Yes	None	No
Total	11	11	3	13	1	4

[1]"Other services" include drug maintenance and collateral contacts.
[2]Clinic service benefits in these States apply to all clinic services generally; they are not specific to substance abuse clinics.
[3]Illinois does not cover family therapy.
[4]New York has separate policies for alcohol and drug abuse reimbursement. In cases in which both policies apply, the alcohol policy is listed first, followed by the drug policy.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 8
State Coverage of Mental Health Rehabilitative Services, as of June 30, 1989

State	Individual, Group, and Family Therapy Covered	Living Skills Training Covered	Crisis Intervention Covered	Psychosocial Rehabilitation Covered	Day Treatment Covered	Limits	Prior Authorization Requirement
Connecticut	Yes	No	No	No	No	1 visit/day	No
Florida	Yes	No	No	Yes	Yes	None	No
Kentucky	Yes	No	No	No	Yes	None	No
Maine	Yes	Yes	Yes	Yes	Yes	None	No
Minnesota	Yes	No	No	No	Yes	Varies with intervention	Yes
Mississippi	Yes	No	No	No	Yes	Varies with intervention	No
Ohio	Yes	Yes	Yes	No	Yes	None	No
Oregon	Yes	Yes	Yes	No	Yes	None	No
Rhode Island	Yes	No	Yes	Yes	Yes	None	Yes
South Carolina	Yes	No	Yes	Yes	Yes	None	No
Utah	Yes	No	Yes	No	Yes	None	No
Wyoming	Yes	Yes	No	No	No	None	No
Total	12	4	6	4	10	3	2

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 9
State Coverage of Substance Abuse Rehabilitative Services, as of June 30, 1989

State	Assessment	Individual, Group, and Family Therapy	Crisis Intervention	Drug Maintenance	Other Services	Day Treatment	Coverage Limits	Prior Authorization Requirement
Florida	Yes	Yes	No	No	No	Yes	None	No
Illinois	Yes	Yes [1]	No	No	No	Yes	None	No
Maine	Yes	Yes	Yes	No	Yes	No	Varies with intervention	No
Michigan	No	Yes	No	Yes	No	No	None	No
Minnesota	No	Yes	No	No	Yes	No	None	Yes
Mississippi	Yes	Yes	No	Yes	No	Yes	Varies with intervention	Yes
Oregon	Yes	Yes	No	Yes	Yes	No	Varies with intervention	No
Rhode Island	Yes	Yes	No	No	No	No	Varies with intervention	Yes
South Carolina	Yes	Yes	Yes	No	Yes	Yes	None	No
Wisconsin	Yes	Yes	Yes	Yes	No	Yes	None	Yes
Total	8	10	3	4	4	5	4	4

[1]Family therapy is not covered.

SOURCE: Information obtained from telephone interveiws with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 10
State Coverage of Other Licensed Practitioner Services, as of June 30, 1989

State	Psychologists	Social Workers	Coverage Limits	Prior Authorization Requirement
California	Yes	No	2 visits/month for all psychologist, speech therapy, and occupational therapy	Yes
Colorado	Yes	No	None	No
Connecticut	Yes	No	None	Yes
Hawaii	Yes	No	None	Yes
Idaho	Yes	No	45 visits/year	No
Indiana	Yes	No	None	Yes
Iowa	Yes	No	40 visits/year	No
Kansas	Yes	No	Varies with service, 200 visits/lifetime for all outpatient mental health	No
Maine	Yes	No	1 hour/day, 5 hours/week	No
Massachusetts	Yes	Yes	None	No
Minnesota	Yes	No	Varies with service for all outpatient mental health	No
Montana	Yes	Yes	22 visits/year for all psychologist and social worker	No
Nevada	Yes	No	None	Yes
New Hampshire [1]	Yes	No	12 visits/year	No
New Jersey	Yes	No	None	Yes
New Mexico	Yes	No	Lifetime limit for all outpatient mental health, varies with diagnosis	Yes
New York	Yes	No	None	No
Ohio	Yes	No	Varies with service	No
Oregon	Yes[2]	No	None	Yes
Utah	Yes	No	None	Yes
Vermont	Yes	No	None	Yes

Appendix Table 10 (Cont.)
State Coverage of Other Licensed Practitioner Services, as of June 30, 1989

State	Psychologists	Social Workers	Coverage Limits	Prior Authorization Requirement
Virginia	Yes	No	52 visits/1st year, 26 visits/following years for all outpatient mental health	Yes
Washington	Yes[2]	No	1 evaluation/year	No
West Virginia	Yes	No	None	Yes
Wisconsin	Yes	No	None	Yes
Total	25	2	12	13

[1]New Hampshire reimburses community mental health centers under this category.
[2]Oregon and Washington limit psychologists' services to testing and evaluation.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 11
State Coverage of Inpatient Psychiatric Facilities for Individuals Under 21, as of June 30, 1989

State	Psychiatric Hospitals	ICF's or SNF's*	Residential Treatment Facilities	Includes Substance Abuse Treatment	Coverage Limits	Prior Authorization Requirement
Alaska	Yes	No	No	As secondary diagnosis	No	Yes
Arkansas	Yes	No	Yes	As secondary diagnosis	No	Yes
California	Yes	No	No	As secondary diagnosis	No	Yes
Colorado	Yes	No	Yes	As secondary diagnosis	No	Yes
Connecticut	Yes	No	No	As primary diagnosis	No	No
District of Columbia	Yes	No	No	As secondary diagnosis	No	No
Illinois	Yes	No	No	As secondary diagnosis	No	No
Indiana	Yes	No	No	As primary diagnosis	No	Yes
Iowa	Yes	No	Yes	As secondary diagnosis	No	No
Kansas	Yes	Yes	No	As primary diagnosis	No	No
Kentucky	Yes	No	No	As secondary diagnosis	No	No
Louisiana	Yes	No	No	As primary diagnosis	No	No
Maine	Yes	No	No	As primary diagnosis	No	No
Maryland	Yes	No	Yes	As secondary diagnosis	No	No
Massachusetts	Yes	No	No	As primary diagnosis	No	No
Michigan	Yes	Yes	No	As secondary diagnosis	No	Yes
Minnesota	Yes	No	No	As secondary diagnosis	No	Yes
Missouri	Yes	No	No	As primary diagnosis	No	No
Montana	Yes	No	No	No	No	Yes
Nebraska	Yes	No	No	As secondary diagnosis	No	Yes
New Jersey	Yes	No	Yes	As secondary diagnosis	No	Yes
New York	Yes	No	No	As secondary diagnosis	No	No

Appendix Table 11 (Cont.)
State Coverage of Inpatient Psychiatric Facilities for Individuals Under 21, as of June 30, 1989

State	Psychiatric Hospitals	ICF's or SNF's*	Residential Treatment Facilities	Includes Substance Abuse Treatment	Coverage Limits	Prior Authorization Requirement
North Carolina	Yes	No	No	As primary diagnosis	No	No
North Dakota	Yes	No	No	As secondary diagnosis	No	No
Ohio	Yes	No	No	As secondary diagnosis	No	No
Oklahoma	Yes	No	Yes	As primary diagnosis	60 days/year	No
Oregon	Yes	No	No	Detox as secondary diagnosis	No	Yes
Pennsylvania	Yes	No	No	As primary diagnosis	No	No
Rhode Island	Yes	Yes	Yes	As primary diagnosis	No	No
South Carolina	Yes	No	No	As secondary diagnosis	No	No
Tennessee	Yes	No	No	As secondary diagnosis	No	Yes
Utah	Yes	No	No	Detox as secondary diagnosis	No	Yes
Vermont	Yes	Yes	No	As primary diagnosis	No	Yes
Washington	Yes	No	No	As secondary diagnosis	No	Yes
West Virginia	Yes	No	No	As primary diagnosis	No	Yes
Wisconsin	Yes	No	No	As primary diagnosis	No	Yes
Total	36	4	7	35	1	17

*Skilled nursing facilities and intermediate care facilities.

SOURCE: Information obtained from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

Appendix Table 12
State Coverage of Targeted Case Management Services for Children and Adolescents with Mental Health or Substance Abuse Problems, as of June 30, 1989

State	Any Persons With Mental Health Problems	Only Persons Who Are Severely Emotionally Disturbed		Any Persons With Substance Abuse Problems
		18 to 21	All Ages	
Alaska	Yes	No	No	No
Georgia	No	No	Yes	Yes
Maine	No	No	Yes	No
Michigan	No	No	Yes	No
Minnesota	No	Yes	No	No
North Carolina	No	No	Yes	Yes
Oklahoma	No	No	Yes	No
Rhode Island	No	Yes	No	No
South Carolina	Yes	No	No	No
West Virginia	No	No	Yes	Yes
Wisconsin	No	No	Yes	Yes
Total	2	2	7	4

SOURCE: Information obtained from telephone interviews with State Medicaid staff during the spring and summer of 1989.

Appendix Table 13
State Coverage of Out-of-State Inpatient Psychiatric Services, as of June 30, 1989

State	Types of Facilities			Special Criteria for Out-of-State Coverage
	Psychiatric Hospitals	General Hospitals	Residential Programs	
Alabama	No	Yes	No	Emergency and prior authorization
Alaska	Yes	No	No	Service not available in State
California	Yes	No	No	Emergency
Colorado	Yes	Yes	No	Emergency and court order
Connecticut	Yes	Yes	No	Emergency and service not available in State
Delaware	No	Yes	No	Service not available in State
District of Columbia	Yes	Yes	No	Service not available in State
Florida	No	Yes	No	Emergency
Georgia	No	Yes	No	Emergency
Hawaii	No	Yes	No	Emergency
Idaho	No	Yes	No	Service not available in State
Illinois	Yes	Yes	No	None
Indiana	Yes	Yes	No	Prior authorization
Louisiana	Yes	Yes	No	Emergency, service not available in State, and prior authorization
Maine	Yes	No	No	Emergency, service not available in State, and prior authorization
Maryland	Yes	Yes	Yes	For residential treatment and elective admissions: service not available in State
Massachusetts	Yes	Yes	No	Emergency and service not available in State
Michigan	Yes	Yes	No	Emergency and service not available in State
Minnesota	Yes	Yes	No	Service not available in State
Mississippi	No	Yes	No	None

Appendix Table 13 (Cont.)
State Coverage of Out-of-State Inpatient Psychiatric Services, as of June 30, 1989

State	Types of Facilities			Special Criteria for Out-of-State Coverage
	Psychiatric Hospitals	General Hospitals	Residential Programs	
Missouri	Yes	Yes	No	Emergency and prior authorization of nonemergency
Montana	Yes	No	No	Service not available in State
Nebraska	Yes	Yes	No	Prior authorization
Nevada	No	Yes	No	Service not available in State and prior authorization
New Hampshire	No	Yes	No	Service not available in State
New Jersey	Yes	Yes	Yes	Emergency; prior authorization and service not available in State for nonemergency
New Mexico	No	Yes	No	Emergency
New York [1]	Yes	Yes	No	Service not available in State and prior authorization
North Carolina	Yes	Yes	No	Service not available in State
North Dakota	Yes	Yes	No	Service not available in State
Ohio	No	Yes	No	Prior authorization
Oklahoma	Yes	Yes	No	Nearest appropriate facility
Oregon	No	Yes	No	Emergency
Pennsylvania	Yes	No	No	Nearest appropriate facility
Rhode Island	Yes	No	No	Emergency and prior authorization
South Carolina	Yes	No	No	Prior authorization
South Dakota	No	Yes	No	None
Tennessee	Yes	Yes	No	Prior authorization
Texas	No	Yes	No	Emergency and prior authorization
Utah	No	Yes	No	Emergency
Vermont	No	Yes	No	Prior authorization
Virginia	No	Yes	No	None
Washington	Yes	Yes	No	Prior authorization

Appendix Table 13 (Cont.)
State Coverage of Out-of-State Inpatient Psychiatric Services, as of June 30, 1989

State	Types of Facilities			Special Criteria for Out-of-State Coverage
	Psychiatric Hospitals	General Hospitals	Residential Programs	
West Virginia	Yes	No	No	Prior authorization
Wisconsin	Yes	Yes	No	Emergency and prior authorization
Wyoming	No	Yes	No	Prior authorization
Total	28	38	2	42

[1]New York has separate policies for alcohol and drug abuse reimbursement. In cases in which both policies apply, the alcohol policy is listed first, followed by the drug policy.

SOURCE: Information obtained from telephone interviews with State Medicaid staff during the spring and summer of 1989.

Appendix B

Glossaries

Glossary 1—Medicaid Terms

AFDC-Related Individuals. Individuals who are *not* cash assistance recipients under the Aid to Families with Dependent Children (AFDC) program but who meet at least some of the criteria of that program and are eligible for a State's Medicaid benefits under an optional categorically needy group. Also included as AFDC-related individuals are those children and pregnant women not required to meet *either* the financial or the categorical criteria for AFDC: children up to age 6 and pregnant women with family incomes up to 133 percent of the poverty level who are given mandatory eligibility, and both children aged 6 with incomes up to 100 percent of the poverty level and infants and pregnant women with family incomes up to 185 percent of the poverty level who may be covered at a State's discretion.

Capitation Fee. The amount that a Medicaid agency pays on a per-recipient basis to a contractor who agrees to provide some or all of the medical services included in the State's plan, regardless of whether individual recipients actually receive these services during the period covered by the fee.

Categorically Eligible Individuals. Individuals who are eligible to participate in the regular Medicaid program, as distinct from the medically needy program. They include (1) persons participating in one of the cash assistance programs—AFDC (Aid to Families with Dependent Children), SSI (Supplemental Security Income), and foster care and adoption assistance; (2) financially eligible children and pregnant women given "qualified" categorically needy status; and (3) persons covered as optional categorically needy.

Categorically Related Individuals. Individuals covered under the categorically needy program who are *not* actual recipients of AFDC (Aid to Families with Dependent Children) or SSI (Supplemental Security Income) but who meet at least some of the criteria for AFDC or SSI cash assistance and are provided Medicaid coverage through one of the mandatory or optional eligibility provisions.

Certified Provider. An individual or institution that meets all of Medicaid's statutory and regulatory conditions of participation and coverage.

Clinic Services. An optional Medicaid benefit defined as any preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients by or under the direction of a physician or dentist in a facility that is not a hospital but is organized and operated to provide medical care to outpatients. [42 C.F.R. section 440.90 (1988)]

Comparability. The Medicaid requirement that all services specified in the State plan (except for EPSDT services and case management services) be offered in equal amount, duration, and scope to all categorically needy individuals. For demonstration projects or waiver programs, States may seek a waiver of the comparability requirement from the Health Care Financing Administration (HCFA).

DRG's (Diagnosis-Related Groups). A classification system that groups cases by diagnoses to reflect the consumption of hospital resources and provides a basis for setting per-case prospective payment rates for inpatient hospital services.

Deeming. A provision used to determine income eligibility under the Supplemental Security Income (SSI) program, which requires that the income and resources of a parent or spouse be considered (or deemed) available to an applicant if he or she is living in the same household. After 1 month of institutionalization, however, family income and resources are no longer deemed available, making an applicant who meets the disability criteria eligible for SSI payments, and usually Medicaid benefits, regardless of family income. Recognition of this built-in bias toward institutionalization resulted in creation of the section 2176 waiver options and the "Katie Beckett" Amendment, both of which waive deeming requirements and allow the disabled individual who otherwise would require institutionalization to maintain Medicaid eligibility while receiving home- and community-based care of equal or lesser cost.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). A mandatory Medicaid benefit for all recipients under the age of 21, except those who are medically needy. It includes screening and diagnostic services to detect physical or mental defects and health care, treatment, and other measures to correct or ameliorate any defects or chronic conditions discovered. [42 C.F.R. section 440.40 (1988)]

Financial Eligibility. Under Medicaid, this is determined through examination of an applicant's income and resources. Income testing examines the applicant's gross and countable (gross income less certain disregarded amounts) incomes. The maximum eligible income varies from State to State. Resource testing examines the worth of any real or personal property, with some exclusions for basic maintenance items such as home, automobile, clothing, and furniture. Resource limits for the categorically needy program are established under Federal law. Resource limits for medically needy programs vary from State to State.

Freedom-of-Choice. Federal Medicaid law requires that individuals be permitted to receive covered services from any Medicaid-certified provider. States can seek waivers of the freedom-of-choice requirement from the Secretary of Health and Human Services under section 1915 of the Social Security Act.

Inpatient Hospital Services. A mandatory Medicaid benefit that includes services furnished in a hospital for the care and treatment of inpatients and provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by a designated State standard-setting authority, and it must either be qualified to participate under Medicare or have been determined to meet the requirements of participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program. [42 C.F.R. section 440.110 (1988)]

Inpatient Psychiatric Services for Individuals Under 21. An optional Medicaid benefit defined as services provided under the direction of a physician by a psychiatric facility or program in a psychiatric facility that is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) to provide inpatient psychiatric care. [42 C.F.R. section 440.160 (1988)]

(IMD) Institution for Mental Disease. An optional Medicaid service defined to include only JCAHO-accredited hospitals, skilled nursing or intermediate care facilities (SNF's or ICF's), or other institutions of more than 16 beds that are primarily engaged in diagnosing, treating, or caring for persons with mental disease, including medical attention, nursing care, and related services. [42 C.F.R. section 440.140(a) (1988)]

Medical Necessity. This is a prerequisite for Medicaid reimbursement of covered services. The determination that a service is medically necessary is made according to criteria established by each State Medicaid program.

Other Licensed Practitioner Services. An optional Medicaid benefit defined as any medical or remedial care or services, other than physician's services, that are provided by licensed practitioners within the scope of practice defined under State law. [42 C.F.R. section 440.60 (1988)]

Outpatient Hospital Services. A mandatory Medicaid benefit defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a physician or dentist. The services must be provided on an outpatient basis in a facility that meets the Medicaid requirements established for inpatient hospital facilities. [42 C.F.R. section 440.20 (1988)]

Personal Care Services. An optional Medicaid benefit defined as services prescribed by a physician in accordance with a plan of treatment and provided by an individual who is (1) qualified to provide the services; (2) supervised by a registered nurse; and (3) not a member of the recipient's family. [42 C.F.R. section 440.170(f) (1988)]

Physician Services. A mandatory Medicaid benefit defined to include services provided within the scope of practice of the profession, as defined by State law, and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. [42 C.F.R. section 440.50 (1988)]

Prior Authorization. An optional mechanism of utilization control that requires that the provider obtain approval for reimbursement from the State Medicaid agency (sometimes involving referral to a special committee) before a service is rendered.

Rehabilitative Services. An optional Medicaid benefit defined as any medical or remedial services recommended by a physician *or* other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability *and* restoration of a recipient to his or her best possible functional level. [42 C.F.R. section 440.130(d) (1988)]

Ribicoff Children. Named for the chief sponsor of the legislation establishing this optional Medicaid category, Ribicoff children are an AFDC-related group of children who live in two-parent families or otherwise fail to meet the State's AFDC categorical criteria, but whose families would qualify for Medicaid coverage on the basis of income. Ribicoff children aged 6 now have mandatory eligibility status as "qualified" children.

SSI-Related Individuals. Those individuals who are not cash

assistance recipients under the Supplemental Security Income (SSI) program but who meet at least some of the criteria of that program and are eligible for a State's Medicaid benefits under an optional categorically needy group.

Statewideness. The requirement that services in the State plan be covered equally in all regions of the State. Waivers of statewideness may be obtained from the Health Care Financing Administration (HCFA) for demonstration projects or waiver programs.

Targeted Case Management. An optional Medicaid benefit defined as services that will help eligible individuals to gain access to needed medical, social, education, and other services. [*Social Security Act,* section 1915(g)(2) (1989)]

209(b) States. Those States electing not to make all SSI recipients automatically eligible for Medicaid and to apply instead eligibility criteria that are more restrictive with respect to the definition of disability, the standards of income and resources, or both.

Utilization Control. Procedures for the ongoing evaluation, on a sample basis, of the need for and the quality and timeliness of all Medicaid services provided under a State plan. The agency must have a postpayment review process that allows State personnel to develop and review recipient utilization profiles, provider service profiles, and exceptions criteria, and to identify exceptions so that the agency can correct misutilization practices of recipients and providers. Specific utilization control procedures, collectively termed utilization review, are required for inpatient facilities.

Utilization Review. An instrument of utilization control requiring the assessment by professional health personnel of appropriateness and quality of services rendered in inpatient facilities and conducted by the State health agency or other appropriate State agency under contract to the Medicaid agency. Requirements for utilization review include review of certifications of need for care and written plans of care for each patient, and the conduct of medical care evaluation studies specific to each institution. These studies identify and analyze patterns of patient care including length of stay and use of professional and ancillary services, and suggest changes needed to maintain consistently high-quality patient care and effective and efficient use of services.

Glossary 2—Abbreviations

AAP	American Academy of Pediatrics
AFDC	Aid to Families with Dependent Children
CASSP	Child and Adolescent Service System Program
CFR	Code of Federal Regulations
CMHC	Community Mental Health Center
DRG	Diagnosis-Related Group
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FMAP	Federal Medicaid Assistance Percentage
HCFA	Health Care Financing Administration
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
IEP	Individualized Education Plan
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IMD	Institution for Mental Disease
OBRA '89	Omnibus Budget Reconciliation Act of 1989
RTC	Residential Treatment Facility
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TEFRA '82	Tax Equity and Fiscal Responsibility Act of 1982

Endnotes

1. The phrase "substance abuse" is used in this report to refer to both alcohol abuse and drug abuse. Where information provided pertains only to alcohol or drugs, the appropriate term is used.

2. The words "child" and "children" are used in this report to refer to individuals up to 21 years of age.

3. The District of Columbia is considered a State for the purposes of this report.

4. A more detailed description of our survey methods appears at the beginning of chapter 2.

5. Harriette B. Fox and Ruth Yoshpe, *An Explanation of Medicaid and Its Role in Financing Treatment for Severely Emotionally Disturbed Children and Adolescents*, CASSP Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., August 1987.

6. Harriette B. Fox, *Mental Health Rehabilitative Services*, CASSP Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., March 1989.

7. Unpublished data from the March 1989 Current Population Survey microdata tapes for 1988.

8. *Ibid.*

9. Unpublished data from HCFA-2082 (Health Care Financing Administration) forms for fiscal year 1988.

10. See Beth A. Stroul and Robert M. Friedman, *A System of Care for Severely Emotionally Disturbed Children and Youth*, CASSP Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., July 1986.

11. Primary diagnostic data for physician and hospital services for 1983 in one State (Michigan) suggest, however, that mental health and substance abuse services account for a relatively small proportion of total Medicaid claims. For children receiving welfare payments, by far the largest group of Medicaid children, mental disorders represented less than 1 percent of the total hospital discharges and expenditures for children, and 2 percent of physician and other ambulatory care visits and expenditures. For children receiving cash assistance because of disability, a smaller group with higher utilization rates, mental disorders represented 1 percent of hospital discharges and expenditures and 10 percent of physician and other ambulatory care visits, but 12 percent of expenditures. Data for clinic and other relevant services were not analyzed. See Marilyn Rymer and Gerald Adler, *Children and Medicaid: The Experience in Four States*, SysteMetrics/McGraw-Hill, Lexington, Mass., October 1987.

12. Information obtained by the authors from a telephone conversation with HCFA Medicaid Statistics Branch staff, July 1990.

13. At State option, AFDC benefits may be provided to children up to 18 years of age who are full-time students in secondary school or the equivalent level of vocational or technical training and can be expected to complete the program before reaching their 19th birthday.

14. A child considered to be dependent is any child who is under 18 and who lives in a family in which one parent is dead, incapacitated, or absent. An example of a child who is not dependent is one who lives in a two-parent family where the principal wage-earner is employed.

15. The Family Support Act of 1988 mandates that, effective October 1, 1990, States provide AFDC cash assistance to two-parent families in which the principal wage-earner is unemployed. Cash assistance may, at State option, be limited to 6 months in any 12-month period, but full Medicaid coverage must be provided to all family members even when cash payments are not made.

16. Information obtained by Fox Health Policy Consultants in telephone interviews with State Medicaid agency staff in April 1988 and January 1990.

17. Under SSI law, States are able to establish a lower financial eligibility cutoff for individiuals in medical care facilities. This Medicaid option affects only children with significant income of their own because parental income is not deemed available to institutionalized children after a 30-day period.

18. Information obtained by the authors from a telephone conversation with HCFA Medicaid Statistics Branch staff, July 1990.

19. The maximum AFDC payment standard is the maximum amount that an AFDC-eligible individual or family may be paid. Because all countable income is subtracted from the maximum payment standard to determine the payment amount, the payment amount can never exceed the standard.

20. Information obtained by the authors from a telephone conversation with HCFA Medicaid Statistics Branch staff, July 1990.

21. They also must cover pregnant women, but not the aged and adult caretakers.

22. These States are Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

23. A discussion of how States' general authority to limit coverage of a particular service relates to the new EPSDT service coverage mandate is provided in Harriette B. Fox, *1989 Legislative Provisions Affecting Access to Care by Children and Pregnant Women*, Fox Health Policy Consultants, Washington, D.C., January 1990.

24. See U.S. Congress, House Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis*, Congressional Research Service, Committee Print 100-AA, 100th Congress, 2d sess., November 1988.

25. See U.S. Congress, House, *Omnibus Budget Reconciliation Act of 1989*, Conference Report 101-386 to Accompany H.R. 3299, 101st Congress, 1st sess., 1989.

26. Health Care Financing Administration, U.S. Department of Health and Human Services, *Health Care Financing Program Statistics: Medicare and Medicaid Data Book, 1988*, HCFA Pub. No. 03270, Baltimore, Md., April 1989.

27. *Ibid.*

28. Information obtained by the authors from telephone interviews with State Medicaid agency staff during the spring and summer of 1989.

29. Arizona was excluded from our survey because its entire Medicaid program operates under a waiver.

30. We do not provide information on services furnished under 2176 home- and community-based services waivers. We made this decision because only one State (Vermont) uses the waiver to serve children with severe mental health or substance abuse problems, and because all, or nearly all, the services that State Medicaid programs can pay for with an approved waiver can be paid for under existing benefit categories, particularly EPSDT.

31. All but one of the States (New Jersey) that operate a medically needy program has elected to provide medically needy children a benefit package that includes EPSDT services.

32. 42 C.F.R. section 440.40 (1988).

33. The intent of these efforts is essentially to "enroll" Medicaid children in the EPSDT program so that they get help scheduling screens, transportation, and followup services; but *all* Medicaid children may receive EPSDT services, upon request to a provider, regardless of whether their families had previously agreed to participate in the EPSDT tracking system. Many State Medicaid agencies have mistakenly presumed that children must be formally "enrolled" in EPSDT to receive the screening and followup services.

34. 42 C.F.R. section 441.56 (1988).

35. *Omnibus Budget Reconciliation Act of 1989*, Conference Report, 1989; *State Medicaid Manual*, Transmittal #3, section 5123(1)(a), April 1990.

36. Transmittal #3, section 5140(B), 1990.

37. Children are to receive screenings for any suspected health, mental health, or developmental problems and are to be referred for screenings by any health, developmental, or educational professional with whom they come into contact. States may require that medical necessity criteria for interperiodic screenings be met, but the legislative history makes clear Congress' intent that prior authorization of screenings not be required. See U.S. Congress, House Subcommittee on Health and the Environment, *Medicare and Medicaid Health Budget Reconciliation Amendments of 1989*, Committee Print 101-M, 101st Congress, 1st sess., 1989.

38. Under policy guidelines issued by HCFA, States retain at least some of their usual latitude in structuring three aspects of EPSDT coverage policy: (1) service definition and specification of medical necessity criteria; (2) imposition of limits on amount, duration, and scope of services; and (3) implementation of prior authorization and other utilization control procedures. When medical necessity criteria are met, however, any limits on the amount of service coverage apparently will have to be reconsidered in the context of the individual child's situation. See Transmittal #3, section 5122(F), 1990.

39. In addition to two in-hospital newborn examinations, the AAP guidelines call for a total of 20 screening examinations, including 9 for children newborn to 3, 5 for children aged 3 to 10, and 6 for children ages ten to 21. Additional examinations are recommended for children who are not receiving competent parenting, manifesting symptoms of an important health problem, or not growing and developing normally. See Committee on Practice and Ambulatory Medicine, *Recommendations for Preventive Health Care*, American Academy of Pediatrics, Elk Grove, Illinois, September 1987.

40. 42 C.F.R. section 440.50 (1988).

41. Residential treatment facilities of more than 16 beds providing primarily mental health or substance abuse tretment services are likely to be considered Institutions for Mental Disease (IMD's) under Medicaid law. No services furnished to Medicaid recipients under age 65 who reside in such facilities can be reimbursed by a Medicaid program. *Social Security Act*, sections 1905(a)(21)(B), 1905(i).

42. These States include California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

43. 42 C.F.R. section 440.20 (1988).

44. One of these States (New York) covers partial hospitalization only for alcohol abuse treatment.

45. 42 C.F.R. section 440.110 (1988).

46. Under a DRG methodology, reimbursement is based on estimates of the hospital resources that will be consumed during various types of inpatient stays, which are grouped by diagnoses and assigned reimbursement rates. The 15 States applying a DRG methodology to inpatient stays in the psychiatric unit of a general acute care hospital are Colorado, Iowa, Kansas, Maryland, Minnesota, Missouri, New Hampshire, New Jersey, Ohio, Oregon, South Carolina, South Dakota, Texas, Utah, and Washington.

47. 42 C.F.R. section 440.90 (1988).

48. Mississippi, Rhode Island, and Wisconsin do not reimburse services under the clinic services benefit category. However, a number of States, including these three, provide reimbursement for some or all types of clinic services under another benefit category. It may be, for example, that Medicaid-certified physicians or other practitioners working at a clinic bill their services directly or that reimbursement is available under the rehabilitative services benefit category.

49. 42 C.F.R. section 440.130(d) (1988).

50. These States are Connecticut, Florida, Kentucky, Maine, Minnesota, Mississippi, Ohio, Oregon, Rhode Island, South Carolina, Utah, and Wyoming.

51. These States are Florida, Maine, Michigan, Minnesota, Mississippi, Oregon, Rhode Island, South Carolina, and Wisconsin.

52. One of these States (Minnesota) reimburses community mental health centers only for day treatment services.

53. Four of these five States require that the freestanding agency or clinic be able to provide comprehensive mental health services and the fifth State reimburses freestanding agencies and clinics only for day treatment program services.

54. In many of these 11 States, off-site mental health rehabilitative services include types of services that could not otherwise be reimbursed under the clinic option (e.g., crisis intervention in the home) as well as traditional therapy visits.

55. In addition, one of the States (Ohio) that has a distinct day treatment program benefit also permits multiple billings of services per day to provide what is, in effect, a day treatment program. According to Medicaid staff in that State, some providers bill for day treatment in one way and some providers in the other.

56. Three States, though, moved day treatment from the clinic to the rehabilitative category as part of a general plan to cover all mental health services under rehabilitative services, and only two of these (Florida and Oregon) permit day treatment services to be delivered off-site. The third State (Rhode Island), which permits no off-site services, put day treatment under rehabilitative services because that is the benefit category under which the chronically mentally ill population is served.

57. One State (Kentucky) has established reimbursement for day treatment services provided to children and adolescents in conjunction with their schooling. The program is designed so that children participate in day treatment for part of the day and spend the remainder of the day in an educational program.

58. The "family homes" are similar to therapeutic foster care homes, except that not all of the children placed in the homes are foster children.

59. 42 C.F.R. section 440.60 (1988).

60. In 1989, psychologists were licensed in all States and clinical social workers were

licensed in 37. Information was obtained by the authors from telephone interviews with the staff of the American Psychological Association and National Association of Social Workers, respectively, in January 1990.

61. 42 C.F.R. section 440.170(f) (1988).

62. *State Medicaid Manual*, section 5-140-00.

63. The services must be provided to recipients before age 21 or, if the recipient was receiving services immediately before he or she reached the age 21, before the earlier of the following: (1) the date he or she no longer requires services or (2) the date he or she reaches age 22.

64. 42 C.F.R. sections 440.160, 441.51 (1988).

65. 42 C.F.F. sections 441.152-441.156 (1988).

66. Two of these States limit reimbursement for substance abuse treatment to detoxification services only.

67. *Social Security Act*, section 1915(g)(2) (1989).

68. For all other types of case management services (except those to the mentally retarded or developmentally delayed), the State Medicaid plan amendments may not specify a particular type of *service provider* but instead may present the provider *standards* that applicants must meet to receive certification. See *State Medicaid Manual*, section 4302.2.

69. *State Medicaid Manual*, section 4302.2.

70. Concern about the validity of a monthly capitation rate stems from a belief that not all clients receive significant amounts of service every month.

71. Federal regulation requires that a single State agency administer, or supervise the administration of, the Medicaid program. For a mental health or substance abuse agency to perform prior authorization of Medicaid services requires a formal, interagency agreement under which the Medicaid agency delegates the authority.

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