STATE PUBLIC MENTAL HEALTH SERVICES: A PRIMER

Prepared for the
HJR 1 Study of Mental Health Services
by

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INTRODUCTION

Public mental health services are funded by the state and local governments and local school districts. The most extensive public mental health programs are administered by the Department of Public Health and Human Services (DPHHS), which received $119.2 million in appropriations specific to mental health services and administration for fiscal 2002.

This sketch of public mental health service funding, eligibility for services, access to services, and federal regulations impacting services and eligibility is intended to help persons gain an understanding of the current state government funded public mental health services. The report focuses on state programs and does not explain or quantify services funded by local governments or schools.

EXECUTIVE SUMMARY

Medicaid, funded by state and federal funds, is the most significant public funding source for mental health services, accounting for nearly 60 percent of the mental health services appropriation. Medicaid is governed primarily by federal regulations, with some latitude for states to add services and categories of eligibility.

Eligibility for Medicaid funded services is the most complex of the three major state funding sources. There are 35 separate types of Medicaid eligibility and states may opt to add optional categories of eligibility. Medicaid eligibility is based on income and resources and both children and adults can be eligible. Age, determination of disability, and presence of dependent children in a family or minor children are also factors considered in determining eligibility. Childless adults who are not disabled or aged are almost always ineligible for Medicaid, regardless of their income level.

Medicaid services are the most comprehensive of the state mental health funded programs and include coverage for physical health services as well. Once a state opts into the Medicaid program there are certain services it must cover (mandatory services) and some services that are optional. Examples of mandatory services are hospital, nursing home, and physician services, while prescription drug, and most mental health services are examples of optional services.

Once a state opts into Medicaid its plan must meet other federally established conditions. For instance, all Medicaid services must be offered statewide and the state must allow freedom of choice among providers. A state must obtain a waiver of federal regulations if it wishes to change services or access to services in a way that is contrary to federal rule.

The Mental Health Services Plan (MHSP) provides mental health services for adults and children not eligible for Medicaid. MHSP is funded by general fund and Children's

Health Insurance Program (CHIP) federal grant funds. MHSP does not provide physical health services.

The MHSP service array varies between adults and children. Some services, such as case management are provided to adults but not to children. MHSP services for adults generally compare to mental health services provided by Medicaid except that MHSP does not pay for hospital services while Medicaid does. MHSP services for children compare to the service array provided by Medicaid except that MHSP does not cover case management or hospital services.

Eligibility for MHSP depends on income and severity of mental illness. Adults must be determined to have a severe and disabling mental illness and children must be in enrolled in the CHIP program and determined to be seriously emotionally disturbed.

The state establishes criteria for MHSP services for adults. Since federal CHIP funds support MHSP service for children, there are some federal guidelines that impact MHSP children's services. For instance, once a child meets CHIP and is determined to be seriously emotionally disturbed, that child may receive medically necessary MHSP services after CHIP benefits have been exhausted.

CHIP eligibility is determined by income. However, children whose parents are employees of state governments or whose families have health insurance are not eligible for CHIP even if the family income meets financial eligibility criteria. All CHIP eligible children receive physical health services similar to the state employee benefit package. Once a CHIP eligible child is determined to be seriously emotionally disturbed and has exhausted CHIP mental health benefits, he or she is then eligible for expanded MHSP mental health services, which are funded about 19 percent general fund and the balance from the federal CHIP grant.

Finally, DPHHS administers a program for about 125 low-income children that provides basic mental health services, but no physical health services. While some outpatient services and prescription drugs are covered, out-of-home services are not. The general fund that supports the basic mental health services is part of the maintenance of effort the state is required to spend to draw down the Temporary Assistance for Needy Families (TANF) block grant (about $45 million annually). Eligibility for basic mental health services is based on family income and the determination that a child has a serious emotional disturbance. The state establishes all guidelines for basic mental health services.

Eligibility, and therefore access, to all state government funded mental health services are based on income and, depending on the funding source, determination of disability or diagnosis. Types of services funded, service limits, and co-payments for services also vary and are determined in some instances by funding source.

DPHHS also administers the two state institutions for adult mental health services – the Montana State Hospital (MSH) and the Montana Mental Health Nursing Care Center.

Both institutions are certified under federal Centers for Medicare and Medicaid Services (CMS - formerly the Health Care Financing Administration) standards. MSH is licensed and certified as a hospital and MMHNCC is licensed and certified as a nursing home. Both institutions are supported by a variety of funds including general fund and payment from Medicaid, Medicare, private insurance, counties, and Indian Health Services. Both institutions specialize in provision of mental health services and provide some physical health services as well, referring patients to outside medical providers for physical health services as needed.

Medicaid is an entitlement and enrollment cannot be capped. Enrollment in all other community mental health service programs administered by DPHHS is capped with the number of enrollees based on the appropriation and expenditure patterns. MSH must accept persons appropriately referred for treatment by another hospital or court ordered for commitment or evaluation. Admission to MMHNCC is usually voluntary with DPHHS having the authority to decide whether or not to admit an individual.

Once a state opts into Medicaid, its program must meet certain federal criteria. Three of the most basic program criteria are: 1) program participants must have freedom of choice among providers; 2) any willing provider meeting established criteria must be able to participate in the program; and 3) services must be available statewide (to the extent providers are willing to participate). If a state wishes to bypass any of these federal criteria, it must get a waiver or it will be out of compliance with federal Medicaid criteria.

If a state wishes to limit the number of providers that can participate it must obtain a waiver of freedom of choice. However, it appears that a state can never waive compliance with federal procurement criteria if it wishes to limit the number of providers that can deliver a Medicaid service.[1]

If a state is found to be out of compliance, it will have a period of time to implement corrective actions to come back into compliance and most probably avoid a sanction. If a state does not comply with federal Medicaid criteria, it can be fined all or part of the federal financial participation in its Medicaid program.

States can create flexibility in program design, reimbursement methods, and limit provider participation using Medicaid waivers. But the waiver process can be time consuming, both to develop programs and administer the waiver and, depending on program design, approval of the waiver can take more than two years.

States can use a prepaid health plan (PHP) to develop flexibility in funding and provision of services within Medicaid programs. A PHP must be funded with a capitated rate and may include services in addition to those approved in the state Medicaid plan. A PHP can also include fewer services than those approved in the state Medicaid plan. States can avoid waivers and compliance with the federal procurement process if any willing provider can participate in the PHP and if consumers have a choice to participate either in

[1] Letter to Senator John Cobb from Greg Petesch, Director of Legal Services, Legislative Services Division, October 31, 2001, p. 4.

the PHP or in the traditional fee-for-service system. Federal review of PHPs is not required if the total contract reimbursement is less than $1 million per individual provider.

If Medicaid consumer participation in a PHP is voluntary it may result in adverse selection, especially if the PHP includes a comprehensive array of services. Voluntary participation may pose financial risks for both the state and the provider, depending on plan design.

A PHP holds promise to provide funding flexibility for Medicaid services. However, it must be designed carefully if a state wishes to avoid obtaining a waiver of federal Medicaid criteria, bypass federal procurement criteria, and be funded adequately.

TOTAL EXPENDITURES FOR PUBLIC MENTAL HEALTH SERVICES NOT RECORDED

Most public mental health services are funded by the Addictive and Mental Disorders Division (AMDD) of DPHHS. The fiscal 2002 appropriation for mental health services is $119.2 million, including $51.4 million general fund. CHIP, administered by the Health Policy Services Division of DPHHS, also provides funds for mental health. However, the CHIP appropriation of $13.1 million total funds, including and $2.5 million general fund, in fiscal 2002 year was not segregated between physical and mental health benefits.

Although, most public mental health services are funded by DPHHS, other state departments (Corrections and the Office of Public Instruction) as well as local governments and schools also provide public mental health services. The Office of Public Instruction (OPI) receives an appropriation for special education, which includes education and related services necessary for seriously emotionally disturbed children, which may include some mental health services. However, the OPI appropriation and additional expenditures by local school districts are not allocated nor are expenditures recorded by type of disability, making it difficult to accurately determine school related mental health service expenditures.

No single entity tracks or captures the total cost of public mental health services and, in some instances, mental health expenditures are combined with other types of expenditures. There is insufficient data to determine total expenditures for public mental health services in Montana.

STATE GOVERNMENT APPROPRIATION FOR PUBLIC MENTAL HEALTH SERVICES

There are four sources of funds, excluding OPI, juvenile corrections and foster care expenditures, that support state government expenditures for public mental health services in Montana: 1) general fund; 2) federal Medicaid funds; 3) federal CHIP funds; and 4) two small federal block grants.[2] The block grants, general fund, and Medicaid funds supporting mental health services are appropriated to AMDD, while CHIP funds, including the state match, are appropriated to the Health Policy Services Division, both divisions in DPHHS.

OPI, juvenile corrections and foster care programs may also fund mental health services for children who are not eligible for programs or who require services that are not reimbursed by programs administered by AMDD. Mental health expenditures by entities other than AMDD are generally not recorded separately from other types of expenditures.

Table 1 shows the fiscal 2002 appropriation for public mental health services and administration to AMDD by fund type and major service. CHIP funds ($13.1 million annually, including $2.5 million general fund) were appropriated without distinction as to how much of the appropriation would support mental health services and how much would support physical health services, so CHIP appropriations are not reported in the table.

[2]Other divisions in DPHHS, other state agencies, and local governments may also incur general fund costs for mental health services if Medicaid funds cannot be used for services for Medicaid eligible persons or for community hospitalizations of some persons.

Table 1
Fiscal 2002 Appropriations for Mental Health Services
Addictive and Mental Disorders Division

Function	General Fund	State Special	Federal Funds	Total	Percent of Total
Mental Health Medicaid Services	$ 16,082,466	$ 2,256,364	$ 52,668,440	$ 71,007,270	59.6%
Montana State Hospital	18,043,873	2,031,287	552,126	20,627,286	17.3%
MSH/Community Incentives (Biennial/OTO)	1,156,720	-	-	1,156,720	1.0%
Subtotal	19,200,593	2,031,287	552,126	21,784,006	18.3%
Montana Mental Health Nursing Care Center	3,501,127	355,957	2,734,488	6,591,572	5.5%
Mental Health Services Plan	9,258,165	720,075	3,827,934	13,806,174	11.6%
Basic Mental Health Services - TANF Restricted	647,952	-	-	647,952	0.5%
Subtotal	9,906,117	720,075	3,827,934	14,454,126	12.1%
Mental Health Direct Service Contracts	1,046,276	-	346,052	1,392,328	1.2%
Mental Health Services Bureau	1,437,924	1,280	1,947,652	3,386,856	2.8%
Regional Mental Health (Restricted, Biennial)	208,531	-	278,041	486,572	0.4%
Law Enforcement/Judicial Education (Restricted)	42,219	-	25,332	67,551	0.1%
Subtotal	1,688,674	1,280	2,251,025	3,940,979	3.3%
Total Mental Health Appropriations - AMDD	$ 51,425,253	$ 5,364,963	$ 62,380,065	$119,170,281	100.0%
Percent of Total	43.2%	4.5%	52.3%	100.0%	

Appropriations include pay plan and represent AMDD allocations among functions.
Amount of biennial appropriations equals 1/2 of the appropriation to be spent during fiscal 2001.
State special revenue for Medicaid services includes interest income from the Tobacco Settlement Trust fund and county revenue from intergovernmental transfer programs.
State special revenue for the state hospital and nursing care center includes canteen funds, alcohol tax revenue, and federal Medicaid funds.

General fund supports 43 percent of the total amount appropriated to AMDD for mental health services and administration. Together appropriations for Medicaid and MHSP services account for about 72 percent of the total appropriation.

GENERAL FUND

General fund supports the full cost of the MHSP adult services, most of the MSH cost (explained later), and the state match for federal Medicaid and CHIP funds. Administrative activities related to the Medicaid program require a 50 percent state match. The state match rate for Medicaid eligible services changes annually and is based on a formula that takes into account changes in state per capita income compared to national per capita income. The Montana match rate for services has varied from a high of 38.9 percent in fiscal year 1979 to a low of 27.12 estimated for fiscal 2002.[3] CHIP

[3] The projected fiscal 2003 state Medicaid match is 26.98 percent.

benefits require a state match equal to 80 percent of the state Medicaid benefit match rate. The CHIP benefit match rate for fiscal 2002 is about 19 percent.

STATE SPECIAL REVENUE FUNDS

Table 1 includes state special revenue appropriations as well. State special revenue appropriations for Medicaid services include intergovernmental transfers of county funds that support community mental health centers and interest income from the constitutional tobacco settlement trust. Both of these revenue sources were added by the 2001 legislature to fund a portion of provider rate increases.

State special revenue appropriated for the state hospital and nursing care center includes canteen funds, alcohol tax revenue to fund treatment of persons who are both mentally ill and chemically dependent, and federal Medicaid reimbursement funds[4].

FEDERAL FUNDS

Medicaid matching funds are the largest single source of federal funds appropriated for mental health services. Federal Medicaid services funds account for 44 percent of the total mental health services appropriation in fiscal 2002.

The state receives two federal block grants ($1.5 million for fiscal 2002) to fund mental health and homeless services (Mental Health Block Grant and the PATH grants.) Both block grants support MHSP services and the PATH grant is included the direct service contract amounts. The state must submit an annual plan and spend enough state funds to meet a maintenance of effort requirement for the mental health block grant.

ELIGIBILITY FOR SERVICES

Eligibility for services varies among the three major funding sources of public mental health services. Medicaid eligibility is the most complex and considers income, resources, and certain categorical criteria such as age, determination of a severe medical impairment, blindness or presence of a dependent child in a family or minor child. Medicaid income eligibility varies by eligibility category.[5]

CHIP, MHSP and basic mental health services consider income, but not resources in eligibility determination, and other factors. Income eligibility for these programs is 150 percent of the federal poverty level.

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[4] Section 53-1-413(4), MCA requires that Medicaid reimbursement to MSH and MMHNCC be expended as federal special revenue. The legislature specifically appropriated Medicaid funds to support the two institutions in the federal special revenue fund in compliance with state statute.

[5] Some states have opted to disregard income, thereby increasing the number of persons eligible for Medicaid. States can also eliminate the assets tests for Medicaid eligibility.

CHIP is a health insurance program for low-income children. CHIP does not cover adults and federal regulations do not allow coverage for children in families where a parent works for state government or the family has health insurance.

Table 2
Calendar Year 2001 Federal Poverty Level
Various Poverty Level Incomes by Family Size

Family Size	40%	**Poverty Level**	133%	150%	200%
1	$ 3,436	$ 8,590	$ 11,425	$ 12,885	$ 17,180
2	4,644	11,610	15,441	17,415	23,220
3	5,852	14,630	19,458	21,945	29,260
4	7,060	17,650	23,475	26,475	35,300
5	8,268	20,670	27,491	31,005	41,340
6	9,476	23,690	31,508	35,535	47,380
7	10,684	26,710	35,524	40,065	53,420
8	11,892	29,730	39,541	44,595	59,460
Each Additional Person	$ 1,208	$ 3,020	$ 4,017	$ 4,530	$ 6,040

The poverty level is updated annually in February or March and historically has increased from 2 to 5 percent.

MHSP provides only mental health services and covers low-income children and adults. An adult must be determined to have a severe and disabling mental illness to be eligible. MHSP services are provided CHIP eligible children who are also determined to be seriously emotionally disturbed. Income eligibility is set at 150 percent of the federal poverty level.

Basic mental health services are provided to children who would otherwise be eligible for MHSP but aren't due to federal CHIP eligibility restrictions or because CHIP is not accepting new enrollees.

Enrollment is capped in the state administered programs, but not for Medicaid. Table 2 shows the number of slots budgeted by program during the 2001 legislative session compared to program enrollment in November 2001.

MEDICAID ELIGIBILITY FOR SERVICES

Once a state opts to accept federal Medicaid funds, there are defined services and categories of eligibility that it must include in its state plan. Other defined types of services and eligibility can be added at a state's discretion. Most mental health services are optional, however, mental health services provided by a physician or hospital are mandatory. Montana has added some optional services because optional services can provide a lower cost alternative to mandatory Medicaid services. For instance, some optional outpatient services are lower cost than comparable, mandatory inpatient services.

Federal Guidelines

Federal guidelines establish criteria for Medicaid eligibility, with some flexibility for state discretion. The following discussion contains basic information about Medicaid

eligibility and omits references to narrower, specific types of eligibility and nuances of eligibility for specific eligibility subgroups.[6] For instance, there are 35 unique, separate categories of Medicaid eligibility and this discussion highlights only the three major, broad categories of Medicaid eligibility.

In general, federal guidelines establish categories of eligibility that must be included in a state Medicaid plan. There are three types of categorical eligibility: 1) persons who are aged, blind or disabled; 2) families with dependent children; and 3) minor children. In general, in order to be Medicaid eligible persons and families must meet resources (assets) and income tests.

Aged, Blind, Disabled Medicaid Eligibility

Individuals who are aged, blind or disabled must establish other criteria pass as well as pass income and resources tests to become Medicaid eligible. Persons must be over the age of 65 or present evidence that they are legally blind. In order to be considered for the disabled eligibility category, persons must meet the disability criteria and resources and income limits established by the federal Social Security Administration.[7]

If a person is determined to meet disability criteria by the Social Security Administration, then he or she is eligible to receive a monthly payment – Supplemental Security Income (SSI). Persons receiving SSI payments are automatically eligible for Medicaid.[8]

Federal Disability Determination

The Social Security Administration contracts with DPHHS, as required by federal law, to determine disability eligibility for SSI. Federal guidelines anticipate that the SSI eligibility determination process should take no more than 120 days for the first two levels of appeal. The entire process can involve up to five levels of appeal. Some persons who have helped mentally ill people apply for SSI participated in eligibility determination processes that took 18 months.[9]

Federal regulations, laws, and court decisions guide the determination of severe medically determined impairment. The review focuses on level of functioning with

[6] Kathy Quittenton, Family Medicaid Policy Specialist, and Nancy Clark, SSI Medicaid Policy Specialist, Human and Community Services Division, DPHHS, and Michelle Thibodeau, Chief, Disability Determination Services Bureau and Kathy Surdock, Adjudication Team Coach, Disability Services Division, DPHHS provided information about Medicaid eligibility and SSI medical impairment.

[7] SSI resource and income tests adopted by the Social Security Administration are very similar to those used by the Montana Medicaid program for the aged, blind, and disabled category of eligibility.

[8] In December 1998 there were 13,853 adults in Montana receiving SSI and 2,017 children. Of the adults, 12,252 were disabled; 1,190 were aged; and 138 were blind. The average SSI payment to eligible Montanans was $322 per month.

[9] Jeff Sturm, Director of Tri County Services, Golden Triangle Community Mental Center, personal communication, January 10, 2000.

emphasis on ability to perform simple unskilled work in a timely manner without inordinate supervision and relate well enough to others to perform such work and not interfere with the work of others. While diagnosis is a component of the review, the ability to participate in daily life activities, including work, is the most significant determinant.

Medical findings, symptoms, age, education, and work history are examples of information that is considered in making the determination for adults. In determining SSI eligibility for children five categories are considered.[10] Due to court decisions, children's SSI eligibility considers an applicant's ability to function compared to a normal, similar age child.

Federal regulations require that each person receiving SSI or Social Security Disability Insurance benefits (discussed in the following section) undergo a continuing disability review every 1 to 7 years, depending on the type of disability. Children at age 18 are subject to re-determination of medical impairment using adult disability criteria. The main difference between evaluating medical impairment between a child and an adult is the ability of an adult to function in a work environment. Furthermore, there are different diagnostic categories for children that are not analogous to adult mental disorders. Continued eligibility for SSI payments for all persons also depends on changes in individual or family income.

SSI eligibility can lapse if a person has not received an SSI payment for more than a year. For example, persons admitted to MSH longer than one year or persons in prison longer than one year would lose their SSI eligibility because federal regulations generally prohibit SSI payments to persons in a public institution. Persons must reapply for SSI once their eligibility lapses, which may include a re-determination of severe medical impairment.

Social Security Disability Insurance Benefits

If a person has sufficient earnings history, he or she may be eligible for Social Security Disability Insurance benefits (SSDI), a second type of benefit available to persons determined to have a severe medical impairment.[11] In such instances, the Social Security Administration may continue with a disability determination even if a person has income in excess of SSI criteria. SSDI payments vary based on a person's past earnings and increase annually based on changes in the consumer price index.

[10] The five areas are: 1) cognitive and communicative functioning; 2) social functioning; 3) motor functioning; 4) personal functioning; and 5) concentration, persistence and pace (how long it takes an applicant to complete a task). In younger children, the ability to concentrate and persist in completing tasks is not as significant a component of determination of a severe medical impairment as in older children.

[11] As of December 1998, there were 16,146 persons in Montana receiving SSDI. Of those, 3,438 or 21 percent were eligible due to a mental disability.

People who receive SSDI may or may not be eligible for Medicaid or MHSP depending on the amount of their SSDI payments. However, persons receiving SSDI benefits are automatically eligible for Medicare, but coverage doesn't begin until about two years after their SSDI payments begin. Mental health benefits covered by Medicare are more restricted than the benefits available under Medicaid or MHSP with the most significant differences being that Medicare does not cover medication, case management, or some outpatient services, while these services are covered by Medicaid and MHSP.

Montana Disability Determination

DPHHS contracts for disability determination for those persons whose incomes exceed the Social Security Administration thresh hold, but whose resources meet Medicaid eligibility thresh holds. The contractor uses the same criteria as the Social Security Administration to determine whether persons meet federal disability criteria. If the contractor determines that the person meets federal disability criteria, then the person could become eligible for Medicaid by incurring medical bills sufficient to spend down their income to Medicaid standards. (This category of eligibility called medically needy, is summarized in a later section of this report.)

Income and Resources for SSI Eligibility

In order to be eligible for Medicaid in the aged, blind, disabled category, a person's countable income cannot exceed the Social Security Administration guidelines for SSI, which varies by family size ($531/month per individual and $796 for couples for calendar year 2001). SSI income limits change annually based on the consumer price index. Income that is excluded from consideration includes: $20 of earned or unearned income; $65 plus one half of any earned income; non recurring lump sums such as a birthday gift; certain government settlements such as those for Agent Orange and Japanese Americans interred during World War II; and certain Indian income.

In order to be eligible in the aged, blind or disabled category resources may not exceed $2,000 for an individual and $3,000 for a couple. Examples of resources include savings and checking accounts, promissory notes, trusts, stocks and bonds. Certain resources are excluded from consideration such as: the home in which the family or individual lives and appurtenant acreage; a vehicle if it used for medical care, day to day activities, or medical transportation; items necessary for self employment such as tools and a vehicle if it is owned by the business; a life insurance policy with a face value of $1,500 or less; and prepaid, nonrescindable, burial contracts.

1619(b) Eligibility for Persons Receiving SSI

If disabled persons eligible for Medicaid recover sufficiently and become employed, and their incomes rise sufficiently so that they are no longer income eligible for an SSI

payment, Medicaid eligibility can continue (section 1619(b) of the Social Security Act). The Social Security Administration must determine that the disabled person cannot afford to pay for the medical care necessary to maintain their health and continue employment in order to continue Medicaid eligibility. Persons must still meet resources tests in order to maintain Medicaid eligibility under 1619(b). The Social Security Administration certifies 1619(b) Medicaid eligibility.

Family and Minor Children Medicaid Eligibility

Table 3
Enrollment Estimated During 2001 Legislature Compared to Current Enrollment in Capped Programs

Program	Estimate During Session	November* 2001
Adults		
MHSP Only	3,212	2,858
MHSP/Medicaid**		388
Subtotal Adults		3,246
Children		
MHSP/CHIP	320	185
Basic Mental Health Services	125	125
Medicaid/MSHP**		66

*Enrollment numbers provided by AMDD staff November 20, 2001.

**Persons who qualify for Medicaid under the medically needy option can receive services in the months that they are not eligible for Medicaid through the 100% general fund programs.

Medicaid income and resource tests are a bit different for the family and minor children categories than for the aged, blind, and disabled categories. Generally, families must include a dependent child in order for adults in a family to be eligible for family Medicaid. Childless, healthy, able-bodied adults under the age of 65 are not eligible for Medicaid.

Generally, families where adults are eligible for Medicaid must have incomes less than 40 percent of the federal poverty index. Otherwise, in families where only the children are eligible for Medicaid, family income may be no greater than 100 to 133 percent of poverty depending on the age of the child.[12] Up to 12 months of extended Medicaid is available to all family members in families: 1) that leave the financial assistance program (FAIM) due to a qualifying event; and 2) with incomes less than 185 percent of the federal poverty level. Table 2 shows the federal poverty index for 2001, compared to 40 percent, 133, 150, 185 and 200 percent of the poverty level by family size.

Families may have no more than $3,000 in countable resources. DPHHS obtained a waiver of federal Medicaid regulations in order to raise the resource exclusion to $3,000 for families and minor children. Examples of resources include savings and checking accounts, promissory notes, trusts, stocks and bonds. Some resources are excluded such

[12] Family income limits for children only coverage are: 1) 133 percent of the federal poverty index for children between 0 to 6 years old; 2) 100 percent of the federal poverty index for children born after 10-1-83 and who are at least 6 years old; and 3) less than 40 percent of the federal poverty index for children born prior to 10-1-83 who have not yet attained age 19. Pregnant women with incomes up to 133 percent of poverty are also eligible for Medicaid, provided they also meet the resource test. There are no income limits, only resource limits, for Medicaid coverage of some newborns.

as: one vehicle of any value; income producing vehicles and assets such as tools; the home in which a family lives and contiguous land upon which the home is located; livestock (generally); and proceeds from casualty insurance.

Medically Needy Spend Down to Become Medicaid Eligible

Medically needy is an optional category of Medicaid eligibility that Montana has adopted. In order to be medically needy a family or individual must be categorically eligible (family with a dependent child, minor child or aged, blind or disabled) and meet resource tests for Medicaid. Income may exceed standards. Medically needy eligibility is available to aged, blind, or disabled persons, but only children in low-income families. Adults in low-income families with dependent children are not eligible for Medically needy.

Persons become eligible for Medicaid when they incur medical bills sufficient to spend down their income to medically needy standards.[13] Persons can "bounce" in and out of Medicaid eligibility depending on the amount of medical bills and when they incur medical bills. For instance, persons may have a large bill at the time they apply for coverage that will meet the spend down/incurment for two months eligibility. But during the third month, if they incur no additional or insufficient medical bills, their eligibility will lapse. The incurment amount is the difference between total countable income and the medically needy income limit ($500 for a one or two person household). At higher incomes, the incurment can become a significant portion of total income.

Other Medicaid Eligibility Options for States

States can opt to establish Medicaid eligibility at higher income and assets limits. Some states have chosen to disregard income up to a certain level. For instance if all income up to 200 percent of the federal poverty level is disregarded, then the effective income eligibility limit is raised. States can also opt to discontinue asset tests, which also increases the number of persons eligible.

Two recently enacted pieces of federal legislation establish new types of Medicaid eligibility that states may offer. The 1997 Balanced Budget Act permits states to offer a Medicaid buy-in for persons with incomes up to 250 percent of the poverty level who would be eligible for SSI, except for their income. Buy-ins would allow persons who are ineligible for Medicaid because their earnings are too high the option to remain eligible for Medicaid if they pay all or part of their coverage.[14]

[13] There is also a category of medically needy eligibility where eligible persons do not need to incur a spend down.

[14] "President Clinton Signs Historic Work Incentives Legislation into Law"; NAMI E-News; Volume 00-71; December 17, 1999, p. 2.

The Ticket to Work and Work Incentive Improvement Act (TWWIIA HR 1180) was effective October 1, 2000. This act established two new optional categories of Medicaid eligibility.

The first TWWIIA option expanded changes authorized by the 1997 Balanced Budget Act by allowing states to offer Medicaid coverage to persons with disabilities who work and earn up to 450 percent of the federal poverty level. States can establish income limits, require cost sharing and establish sliding scale payments for premiums based on income. States can require persons with incomes between 250 and 450 percent of the federal poverty level to pay the full premium amount as long as premiums do not exceed 7.5 percent of their income. Persons with incomes greater than $75,000 annually must pay the full premium unless a state chooses to subsidize the premium payment from state funds. The second option is that states may also extend Medicaid coverage to persons who continue to have a severe and medically determinable impairment, but lose eligibility for SSI or SSDI because their medical condition improves. [15]

Any change to eligibility for mental health services would extend to Medicaid funded physical health services as well. It is not possible to expand eligibility for mental health services alone without a waiver of federal regulations.[16]

Entitlement

Medicaid is an entitlement program. Once a state establishes Medicaid eligibility criteria anyone meeting those criteria is entitled to services offered under the state plan. In general, a state may not restrict enrollment in Medicaid or a type of Medicaid service without a waiver of federal regulations.

The other state funded community mental health service programs are not entitlements. DPHHS has restricted enrollment in the programs. The appropriation level determines the number of persons eligible for services.

MSH and MMHNCC are not entitlements per se, but DPHHS cannot refuse to provide services to persons who are committed or court ordered to the state institutions. State and federal law govern the circumstances under which MSH can refuse admissions or transfers that are not court ordered.[17] The federal Emergency Medical Treatment and Labor Liability Act (EMTALLA), commonly known as "anti-dumping" legislation, requires a hospital to provide treatment for emergency medical conditions and stabilize the patient.

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[15] Ibid.

[16] In the original design of the Montana Health Access Plan, DPHHS planned to expand Medicaid eligibility for mental health services only. The federal Department of Health and Human Services would not approve the expansion without a companion eligibility change for physical health services.

[17] DPHHS believes that MSH can refuse admission of patients transferred, if it does not have a bed available or if it does not have the expertise necessary to treat the patient. Comments included in review of a draft of this report received November 26, 2001.

ELIGIBILITY FOR SERVICES - MHSP

Eligibility for MHSP depends on income and severity of mental illness. Unlike Medicaid, MHSP eligibility does not consider resources or assets. Adults who have a severe and disabling mental illness and income below 150 percent of the federal poverty level are eligible for MHSP. Children who are enrolled in CHIP and who are seriously emotionally disturbed are also eligible. Children who are not eligible for CHIP but have a family income below 150% of poverty and who are seriously emotionally disturbed are eligible for basic mental health services. Persons who are eligible for Medicaid are not eligible for MHSP. Table 3 on page 11 shows MHSP income eligibility by family size for 2001.[18]

Income eligibility is prospective – meaning that future earnings, not past earnings, determine eligibility. Eligibility lasts for one year before a mandatory income redetermination takes place. However, persons are required to report income changes as soon as the change occurs.

ELIGIBILITY FOR SERVICES - CHIP

In Montana, only children are eligible for CHIP coverage.[19] Like MHSP, children in families with incomes up to 150 percent of the poverty level are eligible for CHIP and there are no resource or asset tests, but there are some federal restrictions. Federal rules specify that children who are eligible for Medicaid, whose parent(s) works for state government, or whose family has health insurance are not eligible for CHIP.

CHIP eligibility is not dependent on a diagnosis of serious emotional disturbance as is MHSP eligibility. However, CHIP service limits for mental health services vary according to the diagnosis of the child. CHIP does not impose restrictions on covered services for eligible children diagnosed with schizophrenia, schizoaffective disorder, bi-polar disorder, major depression, panic disorder, obsessive compulsive disorder, or autism.[20] Seriously emotionally disturbed CHIP eligible children receive expanded mental health services through MHSP.

ELIGIBILITY FOR SERVICES – BASIC MENTAL HEALTH SERVICES

The 2001 legislature approved the addition of a limited program of basic mental health services for children. Such services are funded fully from the general fund portion of the maintenance of effort required for the TANF block grant and services are limited to about

[18] Federal poverty levels change each year and have historically increased between 2 to 5 percent annually.
[19] Federal regulations allow coverage of adults in certain circumstances.
[20] Examples of service limits in CHIP include: reimbursement is limited to 21 days of inpatient treatment and 20 outpatient visits per year under CHIP.

125 children per year. Eligibility is established at 150 percent of the federal poverty level.

COMPARISON OF SERVICES AMONG FUNDING SOURCES

Medicaid funding supports the most extensive array of mental health services of all state funding sources. Table 4 shows the major services and those covered by each funding source. One primary distinction among the three funding sources is that Medicaid and CHIP also cover physical health services, while MHSP coverage is restricted to mental health services.

As with eligibility, federal guidelines also specify what services are eligible for federal Medicaid reimbursement. So even if a person is Medicaid eligible, there are some medical services that are not eligible for federal reimbursement. For example, respite is not a covered service in Medicaid.

Table 4
Comparison of Services Among Major
Public Mental Health Funding Sources

Service	Medicaid	MHSP Adults	CHIP	CHIP/ MHSP	Basic Services
Physical Health Services	X		X		
Inpatient Hospital and Emergency Room	X	X	X		
Partial Hosptalization	X	X			
Outpatient Hospital	X	X	S*	X	
Prescription Drugs	X	X	X	S*	S*
Physician/Psychiatrist	X	X	X	X	X
Comprehensive School and Community Treatment	X		X	X	X
Day Treatment	X	X	X	X	X
Foster Care and Group Home	X	X	X	X	
Case Management	X	X			
Therapeutic Aide	X	X	X	X	X
Outpatient Mental Health Services	X	X	X	X	X
Travel	X				
Substance Abuse Services	X		S*		
Outpatient Hospital Based	X				
Outpatient Non Hospital	S*				

S* indiciations that the benefit includes special conditions or limitations.

Services provided by a state institution for mental disease to persons 21 through the age of 64 are not eligible for Medicaid reimbursement. Since more aged persons are served by the nursing care center, more services provided by MMHNCC can be funded by Medicaid than can state hospital services. This federal programmatic distinction shifts costs from Medicaid (about 28 percent general fund during the 2003 biennium) when

Medicaid eligible persons are served in the community to the general fund when those persons enter MSH.[21]

Major services paid for by the Montana Medicaid plan include: inpatient and emergency hospitalization; partial and outpatient hospitalization; school based services; day treatment; psychiatrist and physician services; therapeutic services provided to children in group home and foster care; outpatient therapy; medications; therapeutic aides; case management; chemical dependency services delivered in a hospital setting; and travel to receive medical services.

MHSP services are generally about the same as those covered by Medicaid, with the exception of inpatient or emergency room hospitalization, substance abuse services, and travel. MHSP does not cover the cost of hospitalization and travel to access medical services, while Medicaid does. Only psychotropic prescriptions for the treatment of mental illness are covered by MHSP, while Medicaid covers the cost of any medically necessary prescription.

MHSP covers respite care, while Medicaid does not. MHSP covers case management for adults, but not for children.

CHIP is similar to a traditional insurance plan and covers fewer mental health services than either Medicaid or MHSP. For instance, CHIP does not cover such services as therapeutic aides, therapeutic group home care, case management, or day treatment. If CHIP eligible children who are seriously emotionally disturbed need services that are not funded by CHIP, they can receive extended mental health services through MHSP.

Children's Mental Health Services

Table 5 shows the services provided by type of funding source. Eligibility for and access to mental health services is more complex for children than for adults. In order to continue to provide services to as many children as possible and reduce general fund costs of mental health services, the 2001 legislature accepted executive recommendations regarding funding and service reductions.[22] Such changes were in part responsible for the complexity of service coverage related to eligibility.

[21] If a Medicaid eligible person has income or resources, he or she will be billed for the cost of MSH care. Payments received for MSH care are deposited to a debt service account to fund repayment of bonds issued for the construction of the new state hospital. Such income is not available to support MSH operations.

[22] The legislature accepted the executive recommendation to: 1) provide expanded mental health services through MHSP to CHIP eligible SED children and fund the services with 80 percent federal funds instead of 100 percent general fund; 2) provide basic mental health services to about 125 SED children not eligible for CHIP; 3) discontinue case management for all children in MHSP; 4) reducing rates for partial hospitalization services; and 5) discontinue coverage of partial hospitalization services for children provided in a facility not co-located with a hospital.

TABLE 5
Comparison of Children's Mental Health Benefits

All services must be medically necessary

September 2001

Mental Health Benefit	CHIP and MHSP Dually Enrolled (MHCH)		Children's Basic Coverage (CBC) MHSP Enrolled, Not CHIP or Medicaid Enrolled (Enrollment limited to 125)	Medicaid
	Covered by Insurance (Insurance Plan Pays)	Covered by MHCH		
Physician visits Individual therapy	Covered, 20 visits per benefit year[1]	Services that exceed CHIP insurance limits are covered	Covered, no limit	Covered, no limit
Residential treatment center	Covered, 21 days per benefit year[1]		Not covered	
Pharmacy	Covered, no limit	(Covered by CHIP ins.)	Covered, no limit	
Partial hospitalization	Covered, 42 days per benefit year[1,2]	Not covered after limit	Not covered	
Inpatient hospitalization	Covered, 21 days per benefit year[1]	Not covered after limit	Not covered	
Inpatient and outpatient services for children with 7 "parity" diagnoses[3]	Covered, no limit		Not covered	
Family therapy services Therapeutic group and foster care	Not covered	Covered, no limit	Not covered	
Group therapy Day treatment Comprehensive school and community treatment (CSCT) Community based rehab			Covered, no limit	
Case Management	Not covered	Not covered	Not covered	
Respite care	Not covered	Covered, no limit	Covered, no limit	Not covered[4]

[1]Benefit year is October 1 through September 30

[2]Use of partial hospitalization applies to inpatient hospital limit at the rate of two partial hospital days for one inpatient hospital day.

[3]No limit on CHIP insurance benefits (covered services) for mental health services for children with the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

[4]Children eligible for Medicaid *and* MHSP will have respite care covered under CBC.

Source: Department of Public Health and Human Services

Prior Authorization/Medical Necessity

Services funded by either Medicaid or MHSP must be medically necessary and some services must also be prior authorized in order to receive reimbursement.[23] DPHHS contracts for review of medical necessity and prior authorization. Services requiring prior authorization are: inpatient and partial hospitalization; residential treatment; therapeutic foster and group care; adult foster and group care; comprehensive school and community treatment; and a few prescription medications.

FLEXIBILITY IN MEDICAID

Medicaid funds are the most significant source of funding for state administered public mental health services in Montana. However, federal participation in the cost of services (about 72 percent during the 2003 biennium) comes with federal rules and restrictions governing how Medicaid funds can be spent. The twofold challenge that states face in using Medicaid funds to pay for services or programs to meet unique state needs is: 1) ensuring compliance with federal rules and regulations; and 2) avoiding greater workloads (and potentially greater state costs) to administer and manage innovative programs funded with Medicaid funds.

STATE MEDICAID PLANS

States submit a plan explaining their Medicaid programs. The plan is reviewed and approved by the CMS, which has 90 days to review a plan once it is submitted. If CMS requests additional information from the state in order to complete its review, a new 90-day clock starts when the state submits the additional information. There is no time limit within which CMS must approve a state Medicaid plan. The number of 90-day clocks that can be initiated due to CMS information queries is not limited. However, state plan reviews are usually completed within six months.[24]

States can amend their state Medicaid plans. Generally, states can (and frequently do) implement the amendment prior to final acceptance of the amendment by CMS.[25] CMS follows the same time schedule in reviewing and approving plan amendments as it does

[23] If a continued placement in out-of-home care, such as residential treatment, is determined to no longer be medically necessary, the child must be discharged or an entity other than AMDD must pay for continued placement. If the child is Medicaid eligible and in the custody of DPHHS, then the Child and Family Services Division would pay for any continued care if an alternative, appropriate placement cannot be located. In such cases treatment costs would shift from the Medicaid budget (28 percent general fund) to the general fund budget of the Child and Family Services Division.

[24] David Selleck, Manager State Programs Branch, Region VIII, Health Care Financing Administration, personal conversation, February 23, 2000.

[25] Betty Strecker, Health Insurance Specialist, Health Care Financing Administration, Region VIII, personal conversation, February 10, 2000.

in approving state Medicaid plans. If CMS does not approve an amendment that the state has already implemented, the state may be liable for repayment of the federal financial participation.[26]

UNIVERSAL MEDICAID CRITERIA

States must offer mandatory services in their Medicaid plans and may choose to provide optional services, within federal guidelines. Eligibility is similar with mandatory coverage for some groups with some state flexibility to add optional categories of eligibility within federal guidelines.

There are federal rules regarding Medicaid service availability. Once a service is included in a state plan, it must be available statewide. That does not mean that if psychiatric services are covered by the plan and there are no psychiatrists available in Malta, for instance, that the state Medicaid program must provide psychiatric services to Medicaid eligible persons in Malta. A Medicaid service must be available to the Medicaid population in the same proportion it is available to the general population.[27]

Services must also be available to all eligible persons, but states can limit access (payment for services) based on medical necessity. For instance, a state may chose to cover inpatient residential psychiatric care for children as Montana does, but reimbursement for services is denied if the service is not medically necessary or is no longer medically necessary.

States cannot artificially limit access to services if a service is medically necessary and there are providers willing to supply the service. Providers meeting state criteria for participation in the Medicaid program must be allowed to participate.

Waivers of Federal Medicaid Regulations

One way to create flexibility in the design of a Medicaid funded program is to request a waiver of federal regulations. Waivers can (and must) be used if a state wishes to: limit the availability of services; limit access to services; restrict freedom of choice among providers; fund services from a capitated or case rate if consumers cannot chose among providers; demonstrate unique service models; or pay for services that are not Medicaid reimbursable. There are two types of waivers: 1) a more routine type waiver – a 1915(b); and 2) a research and demonstration type waiver – an 1115. One condition common to both waivers is that the changes resulting from waivers must be cost neutral with respect to federal financial participation.

[26] David Selleck, personal conversation, February 23, 2000.

[27] Please note that some Medicaid services may not have exact private market duplicates in order to validate this federal requirement. For instance, therapeutic foster care is not a readily available service in the private market for mental health services.

1915 (b) Waiver

The most common waiver, called a 1915(b) waiver, can be used to waive such criteria as statewide availability of services and freedom of consumer choice among providers.[28] It has advantages over the 1115 waiver in that the application process is straight forward, the time period for approval or denial is regulated and it can be renewed indefinitely. The 1915 (b) waiver is somewhat limited in that it cannot be used to waive some criteria including funding restrictions, so a 1915 (b) waiver may not be able to accommodate some types of flexibility that a state may want to add to its Medicaid funded program.[29] Examples of 1915 (b) waivers that DPHHS administers are the home and community based services waivers for persons who are developmentally disabled or who are severely physically disabled. The Mental Health Access Plan (MHAP) required a 1915 (b) waiver of freedom of choice, since all Medicaid eligible participants were required to access services through a single managed care company.

1115 Waiver

The second, usually more complex waiver, called an 1115 waiver, is used to demonstrate a program or project that has not been tried or proposed on a wide spread basis.[30] There are two types of 1115 waivers: a waiver of Medicaid regulations only; or a waiver plus grant money. Grant money is available in defined areas of interest to CMS and is awarded on an annual grant cycle using application criteria defined by CMS. Projects can usually be renewed on a non-competitive basis for three years. Projects extending beyond three years must compete with new applications to extend the waiver and grant funding.[31]

The 1115 waiver of regulations only is easier to obtain than an 1115 waiver with a grant, but nearly always more complicated or time consuming than obtaining a 1915 (b) waiver. The 1115 waiver is usually required to demonstrate unique aspects of special programs. It is typical for CMS to authorize only one of a type of demonstration waiver and not duplicate other demonstrations. The average time for review and approval of an 1115 waiver is 20 to 24 months.[32]

An 1115 waiver must demonstrate cost neutrality or savings. The waiver request (and the cost of demonstration project) must include an evaluation of results by an entity independent from the state Medicaid program. If an 1115 waiver is not cost neutral, a state may be required to repay the portion of federal Medicaid costs that were paid in excess of the program cost without the waiver.

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[28] Mary Dalton, Chief, Medicaid Services and CHIP Bureau, Health Policy Services Division, Department of Public Health and Human Services, personal communication, February 2, 2000.
[29] Health Management Associates, "Montana Managed Mental Health Care: Program Considerations and Recommendations", September 24, 1994, p. 3.
[30] Cindy Smith, Health Insurance Specialist, Region VIII, Health Care Financing Administration, electronic mail communication, March 2, 2000.
[31] Health Management Associates, p. 3.
[32] Cindy Smith, personal conversation, February 29, 2000.

DPHHS would have needed an 1115 waiver to implement MHAP as it was originally conceived. The original MHAP plan anticipated extending Medicaid eligibility for mental health services only to persons with incomes up to 200 percent of the federal poverty level. CMS would not approve the waiver unless eligibility for physical health services was also included in MHAP. CMS staff reasoned that mental health services are an optional service under Medicaid and that expansion of an optional service without a commensurate expansion of mandated physical health services was contrary to Congressional intent in establishing the Medicaid program.

Expanding Medicaid eligibility to 200 percent of poverty for mental health services would have allowed services to be funded 70 percent federal Medicaid funds and 30 percent state match instead of 100 percent general fund. Expanding Medicaid eligibility would have leveraged existing expenditures of general fund to provide mental health services to additional persons. DPHHS decided to not pursue the 1115 waiver since the general fund cost to pay for physical health services as well as mental health services would have exceeded what the executive branch planned to spend for MHAP.

Although waivers can provide the most flexibility in funding unique services within Medicaid programs, designing and pursuing a waiver can be time consuming. For example, the original MHAP proposal was developed over three years.

PREPAID HEALTH PLANS

There is another option that states can use to bring funding flexibility to Medicaid services – a prepaid health plan (PHP).[33] A PHP is a specific option available to states authorized in federal Medicaid law (42 CFR 431.54b). A PHP uses a capitated rate to reimburse a bundle of services defined by the plan. It replaces Medicaid fee-for-service reimbursement methods that otherwise probably require a waiver of federal Medicaid reimbursement criteria.
Depending on how a PHP is structured it would require a state plan amendment, but not a waiver.[34] PHPs foster flexibility in that states can make a capitated payment for a "bundle" of services and structure unique programs without a waiver.

States do not have to follow federal procurement guidelines if any willing provider can participate in the PHP. If a state wishes to limit the number of providers selected to participate in a PHP, it must follow federal competitive procurement guidelines if the

[33] It is interesting to note that MHAP was a prepaid health plan, but required a waiver because freedom of consumer choice was restricted. The PHP alternative outlined in this report envisions a series of prepaid health plans designed to allow any willing provider to participate with consumer choice among fee for service providers and a PHP thereby avoiding the requirement of a waiver.
[34] Cindy Smith, Health Insurance Specialist, Region VIII, Health Care Financing Administration, personal conversation, February 23, 2000.

services are to be funded from Medicaid funds.[35] Competitive procurement requires issuing a request for proposal and competitive bid process.

CMS review and approval of the PHP contract is required if payments to individual providers will exceed $1 million. Otherwise, contract review by CMS is optional. Many states prefer to have PHP contracts reviewed even if it is not required.[36]

Services Included in a PHP

When a state uses a PHP it may include services that are in addition to those listed in the state Medicaid plan. A state can also include services that are not reimbursable under the Medicaid program, such as respite care, but the state cannot claim federal financial participation for those services.[37]

PHP and Capitation

A PHP by definition uses a capitated reimbursement method. Other service models using capitated reimbursement would require a waiver of Medicaid regulations.

The capitated rate cannot be greater than the upper payment limit. Generally, the upper payment limit is the amount that a state would have paid for Medicaid services in the fee-for-service system. Only the expenditures made for the Medicaid reimbursable services included in the PHP can be used to determine the upper payment limit and subsequently the capitation rate.

States have determined capitated rates based on actuarial analysis as did DPHHS in determining MHAP payment rates and states have determined capitated rates based on fee-for-service data compiled by state staff. CMS reviews calculation of the upper payment limit.

As noted earlier, a PHP may contain services in addition to those authorized in the Medicaid state plan and may contain services that cannot be funded by Medicaid. If the PHP includes services that cannot be funded by Medicaid, the capitated rate cannot be increased to include federal participation in the cost of those services. If the cost of additional services must be funded either within the savings achieved by providers or the state can increase the capitation rate, but the increase must be funded from state funds.

The philosophy of a PHP is like that envisioned for MHAP and recent pilot projects undertaken by DPHHS: providing appropriate services at the appropriate time, especially

[35] David Selleck, personal conversation, February 23, 2000. Federal requirements are referenced in 45 CFR 74.
[36] Cindy Smith, personal conversation, February 23, 2000.
[37] Ibid.

appropriate services in the community, should achieve savings by preventing placement or shortening length of stay in higher end, more expensive services.

Voluntary Participation in a PHP/Adverse Selection

If the PHP is comprehensive (includes all services) and consumer participation is voluntary, it becomes difficult to determine what the capitated payment should be. Capitation payments are based on average utilization.

Voluntary participation could create an adverse selection by Medicaid recipients. If only the "healthier" consumers select the PHP, the capitation rate might result in DPHHS paying too much for the services. If only the "most ill" consumers go to the PHP, the capitation rate will under fund the true cost of care, making financial viability of the plan unlikely.
Proponents of a voluntary participation model believe that the types of wrap around services that can be funded will be attractive enough to gain diverse membership thereby negating potential adverse selection.

PHP Could Fund Wrap Around Community Service Models

A PHP could be used to fund models that provide wrap around community mental health services. A PHP can provide funding flexibility and does not require a waiver of federal Medicaid criteria as long as: 1; 2) total payments to an individual provider participating in a PHP do not exceed $1 million; and 3) Medicaid recipients have a choice between receiving services from a PHP and fee for service providers. If any willing provider can participate in a PHP, then the state does not have to comply with federal procurement requirements.

DPHHS has already funded pilot projects that provide intensive community support services for adults and children, with federal Medicaid funds and general fund, using a modified case rate funding mechanism for the children's demonstration. A PHP could have been used to fund the pilot and demonstration projects.

EPSDT

Some consultants who have made presentations in Montana describing wrap around service models for children have indicated that the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit within the Medicaid program can be used to fund such services. EPSDT is like an entitlement within an entitlement program. If a Medicaid-eligible child needs a service that is eligible for Medicaid funding and it is the only service that can provide the medically necessary treatment, then the state must pay for the benefit even if the benefit is not included in its state plan.

However, EPSDT is limited in its ability to fund wrap around services in that it only applies to children and it cannot be used to fund services that are not eligible for federal Medicaid reimbursement such as respite care.[38] The PHP model would have more flexibility than EPSDT because it can apply to children and adult services and can include services that are not part of the Medicaid program.

Conclusion

Access to public mental health services administered by AMDD depends on eligibility by funding source. Medicaid funds support the largest portion such services and have the most federal criteria governing the administration of services. Eligibility and access for appropriate Medicaid services is an entitlement. The state has more latitude to determine service and limitations and eligibility for services under the MHSP, CHIP and basic mental health services programs, including the ability to limit provision of services or enrollment.

Creating flexibility in Medicaid funding to provide unique or wrap around services requires planning and creativity on the part of states and nearly always requires a waiver of some federal criteria. While opportunities exist to expand Medicaid funding, the cost of such expansions may be difficult to calculate and control.

[38] David Selleck, personal conversation, February 23, 2000.

APPENDIX A

CO-PAYMENTS

Each major state-funding source that pays for public mental health services requires co-payments.

States can establish Medicaid co-payments within federal limits. Montana generally has established the highest co-payments allowed for Medicaid services and co-payments range from nothing for some persons by type of eligibility to $100 per discharge for an inpatient hospital stay. Total co-payments for each Medicaid recipient cannot exceed $200 per state fiscal year. Children under 21, pregnant women, and persons in nursing homes are exempt from Medicaid co-payments.

Co-payments for adults eligible for MHSP services and children eligible for basic mental health services apply only to prescriptions. Each eligible person must pay co-payments and the amount does not vary by family size, income or the number of prescriptions. If more than two persons in a family are eligible for MHSP, then the family must make a co-payment for each person. Co-payments range from $0.00 to $25 for brand name medications when there is a generic medication available. There is no limit on the amount of co-payment that a person or family can incur.

CHIP requires co-payments for services by families with incomes at or above 100 percent of the federal poverty. Co-payments vary by service from a low of $3 for a physician visit to a high of $25 for an inpatient hospital stay. There is a cap on total co-payments of $215 per year per family.

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