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ABSTRACT

Medicaid is the key source of health insurance for those who would otherwise have to rely solely on emergency rooms and public health clinics for services. This report provides an overview of Medicaid programs and the newly enacted Children's Health Insurance Program (CHIP), and outlines the implications of key program provisions for professional counselors and consumers. A state-by-state chart indicates if Medicaid fee-for-service direct reimbursement is provided for professional counselors, psychologists, and clinical social workers. The chart also provides contact information for the offices in all 50 states that handle Medicaid. Summaries of waiver programs that affect the delivery of mental health and substance abuse services are included for all 50 states. A second chart lists state CHIP program contacts, recent actions, and anticipated funding for all 50 states. (MKA)

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THE MEDICAID MAZE

An Overview of Federal and State Policies

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Introduction

A number of different sources of information helped make this report possible, and are listed at the end of each major section. The details and permutations of the program cannot be described succinctly in any one document; this report simply attempts to provide an overview of the program and the way it works, and the major policy issues involved in the way it is structured.

This report is an update of a report released last year. As it will again be updated, comments, corrections, and suggestion are welcomed. Please contact ACA at 800 347-6647 x234, or via e-mail at "sbarstow@counseling.org" with any feedback you may have.

Given the swiftness with which states are changing their programs and developing new ones, much of the information in this report unfortunately may become outdated rather quickly. For the most up-to-date description of what's happening in your state, it is important to contact your state's Medicaid department directly.

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The Medicaid Maze: An Introduction

Medicaid is the major component of our nation's public health safety net, providing health insurance to roughly 40 million low-income Americans. However, the program varies significantly from state to state, as states have considerable authority to shape their Medicaid program as they see fit. As a result of The Balanced Budget Act of 1997 (BBA). Medicaid program changes will occur even more rapidly than before. The new law gives states more leeway in requiring beneficiaries to enroll in managed care programs. Managed care, now the rule rather than the exception in the private health care marketplace, is steadily taking over Medicaid and the other major public health care program, Medicare.

It is important that professional counselors understand Medicaid and the newly-enacted provisions affecting the program, including the children's health insurance block grant program established by the Balanced Budget Act. Medicaid is the key source of health insurance for those who would otherwise have to rely solely on emergency rooms and public health clinics for services. Medicaid can also be a source of reimbursement for professional counselors. Among the provisions affecting Medicaid included in the Balanced Budget Act is a provision which may make Medicaid reimbursement more accessible for some professional counselors. This report provides an overview of the Medicaid program and the newly-enacted Children's Health Insurance Program, and outlines the implications of key program provisions for professional counselors and for consumers.

The Basics of Medicaid

Medicaid, authorized under Title XIX of the Social Security Act is a joint federal and state entitlement program which provides health care coverage for more than 40 million low-income individuals nationwide — low-income children and families, pregnant women, the elderly, the blind, and persons with disabilities. Federal funding pays anywhere from 50% to 80% of each state's Medicaid's costs, depending upon the state's average per capita income. In general, the more money a state spends on its program, the more federal money is contributed. In order to participate in the Medicaid program and receive federal funding, states must agree to cover certain population groups and to provide certain mandated services.

States can also cover other, optional groups and services, with federal funding assistance. So long as States cover mandated groups and services, the federal government gives states broad discretion to customize their Medicaid programs. For example, states are able to:

- determine the amount and duration of services offered under their Medicaid programs;
- establish provider payment rates (which are notoriously low);
- place appropriate limits on services based upon such criteria as medical necessity.

Due to these factors—and to the establishment by states of "waiver" programs, discussed below—Medicaid programs vary dramatically from state to state.

Earlier this year Congress passed and the President signed into law legislation—the Balanced Budget Act of 1997, Public Law 105-33—which gives states expanded authority to set up managed care plans for their Medicaid beneficiaries. Previously under Medicaid law, beneficiares could be given the option of enrolling in managed care plans, but could not be required to do so. However, states were allowed to submit applications for waivers of certain federal program requirements, including the requirement that enrollees be given the freedom to choose their health care provider.

These waiver programs—some of which have been in operation for over two decades—typically have been used to require certain Medicaid beneficiaries to enroll in managed care plans. Although almost all states are currently operating waiver programs, it is expected that the new managed care program options made available to states under BBA will begin to be used instead. According to the federal Health Care Financing Administration, as of June 30, 1995 approximately one-third of all Medicaid beneficiaries were being served by managed care programs of various types. Even before BBA was enacted, enrollment in Medicaid managed care plans increased more than 170% between January 1, 1993 and January of 1997. In addition to giving states more flexibility to establish Medicaid managed care programs, BBA also creates the Children's Health Assistance Program (CHIP). This program is designed to help expand insurance coverage among the nation's children, and will be coordinated with states' Medicaid programs.

Federally-Mandated Coverage Under Medicaid

Due to the mixture of extensive federal and state laws, as well as private contracting, Medicaid is a complicated program. However, it is also a vitally-important safety net of care: during the period between 1988 and 1994, the percentage of Americans covered by employer-sponsored health insurance fell from 67% to about 61%; during this same period, Medicaid coverage increased from 9% to 13% of the population. For those populations who are entitled to coverage by their state under federal law, Medicaid can be a life-saver.

Unfortunately, less than half of all Americans living in poverty are insured by Medicaid. Medicaid is typically available only to members of low-income families with children and pregnant women, and to individuals who are over age 65 or who have a disability. Persons not falling into one of these categories, such as childless couples and single adults, cannot qualify, regardless of the amount of their income.

Covered Populations

In general, states are required to provide Medicaid coverage for the following population groups:

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- ***all persons who <u>would have</u> received cash assistance under the Aid to Families with Dependent Children program (AFDC);***

  Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), AFDC was abolished, and replaced with "block grants for temporary assistance for needy families", or TANF. However, under the welfare reform law, states are required to use the old AFDC eligibility, income, and resource rules which they had in place as of July 16, 1996 for purposes of determining individuals' eligibility for Medicaid coverage. As of 1992, the median state income limit for receiving AFDC benefits was 38% of the federal poverty level for a family of three.

  This provision of the welfare reform bill protects millions of beneficiaries who are currently covered by Medicaid. However, families and individuals who receive assistance under the new TANF block grant program operated by their state, but who would not be eligible for AFDC benefits under the old program rules, are not automatically eligible for Medicaid.

- ***pregnant women and children below age 6 with family incomes below 133% of the federal poverty level, and children born after September 30, 1983 in families whose income is below 100% of the federal poverty level;***

  For pregnant women, states are only required to cover services related to the pregnancy or complications of the pregnancy.

- ***low-income persons who are age 65 or older, and individuals who are blind or who have another disability receiving Supplemental Security Income (SSI) payments;***

  Eligibility for SSI is determined under federal disability standards. Twelve states which had in place slightly more restrictive eligibility standards than the federal SSI rules have been allowed to continue to use them. These states are California, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.

- ***Medicare beneficiaries;***

  States are required to pay Medicare Part B premiums, coinsurance, and deductible amounts for aged and disabled Medicare beneficiaries whose income is below 120% of the federal poverty level.

The above-listed individuals are *entitled*, by federal law, to coverage by their state's Medicaid program, and individuals who are inappropriately denied care by their state have the right to bring suit against that state in federal court. This individual entitlement to care is one of the program's great strengths, ensuring that politically weak populations cannot be ignored by states attempting to cut corners on their health care assistance programs.

Covered Services

Except for qualified Medicare beneficiaries, states must cover the following services for the above "categorically needy" individuals:

- inpatient and outpatient hospital services;
- physicians' services, including those of psychiatrists;
- medical and surgical dental services;
- laboratory and X-ray services;
- early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under age 21;
- family planning services;
- nursing facility services for individuals over the age of 21;
- home health services for any individual entitled to nursing facility care;
- rural health clinic and federally qualified health center services; and
- services of nurse-midwives, pediatric nurse practitioners, and family nurse practitioners.

Under the EPSDT requirement, states must cover any follow-up services indicated for a child as a result of screening or diagnosis. This requirement provides coverage for services for children which is frequently more generous than coverage for adults, including mental health and substance abuse services which otherwise would not be covered. EPSDT coverage is one of the most important pillars of the Medicaid program, and child health advocates zealously guard against attempts to eliminate the requirement or water it down.

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Medicaid eligibility rules were changed for two categories of individuals:

- Children with disabilities. Under PRWORA, a child shall be considered to have a disability if he or she has a "medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The bill also eliminates the use of individualized functional assessments (IFAs) for purposes of determining eligibility. The changes have made it more difficult for children with mental and emotional disorders to qualify for the Supplemental Security Income (SSI) program, and thus for Medicaid. According to the Congressional Budget Office (CBO), it is estimated that of the 300,000 or more children who will lose their SSI eligibility over the next few years, approximately 40,000-50,000 of them will also lose their eligibility for Medicaid.
- Individuals with substance abuse disorders. Prior to enactment of PRWORA, SSI recognized drug abuse or alcoholism as a disabling condition. Individuals qualifying for SSI on this basis were required to be in substance abuse treatment, and could have their benefits suspended for failure to be in treatment. In addition, benefits were paid not to the individual, but to a "representative payee," a responsible person or agency charged with ensuring that the individual spent their benefits on allowed items such as treatment or food.

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Under PRWORA, SSI and Social Security Disability Income (SSDI) benefits were terminated for all individuals for whom alcoholism or drug addiction was a contributing factor material to their disability. This has resulted in the loss of eligibility for SSI/SSDI benefits—and consequently the loss of Medicaid coverage—for those individuals with substance abuse disorders who do not have other disabilities. In addition, since alcoholism and drug abuse disorders are no longer considered a covered disability, the representative payee structure for individuals with these disorders has been eliminated.

Other Federal Requirements

In addition to covering the above-listed services for the specified populations, state Medicaid programs must meet the following basic requirements in designing their benefit packages:

- Covered services must be sufficient in amount, duration, and scope to reasonably achieve their treatment purpose. States cannot arbitrarily deny or reduce coverage solely on the basis of the type of illness or condition being treated. States are allowed to limit services to those that are medically necessary.
- Services must generally be equal in amount, duration, and scope to those available to other program beneficiaries in the state.
- Services must be available on a statewide basis.
- Beneficiaries must be free to obtain services from any institution, agency, pharmacy, person, or organization that undertakes to provide the services, is covered by the state's program, and is determined by the state to be qualified to perform the services.

As has been mentioned, Medicaid law allows states to apply for waivers of these requirements. Typically, states request waivers for their Medicaid programs in order to require beneficiaries to enroll in managed care plans. However, the Balanced Budget Act of 1997 makes it much easier for states to set up mandatory managed care plans. As a result of both existing waiver programs and the new authority granted by the Balanced Budget Act, within the next few years managed care is likely to become the rule rather than the exception for Medicaid beneficiaries.

State-Determined Optional Coverage

States can expand their coverage beyond the minimum mandatory populations and services, and receive federal funding in doing so. States are permitted to expand coverage—using federal matching funds—to pregnant women and infants under 1 year old with incomes between 133% and 185% of the federal poverty level. States are also permitted to provide Medicaid to individuals who do not receive SSI but who are receiving state-provided supplementary cash subsistence payments.

Most states also opt to provide coverage for "medically needy" individuals, who meet the nonfinancial standards for inclusion in one of the categories listed above, but whose income or resources

are too high. Individuals are allowed to "spend down" to their state's medically needy resource levels in the process of incurring health care costs, at which point they can become eligible for Medicaid.

In addition, states may provide coverage for any of a broad range of optional services, with federal support. Among these optional services are:

- prescription drugs
- dental and optical services
- clinic services
- physical therapy
- occupational therapy
- prosthetic devices
- care provided in institutional care facilities for the mentally retarded
- chiropractors' services
- hospice services
- Christian Science care
- other practitioners' services.

The federal government only requires that states cover the services of physicians. Thus, any coverage of non-physician providers, including professional counselors, clinical social workers, and psychologists, is done solely at the state's option.

Medicaid Coverage of Mental Health Services

Medicaid is an important source of funding for the treatment of mental disorders, paying for roughly 20% of the nation's mental health care costs. Individuals do not have to meet separate eligibility criteria in order to receive mental health services; most Medicaid beneficiaries receiving mental health services have qualified for coverage upon becoming eligible for SSI benefits (due to having a disabling mental disorder), or after spending enough of their own money for mental health care that they qualify for their state's "medically needy" coverage. Medicaid's EPSDT requirement is an important source of coverage for needed mental health services for children.

Inpatient Mental Health Care

As noted above, state Medicaid programs are required to cover inpatient and outpatient services provided in general hospitals. States may choose to provide indirect reimbursement for licensed or certified professional counselors' services in hospital settings.

State Medicaid programs operate under strict guidelines regarding coverage of inpatient mental health care. States are generally not allowed to use Medicaid to pay for care provided in psychiatric hospitals (defined as "institutions for mental disease" or IMDs: facilities having more than 16 beds which are primarily for the care and treatment of individuals with mental disorders). This prohibition is an attempt by the federal government to avoid picking up the costs of operating public mental hospitals, which have traditionally been funded and run by states.

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States *do* have the option of using Medicaid to pay for care provided in inpatient psychiatric hospitals to persons under the age of 22, and to cover inpatient hospital or nursing facility care for persons over the age of 64. In fact, Medicaid is a significant payor of nursing home costs. For those between the ages of 21 and 65, inpatient mental health care can only be provided in general hospitals or in facilities with fewer than 16 beds. Consequently, many states have established small (fewer than 16 beds) community-based facilities—often associated with a general hospital—to care for individuals with mental illnesses using Medicaid funds. Again, states may choose to cover professional counselors' services provided in these facilities.

Outpatient Care and Reimbursement of Non-Physician Providers

In most states, Medicaid beneficiaries receive mental health services from psychiatrists under the same rules that apply when they obtain services from physicians in other specialties. However, states may also cover mental health services provided by non-physicians—including psychologists, social workers, professional counselors, psychiatric nurses, and psychology assistants—and can reimburse these practitioners directly.

Non-physician mental health care providers can also be reimbursed indirectly when providing care under a psychiatrist or other physician's supervision through a clinic, physician's office, or group practice. When working under the direct supervision of a psychiatrist, the psychiatrist typically must be immediately available to provide assistance and direction throughout the time the non-physician is performing services. Direct supervision does not mean the psychiatrist is present in the same room while the non-physician is providing services.

The majority of states *do not* provide direct reimbursement to professional counselors for mental health services provided to Medicaid beneficiaries in fee-for-service settings. However, if the counselor is employed by an approved mental health clinic, hospital, or state agency that contracts with the Medicaid agency for mental health services, his or her services are indirectly reimbursable.

According to an ACA survey conducted in 1996 (and updated with recent information provided by ACA branch leaders), Medicaid reimbursement for fee-for-service program beneficiaries breaks down as follows:

- 42 states directly reimburse clinical psychologists;
- 17 states directly reimburse clinical social workers;
- 13 states directly reimburse professional counselors, including California, Maine, Mississippi, Missouri, Montana, New Hampshire, North Carolina, Oregon, Rhode Island, South Carolina, South Dakota, Texas, and Virginia.

In some cases, non-physician mental health providers are reimbursed only under the EPSDT portion of the state's program.

Waiver Programs and The Balanced Budget Act of 1997

The structure and extent of the public health safety net has changed considerably over the past year and a half. The Balanced Budget Act contains provisions which have fundamentally altered both the Medicaid and Medicare programs. In both cases, the restructuring was done in order to increase beneficiaries' enrollment in managed care plans.

Medicaid managed care plans can be categorized as one of three types:

- Primary Care Case Management (PCCM). Under a PCCM program, a Medicaid beneficiary selects or is assigned to a single primary care provider, which provides or arranges for all covered services. The primary care provider is reimbursed on a fee-for-service basis in addition to receiving a small monthly "management" fee.
- Fully capitated HMOs and Health Insuring Organizations (HIOs). Fully capitated plans contract with the state agency to provide beneficiaries with a comprehensive set of covered services in return for a flat monthly capitation payment.
- Partially capitated Pre-Paid Health plans (PHPs). Partially capitated plans provide a less than comprehensive set of services on a risk basis; services not included in the contract are reimbursed on a fee-for-service basis.

The Old Waiver System

Prior to this year, states would submit formal applications in order to obtain permission to change the structure of their Medicaid program. Usually, this has been done in order to require beneficiaries to enroll in managed care plans (establishing voluntary enrollment in managed care plans does not require a waiver). Most states operate waiver programs, and it is estimated that each month more than 60,000 beneficiaries are moved into a Medicaid managed care program. Under Sections 1915 and 1115 of the Medicaid statute, states may ask the Health Care Financing Administration (HCFA) for waivers of certain Medicaid requirements (see "Other Federal Requirements" above). There are two basic types of Medicaid waivers: demonstration waivers and program waivers.

Demonstration Waivers

Demonstration waivers, authorized under Section 1115(a) of the Social Security Act, are quite broad and permit states to experiment with their Medicaid programs in several areas. Under these demonstration projects (known as "eleven-fifteen waivers"), states may cover new services, test new reimbursement methods, change Medicaid eligibility criteria, or contract with a variety of managed care organizations. However, states are not given unlimited freedom: states cannot waive services for pregnant women and children, and they must maintain appropriate levels of access to and quality of care. Section 1115 waivers can be granted for up to 5 years.

Program Waivers

While not as far-reaching as 1115 waivers, program waivers—authorized under Sections 1915(b) and 1915(c) of the Social Security Act—permit states to operate certain types of special programs on an ongoing basis. The two primary types of program waivers being used by states are freedom-of-choice waivers and home and community-based care waivers.

- **Freedom-of-Choice waivers ("Section 1915(b)" waivers)**— These waivers allow states to waive federal Medicaid requirements regarding beneficiaries' freedom of choice of healthcare provider, comparability of services, and program statewideness. Freedom-of-choice waiver programs may require beneficiaries to obtain services from specific providers or managed care organizations with whom the state has entered into a contract. Medicaid recipients are either enrolled in health maintenance organizations (HMOs), health insuring organizations (HIOs), or prepaid health plans (PHPs). These waivers are approved for a 2-year period and may be renewed at 2-year intervals. It is worth noting that states may establish voluntary enrollment in managed care plans *without* a waiver. A table listing 1915(b) waiver programs which cover mental health services is included in this report.

- **Home and Community-Based Care waivers ("Section 1915(c)" waivers)**— Under these waivers, states may develop alternatives to institutionalizing Medicaid-eligible individuals, allowing individuals at risk of institutionalization to be cared for at home and in their communities. Beneficiaries can receive case management, homemaker services, home health aide services, personal care services, adult day health treatment, rehabilitation and respite care, and clinic services. Home and community-based care waiver programs serve older Americans and those with disabilities. States conducting such waiver programs must demonstrate that expenditures for individuals receiving home and community-based services will not exceed estimated expenditures had services been provided in an institution.

  Home and community-based care waivers may also be configured to serve individuals with a specific condition or illness. Two examples are programs for elderly individuals with disabilities and for children with drug dependence disorders. Almost all states have home and community-based care waiver programs.

The New Waiver System

Under the Balanced Budget Act, states will no longer need to obtain section 1915(b) waivers in order to sidestep federal freedom of choice, comparability, and uniformity requirements. The new law allows states to require beneficiaries to enroll in managed care programs without obtaining a waiver, and instead by filing a plan amendment (a much less detailed and formal process). In addition, the law classifies mandatory enrollment in primary care case management programs ("PCCMs", described below) as an optional service which states may cover. Finally, the "75:25 percent" rule, which required at least 25% of a Medicaid managed care plan's enrollment to consist of individuals not receiving Medicaid or Medicare, is repealed. This requirement had been in place as an indirect means of ensuring plan quality; the expectation was that managed care plans would provide the same quality of service to public enrollees

as they did to privately-insured enrollees. Now this requirement is gone. All of these provisions are in effect now, and are expected to make most—if not all—1915(b) waivers obsolete. Section 1115 waivers will still be needed for more far-reaching program restructurings affecting benefits and eligibility criteria.

There are still some roadblocks and requirements in place before states may require all beneficiaries to enroll in managed care plans:

- states must file a plan amendment before making program changes;
- states cannot require children under age 19 with special needs, Medicare-related beneficiaries, or Native Americans to enroll in Medicaid managed care plans without a waiver;
- states must allow beneficiaries (except those in rural areas) to choose from at least two managed care entities;
- states must allow beneficiaries to disenroll from a managed care plan at any time for cause, and to disenroll without cause within the first 90 days of enrollment and at least once a year thereafter. Thus, states can lock enrollees into a managed care plan for up to 12 months;
- upon request, managed care plans must make information available to enrollees and potential enrollees about the plan's providers, enrollee rights, and plan grievance and appeals procedures;
- Medicaid managed care plans may not place "gag rules" on provider-patient communications;
- Medicaid managed care plans must establish internal grievance procedures to allow enrollees to challenge denials of coverage or payment; and
- independent annual reviews of any Medicaid managed care organizations must be conducted, with the results to be made public.

Types of Medicaid Managed Care Plans

While Medicaid managed care programs can take different shapes, they usually fall into one of the following categories:

Health Maintenance Organizations (HMOs): These are public or private entities which contract with the state Medicaid agency to provide a portion of the services covered in the state's Medicaid benefit package. HMOs are usually at some degree of risk: if the payment they receive from the state to cover contracted services falls short of the actual cost of these services, the HMO loses money; if services cost less than the payment amount, the HMO makes a profit. As a consequence of this payment structure, HMOs have *no* incentive to provide services for which it is not contractually responsible.

Health Insuring Organizations (HIOs): HIOs act as fiscal intermediaries between the State Medicaid agency and health care providers. Like HMOs, HIOs may be responsible for only a portion of the Medicaid benefit package, and typically contract with a State Medicaid agency on a risk basis. Unlike HMOs, HIOs do not deliver care.

Prepaid Health Plans (PHPs): PHPs are similar to HMOs, with the difference that PHPs contract to provide services on a nonrisk basis. Some PHPs contract on a risk basis just like HMOs, and are allowed to do so because they were "grandfathered" into earlier legislation.

Primary Care Case Management Programs (PCCM): The term "PCCM" does not refer to a distinct organization or health care plan, but instead refers to the practice of requiring Medicaid beneficiaries to use a "gatekeeper" provider as a conduit for all needed care. Primary care case managers are usually paid on a fee-for-service basis, and receive a small fee from the state in exchange for managing their patient's care. States with PCCM programs may not pay for a Medicaid beneficiary's health care if it is not first approved by a primary care provider.

Contracts Between States and MCO's

Regardless of whether behavioral health services are "carved-out" or "carved-in" (covered by the same entity responsible for all other health care services), the details of provider paneling and eligibility are negotiated between either the state and the managed care plan(s) or the managed care plan and the subcontracting managed behavioral healthcare organization in the course of arriving at a contract. ***Professional counselors are encouraged to contact their state Medicaid agencies to advocate for the inclusion of professional counselors' services under their Medicaid plans, and to allow Medicaid managed care plans to contract with professional counselors and other non-physician practitioners for the provision of services to Medicaid beneficiaries.***

It is important to stress that the strength, breadth, and level of detail of state Medicaid contracts with managed care entities vary considerably. Most Medicaid-managed care contracts cover only a portion of enrollees' benefits, and leave the state Medicaid agency responsible for all other services. In addition to the set of services assigned to the managed care contractor, state Medicaid contracts vary in their degree of specificity regarding coverage of particular services, and in the guidance given plans regarding coverage determinations, including decisions on the "medical necessity" of services. Since courts usually interpret ambiguities in contracts *against* the party who drafted the contract, poorly-worded or insufficiently explicit contracts with managed care entities may result in the state Medicaid agency being responsible for services or populations which "fall through the cracks" in the contract. Managed care organizations usually have the ability to terminate contracts at will, and at any time, which can make it difficult for state agencies to challenge managed care plans' actions. As a result of these factors, Medicaid contracts between states and managed care organizations often favor the managed care organizations.

In any contractual tug-of-war between managed care organizations and providers, the managed care organization almost *always* wins. This is due to a number of characteristics usually encountered in plan-provider contracts:

- Contracts may result in providers being placed at significant financial risk, due primarily to low reimbursement rates;

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- Contracts may make providers responsible for all necessary treatment provided to an enrollee after either the enrollee or the provider is terminated by the plan;
- Providers may be made responsible for collecting payments from third-party insurers when they are deemed liable, and may be required to seek out and collect from any other forms of insurance the client may have, prior to billing the managed care plan;
- Contracts usually make it the provider's duty to see all patients referred to them by the managed care organization, making it difficult or even impossible for a provider to refuse to see a plan patient.

Professional counselors should enter into all contracts with managed care organizations carefully. Ideally, professional counselors should have such contracts reviewed by an attorney prior to signing on the dotted line.

Non-discrimination Against Providers

Of perhaps the most importance to professional counselors, the Balanced Budget Act contains a provision prohibiting Medicaid managed care plans from discriminating against any provider with respect to plan participation, reimbursement, or indemnification solely on the basis of that provider's license or certification. The provision states that this shall not be contrued "...to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization." In other words, if a State licenses or certifies a health profession, Medicaid managed care plans may not exclude all such health professionals based on their type of licensure or certification. Plans are not required, however, to contract with <u>all</u> providers in the state.

While this provision applies to both future and current Medicaid managed care plans, it does *not* apply to primary care case management (PCCM) programs. The legislation does not discuss standards under which managed care organizations would demonstrate that providers are not necessary; regulations in this area will be issued by HCFA.

Because states will only have to submit plan amendments, instead of formal waiver applications, in order to establish managed care plans, professional counselors and other provider and consumer advocates will need to pay close attention to how their states implement such programs. The waiver application process has provided advocates with valuable opportunities to provide input on plan configuration. The plan amendment process, however, is much less rigorous. It appears that twenty-seven states never filed a state plan amendment describing changes brought about by last year's welfare law. Unlike section 1915 or 1115 waiver applications, state Medicaid plan amendments can be approved retroactively, and although states may risk losing federal money if their amendment is ultimately disapproved, this has rarely occurred. According to an analysis by the National Health Law Program, "Clearly, the state plan amendment process is not currently allowing for consumer participation or public information. Much work is needed to help advocates use the process and work with state and HCFA officials to maximize the consumer role during it."

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Mental Health Carve-Outs

Currently, roughly half of the states either have established or are pursuing waivers to allow them to set up mental health "carve-outs" within their Medicaid programs. Under these carve-out arrangements, a private managed behavioral health care firm is contracted with to provide a specific set of services to a defined population. Thus, these benefits are "carved out of" the overall benefit package, and handed over to an entity separate from the Medicaid department.

Carve-outs also frequently occur within a managed care organization's benefit package. Managed care organization "A" may have a contract with the state agency to provide all covered services to Medicaid beneficiaries in a specific area. The organization may decide to carve-out the behavioral health benefit by subcontracting with managed behavioral healthcare organization "B" to provide all mental health and substance abuse services to these Medicaid beneficiaries, under the same terms and conditions as were agreed to between managed care organization "A" and the state Medicaid agency. Thus, Medicaid beneficiaries in this area would receive general medical services from managed care organization "A", but would receive all behavioral health (mental health and substance abuse treatment) services through managed behavioral healthcare organization "B".

The Child Health Insurance Program (CHIP)

Established within the same Balanced Budget Act as the new Medicaid provisions, the Child Health Assistance Program (CHIP) seeks to reduce the number of uninsured children in the country, recently pegged at over 10 million. Although similar to Medicaid, CHIP gives states much more freedom to determine how they want to use their share of the $20.25 billion in federal money to be spent on the program over the next five years. A chart listing the number of uninsured children in each state and the amount of funding the state will receive under the program follows.

The program is targeted at children in families with incomes under 200% of poverty (defined as roughly $32,100 in annual income for the average family of four), and is projected to help provide insurance to roughly two million uninsured children who are not now eligible for Medicaid. States *cannot* use their new CHIP money to pay for coverage of children currently covered by their Medicaid program; states' eligibility rules for Medicaid in effect on June 1, 1997 cannot be lowered.

States have three options for using their CHIP funds. They can use the money to:

- **Expand their Medicaid program.** If a state chooses to use some or all of their funds to expand their current Medicaid program, the proportion of the cost of care the federal government will pay is higher than in the regular Medicaid program;
- **Purchase insurance policies**.
- **Purchase services directly,** such as from a community program. States may not use more than 10% of their funds to pay for their administrative costs, outreach efforts, *and* the direct

purchase of services. States are required to spend at least 90% of CHIP funds on Medicaid expansion and/or the purchase of insurance coverage.

Benefit Packages

For states choosing to purchase health insurance for uninsured children, the benefit package for the policy must be equivalent to one of three benchmark packages:

- the federal employees' standard Blue Cross-Blue Shield preferred provider option;
- a plan offered to state employees; or
- the plan offered by the HMO in the state that has the largest commercial (non-Medicaid) enrolled population.

The state may either purchase a plan with the same services covered in one of the three options above, or it may purchase a different benefit package which is "actuarially equivalent" to one of the three benchmark plans. If a state chooses to buy an "actuarially equivalent" package, the actuarial value of the mental health services covered in the package must be at least 75% of the actuarial value of the benchmark plan's mental health services. While this falls short of an explicit requirement that health benefits packages include mental health coverage, the anticipated effect of the 75% requirement will be to ensure at least minimal mental health coverage for children. Obviously, the effect of the law's "75% of the actuarial value" floor will vary greatly depending on the plan the state chooses to base its program on.

None of the benefit package rules apply in the states of New York, Florida, and Pennsylvania. These three states lobbied successfully to be allowed to continue offering the benefits furnished through their current programs for uninsured children.

Other Requirements

States must meet a number of requirements in order to receive funds:

- States must maintain their current Medicaid program eligibility standards;
- Eligibility standards for CHIP programs cannot be based on a child's diagnosis or health status, and no health plan under this program may deny eligibility to a child because of a pre-existing condition;
- before being enrolled in a CHIP plan, children must be screened for Medicaid eligibility. Only children who are not already eligible for Medicaid can be covered through a health insurance policy purchased with CHIP funds; and
- States must ensure that insurance coverage provided through this program does not substitute for employer-sponsored coverage.

States can begin to receive funds on October 1, 1997, and have until September 30, 1998 to apply for first-year funds. States may carry over unused grant funds from one year into the succeeding two fiscal years. Funds will not be disbursed to a state until the state submits a description of its proposed

child health plan, including the state's current health efforts for children, the eligibility criteria to be used in the CHIP program, how outreach to eligible families will be conducted, and how child health block grant funds will be coordinated with Medicaid or other state health initiatives. States are also required to provide an annual report to the federal government, evaluating their program's success in covering uninsured children and its coordination of CHIP with other types of health care coverage.

In those states which have not already decided how to use their CHIP funds, professional counselors and other advocates can play a key role in influencing their state's decisions regarding CHIP programs. Many states are currently in the process of making decisions on how to use their grant money. Especially in states which do not use their CHIP funds to expand their Medicaid program, and which may essentially be creating a brand new benefit package or choosing from a few different packages, professional counselors have the opportunity to influence what services are covered. It is imperative that advocates make clear the importance of giving children access to an adequate array of effective mental health and substance abuse treatment services, and that States cover professional counselors' services. As with Medicaid, States may choose to cover professional counselors' services as part of their CHIP program. Whether or not they do depends largely on the efforts of advocates within the state.

For more information, contact your state's Medicaid agency or department of health programs. A directory of these agencies, including addresses and phone numbers, is included in the table which follows. Also included is a list of state contacts on CHIP programs, and a description of current activity in implementing these programs.

Links and Sources of Information

A number of organizations have produced material which was used in preparing this report. Among them are:

- The Bazelon Center for Mental Health Law, and its report entitled *Summary of the Child Health Assistance Program (CHIP)*. The Bazelon Center can be reached by phone at (202) 467-5730, or on the internet at *http://www.bazelon.org/*.
- The National Health Law Program, and its reports entitled *The Balanced Budget Act of 1997 — Reshaping the Health Safety Net for America's Poor*, and *An Analysis of Welfare Changes and their Effects on Medicaid Recipients*. The National Health Law Program (NHeLP) is on the internet at *http://ww.healthlaw.org/*, and can be reached by phone at (202) 289-7661.
- The National Association of State Medicaid Directors (NASMD), and information available on its web page at *http://medicaid.apwa.org/*. NASMD can be reached by phone at (202) 682-0100.
- The federal Health Care Financing Administration (HCFA). HCFA's web site contains a wealth of useful information on Medicaid, Medicare, and managed care plans under both programs. The site is located at *http://www.hcfa.gov/*.
- Information has also been used from the report *Managed Medicare & Medicaid: Facts, Trends and Data*, published by Atlantic Information Services, Inc.

State Medicaid Fee-For-Service Reimbursement

State	*Direct Reimbursement for Professional Counselors*	*Direct Reimbursement for Psychologists*	*Direct Reimbursement for Clinical Social Workers*
ALABAMA Medicaid Agency 501 Dexter Avenue P.O. Box 5624 Montgomery, AL 36103-5624 (334) 242-5600	No	Yes	No
ALASKA Division of Medical Assistance Department of Health & Social Services P.O. Box 110660 Juneau, AK 99811 (907) 465-3355	No	No	No
ARIZONA Arizona Health Care Cost Containment System 701 East Jefferson Phoenix, AZ 85034 (602) 417-4000	No	Yes	No
ARKANSAS Division of Medical Services Department of Human Services P.O. Box 1437 Little Rock, AR 72203 (501) 682-8292	No	Yes	No
CALIFORNIA Department of Health Services 714 P Street, Room 1253 Sacramento, CA 95814 (916) 654-0391	Yes - Marriage, Family, & Child Counselors are directly reimbursed for services provided under the EPSDT program (to those under age 21)	Yes	Yes - for services provided under the EPSDT program (to individuals under age 21)

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
COLORADO Health & Medical Services Department of Social Services 1575 Sherman - 10th Floor Denver, CO 80203-1714 (303) 866-2859	No	Yes	No
CONNECTICUT Department of Social Services 25 Sigourney Street Hartford, CT 06106 (203) 424-5116	No	Yes	No
DELAWARE Medical Services Department of Health & Social Services P.O. Box 906, Lewis Building New Castle, DE 19720 (302) 577-4901	No	No	No
DISTRICT OF COLUMBIA Commission on Health Care Finance Dept. of Human Services 2100 Martin Luther King, Jr., Avenue Room 302 Washington, DC 20020 (202) 727-0735	No	No	No
FLORIDA Agency for Health Care Administration P.O. Box 13000 1317 Winewood Boulevard, Bldg 6 - Room 233 Tallahassee, FL 32317-3000 (904) 488-3560	No	No	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
GEORGIA Dept. of Medical Assistance Two Peachtree Street Suite 27-101 Atlanta, GA 30303-3159 (404) 656-4479	No	Yes - Psychologists are directly reimbursed for services provided to EPSDT eligible individuals (those under age 21)	No
HAWAII Health Care Administration Division Department of Social Services & Housing 820 Mililani Street, Suite 817 Honolulu, HI 96813 (808) 586-5392	No	Yes	No
IDAHO Division of Medicaid Department of Health & Welfare 450 West State Street Statehouse Mail Boise, ID 83720 (208) 334-5747	No	Yes	No
ILLINOIS Medical Operations Department of Public Aid 201 S. Grand Avenue, East Springfield, IL 62763-0001 (217) 782-1214	No	No	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
INDIANA Medicaid Policy & Planning Family & Social Services Administration 402 W. Washington Street, Room W382 Indianapolis, IN 46204-2739 (317) 233-4448	No	Yes	No
IOWA Division of Medical Services Department of Human Services Hoover State Office Building 5th Floor Des Moines, IA 50319-0114 (515) 281-8621	No	Yes	Yes
KANSAS Medical Services Division Dept. of Social & Rehabilitation Services Docking State Office Building Topeka, KS 66612 (913) 296-3981	No	Yes	No
KENTUCKY Dept. for Medicaid Services 275 East Main Street, 3rd Floor Frankfort, KY 40621 (502) 564-4321	No	Yes - for services provided to Qualified Medicare Beneficiaries (QMBs)	Yes - for services provided to Qualified Medicare Beneficiaries (QMBs)
LOUISIANA Bureau of Health Services Financing Dept. of Health & Hospitals P.O. Box 91030 Baton Rouge, LA 70821-9030 (504) 342-3891	No	No	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
MAINE Bureau of Medical Services Department of Human Services State House Station #11 249 Western Avenue Augusta, ME 04333 (207) 287-2674	Yes - LPCs in private practice are directly reimbursed for their services if the services are requested by a caseworker at the Dept. of Human Services. LPCs can also be directly reimbursed for Early Intervention services.	Yes	Yes - Social workers in private practice can be directly reimbursed for their services if the services are requested by a caseworker at the Dept. of Human Services. Social workers can also be directly reimbursed for Early Intervention services.
MARYLAND Department of Health & Mental Hygiene 201 West Preston Street Baltimore, MD 21201 (410) 225-6505	No	Yes - for services provided under the EPSDT program (to those under age 21)	Yes - for services provided under the EPSDT program (to those under age 21)
MASSACHUSETTS Division of Medical Assistance 600 Washington Street Boston, MA 02111 (617) 348-5691	No	Yes	No
MICHIGAN Medical Services Administration Department of Social Services 400 South Pine P.O. Box 30037 Lansing, MI 48909 (517) 335-5001	No	No	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
MINNESOTA Health & Continuing Care Strategy Department of Human Services Human Services Building 444 Lafayette Road St. Paul, MN 55155-3852 (612) 297-3374	No	Yes	Yes
MISSISSIPPI Division of Medicaid Office of the Governor Robert E. Lee Bldg., Room 801 239 North Lamar Street Jackson, MS 39201-1399 (601) 359-6050	Yes - for services provided under the EPSDT program (those under age 21)	Yes - for services provided under the EPSDT program (those under age 21)	Yes - for services provided under the EPSDT program (those under age 21)
MISSOURI Division of Medical Services Department of Social Services 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102 (314) 751-6922	Yes - for services provided under the EPSDT program (those under age 21)	Yes - for services provided under the EPSDT program (those under age 21)	Yes - for services provided under the EPSDT program (those under age 21)
MONTANA Medicaid Services Division Dept. of Social & Rehabilitation Services P.O. Box 4210 Helena, MT 59604 (406) 444-4540	Yes - LPC's services are covered under Montana Medicaid. LPC's are licensed by the board of Social Workers & Professional Counselors, through the Montana Department of Commerce	Yes	Yes

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
NEBRASKA Medical Services Division Department of Social Services 301 Centennial Mall South 5th Floor Lincoln, NE 68509 (402) 471-9147	No	Yes	No
NEVADA Welfare Division Dept. of Human Resources Capitol Complex 2527 North Carson Street Carson City, NV 89710 (702) 687-4867	No	Yes	No
NEW HAMPSHIRE Office of Medical Services NH Division of Human Services Department of Health & Human Services Hazen Drive Concord, NH 03301-6521 (603) 271-4353	Yes - Certified Mental Health Counselors are directly reimbursed as long as they have a NH Board of Examiners Certificate	Yes	Yes
NEW JERSEY Division of Medical Assistance & Health Services Department of Human Services 7 Quakerbridge Plaza CN-712 Quakerbridge Plaza Trenton, NJ 08625 (609) 588-2600	No	Yes	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
NEW MEXICO Medical Assistance Division Department of Human Services P.O. Box 2348 Santa Fe, NM 87503-2348 (505) 827-3106	No	Yes	No
NEW YORK Division of Health & Long Term Care Department of Social Services 40 North Pearl Street Albany, NY 12243 (518) 474-9132	No	Yes	Yes - when providing Medicare covered services to Qualified Medicare Beneficiaries (QMBs)
NORTH CAROLINA Division of Medical Assistance Dept. of Human Resources 1985 Umstead Drive P.O. Box 29529 Raleigh, NC 27626-0529 (919) 733-2060	Yes - LPCs when enrolled in a mental health clinic in counties under the Carolina Alternatives waiver will be directly reimbursed for services. Carolina Alternatives is a mental health & substance abuse waiver which covers all Medicaid recipients under the age of 18.	Yes	Yes - Social workers when enrolled in a mental health clinic in counties under the Carolina Alternatives waiver will be directly reimbursed for services.
NORTH DAKOTA Medical Services Department of Human Services 600 E. Boulevard Avenue Bismarck, ND 58505-0261 (701) 328-2321	No	Yes	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
OHIO Office of Medicaid Department of Human Services 30 East Broad Street - 31st Floor Columbus, OH 43266-0423 (614) 644-0140	No	Yes	No
OKLAHOMA Health Care Authority 4545 N. Lincoln Boulevard, Suite 124 Oklahoma City, OK 73105 (405) 530-3373	No	Yes	No
OREGON Office of Medical Assistance Programs Dept. of Human Resources 500 Summer Street Salem, OR 97310-1014 (503) 945-5772	Yes	Yes	Yes
PENNSYLVANIA Office of Medical Assistance Programs Department of Public Welfare Health & Welfare Building Room 515 Harrisburg, PA 17120 (717) 787-1870	No	Yes	No
RHODE ISLAND Division of Medical Services Department of Human Services 600 New London Avenue Cranston, RI 02920 (401) 464-3575	Yes - Certified Counselors in Mental Health are directly reimbursed	Yes	Yes- Licensed Independent Social Workers are directly reimbursed

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
SOUTH CAROLINA Department of Health & Human Services P.O. Box 8206 Columbia, SC 29202-8206 (803) 253-6100	Yes - Licensed Professional Counselors are directly reimbursed for services when enrolled in the SC Dept. of Disabilities & Special Need Waiver for People w/Mental Retardation & Related Disabilities	Yes - Psychologists are directly reimbursed for services provided under the EPSDT program	No
SOUTH DAKOTA Medical Services Department of Social Services 700 Governors Drive, Kneip Building Pierre, SD 57501-2291 (605) 773-3495	No	Yes	Yes
TENNESSEE Bureau of TennCare Department of Health 729 Church Street Nashville, TN 37247-6501 (615) 741-6050	No	No	No
TEXAS Health & Human Services Commission P.O. Box 13247 Austin, TX 78711 (512) 424-6500	Yes - LPC's are directly reimbursed under Texas' Medicaid program	Yes	Yes - Licensed Masters Social Workers/Advanced Clinical Practitioners (LMSW-ACPs) are directly reimbursable
UTAH Department of Health P.O. Box 16700 Salt Lake City, UT 84116-0700 (801) 538-6111	No	Yes	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
VERMONT Office of Health Access Department of Social Welfare Agency of Human Services 103 South Main Street Waterbury, VT 05676 (802) 241-2880	No	Yes	No
VIRGINIA Department of Medical Assistance Services 600 East Broad Street Suite 1300 Richmond, VA 23219 (804) 786-8099	Yes - LPCs are directly reimbursed for therapeutic day treatment services to individuals under the age of 21 who are "seriously emotionally disturbed" or "at-risk of developing serious emotional disturbance", and for day treatment/partial hospitalization services for adults w/serious mental illness	Yes - Psychologists are directly reimbursed for the same services as LPCs as well as psychiatric services	Yes - Social workers are directly reimbursed for the same services as LPCs as well as psychiatric services
WASHINGTON Medical Assistance Administration Department of Social & Health Services P.O. Box 45080 Olympia, WA 98504-5080 (360) 753-1777	No	Yes	No
WEST VIRGINIA Office of Medicaid Services Department of Health & Human Services 7012 MacCorkle Avenue, SE Charleston, WV 25304 (304) 926-1700	No	Yes	No

State	Direct Reimbursement for Professional Counselors	Direct Reimbursement for Psychologists	Direct Reimbursement for Clinical Social Workers
WISCONSIN Division of Health Department of Health & Social Services 1 West Wilson Street, Rm. 250 Madison, WI 53701 (608) 266-2522	No	Yes	No
WYOMING Division of Health Care Financing 6101 Yellowstone Road Cheyenne, WY 82002 (307) 777-7531	No	No	No

NOTE: *Medicaid programs are being reformulated and reconfigured almost constantly. Consequently, some of the information in this report may be outdated. Please contact ACA's Office of Public Policy and Information at (800) 347-6647 x234 if you encounter any inconsistencies, omissions, or errors in the information.*

Summaries of Waiver Programs Affecting Delivery of Mental Health and Substance Abuse Services

The following information provides an overview of state Medicaid waivers and how they affect behavioral health service delivery. This includes both section 1915(b) and 1115 waiver programs, but does not include voluntary managed care enrollment programs, nor does it provide a comprehensive overview of proposed waivers that have yet to be approved. Most of the information in this report was obtained through the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Although all information is as current as possible, waiver programs are extremely sensitive to change through state legislation, individual contract definitions, and implementation changes. Professional counselors are urged to contact their state Medicaid department or department of health programs for the most current information.

ALABAMA

1915(b) waiver program Primary Care Case Management (PCCM) program

Alabama's 1915(b) waiver program is a mandatory primary care case management program, operating statewide. Under the program, all behavioral health services are provided through the standard fee-for-service Medicaid program, following referral from the beneficiary's primary care provider.

1115 waiver program Alabama BAY (Better Access for You)

The BAY Health Plan consists of a managed care system in which all Medicaid beneficiaries (with the exception of foster children and Medicaid/Medicare dual eligibles) in Mobile County are required to enroll. All standard Medicaid benefits for these beneficiaries will be provided through the plan, including mental health services. Mental health services under the program are provided by Mobile Mental Health, a public sector program considered part of the Alabama Department of Mental Health/Mental Retardation.

ALASKA

1915(b) waiver program None

1115 waiver program None

ERIC

ARIZONA

1915(b) waiver program None

1115 waiver program Arizona Healthcare Cost Containment System (AHCCCS)

All Medicaid beneficiaries in the state receive all covered services through a managed care plan under AHCCCS. Arizona's Medicaid department (which *is* AHCCCS) subcontracts with the Arizona Department of Health Services and its Division of Behavioral Health Services (ADHS/BHS) for the provision of all mental health and substance abuse services to the state's Medicaid beneficiaries. The Department of Health Services in turn contracts with five Regional Behavioral Health Authorities (RBHA's), paying them on a capitated basis for the provision of covered services. For individuals without a serious mental illness between the ages of 18 and 20, AHCCCS contracts with acute care health plans.

ARKANSAS

1915(b) waiver programs Primary Care Case Management (PCCM) program
Benefit Arkansas, waiver application submitted and subsequently withdrawn

Arkansas' PCCM waiver is statewide, but covers only inpatient hospital, outpatient hospital services, family planning services, and physician services. All other mental health services are provided under the fee-for-service portion of the Medicaid program. Arkansas does not recognize substance abuse treatment as a Medicaid-covered service.

Arkansas had been developing a mental health and substance abuse treatment carve-out waiver for a program to be known as Benefit Arkansas. The program would have covered all mental health services for children and adolescents under the age of 21. However, the waiver application has been withdrawn, pending a study requested by the Health, Welfare and Labor Committee in the state legislature.

CALIFORNIA

1915(b) waiver programs Medi-Cal, others

Although California's Medi-Cal program, a statewide selective provider contracting system established under a 1915(b) waiver, has been in effect since 1982, the state has

numerous other 1915(b) waiver programs affecting the provision of mental health and/or substance abuse services to Medicaid beneficiaries.

Under a 1915(b) waiver for Psychiatric Inpatient Hospital Services (PIHS), all funding for inpatient psychiatric services is consolidated at the local level. The state's Department of Mental Health requires these services to be coordinated through local Mental Health Plans (MHPs); currently, all MHPs are county mental health departments. This configuration does not apply in Santa Barbara, Solano, and San Mateo counties, in which separate 1915(b) waiver programs have been established providing inpatient psychiatric care and specialty mental health services to all Medicaid beneficiaries through a health insuring organization (HIO), paid on a capitated basis. The San Mateo county program also covers outpatient specialty mental health services.

In Sacramento County, a waiver program known as the "Geographic Managed Care Program" has been established which provides outpatient mental health services and referrals to inpatient psychiatric care for all AFDC/TANF and related beneficiaries.

For outpatient mental health services, California has a Primary Care Case Management program waiver. Under this program, California's Department of Health Services (DHS) contracts with primary care physicians, clinics, and organizations for the coverage of outpatient mental health services, psychotropic drugs, and referrals for inpatient general medical and psychiatric care. The waiver program, although approved for statewide implementation, is currently operating in only five counties.

1115 waiver programs Senior Care Action Network, On Lok, Sutter Senior Care, Center for Elder Independence, Los Angeles County Demonstration

California has four 1115 waiver programs which cover all mental health services for enrollees ages 65 and older: Senior Care Action Network, for enrollees in Long Beach and Los Angeles; On Lok, for enrollees in San Francisco; Sutter Senior Care, for enrollees in Sacramento; and the Center for Elder Independence, in Oakland. Under these programs, the California Department of Health Services contracts with a single HMO on a capitated basis for all covered mental health services.

California also has a waiver program in effect known as the Los Angeles County Demonstration. Under this program, coverage of physical and behavioral services within clinics for both Medicaid and non-Medicaid eligibles is supported.

COLORADO

1915(b) waiver programs Colorado Mental Health Capitation and Managed Care Program
Colorado Primary Care Physician Program

The Colorado Mental Health Capitation and Managed Care Program is in operation in 51 counties in the state, and covers roughly 70 percent of Colorado's Medicaid population. Colorado plans to expand the program statewide in 1998. Under the program, mental health services are contracted out to seven different Mental Health Assessment and Services Agencies (MHASA), which are paid a capitated amount per enrollee for all mental health services. Covered services include: inpatient care, outpatient services, 24-hour residential care, rehabilitation services, case management, respite care, family preservation services, psychosocial rehabilitation services, and vocational and pre-vocational services.

Colorado's Primary Care Physician Program for physical health services is statewide, and is mandatory for AFDC/TANF and SSI eligible populations. The program allows individuals to choose between either a primary care physician (who acts as a gatekeeper for any specialty care received) under a fee-for-service reimbursement plan, or to enroll in an HMO.

1115 waiver program None

CONNECTICUT

1915(b) waiver program Connecticut Access

Connecticut Access is a statewide, mandatory-enrollment program for AFDC/TANF eligibles, under which the state Medicaid agency contracts with HMOs to provide services. Behavioral health services are integrated with general health services under the program; health plans may provide behavioral health services themselves, or contract these services out to a managed behavioral healthcare organization.

1115 waiver program None

DELAWARE

1915(b) waiver program None

1115 waiver program Diamond State Health Plan

The Diamond State Health Plan is a statewide managed care enrollment program covering almost all Medicaid beneficiaries, including AFDC/TANF and SSI eligible populations, and low-income adults and children with incomes below 100% of the federal poverty level. The benefit package provided by the program's four contracting managed care plans includes some behavioral health services. The plans are responsible for providing up to 30 mental health and substance abuse outpatient visits for children and youth. All other needed services are provided under the management of the state's Department of Services for Children, Youth, and Their Families, Division of Child Mental Health Services.

For adults, plans must cover 30 inpatient units and 20 outpatient units of mental health/substance abuse services. (Beneficiaries may trade one inpatient unit for two residential units or three outpatient service units.) Adults may receive additional services from the state's Department of Health and Social Services Division of Alcoholism, Drug Abuse and Mental Health, if they are determined by the Department to be severely and persistently ill (SPI).

District of Columbia

1915(b) waiver programs Primary Care Case Management (PCCM)

The PCCM program applies to all AFDC/TANF-related enrollees in the District. Under the program, approximately half of the AFDC/TANF population is enrolled in one of six HMO's contracting with the D

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1115 waiver program None

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Connecticut Access is a statewide, mandatory-enrollment program for AFDC/TANF eligibles, under which the state Medicaid agency contracts with HMOs to provide services. Behavioral health services are integrated with general health services under the program; health plans may provide behavioral health services themselves, or contract these services out to a managed behavioral healthcare organization.

1115 waiver program None

DELAWARE

1915(b) waiver program None

1115 waiver program Diamond State Health Plan

The Diamond State Health Plan is a statewide managed care enrollment program covering almost all Medicaid beneficiaries, including AFDC/TANF and SSI eligible populations, and low-income adults and children with incomes below 100% of the federal poverty level. The benefit package provided by the program's four contracting managed care plans includes some behavioral health services. The plans are responsible for providing up to 30 mental health and substance abuse outpatient visits for children and youth. All other needed services are provided under the management of the state's Department of Services for Children, Youth, and Their Families, Division of Child Mental Health Services.

For adults, plans must cover 30 inpatient units and 20 outpatient units of mental health/substance abuse services. (Beneficiaries may trade one inpatient unit for two residential units or three outpatient service units.) Adults may receive additional services from the state's Department of Health and Social Services Division of Alcoholism, Drug Abuse and Mental Health, if they are determined by the Department to be severely and persistently ill (SPI).

District of Columbia

1915(b) waiver programs Primary Care Case Management (PCCM)

The PCCM program applies to all AFDC/TANF-related enrollees in the District. Under the program, approximately half of the AFDC/TANF population is enrolled in one of six HMO's contracting with the District. The rest of this population receives services through a primary care case manager. Behavioral health services—defined as any medically necessary services provided through a clinic, hospital, or physician—are covered under the plan. At a future date, the District plans to modify this waiver so that all AFDC/TANF and related populations are enrolled in a managed care plan in which all behavioral health services are provided under a separate, fee-for-service program.

1115 waiver program Managed Care System for Disabled Children and Youth with Special Needs

This program covers all services, including mental health and substance abuse services, for children and youth below the age of 22 who have a disability and are receiving SSI benefits. The District's Medicaid agency makes capitation payments to the organization Health Services for Children with Special Needs (HSCSN), which is responsible for all needed services.

FLORIDA

1915(b) waiver program Florida Prepaid Mental Health Plan (PMHP)

Florida has a statewide mandatory PCCM (primary care case management) enrollment program for all AFDC/TANF and SSI beneficiaries, known as Medipass. However, this program does not include behavioral health services.

The Florida Prepaid Mental Health Plan provides mental health services to Medipass enrollees in the five-county Tampa Bay area. Under the program, the state contracts with the Florida Health Partnership (FHP)—a coalition of private managed care organizations and community mental health centers—to provide all covered services, including inpatient and outpatient care, targeted case management for the severely mentally ill, community mental healthcare, and the services of certain non-physician providers. The plan does not cover substance abuse services, which are provided under the fee-for-service portion of the Medicaid benefit.

1115 waiver program None

GEORGIA

1915(b) waiver program None

1115 waiver program None

Georgia has submitted an 1115 waiver application to establish a mental health/substance abuse carve-out for its Medicaid program, to be known as the Georgia Behavioral Health Plan. The proposal has not been approved yet.

HAWAII

1915(b) waiver program None

1115 waiver program Hawaii QUEST

Under Hawaii QUEST, all AFDC/TANF beneficiaries, state general assistance beneficiaries, and uninsured individuals with incomes at or below 300% of the federal poverty level receive services through one of five managed care organizations contracting with the state. Other eligible populations (including those receiving SSI or Social Security

disability benefits, and Medicare beneficiaries below the federal poverty level) receive services on a fee-for-service basis from the state's Medicaid department.

Hawaii QUEST managed care plans provide some mental health and substance abuse services to plan enrollees, including inpatient care, crisis services, day treatment, and individual and group therapy. Those beneficiaries determined by the Med-QUEST Division (within the state's Department of Human Services) to be seriously mentally ill/seriously emotionally disturbed are referred to one of two managed behavioral healthcare organizations for further mental health care.

IDAHO

1915(b) waiver program Healthy Connections

Idaho's Healthy Connections program, currently implemented in 26 counties, covers physical health services only. Behavioral health services remain under the state's fee-for-service program, and are available to Healthy Connections enrollees upon referral from a primary care provider.

1115 waiver program None

ILLINOIS

1915(b) waiver program None

1115 waiver program MediPlan Plus

Illinois' MediPlan Plus program operates statewide for AFDC/TANF and aged, blind and disabled clients, as well as children who are wards of the Department of Children and Family Services. The program covers only a few behavioral health services, including pharmaceutical drugs prescribed by a psychiatrist, and psychiatric treatment or psychosocial rehabilitation services which are ancillary to the treatment of a physical health diagnosis. All other mental health and substance abuse services are provided in the fee-for-service portion of the Medicaid program.

INDIANA

1915(b) waiver program Hoosier Healthwise

Hoosier Healthwise is a primary care case management/managed care program for physical health services, and covers all AFDC/TANF and related beneficiaries in the state. Behavioral health services are provided through the traditional fee-for-service system, and can be accessed by Medicaid beneficiaries through self-referral.

1115 waiver program None

IOWA

1915(b) waiver program Mental Health Access Plan (MHAP)
Iowa Managed Substance Abuse Care Plan (IMSACP)
Managed HealthCare (formerly MediPass)

The Managed HealthCare program, operating statewide for certain AFDC/TANF and related eligibles, covers general medical/surgical care only. Beneficiaries are enrolled in either a primary care case management program or an HMO.

Under the Mental Health Access Plan, all Medicaid beneficiaries in the state (with the exception of those over 65, some medically needy beneficiaries, those in Psychiatric Medical Institutions for Children, and those in intermediate care facilities for the mentally retarded) receive mental health services under a carve-out arrangement. The benefits provided under the carve-out are extensive, and include inpatient and outpatient care, partial hospitalization, day treatment, targeted case management, sub-acute care, mobile crisis, mobile counseling, respite services, community support programs, assertive community treatment, and intensive outpatient care. Currently, the state contracts with a single managed behavioral healthcare organization for provision of covered services

The Iowa Managed Substance Abuse Care Plan provides comprehensive substance abuse treatment services ranging from inpatient and medically monitored residential care to extended outpatient services and methadone treatment. The program is statewide, covering virtually all Medicaid beneficiaries, including AFDC/TANF/general assistance and related eligibles, SSI and SSI-related eligibles under the age of 65, and medically needy populations. The state has contracted with a not-for-profit agency to implement the program; the non-profit has in turn contracted with a managed care organization for provision of clinical and administrative services.

1115 waiver program None

KANSAS

1915(b) waiver program HealthConnect Kansas
PrimeCare Kansas

HealthConnect Kansas is a primary care case management program, currently implemented in 39 counties, covering all TANF, SSI, general assistance, and poverty-level eligible beneficiaries. In general, behavioral health services are accessible only through referral from the primary care provider; services provided through a community mental health center do not require referral.

PrimeCare Kansas requires TANF and poverty level eligibles to enroll in an HMO in those areas where an HMO is available. Mental health and substance abuse services are not included in the benefit package, and are provided through the fee-for-service Medicaid system.

1115 waiver program None

KENTUCKY

1915(b) waiver program Kentucky ACCESS

Kentucky ACCESS is a managed behavioral healthcare carve-out program, covering all AFDC/TANF and related eligibles, SSI, and medically needy beneficiaries. The program, which is just getting underway, will be implemented statewide. Under the plan, the state is divided into eight geographic regions. Within each region, the state's Department of Medicaid Services and Department for Mental Health and Mental Retardation Services will jointly contract with either a single behavioral healthcare partnership for provision of services, or with managed behavioral healthcare organizations.

Services covered under the program include inpatient and outpatient services, targeted case management (for adults/ children with serious mental illnesses/serious emotional disorders), therapeutic rehabilitation, non-emergency mental health related transportation, and home health. All willing providers who meet the provider network's standards may contract to provide services to beneficiaries enrolled in Kentucky ACCESS plans.

1115 waiver program Kentucky Healthcare Partnership Plan (KHPP)

As described for Kentucky ACCESS, the Kentucky Healthcare Partnership Plan divides the state into eight separate "Partnership" regions, within which the state will contract with managed care organizations or with a single regional health partnership for the provision of

services to program enrollees. The program covers only physical health services; behavioral health services are provided under Kentucky ACCESS.

LOUISIANA

1915(b) waiver program Community CARE

Community CARE is a primary care case management program, operating in twenty rural parishes. The program is mandatory for AFDC/TANF and SSI eligibles. Mental health and substance abuse services do not require prior physician referral, and are provided under the fee-for-service system.

1115 waiver program Louisiana Health Access (LHA)

LHA is a fully capitated managed care program, which is expected to be in place throughout the state within roughly three years. Behavioral health services will remain under the fee-for-service Medicaid program.

MAINE

1915(b) waiver program Medicaid Managed Care Initiative (MMCI)

This program, currently being implemented, will enroll AFDC/TANF and related eligibles in a managed care plan. Behavioral health services will be excluded from the program, and will remain covered in the fee-for-service system. Ultimately, the state plans to integrate behavioral health services into the waiver program.

1115 waiver program None

MARYLAND

1915(b) waiver program None

1115 waiver program Maryland Medicaid Reform Proposal (MMRP)

Maryland has established a mandatory HMO enrollment program, in operation statewide. Most Medicaid eligible populations are included in the program, with the exception of

Medicare-Medicaid dual eligibles and institutionalized populations. Physical health, substance abuse, and primary mental health services are covered under the state's contracts with HMO's, Federally Qualified Health Centers (FQHCs) and Maryland Qualified Health Centers (MQHCs). Primary mental health services include clinical evaluation and assessement, and services/referrals provided by a primary care provider.

All other mental health services are provided by the Specialty Mental Health System (SMHS), under which the state's Mental Health Administration has contracted with a managed behavioral healthcare organization to credential providers and perform utilization review and other administrative services. Upon referral from the enrollee's HMO (and with the authorization of the managed behavioral healthcare organization), specialty mental health services are provided on a fee-for-services basis by a core service agency in the enrollee's locale. The core service agencies contract with individual providers.

MASSACHUSETTS

1915(b) waiver program MassHealth Managed Care (MHMC)

MHMC is a statewide program covering all AFDC/TANF and SSI eligible beneficiaries, as well as individuals under 65 who are not in institutions, and who have no other third party health insurance coverage. Under the program, beneficiaries are required to enroll in either an HMO or a primary care clinician program. Those enrolling in an HMO receive their mental health and substance abuse care through the HMO; those enrolling in the primary care clinician program receive their mental health and substance abuse services from a separate managed behavioral healthcare organization through a carve-out program.

1115 waiver program MassHealth

MassHealth, which is currently in the implementation stage, will cover AFDC/TANF and SSI eligibles, individuals at or below 133% of the Federal poverty level who are long-term unemployed and are not eligible for Medicaid, those receiving unemployment benefits, and disabled adults and children who are not eligible for Medicaid. Under MassHealth, the benefit package will be integrated, including physical health, substance abuse, and mental health services. Beneficiary services will be provided through HMOs under contract with the state. The existing 1915(b) waiver program will be incorporated into MassHealth.

MICHIGAN

1915(b) waiver programs Medicaid Comprehensive Health Plan

This program is currently being implemented in five counties, and will soon be expanded statewide. Under the program, all AFDC/TANF and SSI recipients are required to enroll in an HMO for needed services. Plans are responsible for only limited outpatient mental health services and for substance abuse services. Other services will be carved out, and provided by Community Mental Health Services Programs (local public entities) on a capitated basis.

1115 waiver program None

MINNESOTA

1915(b) waiver program Consolidated Chemical Dependency Treatment Fund

This statewide program covers substance abuse treatment services for three different groups of beneficiaries. The array of services covered is broad, and includes outpatient and extended rehabilitative programs, residential services, inpatient and outpatient care, treatment in halfway houses, and transportation. Low income individuals who qualify for Medicaid—referred to as Tier 1 beneficiaries for purposes of the program—are entitled to coverage under the program. Support for Tier 2 and Tier 3 populations is dependent on the state's appropriation for the program. Tier 2 persons are defined as those with incomes above Tier 1 levels and below 60% of the state median income. Tier 3 persons are defined as those with below-to-average incomes, earning 60-115% of the state median income.

Under the Consolidated Chemical Dependency Treatment Fund, all substance abuse service funding—including state funds, federal block grants, and Medicaid—are consolidated into one pool by the state Department of Health Services. Funds are then allocated to counties and Indian reservations under a formula. These entities manage the delivery of substance abuse service, which are generally provided on a fee-for-service basis.

1115 waiver program Prepaid Medical Assistance Program (PMAP)
MinnesotaCare

The PMAP program is a mandatory PHP (prepaid health plan) enrollment program operating in 17 counties, and projected to be implemented statewide by 1999. The program applies to AFDC/TANF and general assistance eligibles, and generally covers acute care services but not long-term or continuing care services. In the area of mental

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health, the benefit package includes inpatient hospital, clinic services, non-physician providers, personal care, day treatment, specialized services for children with severe emotional disturbance, and home-based services. Only primary care chemical dependency services are covered, with other substance abuse services provided under the 1915(b) waiver program. Prepaid health plans may subcontract with other entities for provision of services.

MinnesotaCare covers acute care medical services and some behavioral health services for pregnant women and children up to 275% of poverty, and childless adults up to 175% of the poverty level. Covered services in the area of behavioral health are the same as under the Prepaid Medical Assistance Program. Minnesota plans to integrate the PMAP and MinnesotaCare programs.

MISSISSIPPI

1915(b) waiver program HealthMACS

HealthMACS is a statewide mandatory primary care case management program for AFDC/TANF eligibles, which covers physical health services only.

1115 waiver program None

MISSOURI

1915(b) waiver program Managed Care+

Managed Care+ has been implemented in four areas of the state, including the St. Louis and Kansas City areas, and the northwest and central regions of the state. The program requires AFDC/TANF eligibles and pregnant women and children to enroll in an HMO, which is responsible for general healthcare services and for some behavioral health services. Managed Care+ plans typically subcontract the provision of mental health services out to managed behavioral healthcare organizations. Covered mental health services include 30 inpatient hospital days and 20 outpatient hospital visits per year (these limits do not apply to children under 21), and medically necessary psychology and counseling services. EPSDT services related to mental health care are also the responsibility of Managed Care+ plans. Covered substance abuse services for children include inpatient detoxification and outpatient services.

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Substance abuse services for adults are carved out and provided under the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Managed Care Program. CSTAR is just being implemented, and covers both Medicaid and non-Medicaid eligible persons. Services are provided through a managed care system established within the state's Division of Alcohol and Drug Abuse, and include inpatient and outpatient services, and rehabilitation services such as skill-building and education programs, case management, and residential rehabilitation.

MONTANA

1915(b) waiver program Mental Health Access Plan (MHAP)

This program serves as a mental health carve out program for all Medicaid beneficiaries in the state. The program also covers non-Medicaid eligibles whose families live at or below 200% of the federal poverty level. Montana has combined its Medicaid mental health services delivery system with other state mental health funding into one program; all public sector mental health services have been completely privatized. MHAP covers an exhaustive array of services, which are provided under a full-risk contract between the state and a joint venture between a private for-profit managed care organization and a coalition of mental health providers known as Montana Community Partners (MCP).

Substance abuse services are not included in MHAP, and remain under the fee-for-service Medicaid program.

1115 waiver program None

NEBRASKA

1915(b) waiver programs Nebraska Medicaid Managed Care Program for Mental Health and Substance Abuse Services (NMMCP/MHSAS)
Nebraska Primary Care Physician Program (PCCP)

Nebraska's 1915(b) waiver programs divide behavioral health services from physical health services. Under PCCP, AFDC/TANF and SSI eligible Medicaid recipients across the state receive their physical health services through a capitated health plan.

The behavioral health carve out under the other 1915(b) waiver covers inpatient and outpatient care (in a variety of settings), day treatment, and a range of community-based services for clients under age 20. Substance abuse services are not covered for clients over

the age of 20. Behavioral health services are contracted out to a single for-profit managed behavioral healthcare organization, which is at full financial risk.

1115 waiver program None

NEVADA

1915(b) waiver program Integrated Medicaid Primary Access to Care and Treatment (IMPACT)

This waiver program, which is for physical health services only, is currently on hold.

1115 waiver program None

NEW HAMPSHIRE

1915(b) waiver program None

1115 waiver program Application pending

New Hampshire has submitted an 1115 waiver application to change a currently-operating voluntary managed care enrollment program to a mandatory enrollment program. The program's benefit package covers physical health and some behavioral health services.

NEW JERSEY

1915(b) waiver program New Jersey Care 2000

New Jersey Care 2000 is a managed care program covering only physical health services. Behavioral health services are carved out and remain in the fee-for-service program.

1115 waiver program None

NEW MEXICO

1915(b) waiver program Primary Care Network (PCN)

PCN is a statewide case management program for physical health services; behavioral health services are available to enrollees on a self-referral basis, and are provided under the fee-for-service Medicaid system. New Mexico has submitted a waiver request to establish a statewide managed care plan (to be known as SALUD!, or the New Mexico Partnership for Wellness and Health) which would cover all services, including mental health and substance abuse services. This waiver application is still pending.

1115 waiver program None

NEW YORK

1915(c) waiver program Home and Community-Based Services Waiver for Seriously Emotionally Disturbed Children

New York's 1915(c) waiver program provides add-on services such as individual care coordination, intensive in-home services, respite care, and family support services for seriously emotionally disturbed children in six pilot counties and in New York City who are at risk of institutionalization.

1115 waiver program None

New York has submitted a waiver application to HCFA to establish the Partnership Plan. If approved, the plan would provide physical health and some behavioral health services to Medicaid beneficiaries through private, for-profit managed care organizations. Plans would be responsible for inpatient and outpatient clinic visits, and would receive additional reimbursement from the state for medically necessary care provided beyond 20 outpatient visits and 30 inpatient days. Community-based services such as partial hospitalization programs are to be provided on a fee-for-service basis. Adults and children with serious emotional illnesses will receive services through Mental Health Special Needs Plans, providing wrap-around services. Basic substance abuse services will be covered through the managed care organization, with extended services available through New York's Office of Alcoholism and Substance Abuse Services.

NORTH CAROLINA

1915(b) waiver program Carolina Alternatives

Carolina Alternatives covers behavioral health services for children 18 and younger in ten pilot sites. For mental health, North Carolina's Medicaid program covers inpatient and outpatient care, clinic services, partial hospitalization, psychosocial rehabilitation, and case management. Covered substance abuse services include detoxification, opioid maintenance therapy, outpatient services, partial hospitalization, assertive community treatment, and high risk intervention services. Carolina Alternatives covers these behavioral health services for program enrollees, as well as high risk intervention services for children with serious emotional disturbances. The state Division of Medical Assistance, in coordination with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, contracts with qualified area service programs for management of services.

1115 waiver program None

NORTH DAKOTA

1915(b) waiver program North Dakota Access and Care (NoDAC)

NoDAC covers only physical health services; behavioral health services remain under the fee-for-service Medicaid system.

1115 waiver program None

OHIO

1915(b) waiver program None

1115 waiver program OhioCare

OhioCare is a mandatory managed care enrollment program operating in most urban counties, which covers almost all Medicaid beneficiaries. Ohio plans to implement a carve-out arrangement for coverage of all behavioral health services under the program. The state had decided to contract with a single managed behavioral healthcare organization for this, but the contract was overturned due to a court challenge. Once up and running, the carve-out will cover mental health and substance abuse services including acute inpatient

care, acute care alternatives (for individuals who would otherwise need acute inpatient care), and outpatient services.

OKLAHOMA

1915(b) waiver program None

1115 waiver program SoonerCare

Oklahoma's Medicaid department contracts with five managed care organizations to provide health services to the Medicaid population under the state's 1115 waiver. The program encompasses both a capitated managed care plan (known as "SoonerCare Plus") and a primary care physician case manager program (known as "SonnerCare Choice"). SoonerCare Plus is in operation in Oklahoma City, Tulsa, Lawton, and adjacent areas, and SoonerCare Choice is in operation in the rest of the state. Enrollment in these programs is mandatory for AFDC/TANF and related eligibles.

SoonerCare Plus mental health services coverage varies depending on the enrollee's condition. The basic benefit package provides inpatient acute care and outpatient services, day treatment, and crisis intervention. For seriously mentally ill (SMI) adults and children with severe emotional disorders (SED), plans must provide intensive outpatient services, home-based services, and rehabilitatitive services. Those beneficiaries diagnosed with SMI/SED may choose to receive services through the fee-for-service Medicaid system.

Substance abuse service coverage is the same for both SMI/SED and non-SMI/SED populations. Covered services, which are provided on a fee-for-service basis, include outpatient care, detoxification, residential and day treatment

Beneficiaries covered under the SoonerCare Choice program receive both mental health and substance abuse services on a fee-for-service basis.

OREGON

1915(b) waiver program Oregon Mental Health Services

Oregon's 1915(b) waiver program delivers mental health services to Medicaid eligible children in Multnomah County on a capitated basis. The Multnomah County Community and Family Services Division contracts with the state as a mental health organization. Providers are paid on a fee-for-service basis.

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1115 waiver program Oregon Health Plan Medicaid Demonstration

Oregon's 1115 waiver program is somewhat complex. The state has developed a prioritized list of services covered by the Oregon Health Plan, and eligibility for the plan has been expanded beyond the traditional Medicaid population. Currently, about 80% or more of the state's Health Plan enrollees receive services through a managed care organization, or Prepaid Health Plan (PHP) of some sort. Enrollees in areas where PHPs are unavailable receive services through primary care case managers. Substance abuse services are covered along with physical health services in the standard benefit package provided by the prepaid health plans contracting with the state.

In 20 out of the state's 36 counties—including the majority of counties east of the Cascade Mountains, and Benton, Clackamas, Washington, Josephine, and Coos counties—mental health services are provided under a carve-out contract. Mental health services in the eastern region are contracted out to Greater Oregon Behavioral Health, Inc., which subcontracts with the various county mental health agencies in the region for provision of services. In Josephine, Coos, and Clackamas counties, provision of mental health services is contracted out directly to each county's mental health agency. Until carve-out programs are established in the remaining counties, mental health services are provided on a fee-for-service basis.

PENNSYLVANIA

1915(b) waiver program HealthChoices Behavioral Health Services (HCBHS)
HealthChoices 96

Under HCBHS, behavioral health services are carved-out and delivered on a capitated basis for all Medicaid beneficiaries in five southeast counties: Philadelphia, Bucks, Chester, Delaware, and Montgomery Counties. Four of the counties have contracted with a private for-profit managed behavioral healthcare organization for provision of services. The services covered under the waiver program include all those covered under the fee-for-service Medicaid system. For mental health care, this includes inpatient and outpatient clinic care, partial hospitalization programs, targeted case management, and expanded services for children and adolescents such as rehabilitation services, family-based services, and residential treatment. Covered substance abuse services include detoxification, and inpatient and outpatient rehabilitation services.

HealthChoices 96 is an HMO-enrollment program, operating in the same counties as HealthChoices Behavioral Health Services. Only physical health services are covered under the program.

1115 waiver program None

RHODE ISLAND

1915(b) waiver None

1115 waiver program RIte Care

Under RIte Care, AFDC/TANF eligible beneficiaries and certain other low-income women and children throughout the state are required to enroll in managed care plans, which are paid on a capitated basis. Some behavioral health services are covered under this benefit. These include inpatient and outpatient care for both mental health and substance abuse disorders, day treatment, and partial hospitalization services.

Adults determined to be seriously and persistently mentally ill (SPMI) and children determined to be severely emotionally disturbed (SED) have their mental health treatment carved-out and paid for under the Medicaid fee-for-service program. These individuals are eligible for additional services, including individual, group, and family therapy; acute inpatient care; community services; and crisis intervention.

SOUTH CAROLINA

1915(b) waiver program None

1115 waiver program None

Although South Carolina has no waiver program applications pending, the state does operate a voluntary HMO program and a primary care provider program on a pilot basis.

SOUTH DAKOTA

1915(b) waiver program South Dakota Provider and Recipient in Medicaid Efficiency (PRIME)

South Dakota operates a statewide primary care case management program (PCCM), which is mandatory for AFDC/TANF and SSI eligibles, as well as low income children and pregnant women. Both physical and behavioral health services are provided on a fee-

for-service basis. A referral is required for mental health services, except for specialty mental health services for children with serious emotional disturbances (SED) or adults with serious mental illness (SMI).

1115 waiver program None

TENNESSEE

1915(b) waiver program None

1115 waiver program TennCare, TennCare Partners

TennCare is a statewide mandatory managed care enrollment program covering all Medicaid beneficiaries in the state, as well as certain low income uninsured individuals who are ineligible for Medicaid. TennCare covers physical and behavioral health services, but behavioral health services are carved out under the TennCare Partners waiver program. However, the state is planning to fully reintegrate behavioral health services into the TennCare program within the next year.

Mental health and substance abuse services are provided through capitated contracts with two private for-profit managed behavioral healthcare organizations. Covered services include inpatient and outpatient treatment for substance abuse disorders, and inpatient and outpatient care, transportation to covered mental health services, case management, crisis services, and psychiatric rehabilitation for those needing mental health care. Expanded coverage, including removal of certain treatment limits, is available through EPSDT coverage, to adults with serious mental illness (SMI) and to children with a serious emotional disturbance (SED).

TEXAS

1915(b) waiver programs State of Texas Access Reform (STAR) Health Plan
STAR+PLUS

The STAR Health Plan is an HMO/primary care case management program operating in Travis, Bexar, Lubbock, Tarrant, and Harris counties and their contiguous areas. The program is mandatory for AFDC/TANF and related eligibles. The benefit package provided includes both physical and behavioral health services. Mental health services covered under the STAR Health Plan include inpatient hospital care and outpatient treatment (generally limited to 30 sessions per year). STAR Health Plan HMOs can

provide additional services such as day treatment and partial hospitalization if they so choose. Children under the age of 21 are also covered for substance abuse treatment services. The Texas Department of Health contracts with HMOs on a capitated basis for covered services.
The STAR+PLUS health plan is a capitated HMO program scheduled to begin operation in December of 1997, only in Harris County. The program applies to both AFDC/TANF and SSI eligibles, and covers both acute care and long term care services, including behavioral healthcare services. Texas contracts with an HMO for services, which in turn contracts with a managed behavioral healthcare organization to provide behavioral health services.

1115 waiver program None

Texas has submitted an 1115 waiver application to implement the STAR program statewide for all Medicaid beneficiaries, and to provide Medicaid benefits to certain low-income uninsured individuals not currently eligible for Medicaid coverage.

UTAH

1915(b) waiver program Prepaid Mental Health Plan

The Prepaid Mental Health Plan is a mental health carve-out program operating in 25 out of the state's 29 counties. As its name implies, the plan covers only mental health services, for all Medicaid eligibles within the areas of operation. Covered services include inpatient and outpatient services, individual and group therapy, skills development services, and targeted case management for the chronically mentally ill. These services are provided through eight community mental health centers under a capitated contract with the state. Substance abuse services remain covered under the fee-for-service Medicaid system.

1115 waiver program None

Utah has submitted an 1115 waiver application to implement a mandatory managed care enrollment program, and to expand coverage to more low-income individuals in the state. If approved, mental health services will remain carved-out under the Prepaid Mental Health Plan.

VERMONT

1915(b) waiver program None

1115 waiver program Vermont Health Access Plan

The Vermont Health Access Plan is a statewide, mandatory managed care enrollment program, covering AFDC/TANF and related eligibles. Individuals eligible through SSI will begin being phased into the program by the end of the year. The Vermont Health Access Plan covers physical and behavioral health services which are acute or short-term in nature. This includes inpatient and outpatient care, individual and group counseling and psychotherapy, and residential and outpatient substance abuse services. Those with serious mental illnesses receive long term benefits through the public mental health system. Vermont contracts with two managed care firms for provision of services; both firms subcontract out the provision of behavioral health services to other entities.

VIRGINIA

1915(b) waiver program Medallion II

Medallion II is a statewide mandatory managed care enrollment program, for AFDC/TANF and SSI beneficiaries. The state contracts with HMOs for provision of services, including physical and mental health services. Covered mental health services include inpatient and outpatient care, with psychiatric rehabilitation, case management, and residential treatment available through community services boards under the fee-for-service program. Expanded services are available to children under the EPSDT program. Substance abuse services are covered only for pregnant women and adults with dependent children, and are limited to residential and day treatment services.

1115 waiver program None

WASHINGTON

1915(b) waiver programs Coordinated Community Mental Health Plan
Healthy Options

Washington's Coordinated Community Mental Health Plan is a carve-out for outpatient mental health services only, covering all Medicaid beneficiaries with the exception of those in state-owned institutions. The plan operates statewide, under capitation arrangements between the state Mental Health Division and regionally-organized prepaid health plans. Covered services include crisis and stabilization services, assessments and evaluations, group services, day treatment, family therapy, and intensive community support services for clients with special needs.

Health Options is a statewide managed care program covering physical health services only for AFDC/TANF eligibles, to be expanded to cover SSI and SSI-related beneficiaries.

The state has submitted a waiver application to establish an Integrated Community Mental Health Program. This program—to be set up on a statewide basis for AFDC/TANF, SSI and SSI related, and medically needy eligibles—will expand the scope of services covered under the state's existing mental health program to include community psychiatric inpatient care.

Substance abuse services are provided through the fee-for-service system, and are managed by the state's Division of Alcohol and Substance Abuse.

1115 waiver program None

WEST VIRGINIA

1915(b) waiver program Mountain Health Trust

The Mountain Health Trust program does not cover behavioral health services, which remain under the fee-for-service Medicaid system.

1115 waiver program None

Although not a waiver program,West Virginia is implementing a program known as the New Directions in Medicaid Services Initiative. This program is aimed at gathering information regarding service use, with the goal of improving the targeting of services, so that the level of service provided matches the level of need. Ultimately, the program will establish utilization review and prior authorization standards.

WISCONSIN

1915(b) waiver programs Medicaid HMO Program
Primary Provider Program

Wisconsin's Medicaid HMO program is mandatory for AFDC/TANF eligibles throughout the state. Managed care plans under this program are responsible for both physical and behavioral health services. Covered behavioral health services are the same as under the fee-for-service program, and include inpatient hospital and clinic services, targeted case management, and outpatient services provided by some non-physician providers. Partial

hospitalization, crisis intervention, and community support programs are available to children and youth under 21.

1115 waiver program None

Wisconsin operates voluntary managed care programs for Medicaid beneficiaries. Among these are a primary provider program covering physical and behavioral health services for SSI eligibles and a program covering wrap-around services in Milwaukee County, and a program in Dane County covering all necessary behavioral health services for children.

WYOMING

1915(b) waiver program None

1115 waiver program None

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Listing of State CHIP program contacts, recent actions, and anticipated funding*

	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
Alabama	Kathy Vincent Staff Assistant to the State Health Officer Alabama Department of Public Health RSA Tower, Suite 1552 PO Box 303017 Montgomery, AL 36130-3017 ph: 334-206-5300; fax: 334-206-2008 www.alapubhealth.org/index.htm	Plan submitted to HCFA November 3, 1997, proposing Medicaid expansion for children ages 14-19 with family incomes under 100% FPL. Proposed effective date is 2/1/98. children uninsured: 179,000 (15.1% of population)	$85,634,397	$398,860,045
Alaska	Theresa M. Tanoury, Special Assistant Department of Health and Social Services Alaska Office Building, Room 229 PO Box 110601 Juneau, AK 99811-0601 ph: 907-465-3030; fax: 907-465-3068 email: Tanoury@health.state.ak.us	Governor proposes Medicaid expansion. Proposal to be submitted to state legislature in January, 1998. children uninsured: 22,000 (10.8%)	$5,152,000	$26,335,898
Arizona	Lynn Dunton, AHCCS Office of Policy Analysis and Coordination 801 East Jefferson Phoenix, AZ 85034 ph: 602-417-4000; fax: 602-256-6756	Commission reviewing state options. Governor announced on 11/6/97 that she will ask legislature to appropriate full state match. children uninsured: 281,000 (22.4%)	$112,965,830	$518,369,446
Arkansas	Ray Handley Director, Division of Medical Services, DHS Donaghey Plaza South, Slot 1100 PO Box 1437 Little Rock, AK 72203-1437 ph: 501-682-8292; fax: 501-682-1197	Grant money potentially available to fund Medicaid 1115 waiver previously approved covering children up to age 18 from families up to 200% FPL. children uninsured: 139,000 (19.3%)	$46,860,505	$218,689,584

	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
California	Leslie Cummings Associate Director for Health Policy Department of Health Services 714 P Street, Room 1253 Sacramento, CA 95814 ph: 916-653-2223; fax: 916-657-1156 www.dhs.cahwnet.gov/orgs/director/healthy_family/healthy.htm	Plan submitted to HCFA November 20, 1997. Legislation signed by Governor 10/97, expanding Medicaid to 100% poverty level for children ages 14-18, and creating non-Medicaid program ("Healthy Families") for children ages 7-18 (between 100%-200% of FPL) and ages 2-6 (between 133%-200% of FPL). "Healthy Families" program to be implemented 7/1/98. children uninsured: 1,804,000 (18.7%)	$855,208,654	$3,969,181,386
Colorado	Sarah Schulte Senior Policy Analyst Dept. of Health Care Policy and Financing 1575 Sherman Street, Fourth Floor Denver, CO 80203-1714 ph: 303-866-3144; fax: 303-866-2803	Plan submitted to HCFA October 14, 1997. Plan includes new program to insure children under 185% of FPL, beginning 1/1/98. Builds on state's existing non-Medicaid program. children uninsured: 161,000 (14.9%)	$43,219,361	$206,077,579
Connecticut	David Parrella Director of Health Care Administration CT State Department of Social Services 25 Sigourney Street Hartford, CT 06106 ph: 860-424-5116; fax: 860-424-5114 Ardell Wilson, DSS, MPH Bureau Chief, Bureau of Community Health CT State Department of Public Health 410 Capitol Avenue PO Box 340308, MS #11CHB Hartford, CT 06134-0308 ph: 860-548-1661; fax: 860-548-1783 www.state.ct.us/ldp/ps97/jnl/s1029-ss6.htm	Legislation adopted 10/30/97 to expand Medicaid to 185% of poverty level for children through age 18, and create a new program ("Healthcare for Uninsured Kids and Youth", or HUSKY) for those below 300% of FPL. HUSKY Plus component established for children with special physical or mental health services needs. Program scheduled to begin 4/1/98 children uninsured: 90,000 (10.6%)	$36,017,176	$174,685,412

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Delaware	Carmen R. Nazario, Secretary Department of Health and Social Services 1901 N. Dupont Highway New Castle, DE 19720 ph: 302-577-4506; fax: 302-577-4510	State Health Care Commission to submit proposal to the legislature in January, 1998. children uninsured: 24,000 (12.7%)	$8,436,772	$40,792,844
District of Columbia	Donna Folkemer Commission on Health Care Finance 2100 Martin Luther King Ave., SE #302 Washington, D.C. 20020	no recent information available children uninsured: 19,000 (15.7%)	$14,372,424	$69,107,613
Florida	Paul Belcher, Policy Coordinator Health and Human Service Policy Unit Room 1604, The Capitol Tallahassee, FL 32399-0001 ph: 850-488-7734; fax: 850-414-2618	Plan submitted to HCFA December 12, 1997. Major features include extending Medicaid coverage for children 15-19 in families with incomes up to 100% FPL and extending current Florida Healthy Kids program, modified to meet requirements of Title XXI law. Amendments to plan anticipated, following 1998 legislative session (begins 3/98). children uninsured: 652,000 (17.5%)	$279,202,492	$1,304,075,073
Georgia	James G. Ledbelter, PhD Health Policy Center 1 Park Place, University Plaza Room 660 Atlanta, GA 30303-3083 ph: 404-651-3104; fax: 404-651-3147	State Health Policy Center developing recommendations for Governor. State considering public-private option similar to Florida's Healthy Kids Program. children uninsured: 329,000 (15.4%)	$126,783,707	$593,692,703

	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
Hawaii	Charles C. Duarte Med-Quest Division Administration PO Box 339 Honolulu, HI 96809-0339 ph: 808-586-5391; fax: 808-586-5389	no recent information available children uninsured: 22,000 (6.7%)	$10,992,634	$56,705,333
Idaho	Linda Caballero Director Idaho Department of Health and Welfare PO Box 83720 Boise, ID 83720-0036 ph: 208-334-5500; fax: 208-334-6558	Initial Medicaid expansion (increase coverage up to age 19 up to 160% FPL) retroactive to 10/97. Committee to discuss long-term options starting 1/98. children uninsured: 51,000 (13.4%)	$15,694,892	$76,610,121
Illinois	George Hovanec, Administrator Division of Medical Programs 201 S Grand Ave. E, 3rd Floor Springfield, IL 62763 ph: 217-782-2570 Valerie Brooks, Governor's Office ph: 217-524-1422 Ann Patla, Associate Secretary Department of Human Services ph: 217-782-0009	Formal task force formed. Directors of Department of Human Services, Title V CSHCN Program, Governor's office and advocacy groups now in discussion. No formal proposals put forward yet from Governor or state legislature. children uninsured: 332,000 (9.8%)	$128,782,081	$640,384,030
Indiana	Kathy Gifford 402 W. Washington St, Room W382 Indianapolis, IN 46204 ph: 317-233-4455; fax: 317-232-7382	Policy group within Governor's office, including members of various state agencies and departments, meeting to develop plan. children uninsured: 180,000 (11.2%)	$73,093,951	$354,904,721

	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
Iowa	Donald W. Herman Director Iowa Department of Human Services Medical Services Division Hoover State Office Building Des Moines, IA 50319 ph: 515-281-8794; fax: 515-281-4597	Task force holding forums with stakeholders throughout the state. Interagency work group will use information from forums to develop options and submit proposal to Governor. If approved by Governor, proposal to be submitted to state legislature in 1/98. children uninsured: 88,000 (11.4%)	$32,987,149	$156,573,446
Kansas	Ann Koci Commissioner, Adult & Medical Services KS Dept. of Social and Rehabilitation Svcs. Senator Sandy Praeger, Chairperson Statewide SRS Workgroup	Study groups, established by Insurance Dept. and Dept. of Social & Rehabilitation Services, examining options. Proposals to be submitted to legislature 1/98. children uninsured: 76,000 (10.3%)	$31,433,507	$152,505,401
Kentucky	John H. Morse, Secretary Cabinet for Health Services 225 East Main Street Frankfort, KY 40621-0001 ph: 502-564-7130; fax: 502-564-3866	Working group (including Dept. of Insurance, advocacy groups, Medicaid, and mental health agencies) considering options. children uninsured: 160,000 (15%)	$50,701,096	$246,807,956
Louisiana	Carolyn Maggio, Executive Director Division of Research and Development PO Box 2870 Baton Rouge, LA 70821 ph: 504-342-2964	Task force established by Governor to hold public meetings to discuss options, develop recommendations. Study to be completed by 1/98. Special legislative session to be held in 1998 on this issue. children uninsured: 277,000 (20.3%)	$101,768,262	$472,855,637

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Maine	Kevin Concannon Commissioner Department of Human Services #11 State House Station Augusta, ME 04333-0001 ph: 207-287-2736; fax: 207-287-3005	no recent information available children uninsured: 45,000 (14%)	$12,724,728	$61,534,777
Maryland	Martin Wasserman, MD, JD Secretary, Department of Health and Mental Hygiene 201 W. Preston Street Baltimore, MD 21201 ph: 410-767-6505; fax: 410-767-6489	State program based on previously unimplemented child health insurance program ("Thriving by Three") being developed. Medicaid expansion to 200% of poverty for children through age 18 under consideration. children uninsured: 158,000 (11.3%)	$61,706,349	$296,556,514
Massachusetts	Pat Canney Deputy Commissioner's Office Massachusetts Div. of Medical Assistance 600 Washington Ct., 5th floor Boston, MA 02111 ph: 617-210-5672; fax: 617-210-5697	Medicaid expansion proposed to cover children up to age 19 up to 200% FPL. Implementation date not yet set. children uninsured: 141,000 (9.3%)	$45,229,971	$227,638,908
Michigan	James Haveman Director's Office, 6th floor Lewis Cass Building 320 S. Walnut Lansing, MI 48913 ph: 517-335-8024; fax: 517-373-4288	Governor proposing new subsidized insurance program to cover children under 200% FPL. Implementation in five counties targeted for 1/98, with statewide implementation by spring of 1998. children uninsured: 220,000 (8.1%)	$92,045,047	$467,287,706

	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
Minnesota	Commissioner David Doth MN Department of Human Services 444 Lafayette Road St. Paul, MN 55155 ph: 612-296-2701; fax: 612-296-5868	Working group within Department of Human Services meeting internally and with other agencies and advocacy groups to evaluate options. Medicaid expansion of MinnesotaCare being considered. children uninsured: 94,000 (7.1%)	$27,022,565	$142,314,026
Mississippi	Lead not yet identified. Interim contact: Theresa Hannah Office of Insurance 455 N Lamar Street Jackson, MS 39202-4021 ph: 601-359-6050; fax: 601-359-6568	Interagency task force developing proposal and seeking public input on implementation. children uninsured: 156,000 (18.6%)	$55,654,715	$260,977,536
Missouri	Greg Vadner, Director Division of Medical Services Department of Social Services 615 Howerton Court PO Box 6500 Jefferson City, MO 65102 ph: 573-751-6922; fax: 573-751-6564	Plan submitted to HCFA on Sep. 26, 1997. Plan would cover uninsured children up to age 18 through 300% of FPL, and uninsured children in Chapter 1 school districts regardless of income. Implementation by 7/1/98. children uninsured: 184,000 (12.3%)	$59,268,396	$288,234,289
Montana	Mary Dalton, Chief Dept. of Public Health and Human Svcs. Medicaid Services ph: 406-444-4144; fax: 406-444-1861 Nancy Ellery/Laurie Ekanger Dept. of Health and Human Services ph: 406-444-5622; fax: 406-444-1970	Governor considering advisory committee proposal. Public hearings being held. children uninsured: 27,000 (10.7%)	$9,739,680	$47,019,685

	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
Nebraska	Ric Compton, Administrator Medicaid Health Care Benefits HHS-Finance and Support 301 Centennial Mall South Lincoln, NE 68509 ph: 402-471-8241; fax: 402-471-9092 Jennifer Williams, Policy Advisor Governor's Policy Research Office Room 1319 State Capitol Lincoln, NE 68509 ph: 402-471-0280; fax: 402-471-2528	Governor to propose Medicaid expansion, possibly to 200% of poverty for children through age 18. children uninsured: 45,000 (9.4%)	$15,448,224	$76,181,442
Nevada	Chris Thompson Department of Human Resources, Medicaid Division ph: 702-687-4176; fax: 702-687-4733	Governor working with state health agency to plan non-Medicaid program to begin in spring '98. Plan to be developed by 1/98. children uninsured: 86,000 (19.1%)	$32,550,586	$149,726,677
New Hampshire	Kathleen G. Sgambati Deputy Commissioner NH Dept. of Health and Human Services 6 Hazen Drive Concord, NH 03301 ph: 603-271-4602; fax: 603-271-4232	no recent information available children uninsured: 32,000 (10.2%)	$10,910,006	$51,976,292
New Jersey	Karen Squarrell Quaker Ridge Plaza, Rm. 306, Bldg. 7 PO Box 712 Trenton, NJ 08625-0712 ph: 609-588-2601; fax: 609-588-3583	Governor proposed a combination approach, including Medicaid expansion for children up to age 18 through 133% FPL, and a new state program (New Jersey Kidcare) of subsidized insurance for children up to age 18 and up to 200% FPL. children uninsured: 295,000 (13.9%)	$91,592,766	$434,504,171

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	Designated State Agency Lead Contact	State Action, # and Percentage of Uninsured Children	Yearly Grant (1998-2000)	5-Year Total (1998-2002)
New Mexico	Lou Gallegos Acting Secretary Human Services Department PO Box 2348 Santa Fe, NM 87504 ph: 505-827-3020	Medicaid expansion to 235% of FPL for children up to age 5 proposed as amendment to current Medicaid waiver, and expansion of program benefits of Healthier Kids Fund. Target start date is 3/1/98. Proposal to be considered by Governor and legislature starting 1/98. children uninsured: 126,000 (22.9%)	$56,753,577	$256,539,339
New York	Susan Moore Director, Bureau of Health Economics State of New York Department of Health Corning Tower, Empire State Plaza Room 119 Albany, NY 12237 ph: 518-486-7897 www.health.state.ny.us/nysdoh/child/chcont.htm	Plan submitted to HCFA November 5, 1997. Plan expands enrollment and increases premium subsidies in the state's current child health insurance program. Advocates pushing for special session of legislature to expand program benefits to include dental, vision and hearing coverage, and to eliminate family contribution for families under 160% of FPL. children uninsured: 680,000 (13.9%)	$265,835,633	$1,291,959,275
North Carolina	Tom Vitaglione Division of Maternal and Child Health PO Box 29597 Raleigh, NC 27626 ph: 919-715-3808; fax: 919-715-3187	Task force meeting and holding forums. Six-member Governor-appointed commission to review task force's recommendations. Options under review are Medicaid expansion and 3 state insurance programs. Issue may be addressed in special legislative session in February. children uninsured: 284,000 (14.2%)	$79,741,341	$385,769,381

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North Dakota	Dave Zenter Director of Medical Services Department of Human Services 600 East Boulevard, 3rd floor Judicial Wing Bismark, ND 58505-0250 ph: 701-328-2321; fax: 701-328-1544	no recent information available children uninsured: 14,000 (7.9%)	$5,202,463	$26,118,262
Ohio	Barbara Edwards Deputy Director for Medicaid Ohio Department of Human Services 30 East Broad Street, 31st Floor Columbus, OH 43266-0423 ph: 614-466-4443	Medicaid expansion announced for children through age 18 up to 150% of FPL starting 1/1/98. Coverage limited to only some of uninsured. children uninsured: 309,000 (10.1%)	$114,442,019	$571,215,061
Oklahoma	Jerry Regier Secretary of Health and Human Services 3814 N Santa Fe Oklahoma City, OK 73125 ph: 405-530-2806; fax: 405-530-2890	Grant money available for recent Medicaid expansion for children up to age 18 up to 185% of FPL. Future Medicaid expansion planned with sliding-scale premium payments up to 250% of FPL. children uninsured: 201,000 (20.8%)	$79,467,777	$360,183,605
Oregon	Barney Speight, Administrator Office for Oregon Health Plan Policy 255 Capitol Street NE Public Service Building, 5th floor Salem, OR 97310 ph: 503-378-2422 x401 fax: 503-378-5511 Bob Diprete ph: 503-378-2422 x402 fax: 503-378-5511	Probable expansion of Oregon Health Plan, involving raising age eligibility from 11 to 18, increase coverage to age 12 and up to 170% of FPL. Possible expansion of Family Health Insurance Assistance Program, involving raising eligibility from 150% of FPL to 170% of FPL, and up to age 18. children uninsured: 123,000 (14%)	$41,881,622	$202,638,993

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Pennsylvania	Melia Belonus, Senior Policy Analyst Governor's Office of Policy Commonwealth of Pennsylvania Room 506 Finance Building Harrisburg, PA 17120 ph: 717-787-1954; fax: 717-787-9063	Plan submitted to HCFA November 3, 1997. Plan expands state's current child health insurance program to cover more chidren who now qualify. Program provides full subsidy of premiums up to 185% FPL, with a sliding scale to 235% FPL. children uninsured: 288,000 (9.3%)	$123,329,744	$607,039,872
Rhode Island	Clark Greene Office of the Governor Capitol Hill Providence, RI 02903 ph: 401-277-2080; fax: 401-521-1665	Informal study group meeting to review proposals, including Medicaid expansion to cover children up to age 17 and up to 250% of FPL, and program to subsidize employer-based insurance. Department of Human Services to propose plan shortly. children uninsured: 24,000 (9.7%)	$10,673,243	$51,037,602
South Carolina	Gwen Power, Director SC Dept. of Health and Human Services PO Box 8206 Columbia, SC 29202-8206	Proposal submitted to HCFA December 9, 1997. Governor expanded Medicaid Program on 10/1/97 to include children up to age 19 up to 150% of poverty. children uninsured: 174,000 (16.8%)	$65,234,386	$314,707,881
South Dakota	Doneen Hollingsworth Sough Department of Health Pierre, SD 57501 ph: 605-773-3361; fax: 605-773-5683	no recent information available children uninsured: 19,000 (8.5%)	$7,522,023	$37,932,903

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Tennessee	Ann Alderson, Debby Gant Office of Policy and Intergovernmental Relations 729 Church Street Nashville, TN 37247 ph: 615-741-0217; fax: 615-741-0882	U.S. Congress passed amendment on 11/13/97 which would allow state to apply funds to its spring 1997 expansion of the TennCare program. children uninsured: 219,000 (15.1%)	$66,618,662	$330,731,571
Texas	Tyrette Hamilton, Acting Director Texas Healthy Kids Corporation ph: 512-463-3046 Dr. Michael McKinney, Commissioner Health and Human Services Commission ph: 512-424-6502	Options under consideration include Medicaid expansion to raise coverage to 150% FPL and expansion of Texas Healthy Kids Program. children uninsured: 1,440,000 (24.1%)	$558,774,867	$2,523,604,663
Utah	Pat Johnson Division of Health Policy 288 N. 1460 W. Salt Lake City, UT 84111 ph: 801-538-6984; fax: 801-538-6303	Thirteen-member commission led by Governor has proposed subsidized insurance program for children through age 18, between 100%-200% of FPL. Medicaid expansion not planned. Public hearings being held to gather feedback. Program targeted to begin 4/1/98. children uninsured: 75,000 (10.2%)	$25,053,748	$124,222,997
Vermont	Richard Laverty Program Consultant VT Department of Social Welfare 103 S. Main Street Waterbury, VT 05676 ph: 802-241-2994; fax: 802-241-2830	no recent information available children uninsured: 11,000 (7%)	$3,959,814	$20,744,831

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Virginia	Joe Teefey, Director Department of Medical Assistance Services 600 E. Broad Street, Suite 1300 Richmond, VA 23219 ph: 804-786-8099; fax: 804-371-4981	Legislative committee proposal to be presented to legislature in 1/97. children uninsured: 197,000 (11%)	$71,424,313	$345,875,137
Washington	Sue Crystal, Director Governor's Office of Health Policy PO Box 43113 Olympia, WA 98504-3113 ph: 360-902-0607; fax: 360-586-8380 email: Sue.crystal@OFm.wa.gov	Advisory group established to recommend approaches and describe options. children uninsured: 171,000 (11%)	$47,351,081	$230,930,528
West Virginia	Joan Ohl Cabinet Secretary Department of Health and Human Resources 1900 Kanawha Blvd. E. Charleston, WV 25305 ph: 304-558-3194; fax: 304-558-1130	Panel formed by Health Dept. to present proposal to legislature in 1/98. Legislature considering enrolling eligible children into Medicaid before drawing down federal grant funds children uninsured: 47,000 (10.2%)	$23,053,013	$111,158,963
Wisconsin	Joe Leean Secretary, Dept. of Health and Family Services Bureau of Health Care Financing PO Box 309 Madison, WI 53701 ph: 608-266-9622; fax: 608-266-7882 www.dhfs.state.wi.us/NewsInitiatives/ Initiatives/badgercare/badgercareindex.html	Legislature and Governor propose Medicaid expansion to include children 6-18 up to 133% FPL. State insurance plan for working families and their children, between 133%-185% FPL also being considered. children uninsured: 92,000 (6.4%)	$37,300,536	$190,993,635

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Wyoming	Don Rolston Director, Department of Health 2300 Capitol Avenue - 177 Hathaway Bldg. Cheyenne, WY 82002 ph: 307-777-7656; fax: 307-777-7439	no recent information available children uninsured: 20,000 (13.4%)	$7,492,707	$34,804,248

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* Sources:

Summary of State contacts and actions—

- Institute for Child Health Policy and its Center for Policy & Program Coordination, at the University of Florida. Summary based on information made available by the Children's Defense Fund, Health Division, and the American Academy of Pediatrics, Division of State Government and Chapter Affairs. Information is frequently updated on the Institute for Child Health Policy's web site, at *http://www.ichp.ufl.edu/mchb/center/policy/titlexxileads.html.*

- Health Care Financing Administration (HCFA). Much documentation on the CHIP program, including information on state plans, is contained within HCFA's web site at *http://www.hcfa.gov/init/children.htm.*

Grant funding amounts taken from General Accounting Office estimates, August 4, 1997

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