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Key Benefits Under Medicaid and the State Children's Health Insurance Program (SCHIP) for Children With Mental Health and Substance Abuse Problems

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Summary

About 18% of all U.S. adolescents received mental health treatment in 2000. Almost \$7 billion was spent for such services for teens in 1998. While many youth have used alcohol or other illicit drugs, less than 2% received treatment for substance use in 2000. In 1997, costs for such care for children under 18 totaled \$604 million.

In this report, the availability of selected mental health and substance abuse services under Medicaid and SCHIP for low and moderate income children is explored. Under SCHIP, states may provide coverage by expanding Medicaid or creating a separate SCHIP program or both. Data from two CRS-sponsored surveys, documenting general limits placed on such services as of June, 2000, are presented. For Medicaid, including Medicaid expansions under SCHIP, survey results were reported for all 50 states and the District of Columbia. For separate SCHIP programs, survey results were reported for all 41 programs operating in 33 states.

Nearly all Medicaid and SCHIP programs covered inpatient and outpatient mental health services for children, and most also covered inpatient detoxification and outpatient substance abuse treatment. Such benefits were more frequently unlimited under Medicaid than under SCHIP. While the majority of Medicaid programs covered residential treatment centers, most SCHIP programs did not. In many cases, expressing benefit limits as a simple quantity (e.g., days of care, admissions per year, visits/hours per year) did not address the full scope of restrictions on coverage. Other means of limiting benefits were also reported (e.g., use of prior authorization, thresholds specific to condition/diagnosis, and treatment plan requirements). Under SCHIP, but not Medicaid, a single quantity limit was often applied to two or more related benefits combined rather than separately for each benefit category.

Coverage policies and benefit limits for children under Medicaid are seldom absolute in part because of special provisions in the law requiring that children receive all medically necessary services authorized in federal statute. This guarantee does not exist in SCHIP. Instead, SCHIP children have access to similar types of benefit packages available in the private sector.

Facing declining revenues and increased expenses, some states are implementing a number of Medicaid cost containment strategies focused on reductions in provider payments, and reductions in and/or elimination of optional services and populations, mostly affecting adults. Under SCHIP, some states are also capping enrollment and increasing beneficiary cost-sharing. While these proposed strategies appear to leave mental health and substance abuse benefits for children largely intact, they could effectively limit access to care.

Finally, this report also describes mental health parity and its application to Medicaid and SCHIP under current federal law, and related, pending legislation in the 108th Congress.

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Key Benefits Under Medicaid and the State Children's Health Insurance Program (SCHIP) for Children With Mental Health and Substance Abuse Problems

A small, but significant proportion of youth in this country have mental health problems. Some studies estimate that only about one-fourth of those in need of mental health services receive treatment.¹ According to the National Household Survey on Drug Abuse (NHSDA),² about 18% of adolescents ages 12 to 17 received mental health treatment or counseling in 2000. In 1998 (the latest available figures), the estimated annual expenditures for mental health care delivered to all youth ages 1 to 17 was nearly \$12 billion, of which adolescents accounted for almost \$7 billion of that total.³ The majority of these costs were covered by private insurance (48%) and state and local payers (24%). Medicaid financed almost 19% of these expenditures.

A relatively large portion of adolescents have experimented with alcohol and illicit drugs. According to the NHSDA, in 2000, one-third of teenagers reported using alcohol, and about 21% had used an illicit drug. However, only 4.9% of adolescents were classified as needing treatment for an illicit drug problem. An even smaller proportion, just 1.5%, received treatment. Expenditures for substance abuse services for children under 18 years of age totaled just \$604 million nationwide in 1997⁴ which is consistent with the very small proportion of youth who report receiving treatment for alcohol or illicit drug use. The primary sources of payment for substance abuse treatment services included family members (35%), private health insurance (28%), and own savings or earnings (21%). Medicaid covered about

¹ The Rand Corporation, *Mental Health Care for Youth: Who Gets It? How Much Does It Cost? Who Pays? Where Does the Money Go?* Research Highlights (no date).

² The annual NHSDA (now known as the National Survey on Drug Use and Health) is the primary source of information on the use of illicit drugs, alcohol and tobacco by the civilian, noninstitutionalized population in the United States. It also includes a series of questions for respondents ages 12 through 17 on their mental health status and use of related services. See Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Results from the 2001 National Household Survey on Drug Abuse: Volume III*, Sept. 2002.

³ Jeanne Ringel and Roland Sturm, "National Estimates of Mental Health Utilization and Expenditures for Children in 1998," *Journal of Behavioral Health Services and Research*, vol. 28, no. 3 (2001), pp. 319-333.

⁴ Henrick Harwood, Tami Mark, David McKusick, Rosanna Coffey, Edward King, and James Genuardi, "National Spending on Mental Health and Substance Abuse Treatment by Age of Clients, 1997," *Journal of Behavioral Health Services and Research*, (forthcoming).

14% of these costs. SCHIP programs were first implemented in 1998, and thus, would not have accounted for much of the spending on either mental health or substance abuse services in the late 1990s.

In this report, the availability of mental health and substance abuse services offered to low and moderate income children under Medicaid and SCHIP is explored. Data from two CRS-sponsored state surveys on selected benefits and general limits placed on the amount, duration and scope of such services is presented.⁵ Specifically, this analysis compares the methods states use in their Medicaid versus SCHIP programs to define the breadth of children's mental health and substance abuse services. To provide a context for this discussion, this report also gives a basic overview of who is eligible for Medicaid and SCHIP. Then mental health and substance abuse benefits available under each program are described. Differences in the design and nature of benefits for children under Medicaid and SCHIP are delineated. Other strategies states use to contain costs under these programs, and how those strategies may affect access to care apart from setting limits on benefits, is presented. Finally, mental health parity is discussed.

Background

What are Mental Health And Substance Abuse Services?

Mental health and substance abuse services are designed to ameliorate the negative effects of mental illness and use of, or addiction to, illicit drugs, respectively.⁶ According to the 1999 Surgeon General's report on mental health,⁷ mental illness refers to all diagnosable mental disorders, which are conditions characterized by alterations in thinking, mood or behavior (or combinations thereof). Among children, for example, attention-deficit/hyperactivity disorder is primarily marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Depression is characterized by alterations in mood. In general, mental disorders can lead to distress, impaired functioning in daily life, and increased risk of pain, disability, death or loss of freedom. Treatment for mental illness is generally of three types—psychosocial (various types of individual, family and group therapies), pharmacological (prescription drugs), or a combination of both.

The Surgeon General's report also describes a patchwork of mental health services that have come to form a *de facto* mental health system over the past three centuries. This system has distinct sectors, two of which are most relevant to the

⁵ CRS gratefully acknowledges the valuable input of Neva Kaye with the National Academy for State Health Policy for her extensive assistance in analyzing and interpreting the survey data presented in this report.

⁶ This report excludes a discussion of children with mental retardation or developmental disabilities and the services provided to them.

⁷ U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999.

purpose of this report — the specialty mental health sector and the general medical/primary care sector.

Speciality mental health services include services provided by specialized mental health professionals (e.g., psychologists, psychiatric nurses, psychiatrists, and psychiatric social workers), expressly for the provision of mental health care. The general medical/primary care sector consists of health professionals (e.g., family practitioners, nurse practitioners, internists, pediatricians, etc.) who provide the full range of medical and health services, including but not exclusively for mental health care.

Various types of mental health treatment are also defined by their duration and setting. Duration of care is divided into services for the treatment of acute conditions versus long-term chronic care. Settings of care include institutional (e.g., hospital, nursing facility, residential treatment facilities), community-based (e.g., in public and private schools, services provided by mental health professionals in an office), and home-based.

While a recent comprehensive analysis of the current system of care for substance abuse in this country is lacking, the Surgeon General's description of the patchwork nature of the mental health care system likely applies in this context as well. Substance abuse treatment services are generally of two types: (1) detoxification (i.e., to rid the body of the toxic substance) and medication management (i.e., to control withdrawal symptoms and drug craving, and to block the effects of drugs), and (2) education, counseling and rehabilitation. All these services are designed to reduce or eliminate use of and dependence on alcohol or illicit drugs, to improve the individual's ability to function, and to minimize other medical and social complications of drug abuse.⁸ Care is provided in both inpatient and outpatient settings, including community- and home-based services, with varying levels of intensity in response to the individual's acute or chronic care needs. And as with mental health care, there are substance abuse specialty practitioners as well as general medical/primary care providers that treat individuals with alcohol and drug problems.

The Role of Medicaid and SCHIP

Medicaid. Medicaid is a federal-state entitlement program that pays for medical services on behalf of certain low-income individuals. Medicaid provided access to medical services for 44.3 million people in FY2000 (the latest official enrollment figure) at a cost to the federal government of \$116.9 billion, representing 57% of total program costs, the remainder of which was covered by state and local governments. In FY2002, federal payments rose to \$146.2 billion.⁹

Eligibility for Medicaid. To qualify for Medicaid, applicants' income and resources (also called assets) must be within program *financial standards*. These

⁸ See [<http://www.nida.nih.gov/infobox/treatmeth.html>] for additional information.

⁹ See CRS Report RS20245, *Medicaid: A Fact Sheet*, by (name redacted).

standards vary considerably among states, and different standards apply to different population groups within a state. Medicaid eligibility is also subject to *categorical restrictions* — generally, it is available only to low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. In addition, certain individuals within these categories and with higher income, especially those facing high costs for medical care, may also be eligible. (This latter group is sometimes referred to as the medically needy; see below for more details).

The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those who must be covered and those for whom coverage is optional. Eligibility groups have traditionally been divided into two classifications — the “categorically needy” and the “medically needy.” For the purposes of this report, this distinction is important because the scope of services that states must provide to categorically needy individuals is much broader than that required for the medically needy.

In addition to financial requirements, for some eligibility groups, disability status is also considered. For example, the mandatory categorically needy coverage group of recipients of Supplemental Security Income (SSI)¹⁰ requires the presence of a disability. For children, the SSI disability criteria are defined by types of functional impairments affecting daily life and may include mental illness. Substance abuse is not considered to be a disability for SSI purposes, and hence, for Medicaid.

Examples of other major mandatory categorically needy groups relevant to children and for which no disability criteria apply include: (1) members of families who meet the requirements of the former Aid to Families with Dependent Children (AFDC) program as in effect on July 16, 1996, (2) pregnant women and children under six years of age living in families with income up to 133% of the federal poverty level (FPL),¹¹ and (3) children ages 6 to 19 living in families with income up to 100% of the FPL. Children with mental illness and/or substance abuse problems may qualify for coverage under these latter groups if the financial criteria, which in some cases are more generous than the SSI pathway into Medicaid, are met.

The medically needy are persons who fit the definition of a categorical group (e.g., they are aged, disabled, children or members of families), but who do not meet applicable income and/or resource standards. States may establish higher income and resource standards for the medically needy.¹² Also, such persons may “spend down” to the medically needy income standard by incurring medical expenses. That is, net income after subtracting medical expenses is used to determine eligibility.

¹⁰ SSI is a means-tested federal cash assistance program for persons who are aged or with disabilities that meet certain criteria. The income standard for an individual is about 74% of the federal poverty level (FPL) and the resource standard is \$2,000.

¹¹ 100% of the FPL is equal to \$15,260 and 133% of the FPL is equal to \$20,256 for a family of three in 2003.

¹² The income standard for medically needy coverage can be up to one-third higher than the state-specific AFDC standards as of July 16, 1996. The median level for the AFDC standard is roughly 44% of the FPL across states.

States have the option of covering the medically needy, and if they choose to do so, they must include children under 18 who would qualify under a mandatory categorically needy group, and pregnant women who would qualify under a mandatory or optional categorically needy group, except that their income and/or resources are too high. States may also offer medically needy coverage to otherwise ineligible individuals under 21 who meet the applicable financial criteria. States may cover all such individuals or reasonable subclassifications (e.g., those in publically subsidized foster care or adoptions, those receiving active treatment as inpatients in psychiatric facilities or programs). In 2002, 36 states had medically needy programs.¹³

There were 24.2 million children under the age of 21 enrolled in Medicaid in FY2000 (the latest official enrollment information), accounting for nearly 55% of the total Medicaid population nationwide. Total Medicaid expenditures for these children was \$38.5 billion, representing 22.9% of all Medicaid spending in that year.

Mental Health and Substance Abuse Benefits Under Medicaid. As with eligibility, some benefits under Medicaid are mandatory and others may be covered at state option. Some categories of service, by virtue of their label, have an obvious connection to mental health care or substance abuse treatment, while others do not.

The *mandatory* benefits relevant to children that all states must offer to their categorically needy groups, and that are likely to or may include mental health and substance abuse services, are:

- inpatient hospital services (other than in an institution for mental diseases or IMD),¹⁴
- outpatient hospital services,
- rural health clinic services,
- federally-qualified health center services,
- early and periodic screening, diagnosis and treatment (EPSDT) for persons under age 21 years (more on this benefit below),
- physician services (e.g., psychiatrists), and
- home health services for persons entitled to nursing facility care.

The EPSDT program provides screening and preventive care to nearly all groups of Medicaid beneficiaries under 21 years old, as well as services necessary to correct a health problem identified through screening, including mental illness and substance abuse as well as conditions caused by drug use or addiction. That is (with the

¹³ Centers for Medicare and Medicaid Services, *Medicaid At-A-Glance, 2002*, Publication No. CMS-11024-02, (no date).

¹⁴ An IMD is a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in diagnosis and treatment of persons with mental disease, including medical attention, nursing care, and related services. Medicaid statute includes two optional IMD benefits, one for individuals age 65 years and older residing in an IMD, and one covering inpatient psychiatric services for persons under age 21 years (see text for further information).

exceptions noted below), *states are required to provide all federally-allowed treatment to correct identified problems, even if the specific treatment needed is not otherwise covered under a state's Medicaid plan.* Thus, states may be required to cover some services for children that would be optional or not covered at all for adults. EPSDT is *not* a mandatory benefit for the medically needy, although states may choose to make this benefit available to this group.

There are a wide variety of *optional* Medicaid benefits relevant to children which states may offer to their categorically needy groups that could include mental health and substance abuse services. These are:

- medical care provided by other licensed practitioners (e.g., psychologists, social workers),
- other clinic services,
- prescribed drugs,
- other diagnostic, screening, preventive, and rehabilitative services for the maximum reduction of physical or mental disability and restoration to the best possible functional level,
- inpatient psychiatric services for persons under age 21 years (including psychiatric residential treatment facilities¹⁵), and
- case management services.¹⁶

States that cover the medically needy may offer a more restricted set of benefits to these individuals than is offered to the categorically needy. For medically needy beneficiaries, at a minimum, states must cover the following benefits that may include mental health and substance abuse services:

- ambulatory services for those under 18 and persons entitled to institutional services, and
- home health services for persons entitled to nursing facility care.

There are additional benefit requirements for those states that cover IMD services (see footnote 14) or services in intermediate care facilities for the mentally retarded (ICF/MR)¹⁷ for any group of medically needy beneficiaries. In these cases,

¹⁵ Psychiatric residential treatment facilities (or centers) are non-hospital settings that provide a wide range of mental health services to children and adolescents with severe mental illness who require a residential environment offering 24-hour care, but for whom the acute nature of their condition does not warrant more intensive hospitalization. Services may include psychosocial therapy, behavior management, substance abuse counseling, and medication management. Length of stay may be brief (e.g., one month) or long-term (e.g., one year).

¹⁶ Case management includes services which assist eligible individuals with access to, and coordination of, needed medical, social, educational and other services. If states choose to provide targeted case management services, they must specify the applicable “target group” which can be defined in terms of age, type or degree of disability, illness or condition (e.g., chronic mental illness) or any other identifiable characteristic or combination thereof.

¹⁷ An ICF/MR is a facility (or a distinct part of a facility such as a wing, floor, or building)
(continued...)

states must cover either the mandatory services available to the categorically needy (except services provided by pediatric and family nurse practitioners), or alternatively, any seven categories of care and services listed in Medicaid law defining covered benefits. Again, such coverage may include mental health care and substance abuse treatment.

Finally, states may apply for waivers of program rules to establish special programs to accommodate unique needs. Many states have such waivers which can be statewide or limited to certain geographic areas. Such programs may include coverage for mental health care and substance abuse services. Three states — Kansas, New York and Vermont — have waivers specifically to provide special services to children with severe mental illness. Some of the services offered under these waivers include caregiver training and respite care, crisis intervention and support, independent living skills training, and case management. The number of children served under these waiver programs is small (roughly 1,200 in Kansas in 2002, 375 in New York in 2000, and 240 in Vermont in 2001).

SCHIP

SCHIP was established in 1997, and provides health insurance to certain uninsured children in families with modest income. A total of \$39.7 billion has been appropriated for SCHIP for FY1998 through FY2007. Approximately 5.3 million children were enrolled in SCHIP during FY2002. Nationally, through June 2003, \$12.5 billion in federal funds had been spent under the program.

Eligibility for SCHIP. In general, SCHIP allows states to cover uninsured children under age 19 in families with incomes that are above applicable Medicaid financial standards.

States can define the group of children who may enroll in SCHIP. The law allows states to use the following factors in determining eligibility: geography, age, income and resources, residency, disability status, access to other health insurance, and duration of SCHIP enrollment. Children who are eligible for Medicaid or are covered by a group health plan or other insurance are not eligible for SCHIP.

As of FY2002, the upper income eligibility limit under SCHIP had reached 350% FPL (in one state). Nearly one-half (24) of the states and the District of Columbia had established upper income limits at 200% FPL. Another 13 states exceeded 200% FPL. The remaining 13 states set maximum income limits below 200% FPL.

Mental Health and Substance Abuse Benefits Under SCHIP. The SCHIP statute defines child health assistance to include a wide range of coverable benefits. As with Medicaid, some categories of service, by virtue of their label, have an obvious connection to mental health care and substance abuse treatment, while

¹⁷ (...continued)

that provides health and rehabilitation services to residents with mental retardation or related conditions.

others do not. The categories of service that may include mental health care and substance abuse treatment are:

- inpatient hospital services,
- outpatient hospital services,
- physician services,
- clinic services (including health center services) and other ambulatory health care services,
- prescription drugs,
- inpatient mental health services,
- outpatient mental health services,
- home and community-based health care services and related supportive services,
- nursing care services (e.g., psychiatric nurse practitioner)
- inpatient substance abuse treatment services,
- outpatient substance abuse treatment services,
- case management services,
- care coordination services,
- any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (if recognized by state law, and prescribed, furnished or supervised by a physician or other licensed practitioner or state- or local-government operated health care facility), and
- any other health care services or items.

Under SCHIP, states do not simply select among these benefits in establishing what is and is not covered. Rather, states choose from three options when designing their SCHIP programs. They may expand their current Medicaid program, create a new “separate state” program, or devise a combination of both approaches. These program level choices determine the package of benefits offered. All 50 states, the District of Columbia, and five territories have SCHIP programs in operation. As of August, 2003, 19 had Medicaid expansions, 19 had separate state programs, and 18 used a combination approach.¹⁸

States that choose to expand Medicaid to new eligibles under SCHIP authority must provide the full range of mandatory Medicaid benefits for the categorically needy, as well as all optional services covered. Alternatively, states deciding to use a separate state program may choose any of three other benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other benefits plan that the Secretary of Health and Human Services determines will provide appropriate coverage to beneficiaries. The option chosen determines the set of covered benefits under separate SCHIP programs.

A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered

¹⁸ Some states classified as “separate state program states” have more than one such program.

and generally available to state employees in the state involved, and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark equivalent coverage must cover each of the benefits in the “basic benefits category.” The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians’ surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the “additional service category.” These additional services include prescription drugs, mental health services, vision services, and hearing services.

Finally, as with Medicaid, states may apply for waivers of program rules to establish demonstration projects to accommodate unique needs. Currently, only a few states have such waivers under SCHIP. While none of these waivers specifically focus on mental health or substance abuse benefits, they may provide access to such services.

Scope of Mental Health And Substance Abuse Benefits for Children — A Snapshot of Selected Medicaid and SCHIP Coverage Policies in FY2000

In this section, a description of the state survey data collection instruments and implementation issues is provided, followed by important data caveats that affect interpretation of the survey findings presented in the subsequent section.

Survey Design and Implementation

In 2000, the Congressional Research Service (CRS) contracted with the National Academy for State Health Policy (NASHP) to collect data from Medicaid and SCHIP state agencies on limits placed on selected benefits for children under each program. Two parallel survey instruments¹⁹ were developed with extensive input from state officials, one for Medicaid programs and one for separate state SCHIP programs. The benefits data collected from these surveys represent general program policies as of June 2000.

¹⁹ These surveys covered other topics in addition to benefits for children. In the Medicaid survey, detailed data were also collected on eligibility rules and the extent and scope of managed care activities for all Medicaid populations. The SCHIP survey covered many other major aspects of program policy (e.g., eligibility rules, administrative services, outreach activities, employer-sponsored insurance, healthcare marketplace, public input methods, coordination with other state agencies, managed care policies, cost-sharing, and crowd-out prevention). For information on results from these other survey components, go to [<http://www.nashp.org>].

For each benefit category listed on the survey, respondents indicated the amount of each service children could receive without special permission, that is, before prior authorization²⁰ was required. If there was no point at which prior authorization for continued services was necessary, the benefit was identified as unlimited. State officials could also indicate that limits for a specific benefit were absolute, meaning that children could not receive more than the specified amounts even with prior authorization.

For Medicaid, survey results were reported for all 50 states and the District of Columbia. For SCHIP, survey results were reported for 41 separate programs in 33 states, representing the universe of such states and programs in June, 2000. Two states (California and New Jersey) had two SCHIP programs with different benefit plans, and three states (Connecticut, Florida, and Massachusetts) each had three SCHIP programs with different benefit plans.

Because there was limited space available on the two survey instruments for questions on coverage of and limitations placed on benefits, only five general mental health and substance abuse service categories were included. These were inpatient mental health services, outpatient mental health services, inpatient detoxification services, outpatient substance abuse services, and residential treatment center (RTC) services.

There is no direct one-to-one correspondence between each of the five service categories included on the surveys and a single coverable benefit listed in Medicaid statute. This is in part due to the fact that many of the benefit categories listed in Medicaid statute identify a type of provider rather than a type of service. For example, a wide variety of providers can deliver outpatient mental health and substance abuse services. Under Medicaid, the benefit categories listed in statute under which such care is most likely covered include outpatient hospital services, rural health and federally qualified health center services (providers that deliver primary medical services and mental health care), physician services (e.g., psychiatrists), other practitioner services (e.g., psychologists, social workers), and other clinic services (e.g., community mental health centers and other specialty mental health or substance abuse clinics). Inpatient mental health services and inpatient detoxification are most likely covered as inpatient hospital services or inpatient psychiatric services for persons under age 21. Such care is typically delivered in general acute care hospitals with distinct psychiatric care wings or designated psychiatric beds, or in psychiatric hospitals. Residential treatment centers

²⁰ Prior authorization, also referred to as precertification or preadmission screening, means that an entity other than a provider (e.g., state Medicaid agency, fiscal agent, or other contractor) must approve the delivery of a specific service to a specific beneficiary or the Medicaid agency will not reimburse the provider for that service. Examples of other common utilization controls include: (1) concurrent review, which means an authorized entity (e.g., state Medicaid agency, or a contractor) reviews services while they are being provided to a given beneficiary; for example, hospital stays may be subject to concurrent review when they exceed a specified length of stay, and (2) utilization review which is a generic term encompassing all reviews of service provision, whether they happen prospectively, concurrently, or retrospectively.

are typically covered as inpatient psychiatric services for persons under 21, or under the rehabilitative services option.

In general, the coverable benefits listed in SCHIP statute are more closely aligned to the service categories included on the surveys. However, there is not an obvious, single benefit category listed in SCHIP statute that would encompass residential treatment centers. Several could apply here (e.g., inpatient mental health services, inpatient substance abuse services, rehabilitative services).

In sum, each of the five categories of service used in the surveys likely corresponds to multiple benefits listed in both Medicaid and SCHIP statute. This is an important problem for the survey design because very different limits may apply to “outpatient mental health services,” as used on the surveys, when delivered as a “physician service” versus an “other clinic service,” for example. For this reason, the survey data are imprecise. Therefore, the results from the two surveys represent general, statewide benefit limit policies for broad classifications of mental health and substance abuse services for children under each program.

Overall, the value of the survey data presented here is *not* in the specific, detailed responses that each state agency provided on benefit limits for each service category. To further complicate the picture, both Medicaid and SCHIP programs rely on managed care organizations (MCOs) to deliver services to most beneficiaries (described further below). Detailed data on variations in benefit limits specific to individual managed care contracts under each state program, which can differ from the general criteria delineated in state plans as reported here, were *not* captured. Also, states may have changed coverage policies since June, 2000 (the point in time represented by the survey data), especially during the past few years as they began to face growing state budget constraints and rapidly rising Medicaid costs. Instead, the importance of these survey results lies in the identification of the different *methods* states use in their Medicaid versus SCHIP programs to define the breadth of these services for children. Also, these survey data serve as a baseline documenting general coverage policies in place during a strong economic period when many states were expanding their Medicaid and SCHIP programs.

General Coverage Policies

For each of the five mental health and substance abuse benefit categories included in the CRS-sponsored surveys, **Tables 1** through **5** provide a summary of whether the service is covered, and general information about service limits and monitoring activities for Medicaid and separate SCHIP programs across states.

As of June 2000, nearly all Medicaid and SCHIP programs covered inpatient and outpatient mental health services for children. When covered, proportionally more Medicaid programs (about one-third) than SCHIP programs (about one-fourth) reported that inpatient and outpatient mental health benefits for children were unlimited.

Most Medicaid and SCHIP programs also covered inpatient detoxification and outpatient substance abuse services for children. Roughly one-third of Medicaid and SCHIP programs that offered inpatient detoxification services indicated that this

benefit was unlimited. In contrast, with respect to outpatient substance abuse services for children, about 40% of Medicaid programs covering such care identified this benefit as unlimited, compared to approximately 22% of SCHIP programs.

The biggest discrepancies in general coverage between Medicaid and SCHIP programs was for RTCs. Among SCHIP programs, 44% did not make RTC services available. In contrast, only one-fourth of Medicaid programs indicated that RTC services were not covered.

It is no surprise that SCHIP programs often exclude RTC services since this kind of benefit is not typically available in commercial insurance products. It is more noteworthy that some SCHIP programs *do* provide access to RTC services.

Table 1. Coverage of, and Limits for/Monitoring of Inpatient Mental Health Services for Children Under Medicaid and SCHIP

(as of June, 2000)

Program classifications	Medicaid (51 programs in 50 states and DC) ^a		SCHIP (41 programs in 33 states) ^b
	CN only	CN+MN	
Programs that do <i>not</i> cover inpatient mental health services	0	0	2 – CT-B and CT-C
Programs with <i>unlimited</i> inpatient mental health services	3 – MO, OH, OR	15 – AR, CA, DC, IA, IL, KS, MA, ME, NJ, NY, PA, TX, UT, WA, WI	10 – FL-B, FL-C, IL, MA-A, MA-C, ME, MI, OR, VA, WA
Programs <i>with</i> specified limits and/or monitoring of inpatient mental health services	13 – AK, AL, AZ, CO, DE, ID, IN, MS, NM, NV, SC, SD, WY	20 – CT, FL, GA, HI, KY, LA, MD, MI, MN, MT, NC, ND, NE, NH, OK, RI, TN, VA, VT, WV	28 – AL, AZ, CA-A, CA-B, CO, CT-A, DE, FL-A, GA, IA, IN, KS, KY, MA-B, MT, NC, ND, NH, NJ-A, NJ-B, NV, NY, PA, TX, UT, VT, WV, WY
Programs for which limits were <i>not</i> specified	0	0	1 – MS

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS. State abbreviations are used in this table.

^a In the Medicaid column, the sub-column labeled “CN only” means that coverage, limitations and monitoring of inpatient mental health services apply only to beneficiaries classified as categorically needy, and the sub-column labeled “CN+MN” means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the “CN Only” or the “CN+MN” sub-columns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states WITHOUT medically needy programs were AK, AL, AZ, CO, DE, ID, IN, MO, MS, NM, NV, OH, SC, SD, and WY. These 15 states are always listed in the “CN Only” sub-column.

^b In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., CA-A, CA-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., CT-A, CT-B, CT-C).

Table 2. Coverage of, and Limits for/Monitoring of Outpatient Mental Health Services for Children Under Medicaid and SCHIP
(as of June, 2000)

Program characteristics	Medicaid (51 programs in 50 states and DC) ^a		SCHIP (41 programs in 33 states) ^b
	CN only	CN+MN	
Programs that do <i>not</i> cover outpatient mental health services	0	0	1 – CT-B
Programs with <i>unlimited</i> outpatient mental health services	3 – MO, OH, SC	14 – CA, IL, KS, KY, LA, MD, MI, ND, OR, PA, RI, UT, WA, WV	9 – FL-B, FL-C, IL, KY, MA-A, MA-C, MI, OR, WY
Programs <i>with</i> specified limits and/or monitoring of outpatient mental health services	12 – AK, AL, AZ, CO, DE, ID, IN, MS, NM, NV, SD, WY	22 – AR, CT, DC, FL, GA, HI, IA, MA, ME, MN, MT, NC, NE, NH, NJ, NY, OK, TN, TX, VA, VT, WI	28 – AL, AZ, CA-A, CA-B, CO, DE, FL-A, GA, IA, IN, KS, MA-B, ME, MT, NC, ND, NH, NJ-A, NJ-B, NV, NY, PA, TX, UT, VA, VT, WA, WV
Programs for which limits were <i>not</i> specified	0	0	3 – CT-A, CT-C, MS

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS. State abbreviations are used in this table.

- a. In the Medicaid column, the sub-column labeled “CN only” means that coverage, limitations and monitoring of inpatient mental health services apply only to beneficiaries classified as categorically needy, and the sub-column labeled “CN+MN” means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the “CN Only” or the “CN+MN” sub-columns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states WITHOUT medically needy programs were AK, AL, AZ, CO, DE, ID, IN, MO, MS, NM, NV, OH, SC, SD, and WY. These 15 states are always listed in the “CN Only” sub-column.

- b. In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., CA-A, CA-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., CT-A, CT-B, CT-C).

Table 3. Coverage of, and Limits for/Monitoring of Inpatient Detoxification Services for Children Under Medicaid and SCHIP
(as of June, 2000)

Program classification	Medicaid (51 programs in 50 states and DC) ^a		SCHIP (41 programs in 33 states) ^b
	CN Only	CN+MN	
Programs that do <i>not</i> cover inpatient detoxification services	2 – ID, MS	6 – AR, GA, LA, NH, TX, WA	4 – CT-B, CT-C, WA, WY
Programs with <i>unlimited</i> inpatient detoxification services	2 – OH, OR	12 – CA, CT, IA, IL, KS, ME, MI, NJ, NY, OK, PA, WI	11 – FL-B, FL-C, IL, MA-A, MA-B, MA-C, ME, MI, MT, NH, OR
Programs <i>with</i> specified limits and/or monitoring of inpatient detoxification services	12 – AK, AL, AZ, CO, DE, IN, MO, NM, NV, SC, SD, WY	17 – DC, FL, HI, KY, MA, MD, MN, MT, NC, ND, NE, RI, TN, UT, VA, VT, WV	24 – AL, AZ, CA-A, CA-B, CO, CT-A, DE, FL-A, GA, IA, IN, KS, KY, NC, ND, NJ-A, NJ-B, NV, PA, TX, UT, VA, VT, WV
Programs for which limits were <i>not</i> specified	0	0	2 – MS, NY

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS. State abbreviations are used in this table.

- a. In the Medicaid column, the sub-column labeled “CN only” means that coverage, limitations and monitoring of inpatient mental health services apply only to beneficiaries classified as categorically needy, and the sub-column labeled “CN+MN” means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the “CN Only” or the “CN+MN” sub-columns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states WITHOUT medically needy programs were AK, AL, AZ, CO, DE, ID, IN, MO, MS, NM, NV, OH, SC, SD, and WY. These 15 states are always listed in the “CN Only” sub-column.

- b. In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., CA-A, CA-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., CT-A, CT-B, CT-C).

Table 4. Coverage of, and Limits for/Monitoring of Outpatient Substance Abuse Services for Children Under Medicaid and SCHIP

(as of June, 2000)

Program characteristics	Medicaid (51 programs in 50 states and DC) ^a		SCHIP (41 programs in 33 states) ^b
	CN Only	CN+MN	
Programs that do <i>not</i> cover outpatient substance abuse services	3 – CO, ID, SD	3 – AR, TX, VA	1 – CT-B
Programs with <i>unlimited</i> outpatient substance abuse services	4 – IN, MO, MS, OH	14 – CA, IL, KS, LA, MD, MI, MT, ND, OR, PA, RI, UT, WA, WV	9 – FL-B, FL-C, IL, MA-A, MA-C, MI, OR, WA, WY
Programs <i>with</i> specified limits and/or monitoring of outpatient substance abuse services	8 – AK, AL, AZ, DE, NM, NV, SC, WY	19 – CT, DC, FL, GA, HI, IA, KY, MA, ME, MN, NC, NE, NH, NJ, NY, OK, TN, VT, WI	28 – AL, AZ, CA-A, CA-B, CO, DE, FL-A, GA, IA, IN, KS, KY, MA-B, ME, MT, NC, ND, NH, NJ-A, NJ-B, NV, NY, PA, TX, UT, VA, VT, WV
Programs for which limits were <i>not</i> specified	0	0	3 – CT-A, CT-C, MS

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS. State abbreviations are used in this table.

- a. In the Medicaid column, the sub-column labeled “CN only” means that coverage, limitations and monitoring of inpatient mental health services apply only to beneficiaries classified as categorically needy, and the sub-column labeled “CN+MN” means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the “CN Only” or the “CN+MN” sub-columns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states WITHOUT medically needy programs were AK, AL, AZ, CO, DE, ID, IN, MO, MS, NM, NV, OH, SC, SD, and WY. These 15 states are always listed in the “CN Only” sub-column.

- b. In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., CA-A, CA-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., CT-A, CT-B, CT-C).

Table 5. Coverage of, and Limits for/Monitoring of Residential Treatment Center (RTC) Services for Children under Medicaid and SCHIP

(as of June, 2000)

Program classifications	Medicaid (51 programs in 50 states and DC) ^a		SCHIP (41 programs in 33 states) ^b
	CN only	CN+MN	
Programs that do <i>not</i> cover RTC services	5 – AL, ID, IN, OH, WY	8 – FL, HI, IA, LA, NH, TX, UT, WI	18 – AZ, CA-A, CA-B, CO, CT-A, CT-B, CT-C, FL-B, FL-C, IA, IN, MA-A, MA-B, MA-C, NH, NJ-B, WA, WY
Programs with <i>unlimited</i> RTC services	1 – OR	10 – AR, CA, IL, KS, MD, ME, NJ, NY, PA, WA	4 – IL, ME, MI, OR
Programs <i>with</i> specified limits and/or monitoring of RTC services	10 – AK, AZ, CO, DE, MO, MS, NM, NV, SC, SD	16 – CT, GA, KY, MA, MI, MN, MT, NC, ND, NE, OK, RI, TN, VA, VT, WV	18 – AL, DE, FL-A, GA, KS, KY, MT, NC, ND, NJ-A, NV, NY, PA, TX, UT, VA, VT, WV
Programs for which limits were <i>not</i> specified	0	1 – DC	1 – MS

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS. State abbreviations are used in this table.

- a. In the Medicaid column, the sub-column labeled “CN only” means that coverage, limitations and monitoring of inpatient mental health services apply only to beneficiaries classified as categorically needy, and the sub-column labeled “CN+MN” means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the “CN Only” or the “CN+MN” sub-columns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states WITHOUT medically needy programs were AK, AL, AZ, CO, DE, ID, IN, MO, MS, NM, NV, OH, SC, SD, and WY. These 15 states are always listed in the “CN Only” sub-column.

- b. In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., CA-A, CA-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., CT-A, CT-B, CT-C).

Methods for Limiting Benefits

For each of the five mental health and substance abuse benefit categories, **Appendices A through E** provide information on the specific limits and monitoring activities identified by states for their Medicaid and SCHIP programs (when applicable) as of June, 2000. The methods for limiting benefits are summarized below.

Inpatient Mental Health Services. With respect to limits on inpatient mental health services under Medicaid, many states (23 of 51)²¹ reported using prior authorization or other types of review only. A few states specified other kinds of limits in addition to or in lieu of prior authorization or other review, usually in the form of a quantity limit on the number of inpatient mental health days per year or per admission.

In contrast, few separate SCHIP programs relied exclusively on prior authorization or other review only for inpatient mental health services. Nearly one-half of these programs (17 of 39) indicated that specific quantity limits applied to inpatient mental health services. Some of these programs (9 of 17) set a single overall quantity limit, usually expressed in terms of days per year, on inpatient mental health services in combination with other related benefits, such as inpatient substance abuse treatment or other residential care, and in some cases, outpatient mental health and/or substance abuse services, or partial hospitalization programs.²² This practice of applying a single quantity limit to a combination of related services may facilitate the tailoring of benefits to ever changing individual needs, especially for persons with both mental health and substance abuse problems, while at the same time controlling utilization, and hence costs, for services that tend to be expensive.

For several programs (8 of 39), state respondents highlighted that quantity limits for inpatient mental health care varied by managed care organization, while others established thresholds that varied by type of provider (e.g., general acute care versus psychiatric hospitals; 3 of 39) or beneficiary diagnosis or condition (e.g., unlimited care only for children with severe emotional disturbances enrolled in a behavioral health plan; 1 of 39).

Outpatient Mental Health Services. Other types of thresholds were used by states to define the breadth of outpatient mental health services. Under Medicaid, a few states (4 of 51) reported that dollar-based limits were used. More often, other non-dollar quantity limits applied, expressed in units or hours of service, or in visits, typically per year (14 of 51). In a few cases, limits varied by type of outpatient mental health service (e.g., individual versus group versus family therapy; 2 of 51)

²¹ In this section, counts in parentheses are derived from **Appendices A through E** and represent the number of programs with the identified limitation compared to the total number of programs that covered the benefit in question. **Appendix F** provides a definition of abbreviations used in the other appendices.

²² For example, the limit may be defined as a total of 21 days per year for all inpatient mental health and substance abuse treatment, for which 2 partial hospitalization program days may be substituted (exchanged) for one inpatient day.

or by whether the provider was a physician versus other practitioner (4 of 51). A few states (4 of 51) required an initial evaluation and development of a treatment plan for each beneficiary which would determine what the Medicaid agency would pay for on behalf of such individuals.

In general, the types of limits placed on outpatient mental health services under SCHIP were similar to those under Medicaid. Non-dollar quantity limits were applied in over one-half of separate SCHIP programs (22 of 40). In several cases (6 of 40), a single overall quantity limit for outpatient mental health services, in combination with related benefits, was used. Few programs (2 of 40) used dollar-based limits. And a handful of programs had provider-specific, type of service-specific or condition-specific restrictions on outpatient mental health services (4 of 40).

Outpatient Substance Abuse Services. In general, under both Medicaid and SCHIP, the methods used to limit outpatient substance abuse services were similar to those used to define restrictions on outpatient mental health care (see above).

Inpatient Detoxification. The immediate purpose of hospitalizations for detoxification is to rid the body of the toxic substance. Under Medicaid, one-half of the states (22 of 43) used prior authorization or other types of review to monitor such care. In a few cases (3 of 43), day limits for inpatient detoxification tended to be short (e.g., three to five days) probably reflecting per admission/episode limits. Otherwise, such stays were treated in the same way as any other acute care hospitalization, and thus, overall quantity limits (typically expressed as total admissions and/or total inpatient days per year) on general inpatient acute care applied.

Limits placed on inpatient detoxification services under SCHIP were somewhat different from those reported for Medicaid. For example, only three programs relied solely on prior authorization or other review for this benefit. One-fourth of these programs (9 of 37) used day limits per year or benefit period for such care. Some set a single quantity limit for inpatient detoxification services in combination with other related benefits (4 of 37). A few (3 of 37) also specified lifetime limits (e.g., expressed as total dollars or admissions per lifetime) on inpatient detoxification services.

Residential Treatment Center Services. RTCs are rapidly replacing hospitals in treating children with psychiatric disorders.²³ In many state Medicaid programs (19 of 38), prior authorization or other types of reviews accompany admissions to RTCs for children. When quantity limits were specified, they tended to be day limits per admission or episode (4 of 38).

²³ Health Care Financing Administration, "Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21; Final Rule," 66 *Federal Register* 7148, Jan. 22, 2001.

As reported above, under SCHIP, most programs did not cover RTC services at all. Among those which did, most (9 of 23) reported day limits per admission, episode, year or benefit period. As with many of the other services included in the CRS-sponsored surveys, some SCHIP programs (5 of 23) established a single quantity limit applicable to RTC services in combination with other related institutional and outpatient treatments for mental illness and/or substance abuse.

The Nature of Coverage and Benefit Limits for Children Under Medicaid and SCHIP

Comparing benefit limits under Medicaid and SCHIP must be done with care because the term “limits” does not have the same meaning across these two programs. This difference in the meaning of “limits” has implications for both the relative breadth or scope of care available under each program as well as efforts to collect uniform, comparable data on benefit restrictions.

In addition to defining the amount, duration and scope of all covered services, states also elect the service delivery systems under which benefits are made available to Medicaid and SCHIP beneficiaries. There are two primary service delivery systems under each program: fee-for-service (FFS) and managed care. Generally, under FFS, state Medicaid and SCHIP agencies monitor and control all service delivery. In contrast, under managed care, MCOs under contract to states monitor and control all service delivery. These two systems of care are not entirely independent of each other. There are hybrid models across states that combine various features of FFS and managed care for a given population or set of interrelated services. At any given point in time, beneficiaries may obtain all their services under a single system or different sets of services under both systems simultaneously.

Under Medicaid, specific limits on benefits have grown out of the fee-for-service environment in which Medicaid began. State Medicaid agencies determine which optional services will be covered, and set limits on both mandatory and optional services. Such agencies also establish other utilization controls (e.g., prior authorization) to ensure that beneficiaries do not receive services they do not need or in amounts greater than that needed to serve their medical purpose. Providers receive payments from the state based on rates established by the state for a given benefit or type of provider.

Under FFS, health care providers must obtain special permission or approval from the state to continue delivery of medically necessary services beyond the pre-defined, standard upper limit set by the state for a given benefit. For example, a state Medicaid plan may limit coverage of outpatient mental health services to 24 visits per year. But children who need more than 24 such visits in a year can obtain additional visits, as long as the provider of care demonstrates the medical necessity for more visits. Stated limits on benefits reflect what providers can generally expect to be paid for in the absence of official clearance for more services, rather than definitive limits on what beneficiaries may receive. The fee-for-service delivery system is generally used by individuals whose Medicaid eligibility group (e.g., the aged and individuals with disabilities) or geographic location (e.g., rural areas) is not

served through managed care, or for persons who opt out when managed care is voluntary.

Most Medicaid children without disabilities receive services in the managed care setting. Under this system of care, state Medicaid agencies negotiate different benefit plans with one or more contracted managed care organizations (MCOs). MCOs may be commercial plans (e.g., Kaiser Permanente) that serve private sector beneficiaries as well as Medicaid and/or SCHIP enrollees. In some cases, states also contract with Medicaid-only plans. State Medicaid agencies generally pay each MCO a fixed, prospectively determined, monthly fee for each beneficiary enrolled. In turn, the MCOs establish networks of participating providers to deliver the agreed-upon covered services and pay those providers negotiated rates. Benefit plans may be comprehensive or limited in scope (e.g., behavioral health services only, also referred to as “carve out” plans). There are likely to be variations in coverage of, and limits placed on, specific benefits across Medicaid managed care plans within a given state. Managed care plans also employ utilization controls to monitor service delivery and to insure that benefits provided are medically necessary (similar to the point at which prior authorization begins in the fee-for-service delivery system in Medicaid).

Even though most Medicaid programs provide services through managed care plans, especially for children without disabilities and families, most states continue to operate significant, parallel fee-for-service programs. Under a Medicaid managed care plan, if benefit limits are met by a Medicaid child and additional services are medically necessary beyond the contractual agreement between the MCO and the Medicaid agency, additional funding may be provided to the MCO for extended services, or that child may continue to receive such services in the fee-for-service setting.

Coverage policies and benefit limits described in state Medicaid plans are seldom absolute, especially for children, due to the medical necessity criterion, but also because of EPSDT. Under both fee-for-service and managed care, for nearly all Medicaid children, states are required to provide all federally-allowed treatment to correct identified problems, even if the specific treatment needed is not otherwise covered under a state’s Medicaid plan. As a result, when a Medicaid agency reports that a specific benefit is not covered for children, that means the service is only available when delivery of that service meets the EPSDT requirement. In these circumstances, providers typically go through a prior authorization process to receive payment for what are sometimes called “EPSDT extended benefits.”

Unlike Medicaid, but consistent with federal statute, separate SCHIP programs are modeled after private sector, commercial insurance products. The requirement to use benchmark plans (or actuarial equivalents of those plans), most of which are state employee health plans or commercial HMO plans, provides the framework for defining benefit limits.

Under SCHIP, managed care is the predominant service delivery system. At the time of the CRS-sponsored survey (June, 2000), all but five SCHIP programs (Alabama, North Carolina, North Dakota, West Virginia, and Wyoming) contracted with one or more managed care or indemnity plans to deliver care to SCHIP children.

California contracted with 23 comprehensive health plans. Some states also use a FFS delivery system. Under commercial insurance products, benefits are always limited by medical necessity, but other limits, when applicable, vary by insurance product, as do the points at which each insurer monitors service delivery for medical need and appropriateness. Payments to providers participating in these plans may be altered based on the outcome of such service utilization reviews, which can in turn affect access to care.

In the CRS-sponsored survey, some of the benefits for which data on limits were collected (i.e., residential treatment centers) are commonly covered under Medicaid, but not routinely included in commercial insurance products, and hence, SCHIP. There is no federal EPSDT requirement under SCHIP that would guarantee the availability of uncommon, but coverable benefits.

In sum, a small, but significant proportion of children have mental health problems. Some also suffer from the consequences of substance abuse. Medicaid and SCHIP provide access to an array of inpatient and outpatient services that can help such children in low to moderate income families overcome these difficulties. However, the breadth of benefits available under these two programs likely differs within and across states. Limits on benefits for the lowest income children under Medicaid are seldom absolute, while restrictions on services for higher income children under SCHIP may be. SCHIP children have access to the same types of benefit packages available in the private sector as intended by Congress.

Changes in Benefits Under Medicaid and SCHIP Today

Given the recent economic downturn, some members of Congress and advocates for children have raised concerns about the elimination or reduction in benefits under state health care programs. On average, Medicaid expenditures account for approximately 12% of the state funded portion of state budgets. Much of the recent increases in costs have been attributed to pharmaceuticals, nursing home, community-based long-term care services, and payments to managed care plans. However, enrollment increases have also contributed to significant growth in Medicaid costs in the past few years.

Faced with declining revenues and increasing expenses, states proposed or implemented a number of Medicaid cost containment strategies for fiscal years 2003 and 2004.²⁴ The majority of changes have focused on prescription drug costs followed by reductions in provider reimbursement rates, and the elimination or reduction in optional services and populations. Examples of such actions include eliminating coverage for certain adults and non-custodial parents, and eliminating dental, chiropractic, optometry and podiatry services. In addition, many states are delaying or rescinding plans for expansions of services.

Some states are also facing problematic enrollment growth and limited revenues in their SCHIP programs. About one-third of states have either implemented cost

²⁴ National Association of State Budget Officers, *Medicaid and Other State Healthcare Issues: Current Trends*, June, 2003.

containment measures in their SCHIP programs in FY2003 or plan to do so in FY2004. Examples of such activities include eliminating dental care for adults without children (under SCHIP waiver programs), reducing payments for providers, capping enrollment and increasing beneficiary cost-sharing requirements. In some states, cost containment activities under Medicaid, such as reducing pharmacy reimbursement rates and increasing prior authorization for pharmaceuticals, carry over to SCHIP.

Detailed state-level information on explicit plans to reduce benefits for children under either program is not available. While the cost containment strategies summarized above appear to leave mental health and substance abuse benefits for children largely intact, these actions may still effectively reduce access to such care in the near term.

Mental Health Parity

Finally, what about mental health parity?²⁵ While the CRS-sponsored surveys described in this report do not address this question, mental health parity is a leading policy issue for the mental health community and providers, as well as lawmakers.

In 1996, Congress enacted the Mental Health Parity Act (MHPA), which established new federal standards for mental health coverage offered by group health plans. The MHPA, however, is limited in scope and does not compel group plans to offer full-parity mental health coverage. It requires group plans that choose to provide mental health benefits to adopt the same annual and lifetime dollar limits on their coverage of mental and physical illnesses. Group plans may still impose more restrictive treatment limitations and cost sharing requirements on their mental health coverage. MHPA specifically excludes treatment of substance abuse and chemical dependency from the definition of mental health benefits.

Both Medicaid managed care plans and SCHIP programs must comply with the MHPA. Specifically, all prepaid Medicaid managed care contracts that cover medical/surgical benefits and mental health benefits must comply with MHPA without exemptions. The MHPA does not apply to fee-for-service arrangements because state Medicaid agencies do not meet the definition of a group health plan.²⁶ In separate SCHIP programs, to the extent that a health insurance issuer offers group health insurance coverage, which can include, but is not limited to managed care, the MHPA applies.

Congress has reauthorized the MHPA through December 31, 2004. Lawmakers introduced full-parity legislation in the 107th Congress, but it failed to pass. The legislation, which has been reintroduced in the 108th Congress (S. 486/H.R. 953), would expand the MHPA by requiring group health plans to impose the same treatment limitations and financial requirements on their mental health coverage as

²⁵ For a detailed discussion of this issue, see CRS Report RL31657, *Mental Health Parity*, by (name redacted).

²⁶ Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services), letter to State Medicaid Directors on mental health parity, Jan. 20, 1998.

they do on their medical and surgical coverage. The bills are strongly supported by advocates for the mentally ill and have broad, bipartisan support in Congress. Employers and health insurance organizations oppose full-parity legislation because of concerns that it will drive up costs. As with the MHPA, both Medicaid managed care plans and SCHIP programs would have to comply with the full-parity provisions in S. 486/H.R. 953.

Appendix A. Specified Limits and/or Monitoring of Inpatient Mental Health Services for Children Under Medicaid and SCHIP

(as of June, 2000)

Programs	Medicaid				Programs	SCHIP			
	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits		Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service or condition limits
AK	CN only	x			AK	N/A			
AL	CN only		> age 1 yr, 16 days per CY	No limits < age 1 yr	AL				Varies by MCO
AR	CN+MN	Unlimited			AR	N/A			
AZ	CN only			Varies by MCO; no FFS	AZ			30 days/yr combined for MH and SA treatment	
CA	CN+MN	Unlimited			CA-A		30 days		Varies by MCO
					CA-B		10 days		Varies by MCO
CO	CN only	x			CO		45 days		
CT	CN+MN			Assessment (no PA) then treatment follows plan of care	CT-A			specific conditions have max 60 days exchangeable with alternative levels of care	
					CT-B	Not Covered			

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	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service or condition limits
					CT-C	Not Covered			
DC	CN+MN	Unlimited			DC	N/A			
DE	CN only		30 days	Covered in MC only	DE		30 days		Covered in MC only
FL	CN+MN	x			FL-A			30 days or 20/10 split with residential care	
					FL-B	Unlimited			
					FL-C	Unlimited			
GA	CN+MN	x (non-emerg)			GA				30 days per admit only for short-term acute care in general hospital
HI	CN+MN	x	30 days per year		HI	N/A			
IA	CN+MN	Unlimited			IA		60 days per year		Varies by MCO
ID	CN only	x			ID	N/A			
IL	CN+MN	Unlimited			IL	Unlimited			
IN	CN only	x			IN				No coverage for IMDs with > 16 beds

CRS-27

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service or condition limits
KS	CN+MN	Unlimited			KS				Varies by MCO
KY	CN+MN	x			KY	x			
LA	CN+MN	x			LA	N/A			
MA	CN+MN	Unlimited			MA-A	Unlimited			
					MA-B				unlimited-general hospital; 60 days per yr-psych hospital; varies by MCO
					MA-C	Unlimited			
MD	CN+MN	x (non-emerg. admits)			MD	N/A			
ME	CN+MN	Unlimited			ME	Unlimited			
MI	CN+MN		30 days per admit		MI	Unlimited			
MN	CN+MN	x			MN	N/A			
MO	CN only	Unlimited			MO	N/A			
MS	CN only	x	45 days per admit		MS	Not Reported			

CRS-28

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service or condition limits
MT	CN+MN	x			MT			21 days/yr combined for MH and SA treatment; can exchange one IP day for two partial hosp. days	no IP limits for children with severe emotional disturbances under MH PHP
NC	CN+MN	x			NC	x			
ND	CN+MN	x			ND	x	60 days per benefit period; 45 may be used for psychiatric services		
NE	CN+MN	x		prior EPSDT screen required	NE	N/A			
NH	CN+MN	x		payments limited to medically necessary days	NH		15 days per CY		
NJ	CN+MN	Unlimited			NJ-A				Unlimited in general; varies by MCO
					NJ-B		35 days/yr		Varies by MCO

CRS-29

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service or condition limits
NM	CN only	x (FFS admits)			NM	N/A			
NV	CN only	x			NV				Unlimited in general; varies by MCO
NY	CN+MN	Unlimited			NY			30 days/yr combined for IP MH, RTC and IP SA treatment	
OH	CN only	Unlimited			OH	N/A			
OK	CN+MN	x			OK	N/A			
OR	CN only	Unlimited			OR	Unlimited			
PA	CN+MN	Unlimited			PA			90 days/yr combined for IP MH and acute care IP	
RI	CN+MN	x			RI	N/A			
SC	CN only	x			SC	N/A			
SD	CN only	x (non-emerg. admits)			SD	N/A			
TN	CN+MN	varies by MCO		No FFS	TN	N/A			

CRS-30

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service or condition limits
TX	CN+MN	Unlimited			TX			45 days/yr; includes ICF/MR services	
UT	CN+MN	Unlimited			UT			30 days/yr combined for IP and OP MH, RTC and SA treatment	
VA	CN+MN	x			VA	Unlimited			
VT	CN+MN	x (after 14 days; PA for all out-of-state admits)			VT	x (after 14 days; PA for all out-of-state admits)			
WA	CN+MN	Unlimited			WA	Unlimited			
WI	CN+MN	Unlimited			WI	N/A			
WV	CN+MN	x			WV			60 visits including partial hosp and day treatment programs	
WY	CN only	x			WY	x			

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

Note: See Appendix F for definition of abbreviations used here.

Appendix B. Specified Limits and/or Monitoring of Outpatient Mental Health Services for Children Under Medicaid and SCHIP

(as of June, 2000)

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
AK	CN only	x (treatment plan)		All services must be in care plan	AK	N/A			
AL	CN only		3-4 hrs per day; 260 hrs per year		AL		20 visits per year		
AR	CN+MN		\$2,500 per year		AR	N/A			
AZ	CN only			Varies by MCO; no FFS	AZ				30 days per year for MH and SA treatment
CA	CN+MN	Unlimited			CA-A		20 visits per year	Varies by MCO	
					CA-B			Varies by MCO	
CO	CN only			Regional MH/SA PHP decides medical necessity	CO		20 visits	neurobiological illnesses not subject to this limit	

CRS-32

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
CT	CN+MN			Assessment (no PA); then services as defined in care plan	CT-A	Not Reported			
					CT-B	Not Covered			
					CT-C	Not Reported			
DC	CN+MN	x			DC	N/A			
DE	CN only		30 units	covered in MC only	DE		30 units	covered in MC only	
FL	CN+MN			Varies by service type	FL-A		40 visits per year		
					FL-B	Unlimited			
					FL-C	Unlimited			
GA	CN+MN		24 hours per year		GA			psychologist - 24 hrs; psychiatrist - 12 hrs	
HI	CN+MN	x	24 visits per year		HI	N/A			
IA	CN+MN			Statewide BHO	IA		20 visits per year	Varies by MCO	
ID	CN only		12 hours per year		ID	N/A			
IL	CN+MN	Unlimited			IL	Unlimited			

CRS-33

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
IN	CN only	x (services exceeding 20 units per year)			IN	x (after 30 visits per year)	50 visits per year		
KS	CN+MN	Unlimited			KS			Varies by MCO	
KY	CN+MN	Unlimited			KY	Unlimited			
LA	CN+MN	Unlimited			LA	N/A			
MA	CN+MN			BHO	MA-A	Unlimited			
					MA-B		20 visits or \$500 per year	Varies by MCO	
					MA-C	Unlimited			
MD	CN+MN	Unlimited			MD	N/A			
ME	CN+MN		2 hours therapy per week (unless emerg)		ME		2 hours therapy per week (unless emerg)		
MI	CN+MN	Unlimited			MI	Unlimited			
MN	CN+MN		160 hours per year		MN	N/A			
MO	CN only	Unlimited			MO	N/A			

CRS-34

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
MS	CN only			med eval 144 units per year; individual therapy 144 units per year; family therapy 96 units per year; group therapy 160 units per year (unit = 15 mins.)	MS	Not Reported			
MT	CN+MN	x			MT			No IP limit for children with severe emotional disturbances in MH PHP	21 days per year for all MH and SA treatment
NC	CN+MN		26 visits per year without PA	No limits if mental health center	NC	x (after 26 visits per year)			
ND	CN+MN	Unlimited			ND		30 hrs per benefit period		
NE	CN+MN	x (group therapy)	1 eval per episode	annual eval required; must have EPSDT screen before services given; only services in care plan covered	NE	N/A			

CRS-35

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
NH	CN+MN		\$1,800 per year	12 visits if non-MD provider	NH				20 visits/yr combined for OP MH and OP SA
NJ	CN+MN	x			NJ-A			unlimited in general; varies by MCO	
					NJ-B		20 visits per year	Varies by MCO	
NM	CN only	x			NM	N/A			
NV	CN only			psychologist or psychiatrist only	NV			unlimited in general; varies by MCO	
NY	CN+MN		40 visits per year		NY				60 days/yr for OP MH and OP SA treatment
OH	CN only	Unlimited			OH	N/A			
OK	CN+MN	x (evals after 1 st and treatment)		1 st eval (no PA)	OK	N/A			
OR	CN+MN	Unlimited			OR	Unlimited			
PA	CN+MN	Unlimited			PA		50 visits per year		

CRS-36

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
RI	CN+MN	Unlimited			RI	N/A			
SC	CN only	Unlimited			SC	N/A			
SD	CN only		40 hours per year		SD	N/A			
TN	CN+MN	Varies by MCO		No FFS	TN	N/A			
TX	CN+MN		30 visits		TX			60 visits per year for crisis; 60 days per year per diagnosis for rehab	
UT	CN+MN	Unlimited			UT				30 days/yr for IP and OP MH, RTC and SA treatment
VA	CN+MN		26 visits per year (no PA)		VA		26 visits (no PA)		
VT	CN+MN		\$500 before authorization needed		VT		\$500 before authorization needed		

CRS-37

		Medicaid					SCHIP		
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider or service type limits	Programs	Requires PA or other review	General quantity limits	Provider, service or condition limits	Limits combined with other benefit(s)
WA	CN+MN	Unlimited			WA		Can self-refer to Regional Support Networks (paid FFS) or obtain 12 hrs/yr in plan	Psyc testing as needed if problem identified by EPSDT screen; no limits on med management	
WI	CN+MN		15 hours or \$500		WI	N/A			
WV	CN+MN	Unlimited			WV				60 visits including day programs
WY	CN only			community MH centers only	WY	Unlimited			

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

Note: See Appendix F for definition of abbreviations used here.

Appendix C. Specified Limits and/or Monitoring of Inpatient Detoxification Services for Children Under Medicaid and SCHIP

(as of June, 2000)

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, Service, or Condition Limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
AK	CN only	x			AK	N/A			
AL	CN only			No limits < age 1 yr; > age 1 yr, 16 days/yr counted against 16 days/yr IP limit	AL		3 days per episode; 20 days per year		
AR	Not Covered				AR	N/A			
AZ	CN only			Varies by MCO; no FFS	AZ			30 days/yr combined for MH and SA treatment	acute care only
CA	CN+MN	Unlimited			CA-A				Varies by MCO
					CA-B				Varies by MCO
CO	CN only		40 days		CO		3 days		medical detox only
CT	CN+MN	Unlimited			CT-A				MH parity
					CT-B	Not Covered			

CRS-39

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, Service, or Condition Limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
					CT-C	Not Covered			
DC	CN+MN			Covers only removal of toxic matter	DC	N/A			
DE	CN only		30 days	Covered under MC only	DE		30 days		Covered under MC only
FL	CN+MN	x			FL-A		7 days		
					FL-B	Unlimited			
					FL-C	Unlimited			
GA	Not Covered				GA				short-term, acute care only
HI	CN+MN	x (non-emerge. admits)	10 days per admit; 30 days per year		HI	N/A			
IA	CN+MN	Unlimited			IA			\$9,000 per year; \$39,000 per lifetime for both IP and OP care	Varies by MCO
ID	Not Covered				ID	N/A			
IL	CN+MN	Unlimited			IL	Unlimited			

CRS-40

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, Service, or Condition Limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
IN	CN only	x			IN				excludes IMDs > 16 beds
KS	CN+MN	Unlimited			KS				Varies by MCO
KY	CN+MN	x			KY				Acute phase of medical detox only
LA	Not Covered				LA	N/A			
MA	CN+MN			BHO	MA-A	Unlimited			
					MA-B				unlimited in general; varies by MCO
					MA-C	Unlimited			
MD	CN+MN	x (non-emerg. admits)			MD	N/A			
ME	CN+MN	Unlimited			ME	Unlimited			
MI	CN+MN	Unlimited			MI	Unlimited			
MN	CN+MN	x			MN	N/A			
MO	CN only	x (for 4+ days)	3 days		MO	N/A			
MS	Not Covered				MS	Not Reported			

CRS-41

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, Service, or Condition Limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
MT	CN+MN	x (for 5+ days)	4 days		MT	Unlimited			
NC	CN+MN	x		only in general hospital	NC	x			
ND	CN+MN	x			ND		5 days per admit; counted against IP limit		
NE	CN+MN	x (stays longer than 5 days)			NE	N/A			
NH	Not Covered				NH	Unlimited			
NJ	CN+MN	Unlimited			NJ-A				Unlimited in general; varies by MCO
					NJ-B				Varies by MCO
NM	CN only	x (FFS admits)			NM	N/A			
NV	CN only	x			NV				Unlimited in general; varies by MCO

CRS-42

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, Service, or Condition Limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
NY	CN+MN	Unlimited			NY	Not Reported			
OH	CN only	Unlimited			OH	N/A			
OK	CN+MN	Unlimited			OK	N/A			
OR	CN only	Unlimited			OR	Unlimited			
PA	CN+MN	Unlimited			PA		7 days per admit; 4 admits per lifetime		
RI	CN+MN	x			RI	N/A			
SC	CN only	x			SC	N/A			
SD	CN only	x (non-emerg. admits)			SD	N/A			
TN	CN+MN	varies by MCO		No FFS	TN	N/A			
TX	Not Covered				TX			14 days per year for detox and crisis stabilization	
UT	CN+MN		3 days per episode		UT			30 days per year combined for IP detox, plus IP and OP MH, RTC and SA treatment	

CRS-43

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, Service, or Condition Limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
VA	CN+MN	x			VA				for pregnant women, 1 course of treatment per lifetime
VT	CN+MN	x (after 14 days)			VT	x (after 14 days)			
WA	Not Covered				WA	Not Covered			
WI	CN+MN	Unlimited			WI	N/A			
WV	CN+MN	x			WV	x			
WY	CN only	x			WY	Not Covered			

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

Note: See Appendix F for definition of abbreviations used here.

Appendix D. Specified Limits and/or Monitoring of Outpatient Substance Abuse Services for Children Under Medicaid and SCHIP

(as of June, 2000)

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
AK	CN only	x (treatment plan)		All services must be in care plan; extend if medically necessary	AK	N/A			
AL	CN only		6 hours per day; 1,040 hours per year		AL		20 visits per year		
AR	Not Covered				AR	N/A			
AZ	CN only			varies by MCO; no FFS	AZ				30 days per year for MH and SA treatment
CA	CN+MN	Unlimited			CA-A		20 visits per year	Varies by MCO	
					CA-B			Varies by MCO	
CO	Not Covered				CO		20 visits		

CRS-45

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
CT	CN+MN			Assessment (no PA); services as specified in care plan	CT-A	Not Reported			
					CT-B	Not Covered			
					CT-C	Not Reported			
DC	CN+MN	x			DC	N/A			
DE	CN only		30 units	covered in MC only	DE		30 units	covered in MC only	
FL	CN+MN			depends on specific type of service	FL-A		40 visits per year		
					FL-B	Unlimited			
					FL-C	Unlimited			
GA	CN+MN	x			GA			Some services covered; some limits	
HI	CN+MN	x	24 visits per year		HI	N/A			
IA	CN+MN			statewide BHO	IA			\$1,500 for treatment; \$2,500 for counseling; varies by MCO	\$39,000 lifetime limit for IP and OP services

CRS-46

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
ID	Not Covered				ID	N/A			
IL	CN+MN	Unlimited			IL	Unlimited			
IN	CN only	Unlimited			IN	x (after 30 visits per year)	50 visits per year		
KS	CN+MN	Unlimited			KS			Varies by MCO	
KY	CN+MN	x		only for pregnant women and those with concurrent MH disorder	KY			only for those with concurrent MH disorder	
LA	CN+MN	Unlimited			LA	N/A			
MA	CN+MN			BHO	MA-A	Unlimited			
					MA-B		20 visits or \$500 per year	Varies by MCO	
					MA-C	Unlimited			
MD	CN+MN	Unlimited			MD	N/A			
ME	CN+MN		three hours therapy per week		ME		three hours per week		
MI	CN+MN	Unlimited			MI	Unlimited			

CRS-47

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
MN	CN+MN			covered only through special fund	MN	N/A			
MO	CN only	Unlimited			MO	N/A			
MS	CN only	Unlimited			MS	Not Reported			
MT	CN+MN	Unlimited			MT				21 days per year for MH and SA services
NC	CN+MN	x			NC	x (after 26 visits/yr)			
ND	CN+MN	Unlimited			ND		20 visits per benefit period		
NE	CN+MN	x (group therapy)	1 eval per episode	annual eval required; must have EPSDT screen before services given; only services in care plan covered	NE	N/A			

CRS-48

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
NH	CN+MN		\$1,800 per year	12 visits if non-MD provider	NH				20 visits/yr combined for OP MH and OP SA treatment
NJ	CN+MN	x			NJ-A			Unlimited in general; varies by MCO	
					NJ-B			rehab not covered; varies by MCO	
NM	CN only	x			NM	N/A			
NV	CN only			psychologist or psychiatrist only	NV			Unlimited in general; varies by MCO	
NY	CN+MN		40 visits per year		NY				60 days/yr for OP MH and OP SA services
OH	CN only	Unlimited			OH	N/A			
OK	CN+MN	x (evals after first and treatment)		first eval (no PA)	OK	N/A			

CRS-49

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
OR	CN+MN	Unlimited			OR	Unlimited			
PA	CN+MN	Unlimited			PA			30 full visits or equal partial visits per year; 120 days lifetime limit	
RI	CN+MN	Unlimited			RI	N/A			
SC	CN only	x			SC	N/A			
SD	Not Covered				SD	N/A			
TN	CN+MN	Varies by MCO		No FFS	TN	N/A			
TX	Not Covered				TX			12 weeks per episode for intensive OP prog; OP services up to 6 months per episode	
UT	CN+MN	Unlimited			UT				30 days/yr for IP and OP MH, RTC and SA services

CRS-50

	Medicaid					SCHIP			
Programs	Covered groups	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Limits combined with other benefit(s)
VA	Not Covered				VA		26 visits (no PA)		
VT	CN+MN		90 hours per episode		VT		90 hours per episode		
WA	CN+MN	Unlimited			WA	Unlimited			
WI	CN+MN		15 hours or \$500		WI	N/A			
WV	CN+MN	Unlimited			WV	x (after 26 visits)	26 visits per year		
WY	CN only			community MH centers only	WY	Unlimited			

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

Note: See Appendix F for definition of abbreviations used here.

Appendix E. Specified Limits and/or Monitoring of Residential Treatment Center Services for Children Under Medicaid and SCHIP

(as of June, 2000)

	Medicaid					SCHIP			
Programs	Groups covered	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
AK	CN only	x			AK	N/A			
AL	Not Covered				AL				varies by MCO
AR	CN+MN	Unlimited			AR	N/A			
AZ	CN only			varies by MCO; no FFS	AZ	Not Covered			
CA	CN+MN	Unlimited			CA-A	Not Covered			
					CA-B	Not Covered			
CO	CN only	x		no limits - foster care only	CO	Not Covered			
CT	CN+MN			Assessment (no PA); treatment follows approved plan of care	CT-A	Not Covered			
					CT-B	Not Covered			
					CT-C	Not Covered			
DC	CN+MN	Not Reported			DC	N/A			

CRS-52

	Medicaid					SCHIP			
Programs	Groups covered	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
DE	CN only		30 days	covered in managed care only	DE		30 days		covered in managed care only
FL	Not Covered				FL-A			30 days RTS (SA) or 20 days RTS and 10 days behavioral	
					FL-B	Not Covered			
					FL-C	Not Covered			
GA	CN+MN	x			GA				short-term, acute care only
HI	Not Covered				HI	N/A			
IA	Not Covered				IA	Not Covered			
ID	Not Covered				ID	N/A			
IL	CN+MN	Unlimited			IL	Unlimited			
IN	Not Covered				IN	Not Covered			
KS	CN+MN	Unlimited			KS				varies by MCO
KY	CN+MN	x			KY	x			
LA	Not Covered				LA	N/A			

CRS-53

	Medicaid					SCHIP			
Programs	Groups covered	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
MA	CN+MN			BHO	MA-A	Not Covered			
					MA-B	Not Covered			
					MA-C	Not Covered			
MD	CN+MN	Unlimited		MD	N/A				
ME	CN+MN	Unlimited		ME	Unlimited				
MI	CN+MN		30 days per admit		MI	Unlimited			
MN	CN+MN	x			MN	N/A			
MO	CN only			Treatment only; room and board not covered	MO	N/A			
MS	CN only	x	40 days per admit		MS	Not Reported			
MT	CN+MN	x			MT			21 days per year for MH and SA; can exchange one IP day for two partial hosp. days	No IP limits for children with certain MH diagnoses
NC	CN+MN	x			NC	x			

CRS-54

	Medicaid					SCHIP			
Programs	Groups covered	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
ND	CN+MN	x			ND	x	120 days per benefit period		
NE	CN+MN	x			NE	N/A			
NH	Not Covered				NH	Not Covered			
NJ	CN+MN	Unlimited			NJ-A				unlimited in general; varies by MCO
					NJ-B	Not Covered			
NM	CN only	x (FFS admits)			NM	N/A			
NV	CN only	x			NV	x			
NY	CN+MN	Unlimited			NY			30 days/year combined for IP MH, RTC and IP SA treatment	
OH	Not Covered				OH	N/A			
OK	CN+MN	x			OK	N/A			
OR	CN only	Unlimited			OR	Unlimited			
PA	CN+MN	Unlimited			PA		30 days per year; 90 days lifetime limit		
RI	CN+MN	x			RI	N/A			

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	Medicaid					SCHIP			
Programs	Groups covered	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
SC	CN only	x			SC	N/A			
SD	CN only	x (non-emergency admits)			SD	N/A			
TN	CN+MN	x (varies by MCO)		No FFS	TN	N/A			
TX	Not Covered				TX			25 days per year counted against 45 available for IP MH and ICF/MR	
UT	Not Covered				UT			30 days per year for IP and OP MH, RTC, and SA services	
VA	CN+MN	x			VA				Pregnant women only
VT	CN+MN		21 days per episode; two admits and 30 days per year		VT		21 days per episode; two admits and 30 days per year		
WA	CN+MN	Unlimited			WA	Not Covered			
WI	Not Covered				WI	N/A			

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	Medicaid					SCHIP			
Programs	Groups covered	Requires PA or other review	General quantity limits	Provider, service, or condition limits	Programs	Requires PA or other review	General quantity limits	Limits combined with other benefit(s)	Provider, service, or condition limits
WV	CN+MN	x			WV	x			
WY	Not Covered				WY	Not Covered			

Source: Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

Note: See Appendix F for definition of abbreviations used here.

Appendix F. Notes and Abbreviations Used in Appendix A Through E

Notes: In the two “Programs” columns (one for Medicaid and one for SCHIP), state abbreviations are used. For SCHIP, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had two or three such programs with different benefit plans. In this case, an A, B, or C extension was added to the state abbreviation (e.g., CT-A, CT-B, CT-C) to distinguish multiple programs as needed.

In the “Covered groups” column for Medicaid, “CN only” means this benefit is covered for categorically needy beneficiaries only, and “CN+MN” means this benefit is covered for both categorically needy and medically needy beneficiaries.

Under the SCHIP columns, N/A means that the state had no separate SCHIP program at the time of the survey, and thus, coverage of this benefit is not applicable.

Definition of other terms (in alphabetical order):

BHO — behavioral health organization (also see PHP below)

CY — calendar year

day treatment — see partial hosp (below)

eval — evaluation

FFS — fee-for-service

ICF/MR — intermediate care facilities for the mentally retarded

IMDs — institutions for mental disease

IP — inpatient

MC — managed care

MCO — managed care organization

MD — physician

med eval — medical evaluation

med management — medication management (e.g., monitoring use of prescribed drugs to treat mental illness or substance abuse)

MH — mental health

OP — outpatient

PA — prior authorization

partial hosp — also called day treatment or partial care; is a structured environment for youth during the day that does not involve an overnight stay; may include an integrated curriculum that includes education, counseling and family interventions; setting of care may be a hospital, school or clinic; may be a transitional service after inpatient psychiatric or RTC care for youth who no longer require institutionalization but who are not ready to be placed back in the school system due to on-going needs for extensive treatment and supervision.

PHP — prepaid health plan; typically these are managed care plans that provide less than a comprehensive set of benefits (such as behavioral health services that may include only mental health care or mental health and substance abuse services only)

RTC — residential treatment centers (facilities)

SA — substance abuse

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