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SCHIP POLICY STUDIES PROJECT

Issue Brief

Policy Brief #5:

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Executive Summary

This Policy Brief[1] examines behavioral health managed care contracting under separately administered State Children's Health Insurance Programs[2] (SCHIP), i.e., programs that operate under the direct authority of Title XXI of the Social Security Act rather than as expansions of Medicaid. Most separate SCHIP programs buy managed care style health insurance for some or most of their enrolled children. Because Title XXI provides states with far greater administrative flexibility than Medicaid with respect to coverage and

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[1] The Center for Health Services Research and Policy gratefully acknowledges the David and Lucile Packard Foundation for its ongoing support of the managed care studies program. Additional support for this study came from a cooperative agreement from the Health Resources and Services Administration (HRSA) [R40 MC00165-03] as part of the Children's Health Insurance Research Initiative (CHIRI), which is co-funded by the Agency for Healthcare Research and Quality (AHRQ), the David and Lucile Packard Foundation and HRSA.
[2] Title XXI of the Social Security Act, 42 U.S.C. §1397aa et. seq., 42 C.F.R. §457 et. seq.

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benefit design, provision of services, and administration of managed care arrangements, studying separate SCHIP managed care products sheds important light on how states might approach insurance and managed care design generally in the area of behavioral health were Medicaid modified through §1115 demonstration or federal statutory authority to permit greater latitude.

To conduct this analysis, two nationwide databases maintained by the George Washington University Center for Health Services Research and Policy (CHSRP) were used: a database consisting of all Medicaid MCO-style managed care contracts in use in Calendar Year 2000; and a nationwide database consisting of contracts used by separate SCHIP programs for the same calendar year. As of the point of collection in 2000 there were 33 such separate programs; according to CMS' latest website information, that total has now reached 35. Both sets of contracts were analyzed and separated into their components by lawyers experienced in managed care contract analysis and interpretation. The data were entered into working tables that organize the contents of the contracts into a series of searchable domains.

In the case of SCHIP contracts, we were able to identify two subgroups of documents. The first consists of what we term "freestanding SCHIP MCO contracts," that is, contracts that are wholly independent of the Medicaid contract and stand on their own as legal instruments. The second subgroup consists of "modified Medicaid contracts," that is, contracts in which the SCHIP agency uses the Medicaid agreement as its contractual platform and incorporates an addendum that enumerates the special rules of coverage under the separate SCHIP program. By classifying contracts in this fashion, we were able to ascertain those states that use a contract identical to Medicaid with the exception of services or benefits, as well as those states that write wholly independent contracts. This classification system allows us to separately report on the two types of legal documents, as well as to compare the documents in states that use both a Medicaid contract and a freestanding contract.[3]

Of the 27 separate SCHIP programs reporting any managed care services in 2000, 15 purchased services from managed care organizations using freestanding contract instruments, while 12 used a modified Medicaid contract. There is no particular size or geographic pattern associated with these contracting practices. Both large and small states use freestanding contracts, although all of the states that had precursor programs to SCHIP (Florida, Pennsylvania, and New York) use freestanding contracts.

Among the 15 states that use freestanding agreements:

[3] See also, Sara Rosenbaum, Karen Shaw, and Colleen Sonosky. December 2001. "SCHIP Policy Brief #3: Managed Care Purchasing under SCHIP: A Nationwide Analysis of Freestanding SCHIP Contracts." Available at: http://www.gwhealthpolicy.org/chiri.htm.

- Three explicitly require contractors to assess children for physical and mental development;

- Nine specify that contractors must adhere to the Guidelines for Health Supervision developed by the American Academy of Pediatrics, which recommend assessment of physical and mental growth and development;

- Fourteen cover some form of treatment of mental illness and addiction disorders as a class of benefits;

- Certain services for children with special physical health care needs (defined by researchers as including speech therapy, physical therapy, rehabilitation therapy and durable medical equipment) are commonly used services in the case of children with significant limitations in physical activities, however only four contracts include them as specified services;

- Every state that covers any level of behavioral disorders as a contractual benefit applies limitations and exclusions that would not be permissible in the Medicaid program:

    - 14 include coverage of behavioral health as a contractual service; Michigan offers extra-contractual coverage up to unspecified coverage limitations;

    - Of the 14 contracts that identify behavioral services as a covered benefit, 13 impose limits on inpatient days and outpatient services for either mental illness or substance abuse treatment or both forms of treatment. In several states the limitation on outpatient care is as low as 20 visits;

    - Seven states offer conversion benefits (this permits exchanging inpatient days for increased outpatient visits) which would broaden non-inpatient services, in some cases significantly. However, not all states with limits on outpatient care permit conversion of inpatient services; furthermore, conversion obviously poses some level of risk in relation to the need for inpatient care. Iowa, New York, and Pennsylvania include mental health and substance abuse services within their overall limits for inpatient and outpatient care, which includes physical health care services. Colorado and Kansas impose no limits for treatment of mental health conditions of "neurobiological" or "biological" origin, although the terms are not defined in the contracts. Inpatient substance abuse services are not covered in Colorado and Virginia.

The findings from these contracts indicate that transition between programs has received little attention at the contractual level. In none of these 15 states is provider participation in both programs a condition for participation in either program; even more surprising

perhaps, none of the contracts requires that a contractor grant network status to a provider participating in either program who is treating a child with mental illness and who has strong continuity needs under care. This would be a relatively simple means of ensuring at least continuity in the actual provision of care, but does not appear to be a feature of the contracts. Indeed, in only one case has the state required transfer of records and patient information between the contractors.

Two important questions flow from this study. First, is there anything about SCHIP children that would justify lesser coverage of mental illness in the case of near-poor children than the level that is available in the case of children on Medicaid? Second, what happens to children whose needs exceed the limitations or whose chronic conditions place them entirely outside the contract?

Finally, reviewing these states is important because it sheds light on where they might proceed under a Medicaid program modified through a §1115 demonstration waiver. The findings suggest that treatment for mental illness and addiction disorders may be significantly affected by such modification efforts, and that a great deal of further work is needed to determine how much unmet need would flow from such a move, how families, health providers and state agencies would accommodate to such a change, and what alternatives to fixed treatment limits and exclusions might be available.

Introduction

This Policy Brief examines behavioral health managed care contracting under separately administered State Children's Health Insurance Programs[4] (SCHIP), i.e., programs that operate under the direct authority of Title XXI of the Social Security Act rather than as expansions of Medicaid. Most separate SCHIP programs buy managed care style health insurance for some or most of their enrolled children. Because Title XXI provides states with far greater administrative flexibility than Medicaid with respect to coverage and benefit design, provision of services, and administration of managed care arrangements, studying separate SCHIP managed care products sheds important light on how states might approach insurance and managed care design generally in the area of behavioral health were Medicaid modified through §1115 demonstration or federal statutory authority to permit greater latitude.

Following an overview of SCHIP, we present our findings and conclusions.

Overview

SCHIP provides allotments to states with approved plans to support the cost of furnishing "child health assistance" to eligible uninsured low-income children. In administering their

[4] Title XXI of the Social Security Act., 42 U.S.C. §1397aa et. seq.

programs, states have two basic choices. A participating state can elect to administer SCHIP as a Medicaid expansion under Title XIX of the Social Security Act, in which case all Title XIX eligibility, benefit and coverage, and administrative requirements apply[5]. States receive an enhanced federal contribution rate in the case of children whose Medicaid enrollment is underwritten by the federal SCHIP allotment.

Alternatively, a state can elect to administer its SCHIP plan separately from Medicaid and directly under Title XXI, in which case the eligibility, benefit and coverage, and administration requirements of Title XXI apply. [6]

As of Calendar Year 2001, data from the Centers for Medicare & Medicaid Services (CMS) indicate that most states have elected to combine the two approaches, expanding Medicaid coverage for some children (e.g., covering all children under age 19 with family incomes at or below 133% of the federal poverty level), and adding a separate program for near-poor low-income children.[7] It is these separate programs that take on a special interest and that are the focus of this study, because of the design flexibility accorded states under Title XXI.

Medicaid and SCHIP Compared

Figure 1 below displays the most important differences between Medicaid and SCHIP. Unlike SCHIP, Medicaid is an individual federal legal entitlement that guarantees a federally defined set of preventive, diagnostic and treatment benefits to all children eligible under the state plan. In the case of children under 21, the Medicaid Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit requires coverage of federally recognized categories of medical care and services, which must be furnished with reasonable promptness.[8] The Medicaid statute prohibits virtually all cost-sharing, except under § 1115 Health Insurance Flexibility and Accountability (HIFA) waivers.[9]

Figure 1
Key Elements of Federal Medicaid and SCHIP Requirements Related to Coverage and Treatment of Behavioral Health Conditions

Element	Medicaid	SCHIP
Entitlement status of assistance	• individual legal entitlement: eligible children must be enrolled and assisted	• not an individual legal entitlement: not all eligible children need be enrolled and assisted
Federal financial assistance	• open-ended federal/state entitlement	• aggregate annual allotment; state entitlement up to the aggregate
Prompt assistance	• medical assistance must be furnished promptly	• no comparable provision

[5] 42 C.F.R. §§457.10, 457.300(c).
[6] 42 C.F.R. §457.300.
[7] Centers for Medicare & Medicaid Services. Available at: http://www.cms.gov/schip.
[8] 1902(a)(8) of Social Security Act; 42 U.S.C. §1396a(a)(8); 42 C.F.R. §435.930(a).
[9] See http://cms.hhs.gov/hifa/default.asp.

Element	Medicaid	SCHIP
Coverage standards, behavioral health	• assessment of mental health status • medically necessary diagnostic and treatment services for mental health and substance abuse disorders	• "well child" care; no specific mental health status assessment requirement • mental health and substance abuse services as "additional" benefits that must be funded to an actuarial benchmark, broader coverage at state option
Medical necessity and coverage limitations and exclusions	• preventive standard of coverage linked to growth and development • prohibition against discrimination in the provision of required services on the basis of condition (e.g., prohibition on use of "recovery" standard that would limit coverage to conditions from which the patient can 'recover") • prohibition against exclusions when medical need for care is determined by a separate agency	• no comparable provision • no comparable provision; Parity Act limit on annual and lifetime dollar differentials applies • no comparable provision
Cost sharing	• prohibited in the case of nearly all children, except under HIFA waivers	• permitted up to statutory maximums

The Medicaid benefit package for children is unparalleled in public and private insurance law.[10] The care and services to which children are entitled include assessment of "both physical and mental health development" as well as necessary diagnostic and treatment services. Services cannot be excluded simply because their medical need is the result of an evaluation conducted by an educational or child welfare program. Furthermore, in the case of children, Medicaid principles related to the EPSDT benefit provide a unique standard of medical necessity, under which coverage is considered necessary not merely if treatment is needed for a diagnosed illness or condition, but if it is necessary to address matters of growth and development. Moreover, Medicaid's prohibition against discrimination in the provision of required services means that agencies cannot deny coverage because recovery or "significant progress" toward restoration of full functioning is not possible; necessary care that maintains functioning or avoids deterioration would be equal candidates for coverage.

SCHIP was enacted as a mechanism for affording states a structural alternative to Medicaid's extensive coverage and eligibility requirements, which were viewed as a

[10] Sara Rosenbaum and Colleen Sonosky. December 2000. "Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts." Available at http://www.gwhealthpolicy.org/medicaid_publications_epsdt.htm.

disincentive to expansion.[11] As a result, SCHIP, while nominally a program to provide health coverage to low-income children, is fundamentally different. Rather than being an individual legal entitlement, it is a discretionary premium subsidy for low-income uninsured children; however, participating states with approved plans are legally entitled to their allotments. Because SCHIP is not an individual legal entitlement, not all eligible children may receive assistance; for example, a state that is close to exhausting its allotment for a given year may cease enrollment of new children. Only 9 of 33 states with separate SCHIP programs as of 2000 had enacted enabling legislation that could be reasonably interpreted as creating even a limited legal entitlement to assistance.[12]

Unlike Medicaid, SCHIP consists of annual aggregate grants to states and as such, its requirements are considerably relaxed. SCHIP contains no "reasonable promptness" test and permits cost-sharing in all forms (i.e., premiums, deductibles and coinsurance), subject to certain upper limits related to family income.[13] SCHIP contains only limited coverage requirements, both generally and with respect to behavioral health treatment. Under Title XXI, states must offer health coverage that is equivalent to "the benefits coverage in a benchmark package," and are given various options in the selection of a "benchmark."[14] The benefit package must include certain basic services consisting of well-baby and well-child care including immunizations, physicians' and surgical and medical services, emergency services,[15] inpatient and outpatient hospital services, and laboratory and x-ray services.[16] (Assessment of physical and mental health development is not an enumerated component of well-child care as in the case of Medicaid).

The benchmark package also must provide for coverage of certain "additional" services, one of which is behavioral health.[17] Unlike Medicaid however, the sufficiency of this "additional" coverage is measured in terms of actuarial value rather than the depth or structure of specified benefits. In other words, contrary to Medicaid, SCHIP is not a defined benefit statute; instead it authorizes the provision of premium support assistance

[11] Sara Rosenbaum and Colleen Sonosky. 2001. "Medicaid Reforms & SCHIP: Health Care Coverage and the Changing Policy Environment." In: Who Speaks for America's Children? The Role of Child Advocates in Public Policy, Carol DeVita and Rachel Mosher-Williams (eds.) Urban Institute Press. Washington, DC.
[12] Sara Rosenbaum and Barbara Smith. 2001. "SCHIP Policy Brief #1: State SCHIP Design and the Right to Coverage." Available at: http://www.gwhealthpolicy.org/chiri.htm. Under SCHIP, there is no federal legal entitlement to assistance. However, many states provide health coverage for SCHIP-enrolled children through contracts with MCOs. The extent to which state law accords these enrolled children a legal right to enforce these contracts is not known.
[13] Sara Rosenbaum, Anne Markus, and Dylan Roby. 1999. "An Analysis of Implementation Issues Relating to CHIP Cost-Sharing Provisions for Certain Targeted Low-Income Children." Available at http://www.gwhealthpolicy.org/downloads/cs_finalreport_edt.pdf.
[14] 42 U.S.C. §1397cc(a)(1); 42 C.F.R. §457.410.
[15] 42 C.F.R. §457.410(b)(3).
[16] 42 U.S.C. §2103(b); 457 C.F.R. §457.410(b).
[17] 42 U.S.C. §1397cc(a)(2) and (c)(2). Since the "basic service" requirement of Title XXI is expressed in terms of classes of providers rather than condition, a basic service conceivably could encompass treatment for behavioral disorders that falls into one or more of the enumerated basic classes of services. However, Title XXI specifically classifies "mental health services" along with vision care, hearing services, and prescribed drugs, as an "additional" service whose coverage requires only actuarial approximation.

to certain low-income children, with the sufficiency of coverage measured in relation to actuarial value rather through the enumeration of defined benefits. Because mental illness and addiction disorder treatments are additional services, they are bounded by notions of actuarial value measurement rather than specific forms of care.

This statutory structure, along with the limited nature of the federal contribution to state programs, leads to major differences where coverage and treatment are concerned. At their option, states may go beyond basic and additional services and cover virtually all classes of services and benefits that are found in the definition of medical assistance under Title XIX.[18] Our earlier research into state SCHIP plans, as well as that carried out by other researchers, suggests that while many separate SCHIP plans contain enumerated benefit classes that are nearly as broad as Medicaid, in fact, the plans are drafted so vaguely that the existence of limitations on coverage is difficult to discern.[19] An earlier study by CHSRP examining coverage under separate SCHIP plans found that 32 state plans had at least some level of exclusion or limitation on covered medical services, but also concluded that the approved state plans were too broad to permit more detailed analysis of specific coverage limitations and exclusions.[20] Similarly, a study of separate SCHIP programs conducted by the National Academy for State Health Policy reported on classes of behavioral benefits covered but did not contain information on the details of coverage and permissible treatment.[21]

It is logical to believe that SCHIP plans would include many coverage limits. SCHIP was enacted precisely to give states this type of flexibility. Unlike Medicaid, Title XXI does not set the minimum criteria for a pediatric medical necessity standard, nor does it prohibit discrimination against chronic conditions by setting of "recovery" coverage limits. Nothing in the SCHIP statute would require a state to cover care and services identified as medically necessary by any health provider other than a provider authorized to participate in SCHIP.

Because the structure of SCHIP and the discretion it accords state programs administered under Title XXI make ascertaining the coverage limits very difficult, examination of the contracts of insurance coverage that SCHIP agencies negotiate with participating managed care organizations is particularly important. In Medicaid, the full extent of coverage for children is known as a matter of federal law; the only real question is which coverage and treatment duties are assigned to the contractor. In the case of separate SCHIP programs,

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[18] 42 U.S.C. §1397jj(a); 42 C.F.R. §457.402.

[19] See, for example: E. M. Howell, J. A. Buck, and J. Teich. 2000. "Mental Health Benefits Under SCHIP." 19 *Health Affairs* (November/December).

[20] Sara Rosenbaum, Anne Markus, Colleen Sonosky, and Lee Repasch. 2001. "SCHIP Policy Brief #2: State Benefit Design Choices under SCHIP: Implications for Pediatric Health Care." Available at http://www.gwhealthpolicy.org/chiri.htm.

[21] Cynthia Pernice, Kirsten Wysen, Trish Riley and Neva Kaye. 2001. "Charting SCHIP: Report of the Second National Survey of the State Children's Health Insurance Program." National Academy for State Health Policy (NASHP). Portland ME. Table 36.

the contract terms actually take on substantive meaning from the patient's point of view, because there is no coverage beyond what is contracted under the plan.

Methods

To conduct this analysis, two nationwide databases maintained by the George Washington University Center for Health Services Research and Policy (CHSRP) were used: a database consisting of all Medicaid MCO-style managed care contracts in use in Calendar Year 2000; and a nationwide database consisting of contracts used by separate SCHIP programs for the same calendar year. As of the point of collection in 2000 there were 33 such separate programs; according to CMS' latest website information, that total has now reached 35. Both sets of contracts were analyzed and separated into their components by lawyers experienced in managed care contract analysis and interpretation. The data were entered into working tables that organize the contents of the contracts into a series of searchable domains. These two sets of Medicaid and SCHIP tables can be examined and searched electronically at CHSRP's website.[22]

In the case of SCHIP contracts, we were able to identify two subgroups of documents. The first consists of what we term "freestanding SCHIP MCO contracts," that is, contracts that are wholly independent of the Medicaid contract and stand on their own as legal instruments. The second subgroup consists of "modified Medicaid contracts," that is, contracts in which the SCHIP agency uses the Medicaid agreement as its contractual platform and incorporates an addendum that enumerates the special rules of coverage under the separate SCHIP program. By classifying contracts in this fashion, we were able to ascertain those states that use a contract identical to Medicaid with the exception of services or benefits, as well as those states that write wholly independent contracts. This classification system allows us to separately report on the two types of legal documents, as well as to compare the documents in states that use both a Medicaid contract and a freestanding contract.[23]

Findings

Managed care contracting practices in separate SCHIP Programs

Table 1 below shows that of the 27 separate SCHIP programs reporting any managed care services in 2000, 15 purchased services from managed care organizations using freestanding contract instruments, while 12 used a modified Medicaid contract. Figure 2

[22] See http://www.gwhealthpolicy.org (click on "Managed Care Contracting").
[23] See also, Sara Rosenbaum, Karen Shaw, and Colleen Sonosky. December 2001. "SCHIP Policy Brief #3: Managed Care Purchasing under SCHIP: A Nationwide Analysis of Freestanding SCHIP Contracts." Available at: http://www.gwhealthpolicy.org/chiri.htm.

below displays contracting practices in a U.S. map format, showing that there is no particular size or geographic pattern associated with these contracting practices. Both large and small states use freestanding contracts, although all of the states that had precursor programs to SCHIP (Florida, Pennsylvania, and New York) use freestanding contracts.

Table 1
Managed Care Contracting in States with Separately Administered SCHIP Programs, Calendar Year 2000

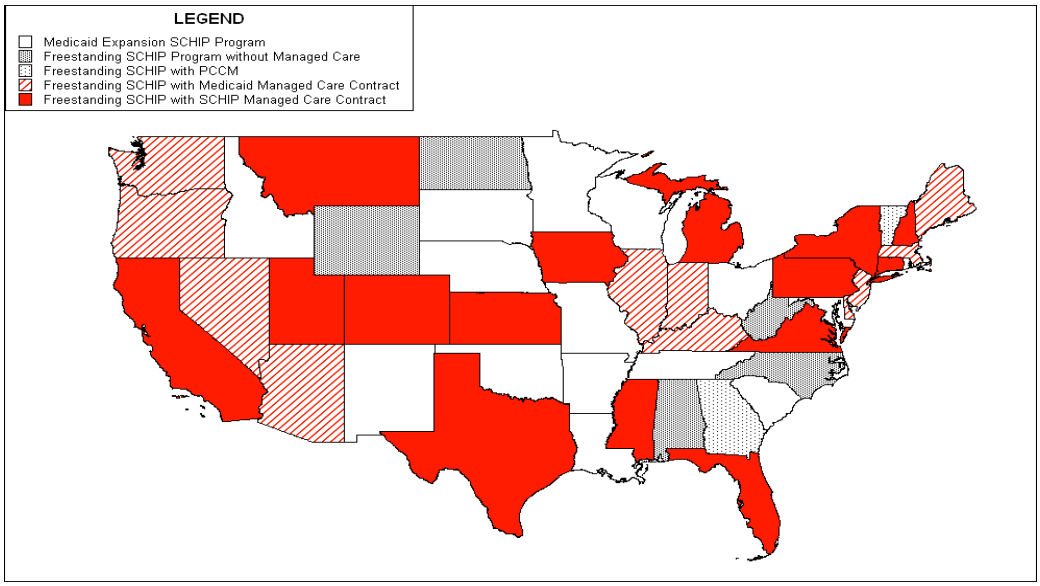
State	Separately Administered SCHIP Programs	Managed Care	*Contracts with MCOs*	
			Modified Medicaid Contract	Freestanding SCHIP Contract
Alabama	✓			
Arizona	✓	Y	✓	
California	✓	Y		✓
Colorado	✓	Y		✓
Connecticut	✓	Y		✓
Delaware	✓	Y	✓	
Florida	✓	Y	✓	✓‡
Georgia	✓	PCCM		
Iowa	✓	Y		✓
Illinois	✓	Y	✓	
Indiana	✓	Y	✓	
Kansas	✓	Y		✓
Kentucky	✓	Y	✓	
Maine	✓	Y	✓	
Massachusetts	✓	Y	✓	
Michigan	✓	Y		✓
Mississippi	✓	Y		✓
Montana	✓			✓*
Nevada	✓	Y	✓	
New Hampshire	✓	Y		✓
New Jersey	✓	Y	✓	
New York	✓	Y		✓
North Carolina	✓			
North Dakota	✓			
Oregon	✓	Y	✓	
Pennsylvania	✓	Y		✓
Texas	✓	Y		✓
Utah	✓	Y		✓
Vermont	✓	PCCM		
Virginia	✓	Y		✓
Washington	✓	♦ Y	✓	

Table 1
Managed Care Contracting in States with Separately Administered SCHIP Programs, Calendar Year 2000

State	Separately Administered SCHIP Programs	Managed Care	*Contracts with MCOs*	
			Modified Medicaid Contract	Freestanding SCHIP Contract
West Virginia	✓			
Wyoming	✓			
Total	**33**	**27**	**12**	**15**

Sources: USDHHS/CMS, (www.hcfa.gov/init/chip-map.htm); GWU/SPHHS/CHSRP, managed care contract database maintained for *Negotiating the New Health System (4th Edition)*, www.gwhealthpolicy.org/
Y = state purchases managed care services; PCCM = managed care purchasing arrangements limited to PCCM entities.
‡ Florida has a Piggyback contract as well as a separate SCHIP contract.
* Montana's document is their Blue Cross/Blue Shield indemnity plan which covers their SCHIP enrollees.

Figure 2
Managed Care Contracting Arrangements in Separately Administered SCHIP Programs



Coverage

An examination of the SCHIP contracts (both freestanding and modified) confirms that separate SCHIP coverage arrangements significantly limit coverage of behavioral health services for low-income children.

Assessment: Table 2 below examines provisions related to developmental assessments in freestanding SCHIP contracts. Among the 15 states that use freestanding agreements, 3 explicitly require contractors to assess children for physical and mental development; another 9 specify that contractors must adhere to the Guidelines for Health Supervision developed by the American Academy of Pediatrics, which recommend assessment of physical and mental growth and development. Three freestanding contracts are silent on the issue of developmental assessment; under normal rules of contract interpretation this would leave to contractor discretion whether periodic well child exams would be required to include an assessment of mental and physical development and if so, how such an assessment would be conducted.

Table 2
Specified Coverage Of Developmental Assessments Under Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Developmental Assessments Specified as a Service
California	AAP‡
Colorado	
Connecticut	AAP
Florida	AAP
Iowa	
Kansas	✓
Michigan	
Mississippi	AAP
Montana	AAP
New Hampshire	✓
New York	AAP
Pennsylvania	AAP
Texas	AAP
Utah	AAP
Virginia	✓
Total	**12**

"AAP": Developmental assessment not specified but adherence to American Academy of Pediatrics standards, which require a developmental assessment, is specified.
‡ The American Academy of Pediatric Recommended Well-Child Guidelines can be found at the AAP web site, http://www.aap.org/policy/re9939.
✓ Developmental assessment required, but AAP standard not specified.
Source: George Washington University School of Public Health and Health Services, Center for Health Services Research and Policy,
Negotiating the New Health System, 4th Edition, Table 2.4, http://www.gwhealthpolicy.org.

Coverage by classes of benefits: Table 3a below shows that 14 of the 15 freestanding SCHIP contracts cover some form of treatment of mental illness and addiction disorders as a class of benefits. There are, however, wide variations in the scope and limits of such treatments as discussed below. Table 3a also indicates that case management services are a feature of approximately half of all contracts, with significant variation in the definition and scope of case management. Certain services for children with special physical health care needs (defined by researchers as including speech therapy, physical therapy, rehabilitation therapy and durable medical equipment) are commonly used services in the case of children with significant limitations in physical activities, however only 4 contracts include them as specified services.

Table 3a
Coverage of Benefits for Children with Illness and Disability in Freestanding SCHIP Contracts, Calendar Year 2000

State	Hospital Inpatient Services	Hospital outpatient Services	Lab/ *X-ray* *Services*	Physician Services	Prescribed Drugs	Behavioral Health Care Services		Case Manage-ment Services	Certain Services* for Children with Special Health Care Needs
						In-patient	Out-patient		
California	✓	✓	✓	✓	✓	✓	✓	✓	
Colorado	✓	✓	✓	✓	✓	✓	✓	✓	
Connecticut	✓	✓	✓	✓	✓	✓	✓	✓	✓
Florida	✓	✓	✓	✓	✓	✓	✓		✓
Iowa	✓	✓	✓	✓	✓	✓	✓		
Kansas	✓	✓	✓	✓	✓	✓	✓		✓
Michigan	✓	✓	✓	✓	✓	†	†		
Mississippi	✓	✓	✓	✓	✓	✓	✓	✓	
Montana	✓	✓	✓	✓	✓	✓	✓		
New Hampshire	✓	✓	✓	✓	✓	✓	✓	✓	
New York	✓	✓	✓	✓	✓	✓	✓		
Pennsylvania	✓	✓	✓	✓	✓	✓	✓‡		
Texas	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utah	✓	✓	✓	✓	✓	✓	✓		
Virginia	✓	✓	✓	✓	✓	✓	✓	✓	
Total	**15**	**15**	**15**	**15**	**15**	**14**	**14**	**7**	**4**

*Includes speech therapy, physical therapy, occupational therapy, rehabilitation therapy and durable medical equipment (may cover one or more of these services).
† Michigan's contract states that "mental health and substance abuse services are the responsibility of community mental health boards and coordinating agencies respectively. However, the Contractor may elect to furnish mental health or substance abuse services, e.g., Attention Deficit Disorder diagnosis and treatment." Levels of inpatient and outpatient services are not defined.
‡ Pennsylvania's contract specifies drug and alcohol abuse treatment, but does not define levels of inpatient or outpatient treatment for substance abuse services.
Source: George Washington University School of Public Health and Health Services, Center for Health Services Research and Policy, *Negotiating the New Health System* 4th Edition, Table 2.1 and Table 2.2. http://www.gwhealthpolicy.org.

Mental health and substance abuse service limitations and exclusions: Table 3b below summarizes the scope of coverage of inpatient and outpatient mental health and substance abuse services in states with freestanding SCHIP contracts. (Tables 4A and 4B in the Appendix display the actual contract language in reference to limitations and exclusions related to behavioral health coverage.) These tables show that, despite the apparent coverage of behavioral health under every separate program, actual coverage levels frequently are quite

limited, and furthermore, that in some states the limitations appear to be inconsistent with the mental health parity requirements contained in the now-expired parity statute.

Table 3b
Annual Coverage Limits of Mental Health and Substance Abuse Benefits for Children with Illness and Disability in Freestanding SCHIP Contracts, Calendar Year 2000

State	Mental Health		Substance Abuse	
	Inpatient	Outpatient	Inpatient	Outpatient
California	30 days	20 visits	"as necessary" for alcohol/drug detoxification	20 visits
Colorado	Unlimited for "neurologically-based" conditions; otherwise 45 days	20 visits	Not covered	20 visits
Connecticut	60 days	30 visits	60 days for drug addiction; 45 days for alcohol addiction	60 visits
Florida	30 days	40 visits	7 days for detoxification; 30 days residential services	40 visits
Iowa	not separately specified	not separately specified	not separately specified	not separately specified
Kansas	Treatment of "biological based" conditions only; number of inpatient days and outpatient visits not specified		60 days	25 visits
Michigan	not required; contractor option to provide	not required; contractor option to provide	not required; contractor option to provide	not required; contractor option to provide
Mississippi	30 days	60 days partial hospitalization; 52 outpatient visits	$8000 per benefit period, $16,000 lifetime maximum; number of inpatient days and outpatient visits not specified; additional $1,000 per benefit period for alcohol abuse care after lifetime max met.	
Montana	21 days	20 visits	Combined inpatient/outpatient benefit (excluding detoxification) $6,000 per year, lifetime maximum $12,000 (after which annual benefit may be reduced to $2,000)	
New Hampshire	15 days	not covered	Number of "medically necessary" days for detoxification only	not covered
New York	Combined 30 days inpatient for both mental health and substance abuse services; combined 60 outpatient visits for both mental health and substance abuse services.			
Pennsylvania	90 inpatient days total for both physical and mental health services; substance abuse services not separately addressed.			
Texas	45 days	Available conversion option of 25 days of inpatient treatment to outpatient or residential setting	14 days for detox/crisis stabilization; 60 days per episode for residential rehab with 180 day lifetime maximum; 3 inpatient and/or residential episodes per plan lifetime	12 weeks per episode for intensive outpatient; 6 months general outpatient per episode; lifetime maximum of 3 outpatient episodes per plan lifetime
Utah	30 days	30 visits	not specified	not specified

Table 3b
Annual Coverage Limits of Mental Health and Substance Abuse Benefits for Children with Illness and Disability in Freestanding SCHIP Contracts, Calendar Year 2000

State	Mental Health		Substance Abuse	
	Inpatient	Outpatient	Inpatient	Outpatient
Virginia	Covered directly by the state	26 visits; one possible extension of 26 more visits; no more than 3 sessions in a 7-day period	not covered	26 visits

Table 4A in the Appendix shows the contract language regarding limitations and exclusions in freestanding contracts as summarized above in Table 3b. It shows that every state that covers any level of behavioral disorders as a contractual benefit applies limitations and exclusions that would not be permissible in the Medicaid program. Of the 15 contracts, 14 include coverage of behavioral health as a contractual service; Michigan offers extra-contractual coverage up to unspecified coverage limitations. Of the 14 contracts that identify behavioral services as a covered benefit, 13 impose limits on inpatient days and outpatient services for either mental illness or substance abuse treatment or both forms of treatment. In several states the limitation on outpatient care is as low as 20 visits. Seven states offer conversion benefits (this permits exchanging inpatient days for increased outpatient visits) which would broaden non-inpatient services, in some cases significantly. However, as Table 4A shows, not all states with limits on outpatient care permit conversion of inpatient services; furthermore, conversion obviously poses some level of risk in relation to the need for inpatient care. Iowa, New York, and Pennsylvania include mental health and substance abuse services within their overall limits for inpatient and outpatient care, which includes physical health care services. Colorado and Kansas impose no limits for treatment of mental health conditions of "neurobiological" or "biological" origin, although the terms are not defined in the contracts. Inpatient substance abuse services are not covered in Colorado and Virginia.

Table 4A also indicates that two states (Montana and Mississippi) use dollar limits on substance abuse coverage, despite the applicability of the mental health parity act. Montana imposes a $6,000 benefit in a 12-month period with an annual lifetime limit of $12,000 (which may be slightly adjusted upward) for substance abuse services.[24] Similarly, Mississippi imposes an $8000 limit per benefit period on substance abuse treatment with a $16,000 lifetime maximum; as with Montana, there is no indication in the Mississippi plan of residual additional coverage. The presence of annual and lifetime dollar limitations in SCHIP contracts despite the parity act is comparable to the continued existence of such limitations in employer-sponsored plans according to GAO studies of parity implementation.[25]

[24] Montana's SCHIP plan does not indicate residual additional coverage beyond this limit.
[25] See, for example, "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," GAO/HEHS-00-95, May 10, 2000; "Private Health Insurance: Access to Individual

By way of comparison, we examined the modified Medicaid contracts on this particular measure. Table 4B in the Appendix presents the results of this comparison review. This table shows that 10 out of 12 states include some level of coverage in the SCHIP coverage provisions of their modified Medicaid contracts. The table also shows however, that among these 10 states, only 4 (a far lower percentage than in the case of the states with freestanding contracts) specify a lower level of care for children covered through a separate SCHIP plan; concurrently, only 1 contract contains a conversion benefit. The fact that coverage limitations on behavioral care are less common in the case of the modified Medicaid contracts is consistent with earlier research conducted by CHSRP, which indicated that many states with separate SCHIP plans have tended to add separate programs as a means of, among other reasons, avoiding further entitlement expansion and in order to be able to place upper limits on enrollment when necessary, not as a strategy for limiting benefits.[26] However, the 15 states that have not only established separate programs but also have adopted freestanding contracts appear to have limitations in coverage as an additional goal, as evidenced by the limitations in the contracts.

Total exclusion of services where improvement or recovery is not possible with short-term therapy: Perhaps the most interesting limitation is that found in California's freestanding SCHIP contract and which appears in Table 4A. The California contract explicitly limits the scope of its SCHIP coverage to "general exclusion: services for conditions not subject to significant improvement through relatively short-term therapy." This exclusion means that even where a service is ostensibly covered, it is excluded in its entirety in the case of any child whose condition is determined not to be amenable to "significant improvement through relatively short-term therapy." The terms "significant," "improvement," and "short-term therapy" are not defined. This is precisely the type of exclusion that is prohibited under the Medicaid anti-discrimination provision, as noted in the Overview above. Furthermore, it is by no means the case that this type of exclusion is present only in the California contract. For example, in Washington's modified Medicaid contract, there is a limitation on delivery of mental health services that distinguishes between a primary care provider (PCP) and a specialist mental health provider. While there are no specific limits placed on delivery of mental health services in the PCP's office, services provided by a psychiatrist or other mental health professional are limited to one hour per month "for conditions which can be expected to result in improvement or be resolved in 12 hours per calendar year or less." Thus, as in the California SCHIP contract, children with severe mental illness, for example, who require intensive long-term care provided by mental health specialists, are excluded from coverage by virtue of this limitation.

Market Coverage May Be Restricted for Applicants with Mental Disorders," GAO-02-339, February 28, 2002. Available at http://www.gao.gov.

[26] Rosenbaum and Smith, op. cit.; Rosenbaum, Markus, Sonosky, and Repasch, op. cit.; Rosenbaum, Shaw, and Sonosky, op. cit.

It is possible that these exclusions are far more common, since the silence in other state contracts could be interpreted as acquiescence to this type of limitation. Because a "recovery" standard in medical necessity definitions is common in conventional insurance, one can presume that the existence of such a clause is in fact common. This provision is important because it is not merely a limitation on otherwise covered care; it is a total exclusion of any coverage in the event that a child is determined by the contractor (it appears) to have a condition that is not covered by the agreement at all. Not only is the exclusion total, but the contractor appears to be given total discretion to make the call. An important question is whether this type of total exclusion creates a sort of parity problem of its own, assuming no similar exclusion in treatments for physical conditions. Nothing in other federal laws, including the Americans with Disabilities Act, would render this exclusion by design unlawful.

As Table 5 below shows, only 6 states with freestanding contracts specify an EPSDT pediatric standard of medical necessity that presumably would prohibit plans from excluding treatments that help a child grow and develop, simply because the child cannot "significantly improve" in the conventional insurance sense. Since only 6 states affirmatively require contractors to adhere to a growth and development standard, this means that in the remaining 9 states with freestanding contracts, the silence on this issue would allow a contractor to use its discretion in adopting a "recovery" standard of medical necessity

Table 5
Medical Necessity Definition in Separate SCHIP State Plans and/or Freestanding SCHIP MCO Contracts
(Calendar Year 2000) (n = 15)

State	SCHIP Plan or contract provides definition	SCHIP Plan or contract uses a preventive pediatric coverage definition
California	✓‡	
Colorado	✓	
Connecticut	✓	✓
Florida	✓	✓
Iowa	✓	
Kansas	✓	✓
Michigan		
Mississippi	✓	
Montana	✓	
New Hampshire	✓	✓
New York		
Pennsylvania	✓	✓
Texas	✓	✓
Utah		
Virginia	✓	
Total	12	6

‡ In the California contract, the general exclusion serves as the medical necessity standard.

Source: Rosenbaum et. al., Policy Brief #2: State Benefit Design Choices under SCHIP: Implications for Pediatric Health Care, SCHIP Policy Studies Project, George Washington University School of Public Health and Health Services, Center for Health Services Research and Policy, *Negotiating the New Health System* 4th Edition, Table 2.7 www.gwhealthpolicy.org.

Care coordination

Care coordination is an important service for children with behavioral disorders, particularly where the child's condition is chronic or spans both physical and mental conditions. Building on our earlier care coordination analyses for SAMHSA, we compare the availability of care coordination under freestanding SCHIP and Medicaid contracts for the 15 study states. The findings are presented on Table 6 below, which shows that in the 15 study states, freestanding SCHIP contracts are somewhat less likely than their Medicaid counterparts to enumerate care coordination as a contractual benefit. To the extent that care coordination involves the types of case management services that are mandatory under Medicaid, the service would be available as a residual benefit in Medicaid expansion SCHIP programs. In the case of separate SCHIP programs, the state plans do not indicate residual availability.

Table 6
Presence of Any Care Coordination Specifications: Medicaid and Freestanding SCHIP Contracts (Calendar Year 2000)

State	Medicaid	SCHIP
California	✓	✓
Colorado		
Connecticut		
Florida	✓	
Iowa	✓	
Kansas		✓
Michigan		
Mississippi		
Montana	✓	✓
New Hampshire	✓	
New York	✓	✓
Pennsylvania	✓	✓
Texas		
Utah	✓	✓
Virginia		
Total	8	6

Note: Five states (California, Montana, New York, Pennsylvania, and Utah) have care coordination language in both their Medicaid and SCHIP contracts.
Source: CHSRP, *Negotiating the New Health System, 4th ed.*, managed care contract data base. www.gwhealthpolicy.org.

Continuity of care

One of the most challenging aspects of Medicaid and SCHIP administration is systems integration in order to accommodate children who move between the programs (typically because of family income fluctuation) or families whose children's eligibility is split between the two programs. Although 5 of the 15 states with separate programs have elected the 12-month continuous enrollment option for SCHIP, at the end of a 12-month enrollment period, transition may be necessary, particularly as family income fluctuates. Since managed care involves an integration of coverage and health care, changes in enrollment sponsorship also can result in breaks in the continuity of care. This discontinuity in care may pose a particular problem in the case of children with mental illness, where provider continuity and familiarity with the child's condition, complex treatment plans, and special needs may be particularly important.

In order to more closely examine the issue of continuity, we examined both the SCHIP and Medicaid contracts in the 15 study states to determine whether the agreements address one or more of the following matters:

- At the most comprehensive level, requiring MCO contractors to participate in both programs as a condition of participation in either program.
- As a secondary approach, requiring as a condition of participation that the contractor include in its network any provider participating in the network of the other program in the event that the provider seeks inclusion in order to maintain a continuous relationship with a patient. For example, are SCHIP contractors required to grant network status to Medicaid network primary or specialty care providers in the case of children who are already under their care and whose source of insurance changes?
- As a minimum approach, specifying coordination and patient information transfer procedures that contractors must follow in the event that a child member is involuntarily disenrolled from one sponsoring program (i.e., Medicaid or SCHIP), re-enrolled in the other sponsoring program, and subsequently assigned to a different managed care contractor that does business with the new sponsoring program.

The results of this set of queries are shown on Table 7 below. As expected, none of the 15 states require MCO contractors to participate in both programs. Informal discussions with both MCO officials and state agency staff suggest that both managed care organizations and state agencies view this joint participation requirement as unworkable due to widespread reluctance on the part of both primary care professionals and specialists to participate in Medicaid. More surprisingly however, we found no states that extended

the equivalent of "any willing provider" laws[27] to those providers who are in fact willing to participate in both programs and wish to do so in order to preserve continuity of care for children with serious illness. Finally, only Texas and Utah maintain any coordination of enrollment and record transfer terms in their contracts to address issues that arise in the event that children move between plans, and in each of these cases, the coordination responsibility was confined to only one contractor.

The findings from these contracts also indicate that transition between programs has received little attention at the contractual level. In none of these 15 states is participation in both programs a condition for participation in either program; even more surprising perhaps, none of the contracts requires that a contractor grant network status to a provider participating in either program who is treating a child with mental illness and who has strong continuity needs under care. This would be a relatively simple means of ensuring at least continuity in the actual provision of care, but does not appear to be a feature of the contracts. Indeed, in only one case has the state required transfer of records and patient information between the contractors.

Table 7.
Continuity of Care Specifications: Medicaid and Freestanding SCHIP MCO Contracts (Calendar Year 2000)

State	Contractor participation in both Medicaid and SCHIP		Network inclusion of any willing provider where necessary for continuity of care		Contractor coordination of patient information and transfer of records	
	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP
California						
Colorado						
Connecticut						
Florida						
Iowa						
Kansas						
Michigan						
Mississippi						
Montana						
New Hampshire						
New York						
Pennsylvania						
Texas					✓	
Utah						✓
Virginia						
Total	**0**	**0**	**0**	**0**	**1**	**1**

[27] "Any willing provider" laws mandate that no licensed provider who meets an MCO's network provider credentialing standards and who agrees to the terms and conditions of an MCO contract shall be denied the right to become a network provider. Rosenblatt RE, Law SA, Rosenbaum S. (1997). Law and the American Health Care System. (p. 641). Westbury, NY: The Foundation Press, Inc.

Source: Tables 1.4, 3.1, and 3.1.1 of the SCHIP Database and Medicaid Managed Care Database. *Negotiating the New Health System* (4th Edition.). http://www.gwhealthpolicy.org.

Conclusions

This review of freestanding contracts used by separate SCHIP programs provides important information on state approaches to behavioral health in a deregulated environment. SCHIP requires only an actuarial benchmark standard for coverage of mental health services, which under the statute are separated from other forms of physician and hospital services and covered by additional levels of state flexibility. States appear to make extensive use of this flexibility in the case of those separately programs that in addition have established freestanding contracts for use with their SCHIP contractors. In nearly all states with freestanding contracts, coverage is limited. One state, California, expressly permits a total exclusion of otherwise-covered care and treatment in the case of children with chronic conditions. While California's contract is the only document that incorporates this express exclusion, the silence on this issue in most of the other contracts means that this type of total exclusion of chronic illness may in fact be more common than express contract terms imply.

Two important questions flow from this study. First, is there anything about SCHIP children that would justify lesser coverage of mental illness in the case of near-poor children than the level that is available in the case of children on Medicaid? We know of no studies that suggest that a child with family income at 90% of the federal poverty level is at appreciably greater risk than one at 120% of poverty, yet precisely this limited gradient can separate a Medicaid child from one enrolled in SCHIP. Furthermore, even if the overall risk of severe mental illness were lower, this alone would not justify eliminating necessary care for the smaller cohort. These types of fixed limits perhaps can be best understood as a state desire to parallel the market and as a response to concerns about underfunding.

The second question is what happens to children whose needs exceed the limitations or whose chronic conditions place them entirely outside the contract? Our earlier work on SCHIP suggests very little in the way of residual coverage under Title XXI state plans; indeed, a benefit of SCHIP compared to Medicaid is that states can avoid residual liability. It may be that some of these children can "spend down" to Medicaid eligibility when their conditions grow sufficiently severe, where coverage is limited only by need. It is possible that any state with a medically needy program effectively uses its program as a "wrap around," although the existence of such a strategy is a matter of complete silence in both the contracts and the state SCHIP plan.

It also could be that other programs assist these children, such as state block grant and special purpose programs for children with mental illness. These sources of funding tend to be modest, and since virtually nothing is known about the number or proportion of SCHIP insured children who exceed contractual limits, it is difficult to know if these other sources of funding are adequate to the task.

Finally, reviewing these states is important because it sheds light on where they might proceed under a Medicaid program modified through a §1115 demonstration waiver. The findings suggest that treatment for mental illness and addiction disorders may be a significant focus of such modification efforts, and that a great deal of further work is needed to determine how much unmet need would flow from such a move, how families, health providers and state agencies would accommodate to such a change, and what alternatives to fixed treatment limits and exclusions might be available.

APPENDIX

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
California	✓	Y	• General exclusion: services for conditions not subject to significant improvement through relatively short-term therapy, including chronic psychosis, chronic brain syndrome, intractable personality disorder and mental retardation. • Inpatient treatment: 30 days per benefit year. Treatment is limited to mental health care when ordered and performed by a participating mental health professional for treatment of an acute phase of a mental health condition during a certified confinement in a participating hospital. Inpatient treatment as necessary for alcohol/drug abuse detoxification. • Outpatient treatment: 20 visits per benefit year for evaluation, crisis intervention, and treatment for conditions which are subject to	Option to substitute 2 days of residential treatment, 3 days of day care treatment, or 4 outpatient visit for each day of inpatient hospitalization.

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			significant improvement through relatively short term therapy. • Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Participating health plans shall offer at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.	
Colorado	✓	Y	• Mental Health Inpatient Hospital care: unlimited for neurobiologically-based conditions; 45-day limit for other classes of mental illness. • Outpatient Mental Health Services: 20 visit limit. • Chemical Dependency Treatments: No Inpatient coverage. Outpatient services: 20 visit limit.	Option to convert 45 days of inpatient treatment into 90 days of day treatment.
Connecticut	✓	Y	• Mental Health Inpatient care: 60 days of inpatient treatment.	Option to convert up to 60 days inpatient care for "alternative"

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			• Mental Health Outpatient care: 30 days. • Substance abuse services: 60/45 inpatient day limits for drug and alcohol treatment, respectively; 60 outpatient visits per calendar year.	levels of care.
Florida	✓	Y	Contractor shall pay an enrollee's covered expenses up to a lifetime maximum of $1 million per covered enrollee… • Mental Health Inpatient Services: 30 days of inpatient treatment, or residential services in lieu of inpatient psychiatric admissions; a minimum of 10 of the 30 days shall be available only for inpatient psychiatric when authorized by TBA physician. • Mental Health Outpatient Services: 40 outpatient visits. • Substance Abuse Services: Inpatient services 7 days per contract year for medical detoxification only and 30 days residential services. Outpatient services 40	*[no relevant language]*

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			visits per year.	
Iowa	✓	Y	Physician services (including …medical, and office visits….mental health visits and substance abuse visits). Service Limits: The Plan may impose limits on Covered Services. Such limits shall be identified by the Plan and shall be considered when determining the benchmark equivalency of the Plan.	*[no relevant language]*
Kansas	✓	Y	• General limitations: treatment of "biological based" mental illness only. • Substance abuse: 60 day/year limit on inpatient treatment; 25 outpatient visits per plan year. Detoxification services and medically related ancillary services when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Contractor discretion to determine inpatient or outpatient setting.	• Option to convert inpatient treatment to partial hospitalization of not less than 3 hours and no more than 12 hours in any 24 hour period based on a preset formula.
Michigan	NO	Y	Services Covered Outside of the Contract (Not the Responsibility of the Contractor)…	*Not applicable*

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			MIChild mental health and substance abuse services are the responsibility of community mental health boards and coordinating agencies respectively. However, the Contractor may elect to furnish mental health or substance abuse services, e.g., Attention Deficit Disorder diagnosis and treatment. In these cases, the Contractor is responsible for reimbursing its service providers…"	
Mississippi	✓	Y	• Mental Health Inpatient treatment: 30 days per benefit period. • Mental Health Partial hospitalization: 60 days per benefit period. • Mental Health Outpatient visits (any ambulatory setting including outpatient hospital): 52 visits per benefit period. • Substance abuse: where the primary diagnosis is substance abuse, $8,000 per Member during benefit period; lifetime maximum of $16,000	*[no relevant language]*

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			per Member. Additional $1000 per benefit period for Inpatient and Outpatient Alcohol Abuse care once the lifetime maximum is exhausted.	
Montana	✓	Y	• Mental Health Inpatient Care: 21 days per year. • Mental Health Outpatient Care: 20 visits per year. • Substance Abuse: Combined inpatient and outpatient benefit for alcoholism and drug addiction treatment, excluding medical detox, subject to a $6,000 benefit in a 12-month period, with lifetime maximum benefit of $12,000, after which the annual benefit may be reduced to $2,000.	• Partial hospitalization may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days.
New Hampshire	✓	Y	• Mental Health Services: 15 inpatient days per year. • Substance Abuse: benefits limited to medically necessary days for medical detox. Substance abuse rehabilitation not	*[no relevant language]*

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			covered.	
New York	✓	Y	• Inpatient care: 30 days per calendar year for inpatient mental health services, inpatient detox and inpatient rehabilitation. • Outpatient Services: combined 60 outpatient days per calendar year. Visits may be for family therapy related to the alcohol or substance abuse. • Substance abuse: no separate limitations.	*[no relevant language]*
Pennsylvania	✓	Y	The contractor must agree to make available the comprehensive minimum benefit package to program eligibles. The comprehensive benefit package includes: - Inpatient hospitalization (including Mental Health) - up to ninety (90) days per year for eligible children... - Emergency, preventive and routine hearing care. This includes the cost of examinations and hearing devices... - Drug and Alcohol Abuse Treatment...	*[no relevant language]*

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			Substance Abuse Services: not specified as to inpatient or outpatient.	
Texas	✓	Y	• Inpatient Mental Health Services: 45 days per 12 month period. •Substance Abuse Services: 14 day annual limit on detox/crisis stabilization. 24-hour residential rehabilitation up to 60 days per episode with 180 day lifetime maximum. Maximum of three inpatient and/or residential episodes per plan lifetime. Intensive outpatient program-up to 12 weeks per episode; general outpatient services-up to six months of treatment per episode. Maximum of three outpatient episodes per plan lifetime. A set of services of less than one month in duration is not counted against the Member's three–episode limit per plan lifetime.	• Option to convert 25 days of inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured service or subacute outpatient (partial hospitalization or rehabilitative day treatment); 20 inpatient days must be held in reserve for inpatient use only. • Substance Abuse Services: 60 days of residential rehab may be converted to partial hospitalization; 30 days must be held in reserve.
Utah	✓	Y	• Inpatient Mental Health Services: 30 days inpatient/residential	• Option to substitute one outpatient visit for each day of

Table 4A
Limitations and Exclusions on Behavioral Health Care Services, Freestanding SCHIP MCO Contracts, Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			care per year. • Outpatient Mental Health Services: 30 visits per enrollee per year. •Substance abuse Services: no separate specified limitations.	for each day of hospitalization.
Virginia	✓	Y	• Inpatient care: Inpatient service limits set forth in the Virginia Administrative Code. Inpatient services in a State Psychiatric Hospital directly covered by state. • Outpatient services: 26 sessions with one possible extension of 26 sessions during first year of treatment or with prior approval by state agency. No more than 3 sessions in any given seven-day period. • Substance Abuse Services: 26 outpatient sessions annually.	*[no relevant language]*
Total	**14**	**15**	**15**	**7**

Table 4B
Limitations and Exclusions on Behavioral Care Services, Modified Medicaid Contracts
Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
Arizona	✓	Y	Behavioral Health Services: • Inpatient Services: (Title XXI limited to 30 days per contract year). • Outpatient Services: 30 visits per year.	*[no relevant language]*
Delaware	✓	Y	Mental Health/Substance Abuse: • Inpatient mental health services: includes services furnished in a state-operated mental hospital and residential or other 24-hour therapeutically planned structural services. Services may be provided as a 'wrap-around' service for up to 31 days per calendar year with the limitation that the 31 days also includes any other mental health and/or substance abuse treatment services (including outpatient, residential and any other treatment modality) outside of the basic MCO benefit of 30	Inpatient mental health services may be provided as a 'wrap-around' service for up to 31 days per calendar year with the limitation that the 31 days also include any other mental health and/or substance abuse treatment services (including outpatient, residential and any other treatment modality) outside of the basic MCO benefit of 30 outpatient visits.

Table 4B
Limitations and Exclusions on Behavioral Care Services, Modified Medicaid Contracts
Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			outpatient visits. Children who need services beyond this will convert to Medicaid Long-Term Care. • Substance Abuse Services: Inpatient substance abuse treatment services and residential substance abuse treatment services. Outpatient services: 30 days.	
Florida	✓	Y	The behavioral health services are those required by federal or state rules governing the Medicaid program, as prescribed by the Medicaid Coverage and Limitations Handbook. • Outpatient mental health hospitalization/emergency health services: The plan shall not be responsible for emergency community mental health services provided to members by out-of-state providers, unless such services are reimbursable under the Medicaid community mental	*[no relevant language]*

Table 4B
Limitations and Exclusions on Behavioral Care Services, Modified Medicaid Contracts
Calendar Year 2000

State	Any Coverage of Behavioral Health Care Services	Limitations/Exclusions (Y/N)	Limitation/Exclusion Described	Conversion Benefit
			health services program.	