A THUMBNAIL SKETCH OF STATE FUNDING FOR PUBLIC MENTAL HEALTH SERVICES AND ELIGIBILITY FOR AND ACCESS TO SERVICES

Prepared for the

Mental Health Services Committee

by

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INTRODUCTION

Public mental health services are funded by state and local governments and local school districts. The largest public mental health programs are administered by the Department of Public Health and Human Services (DPHHS), which received $97.6 million in appropriations specific to mental health services and administration for fiscal 2000.

This sketch of public mental health service funding, eligibility for services, and access to services 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.

Medicaid, funded by state and federal funds, is the most significant public funding source for mental health services, accounting for over one half of the appropriation for mental health services. Medicaid is governed primarily by federal regulations, with some latitude for states to add services and categories of eligibility. The Mental Health Services Plan (MHSP) funded entirely by estate general fund and governed entirely by state law and rules is designed specifically for low-income adults with a severe and disabling mental illness and low-income children who are seriously emotionally disturbed. CHIP, a federal and state funded program, also covers some mental health services for children in low-income families.

Eligibility, and therefore access, to all state government funded mental health services is 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 are also determined by funding source.

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 new optional categories of eligibility due to recently passed federal legislation (Balanced Budget Act of 1997 and the Ticket to Work and Work Incentive Improvement Act). 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. Medicaid has the most extensive array of services of the three major programs.

MHSP covers adults and children. Eligibility for MHSP depends on income and diagnosis. Adults must be determined to have a severe and disabling mental illness and children must be determined to be seriously emotionally disturbed. MHSP services are generally comparable to those offered by Medicaid with a few exceptions.

CHIP eligibility is determined solely by income. CHIP covers only children and mental health service limits are waived for certain mental illnesses. CHIP has the least extensive array of mental health services of the three state funding sources.

Access to services depends on eligibility for services. Changes in income, determination of disability, or diagnosis can make persons ineligible for services. Several examples of such changes highlight the impact on access to services.

TOTAL EXPENDITURES FOR PUBLIC MENTAL HEALTH SERVICES NOT RECORDED

Most public mental health services are funded by DPHHS. However, other state departments (Corrections and the Office of Public Instruction) as well as local governments and schools also fund public mental health services. 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.

Most public mental health services are funded by the Addictive and Mental Disorders Division (AMDD) of DPHHS. The fiscal 2000 appropriation for mental health services is $97.6 million, including $44.6 million general fund. CHIP, administered by the Health Policy Services Division of DPHHS, also provides funds for mental health. However, the CHIP appropriation of $14.6 million federal funds and $2.9 million general fund in fiscal 2000 year was not segregated between physical and mental health costs.[1] The Office of Public Instruction (OPI) receives an appropriation for special education, which includes services for seriously emotionally disturbed children. 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.

STATE GOVERNMENT APPROPRIATION FOR PUBLIC MENTAL HEALTH SERVICES

There are four sources of funds, excluding OPI 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.

[1] The total appropriation for Senate Bill 81 that authorized CHIP was $19.3 million in fiscal 2000, including $4.0 million general fund. The total appropriation includes the cost due to estimated expansion in Medicaid from CHIP outreach.

[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 shows the fiscal 2000 appropriation for public mental health services and administration to AMDD by fund type and major service. CHIP funds ($14.6 million annually, including $2.9 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.

Table 1
HB 2 Appropriations to the Addictive and Mental Disorders
for Mental Health Services and Administration

	Fiscal 2000 Appropriation				Percent
Item	General Fund	SSR	Federal Funds	Total	of Total
Administration*	$362,566	$1,280	$432,308	$796,154	0.8%
Montana State Hospital*	5,339,239	9,848,626	0	15,187,865	15.6%
Nursing Care Center*	247,522	5,995,099	0	6,242,621	6.4%
Medicaid	13,705,700	0	35,524,543	49,230,243	50.4%
State Services (MHSP)	24,890,691	0	871,537	25,762,228	26.4%
PATH (Homeless) Grant	~~98,751~~	~~0~~	~~296,252~~	~~395,002~~	~~0.4%~~
Total*	~~$44,644,469~~	~~$15,845,005~~	~~$37,124,639~~	~~$97,614,113~~	100.0%
Percent of Total	45.74%	16.23%	38.03%	100.00%	

*These appropriations do not include pay plan allocations nor CHIP expenditures for mental health services.

General fund supports 46 percent of the total amount appropriated to AMDD for mental health services and administration. Together appropriations for Medicaid and MHSP services account for over three fourths of the total appropriation.

General Fund

General fund supports the full cost of the MHSP, 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 27.84 in fiscal 2000.[3] CHIP benefits require a state match equal to 80 percent of the state Medicaid benefit match rate. The CHIP benefit match rate for fiscal 2000 is about 20 percent.

[3] The projected fiscal 2001 state Medicaid match is 27.22 percent.

State Special Revenue Funds

Table 1 includes a state special revenue appropriation as well. DPHHS would use state special revenue if it enters into managed care agreements, similar to the 1999 biennium contract with Magellan Behavioral Health Services, that would require contractors to pay for services at the MSH and MMHNC. DPHHS would pay the contractor with general fund and federal funds and then receive payments from the contractor that would be expended as state special revenue to support state institutions. At this time, DPHHS has not entered into such contracts, so the state special revenue appropriation is not being expended. If state special revenue is removed from consideration, general fund supports 55 percent of the appropriation for the mental health programs in AMDD.

Since DPHHS will not use state special revenue to support MSH, it reallocated the general fund appropriation from MHSP to cover expenditures that would have been supported by state special revenue. Therefore, House Bill 2 appropriations overstate the general fund appropriation to MHSP and understate the potential general fund cost of MSH by at least $9.8 million.

Federal Funds

Medicaid matching funds are the largest single source of federal funds appropriation for mental health services. Federal Medicaid services funds account for 36 percent of the total mental health administration and services appropriation in fiscal 2000.

The state receives two small federal block grants ($1.2 million for fiscal 2000) to fund mental health and homeless services. The state must submit an annual plan to receive the mental health block grant funds.

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.

Both CHIP and MHSP consider only income, but not resources in eligibility determination. MHSP requires that an adult be determined to have a severe and disabling mental illness and that a child be determined to be seriously emotionally disturbed. CHIP coverage is income related only, but service limits are waived for children with certain mental illness diagnoses.

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. Mental health services are an optional service. Montana has added some optional services because they 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.[4] For instance, there are 35 unique, separate categories of Medicaid eligibility and this discussion highlights only the 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. [5]

If a person is determined to be disabled by the Social Security Administration, then they are eligible to receive a monthly payment – Supplemental Security Income (SSI). Persons receiving SSI payments are automatically eligible for Medicaid.[6]

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[4] 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.

[5] 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.

[6] 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.

Federal Disability Determination

The Social Security Administration contracts, as required by federal law, with DPHHS 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.[7]

Federal regulations, laws, and court decisions guide the determination of severe medically determined impairment. The review focuses on level of functioning with 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.[8] 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 SSDI (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 redetermination 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

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

[8] 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.

have a severe medical impairment.[9] 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 CPI.

People who receive SSDI may or may not be eligible for Medicaid or MHSP based 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 and 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 ($512/month per individual and $769 for couples for year 2000). 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.

[9] 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.

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

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.[10] 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 1999, compared to 40 percent, 133, 150 and 185 percent of the poverty level by family size.

Table 2
1999 Federal Poverty Index*

Family Size	40%	**Poverty Level**	133%	150%	185%
1	$3,296	**$8,240**	$10,959	$12,360	$15,244
2	4,424	**11,060**	14,710	16,590	20,461
3	5,552	**13,880**	18,460	20,820	25,678
4	6,680	**16,700**	22,211	25,050	30,895
5	7,808	**19,520**	25,962	29,280	36,112
6	8,936	**22,340**	29,712	33,510	41,329
7	10,064	**25,160**	33,463	37,740	46,546
Each Additional Person	$1,128	$2,820	$3,751	$4,230	$5,217

*The 2000 poverty level index will be published in February or March 2000.

Families may have no more than $3,000 in countable resources. DPHHS obtained a waiver of 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 as: one vehicle of any value;

[10] 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.

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 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.[11] 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

Two recent pieces of federal legislation establish new types of Medicaid eligibility that states may offer. As part of the Executive Planning Process for the 2003 biennium budget, DPHHS will review these options. [12] 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.[13]

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]

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

[12] Dan Anderson, Administrator, Addictive and Mental Disorders Division, DPHHS, personal communication, January 10, 2000.

[13] 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.

[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 recently passed by Congress and signed by the President. The law is effective October 1, 2000. This act establishes two new optional categories of Medicaid eligibility.

The first TWWIIA option expands 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]

Eligibility for Services - MHSP

Eligibility for MHSP depends on income and diagnosis. Unlike Medicaid, MHSP eligibility does not consider resources or assets. Adults who have a severe and disabling mental illness and children who are seriously emotionally disturbed and have family incomes below 150 percent of the federal poverty index are eligible for MHSP. Persons who are eligible for Medicaid are not eligible for MHSP. Table 2 on page 9 shows MHSP income eligibility by family size for fiscal year 2000.[16]

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 they occur.

Eligibility for Services - CHIP

Only children are eligible for CHIP coverage. 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. Federal rules specify that children who are eligible for Medicaid 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.[17]

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[15] Ibid.

[16] Federal poverty levels change each year and have historically increased between 1 to 3 percent annually.

[17] Examples of service limits in CHIP include: reimbursement is limited to 21 days of inpatient treatment and 20 outpatient visits per year under CHIP.

Comparison of Services Among Funding Sources

Medicaid funding supports the most extensive array of mental health services of all state funding sources. Table 3 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.

Table 3
Comparison of Services Among Major
Public Mental Health Funding Sources

Service	Medicaid	MHSP	CHIP
Physical Health Services	X		X
Inpatient Hospital and Emergency Room	X		X
Outpatient Hospitalization	X	X	S*
Partial Hospitalization	X	X	S*
Prescriptions	X	S*	X
Physician/Psychiatrist Services	X	X	X
School Based Services	X	X	
Day Treatment	X	X	
Foster and Group Care - Children	X	X	
Case Management	X	X	
Therapeutic Aide	X	X	
Outpatient Mental Health Services	X	X	S*
Travel	X		
Adult Foster and Group Care		X	
Substance Abuse Services			
Inpatient	X		S*
Outpatient - Hospital Based	X		S*
Outpatient - Non Hospital	S*		S*

S* indicates that the benefit includes special conditions.

As with eligibility, federal guidelines also specify what services are not 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.

Services provided by a state institution for mental disease to persons 21 through the age of 64 are not eligible for Medicaid reimbursement. Most services provided by MMHNCC can be funded by Medicaid, since most MMHNCC patients are over 64 and are Medicaid eligible. Conversely very few services provided by MSH to Medicaid eligible persons are funded by Medicaid. This federal programmatic distinction shifts costs from Medicaid (about 30 percent general fund)

when Medicaid eligible persons are served in the community to the general fund when those persons enter MSH.[18]

Major services paid for by Medicaid 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.

MHSP services are generally about the same as those covered by Medicaid, with the exception of inpatient or emergency room hospitalization, substance abuse services, adult foster and group home care, 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.

MHSP covers adult foster and group care, while Medicaid does not. Under MHSP, Medicaid eligible persons with severe and disabling mental illness are eligible for adult foster and group care through MHSP.

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 such services through MHSP.

Families must apply separately for both CHIP and MHSP. While children eligible for MHSP are most likely eligible for CHIP, there are circumstances where that may not be true. For instance, children of state employees cannot be covered by CHIP, but could be covered by MHSP.

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.[19] 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; and a few prescription medications.

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[18] 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.

[19] 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 (30 percent general fund) to the general fund budget of the Child and Family Services Division.

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 services or eligible persons 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.

MHSP co-payments 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 an enrollment fee of $15 and 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 $200 per year per family.

ACCESS TO SERVICES

Once a person (or family) is determined to be eligible for Medicaid, MHSP or CHIP, that person can receive mental health services approved and funded by the respective program. If the person or family loses eligibility for some reason, they can no longer receive services. The following examples are provided to illustrate how eligibility affects access to services. Examples 1 through 6 are based on real life examples and the remainder is hypothetical. The examples also illustrate that sometimes loss of Medicaid eligibility (30 percent general fund) or exceeding service limits in CHIP (20 percent general fund) can shift the cost of mental health services to MHSP or other division and department budgets (100 percent general fund) or local governments or schools.

Real Life Examples

The following examples of changes in access to services are drawn from reports made to Bonnie Adee, the state Mental Health Ombudsman, reports in the media, and from case studies.

Example 1

The wife in a married couple in central Montana was eligible for Medicaid because she receives an SSI payment for mental and physical disabilities. The husband worked, but the family income was within SSI income guidelines. The husband had a job-related accident and became eligible for worker's compensation. Although the worker's compensation payment was less than the husband's wages, the wife became ineligible for SSI because unearned income is considered differently than earned income in maintaining SSI eligibility. The wife lost Medicaid coverage and access to physical health services. The wife was still eligible for MHSP so that she could receive services for her mental disability. But access to services became difficult because MHSP does not cover transportation.

Example 2

There were several Medicare demonstration HMOs, including one in the Billings area. The HMOs covered services that Medicare normally doesn't pay for – outpatient therapy and medications. The Billings HMO demonstration was discontinued and persons enrolled in the HMO reverted to regular Medicare, which doesn't cover medications and requires a significant co-payment for outpatient therapy. Even though some of the persons who lost Medicare HMO coverage could qualify for Medicaid as medically needy, the spend down can be prohibitive. For example, with income of $1,001 per month, the spend down was $700 per month for one individual.

Example 3

In western Montana a person has become employed in retail business after previously receiving case management, counseling, and coverage of medications through MHSP. Although the individual is paid at minimum wage and would continue to qualify for MHSP at that rate working a 40 hour week, the individual lost eligibility because of overtime pay. The individual is required to work over time, but such pay is not guaranteed. The individual will be eligible for employer health coverage in six months, but is financially responsible for the cost of medication in the mean time.

Example 4

In a more rural town in Montana, a case manager has been trying to get a child eligible for MHSP. The child is seriously emotionally disturbed, so the income eligibility is the missing piece of eligibility. The child has been receiving services even though the provider has not been paid. The parents are divorced. While the income of one parent is available (business losses only), the other parent has not cooperated in providing financial information to determine eligibility.

Example 5

A Medicaid eligible person was able to return to work because his mental illness was stabilized, in part due to medication covered by Medicaid. His work related income exceeded Medicaid eligibility standards and he lost his Medicaid eligibility. He could no longer afford the medications and quit taking them. His condition deteriorated and he was committed to MSH.[20]

Example 6

A family of 1 employed parent and 3 children has family income in excess of MHSP standards. One child who is seriously emotionally disturbed and physically disabled is Medicaid eligible. While the Medicaid-eligible child has access to mental and physical health services, the parent and remaining children have access to some services necessary to deal with the impact to the family of the disabled child's behavior. For example, family therapy would be available. However, the remaining family members would not be able to access individualized services such as one on one therapy through Medicaid.

Hypothetical Examples

The following examples are hypothetical examples of access to services based on eligibility rules and regulations.

Example 7

A child with an emotional disturbance is SSI eligible until he reaches age 18. At that time, the Social Security Administration reviews the determination of severe medical impairment and finds that the young adult no longer has a severe medical impairment. At that point the young adult loses access to Medicaid funded services. If he is determined to have a severe and disabling mental illness as an adult and his income is less than 150 percent of the federal poverty level he would be eligible for MHSP services.

Example 8

A married couple are both disabled and both eligible for and receiving SSI. One spouse goes to work and his income exceeds SSI standards. He can maintain SSI-related Medicaid eligibility under the 1619(b) category of eligibility, but the non working spouse cannot and would lose Medicaid eligibility. The 1619(b) category of eligibility is available to individuals only.

[20] Billings Gazette, Pat Bellinghausen, "Justice System Struggles with Mental Illness", January 11, 2000. It is unclear whether this individual would have or does qualify for MHSP.

Example 9

If a child is eligible for MHSP due to a diagnosis of attention deficit hyper activity disorder (ADHD), he or she will lose eligibility when they turn 18 because that diagnosis and related symptoms are not recognized as a severe and disabling mental illness in an adult. There are other diagnoses that cause children to "age out" of MHSP eligibility, but ADHD is the most common example.