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ACCESS TO CARE FOR S-CHIP CHILDREN WITH SPECIAL HEALTH NEEDS

Prepared by
Harriette B. Fox
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of the Maternal and Child
Health Policy Research Center
for
The Kaiser Commission on
Medicaid and the Uninsured

December 2000

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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EXECUTIVE SUMMARY

This issue brief examines access to care for children with special health care needs under the State Children's Health Insurance Program (S-CHIP). The brief is based on a study of S-CHIP programs in five states, of which three—California, Connecticut, and Utah—opted to enroll S-CHIP eligible children into new private health insurance arrangements, and two—Maryland and Missouri—chose to insure them through Medicaid. For each state, we conducted one or more site visits, meeting with the S-CHIP program director and senior staff; the medical director and other key staff from the two managed care organizations with the largest S-CHIP enrollment; key staff from their behavioral health subcontractors or the state's behavioral health plan; a variety of physical and mental health care providers; and families with children enrolled in S-CHIP. We also conducted a detailed analysis of all relevant S-CHIP documents and available enrollment, capitation, and quality data.

Our major study findings reveal that all five states included, to varying degrees, special program features for children with special health care needs. For the most part, children with special needs seemed to receive the services they required. However, for both Medicaid and non-Medicaid programs, problems were sometimes reported with respect to provider availability and service authorization. Accessing needed services for mental health and developmental conditions was often far more difficult than accessing services for physical conditions.

- **Managed care contract provisions.** State managed care contract provisions benefiting children with special needs were included in both Medicaid and two of the non-Medicaid S-CHIP programs we studied. All four had provider network requirements, such as a sufficient mix of specific pediatric specialty providers; all four had access requirements, such as appointment and distance standards for specialty providers; and three had quality requirements, such as utilization reporting for a range of non-physician specialty services.

- **Wrap-around programs.** Both California and Connecticut had wrap-around programs for children with serious physical and mental health conditions. California's programs—which provided all physical health services and almost all mental health services related to the child's eligible condition—experienced some delays in eligibility determination and service access. This was due to plans' confusion about program eligibility, which in the physical wrap-around program resulted in much over-referral; staff shortages in both wrap-around programs; and insufficient financing for the service system infrastuctures. Connecticut's programs—which provided almost all specialty physical health services and most specialized mental health services that exceeded plan benefits in type or amount—experienced fewer problems. Nevertheless, there was a lack of clarity in Connecticut about the wrap-around programs' eligibility and service policies, and plans were confused about when a child should be referred. In both California and Connecticut the wrap-around programs served only a very small proportion of S-CHIP participants, but providers and families viewed these systems as delivering high-quality services.

- **Pediatric subspecialty care.** Obtaining pediatric subspecialty care in the five study states was sometimes difficult. Benefits for specialty physicians were unlimited, and authorization was reportedly not a barrier to care. However, in three of the states, providers— and in some cases families—reported fairly extensive shortages in S-CHIP subspecialty networks, particularly for certain types of specialists, resulting in long delays for appointments. Low reimbursement rates apparently deterred community-based specialists from participating and also contributed to hospitals' inability to retain subspecialty staff.

- **Ancillary therapy services.** Access to ancillary therapy services and, to a lesser extent, home health care, for some S-CHIP children was limited, although those requiring durable medical equipment appeared to experience few difficulties. Benefits for these non-physician specialty care services were far more generous in the Medicaid than the non-Medicaid S-CHIP programs where, particularly for children requiring home health care, the amount of coverage was sometimes insufficient even in one state with a wrap-around program. However, despite differences in benefit amounts and medical necessity standards, ancillary therapies for other than short-term interventions to address serious medical conditions were seldom authorized by plans; children were referred instead to wrap-around programs, early intervention and special education programs, or regional centers. Providers were generally satisfied with plan authorization policies for home health care in most states and for medical equipment in all five, except that delays in approval for medical equipment sometimes created problems for families.

- **Outpatient mental health services.** Obtaining outpatient mental health services was frequently difficult for S-CHIP children. Benefits were more generous in the Medicaid states than in the non-Medicaid states, however, children faced challenges accessing appropriate providers in all five states. In some plans, referral systems for mental health services frustrated families and delayed care. In all plans, though, shortages of participating psychiatrists and their practice of restricting S-CHIP patients—largely because of low reimbursement rates—were associated with unacceptably long waits for psychiatric treatment, particularly medication management. Moreover, therapy beyond initial visits was sometimes not authorized for certain common child and adolescent conditions.

- **Inpatient mental health services.** Access to inpatient mental health services and residential treatment was, to varying degrees, characterized as a problem for S-CHIP children in our study states. Coverage for both services was available in the five states, though benefits varied dramatically. Providers in three states expressed concerns related to the supply, location, and pediatric capacity of networks' inpatient facilities and in all five described general or programmatic shortages in residential treatment centers. Providers also reported that none of the plans were authorizing admissions or lengths for inpatient care to the extent they were required, and plans in some states were restricting residential treatment approval for particular children.

Introduction and Methods

This report, prepared for the Kaiser Commission on Medicaid and the Uninsured and the federal Bureau of Maternal and Child Health, is part of a larger study focusing on implementation issues and challenges during the first year of S-CHIP operation in five states. Our goal was to understand how program arrangements and plan requirements influence the delivery and quality of care for S-CHIP participants and the ease of program implementation for states. In particular, we wanted to assess differences between Medicaid and non-Medicaid programs. Other topics addressed in separate reports in this series are state administration and accountability, managed care contracting, and access to care by adolescents.

Our study states were California, Connecticut, Maryland, Missouri, and Utah. Three of the five states—California, Connecticut, and Utah—developed non-Medicaid programs. The other two—Maryland and Missouri—chose to serve S-CHIP children through Medicaid. The following is a description of the programs, current as of their first year of S-CHIP implementation.

- **California's** non-Medicaid S-CHIP program, Healthy Families, began offering coverage to children in families with incomes above Medicaid eligibility levels[1] and below 200 percent of the federal poverty level (FPL) on July 1, 1998. The program is unique in that it is administered by a quasi-governmental entity, the Managed Risk Medical Insurance Board (MRMIB). Healthy Families participants, all of whom are charged monthly premiums and copayments, receive a benefit package modeled after the insurance program for state employees. Children with intensive physical or mental health needs were eligible for supplemental benefits which, along with their other specialty services, were furnished at no cost through two wrap-around programs operated by the state's Title V program,[2] California Children's Services (CCS), and the county mental health systems. At the end of its first year of operation, Healthy Families was serving 138,869 children.

- **Connecticut's** non-Medicaid S-CHIP program, HUSKY B, which serves children in families with incomes above Medicaid eligibility levels,[3] began enrolling them on July 1, 1998. The program is administered by the state Medicaid agency. Its participants, all of whom are charged copayments, receive the state employees' benefit package. Those with incomes above 225 percent of poverty are required to pay monthly premiums; those with incomes above 300 percent of poverty may buy into the program at full cost. Supplemental services furnished through HUSKY Plus Physical or HUSKY Plus Behavioral are available to children in families with incomes below 300 percent of

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[1] Prior to S-CHIP, Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

[2] Title V of the Social Security Act provides federal block grant funds to the states for child health services. At least 30 percent of each state's block grant must go towards services for children with special health care needs, although states are able to define their own medical criteria and establish their own policies for covered services.

[3] Prior to S-CHIP, Medicaid eligibility levels were set at 185 percent of poverty for children up to age 15 and 100 percent of poverty for children ages 15 to 19.

poverty with intensive physical or mental health needs at no cost. After one year of operation, 3,543 children were participating in HUSKY B.

- **Utah's** non-Medicaid S-CHIP program, CHIP, opened enrollment on August 1, 1998 to children in families with incomes above Medicaid eligibility levels[4] and below 200 percent of the federal poverty level. The state's Medicaid agency administers the program, which provides benefits actuarially equivalent to the state employees' benefit package. Although the program does not impose any premium charges, it requires all participants to pay copayments and those with higher incomes to pay coinsurance for certain services. One year after implementation, CHIP was serving 10,279 children.

- **Maryland's** Medicaid S-CHIP program, the Maryland Children's Health Insurance Program (MCHIP), began offering coverage to all children below 200 percent of the federal poverty level[5] on July 1, 1998. Participants receive full Medicaid benefits with no cost-sharing obligations. Children with one of 33 physical diagnoses may opt out of managed care enrollment and enroll in the Rare and Expensive Case Management Program. According to the state, approximately 57,000 children were participating at the end of MCHIP's first year of operation; however, because of a previously approved Medicaid waiver program that provided limited benefits, the state receives the enhanced federal match for only 14,975 children, those with incomes between 185 and 200 percent FPL.

- **Missouri's** Medicaid S-CHIP program, MC+ for Kids, became operational on July 1, 1998, offering coverage to all children in families with incomes below 300 percent of the federal poverty level.[6] Because Missouri operates its Medicaid program under an approved section 1115 research and demonstration waiver, the state was allowed to modify its existing Medicaid waiver to include S-CHIP participants. All MC+ for Kids participants are charged copayments, and those in families with incomes above 235 percent of poverty are required to pay monthly premiums. Participants receive full Medicaid benefits, with the exception of nonemergency transportation. At the end of its first year of operation, MC+ for Kids was serving 68,475 children.[7]

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[4] Prior to S-CHIP, Medicaid eligibility levels were set at 133 percent of poverty for children up to age six and 100 percent of poverty for children up to age 19.

[5] Prior to S-CHIP, Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, 100 percent of poverty for children ages 6 to 16, and 34 percent of poverty for children ages 16 to 19.

[6] Prior to S-CHIP, Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 19.

[7] Missouri was the only one of the five states not to serve S-CHIP participants through managed care on a statewide basis. Missouri's program operated on a fee-for-service basis in certain rural areas of the state.

[8] Newacheck PW, Strickland B, Shonkoff JM, Perrin JP, McPherson M, McManus M et al. Epidemiologic Profile of Children with Special Health Care Needs. *Pediatrics.* 102(1):117–123, 1998.

The federal Bureau of Maternal and Child Health defines children with special health care needs as those who have, or are at risk for, a chronic physical, developmental, behavioral, or emotional condition requiring health and related services of a type or amount beyond those required by children generally. In McPherson M, Arango P, Fox HB, Lauver C, McManus M, Newacheck PW et al. A New Definition of Children with Special Health Care Needs. *Pediatrics.* 102(1):137–140, 1998. The 18 percent estimate developed by Newacheck et al. refers only to children who have an existing chronic condition.

In addition to selecting states that would enable us to compare Medicaid and non-Medicaid approaches, we required that the study states be operating their S-CHIP programs for at least one year and that they set their upper income eligibility level no lower than 200 percent of the federal poverty level. We also sought to obtain geographic representation and some variation in covered services, cost-sharing requirements, and administrative structure. For example, California and Connecticut have relatively modest cost-sharing requirements, at least for physical health, under their non-Medicaid programs and supplement their basic benefit package with coverage for children with intensive needs. Utah, by contrast, operates a non-Medicaid program that more closely mirrors traditional health insurance. In addition, California uses a quasi-public entity to administer its program, while the other four states rely on their Medicaid administrative structure.

At the outset of the project we developed a detailed set of core research questions. These questions primarily addressed the intent and effect of various state and plan policies, such as state contract requirements regarding benefits, provider networks, quality assurance, and plan payment and authorization policies for important covered services. From these core questions, we developed a model survey instrument for each of the groups to be interviewed. Based on our analysis of each state's S-CHIP plan and contract documents, we modified each instrument to reflect state-specific program arrangements. Each interview took approximately two hours to conduct and was later followed up by additional telephone interviews and data requests to verify or clarify the information provided.

For each state, we conducted one or more site visits between September 1999 and February 2000, meeting with the S-CHIP program director and senior staff; the medical director and other key staff from the two managed care plans with the largest S-CHIP enrollment; providers; and families whose children have special needs. Interviews with S-CHIP officials took place in the state agency offices, and other interviews were conducted in the communities where the state's two largest S-CHIP plans were based. Providers and families typically attended the group interviews from surrounding areas. Only in California, because of its size, was our sample of providers and families limited to a certain geographic area (Los Angeles).

The study is essentially a qualitative study that attempts to glean from the various perspectives of the state, the plans, providers, and families what the first year's experience of the five S-CHIP programs has been—what aspects of the program appear to be working well and what aspects are causing difficulties or confusion. Our findings are not based on large administrative data sets, chart reviews, or consumer satisfaction surveys, although we sought to obtain such data when they were available. Rather, the findings are based primarily on the opinions and insights of key decision makers as well as providers and families affected by state and plan policies. Often the responses of different groups were at odds, and understanding the complete picture was difficult. In these instances, we attempted to piece together the facts and underlying issues.

There are several limitations to this study, however. It is not based on a quantitative analysis of primary and secondary data, and the opinions expressed by interviewees represent an incomplete picture. In addition, our findings are current only as of the date of our site visit. All five S-CHIP programs have now begun their third year of operation, and, as enrollment has grown and plans and providers become more experienced with the program, substantial changes have likely occurred. Finally, and most importantly, our findings are based on a small sample of S-CHIP programs and therefore may not be generalizable to the experiences of other programs.

This issue brief on children with special needs is divided into five sections. The first provides a profile of the population of children with special health care needs. The second summarizes the special S-CHIP program features the five states have structured to serve these children effectively. The third examines the specialty provider networks for physical and mental health services, and the fourth assesses service coverage and access for these services. The fifth section considers other issues affecting access to care by children with special needs, including plan selection, health risk assessments, case management, multidisciplinary care, and cost sharing. The appendix provides a short summary of each state's S-CHIP program and includes three tables. Appendix Table I provides a summary of the five states' S-CHIP programs. Table II describes their benefits in detail, and Table III describes their cost-sharing requirements.

Profile of Children with Special Health Care Needs

National data reveal that 12.5 million or 18 percent of children have a chronic physical, developmental, behavioral, or emotional condition and require an elevated level of health care services.[8] More than one out of every ten of these children were uninsured in 1994–1995; among those in families with incomes between 100 and 200 percent of the federal poverty level, the uninsurance rate was 18 percent, as shown in Table I.[9] Risk of being uninsured in this income group was highest among children ages 13–17, Hispanics, and those residing in the South.[10]

Table I

Sociodemographic Characteristics of Uninsured Children with Special Health Care Needs, Ages 0 through 17, with Family Incomes Between 100–199 Percent of the Federal Poverty Level, 1994–95

Sociodemographic Characteristics	Number (in thousands)	Percent
Age		
All children with special health care needs (CSHCN)	506	100.0%
<1 years	3	0.7
1–5 years	94	18.6
6–12 years	236	46.7
13–17 years	172	34.0
Sex		
Male	299	59.3
Female	208	41.0
Race and Ethnicity		
White, non-Hispanic	346	68.3
Black, non-Hispanic	64	12.7
Hispanic	86	17.0
Other	10	2.0
Living Arrangemen		
With both parents	337	66.8
With one or no parents	168	33.2
Region of Residence		
Northeast	67	13.2
Midwest	86	16.9
South	244	48.2
West	110	21.7

Source: Special tabulations from the 1994 and 1995 National Heath Interview Survey prepared for the Maternal and Child Health Policy Research Center by Yun-Yi Hung and Paul Newacheck of the University of California, San Francisco.

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[9] Of all uninsured children with special health care needs, 42.4 percent had family incomes between 100 and 200 percent of the federal poverty level, 40.2 percent had family incomes below 100 percent of poverty, and 17.4 percent had family incomes at or above 200 percent of poverty, according to data from the 1996 National Health Interview Survey, analyzed by Yun-Yi Hung and Paul Newacheck of the University of California, San Francisco.

[10] Ibid.

Overall, chronic conditions affecting children include only a few highly prevalent conditions, such as asthma, attention deficit and disruptive behavior disorders, depression, frequent migraine headaches, and speech defects. More common among children are low prevalence conditions, such as diabetes, sickle cell disease, eating disorders, cerebral palsy, and spina bifida. Less than a third of children with chronic conditions experience a disability or activity limitation as a result of their condition.[11]

While precise prevalence estimates of children with these conditions are limited, researchers have described these conditions and their associated service needs as follows:

- **Serious physical conditions** affecting children include rare, severe, or disabling conditions and are estimated to be about 10–12 percent of the child population.[12] Health services commonly required by these children include ongoing pediatric medical or surgical subspecialist physician services, medications, lab and x-ray services, hospital care, durable medical equipment and medical supplies, care coordination, and, in a small minority of children, home health care.

- **Developmental conditions** affecting children include delays or disabilities in communication, cognition, mobility, self-direction, and self care, generally as a result of central nervous system dysfunction. An estimated 10 percent of children,[13] have some developmental impairment and often require pediatric medical subspecialists, occupational therapy, speech-language pathology services, physical therapy, medications, durable medical equipment and assistive devices, and care coordination.

- **Behavioral or emotional conditions** affecting children include clinically significant disturbances of thought, behavior, emotions, or relationships that can be described as a syndrome or pattern, generally resulting from neurochemical dysfunction, negative environmental influences, or some combination of both. An estimated 10–20 percent of the child population have had behavioral or emotional conditions[14,15] and many require any of the following services: child and adolescent psychiatrist services; individual, group, or family psychotherapy; substance abuse counseling; medications; home-based services; crisis intervention; day/night hospital services; residential treatment; and care coordination.

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[11] An estimated 6.3 percent of low-income uninsured children experienced some level of disability in 1994. In Newacheck PW. *Children with Disabilities Under the State Children's Health Insurance Program.* Washington, DC: MCH Policy Research Center, December 1997.

[12] Neff JM and Anderson G. Protecting Children with Chonic Illness in a Competitive Marketplace. *Journal of the American Medical Association.* 274(23):1866–9, 1995.

[13] Boyle CA, Decoufle P, Yeargin-Alsopp M. Prevalence and Health Impact of Developmental Disabilities in US Children. *Pediatrics.* 93(3):399–403, 1994.

[14] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[15] Bradenburg NA, Friedman RM, and Starr ES. The Epidemiology of Childhood Psychiatric Disorders: Prevalence Findings from Recent Studies. *Journal of the American Academy of Child and Adolescent Psychiatry.* 29:1, 1990.

The extent of unmet need among children with special health care needs varies depending on the length of time they were uninsured, their participation in special programs for children, and often the type of condition they have. According to the Surgeon General, an estimated 75–80 percent of children requiring mental health interventions fail to receive them.[16] Comparable estimates for children with developmental or complex physical conditions are unavailable; however, findings from the National Health Interview Survey reveal that about one-third of uninsured children with special health care needs with family incomes below 200 percent of poverty have unmet needs for medical care, dental care, prescriptions, and eyeglasses.[17]

Special Program Features

The five S-CHIP programs we examined each, to varying degrees, included program features intended to assure that children with special health care needs were served appropriately. The Maryland and Missouri Medicaid S-CHIP programs both had provider, access, and quality provisions in their managed care contracts to address this population's service needs. In Missouri, plans were given preference in contracting if they included community mental health centers in their networks and they were required to meet appointment standards for mental health services as well as primary care. Quality reporting included utilization data for hospital, mental health, substance abuse treatment, home health, vision, and case management services and clinical effectiveness studies for asthma, diabetes, and mental health care. Children with disabilities that would qualify them for SSI payments[18] were excluded from managed care enrollment and able to receive Medicaid services on a fee-for-service basis. As shown in Table II, Maryland's provisions were far more extensive. Plans were required to have a complete network of pediatric specialty care providers, including ancillary therapists as well as physicians; to allow specialists to serve as primary care providers; and, if assigned by the state, to accept historic providers[19] in their networks. The state had appointment standards for mental health providers and pediatric specialists, and it required that multidisciplinary teams be convened and plans of care be developed for enrollees with complex cases. Quality reporting in Maryland included utilization data for hospital, mental health, substance abuse treatment, and pharmacy services and clinical effectiveness measures for asthma, diabetes, and sickle cell anemia. In addition, the state gave children with selected rare and expensive conditions[20] the option to be excluded from managed care enrollment and receive their care on a fee-for-service basis with comprehensive case management.

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[16] U.S. Department of Health and Human Services, 1999.

[17] Newacheck PW, McManus M, Fox HB, Hung YY, Halfon N. Access to Health Care for Children with Special Health Care Needs. *Pediatrics.* 105 (4 Pt 1):760–6, April 2000.

[18] The federal Supplemental Security Income (SSI) program provides cash payments to blind and disabled children with limited income and resources. To qualify as disabled, a child must have a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

[19] State regulations governing the Maryland Medicaid managed care program define an historic provider as someone who provided a certain number of units of service to Medicaid participants, who received a particular amount of Medicaid payments, or who served a particular number of Medicaid participants between July 1994 and July 1995. The particular amount of service units, payments, and recipients varied depending on whether the provider had participated in the state's voluntary HMO or primary care case management system.

[20] The Rare and Expensive Case Management program covers 33 diagnoses, the majority of which are severe physical health problems, such as HIV, spina bifida, hemophilia, ventilator dependent conditions, cystic fibrosis, brain injury, and aplastic anemia.

In addition, both Medicaid S-CHIP programs required plans to have service coordinators for children with special health care needs. Maryland also required that plans develop treatment protocols and specialty care referral protocols for these children. The identification of children with special health care needs in both states was left to the plans, which presumably were to draw from the health risk assessment information collected by the states at the time of enrollment. Only Maryland furnished plans with a definition of children with special needs, however. Its definition, which is fairly broad—but does not pertain to behavioral health problems[21]—included children "suffering from a moderate to severe chronic health condition, a) with significant potential or actual impact on health and ability to function, b) which requires special health care services, and c) which is expected to last longer than three months."

Utah's non-Medicaid S-CHIP program also established a variety of specific standards regarding the care of children with special needs. Plans were required to assure that their provider networks included primary care providers with experience serving these children and that specialists were able to serve as primary care providers. They also were required to assure timely access to pediatric subspecialty consultation and treatment and pediatric rehabilitation services, meet appointment standards for visits related to monitoring chronic conditions, waive prior authorization requirements for one evaluation and one follow-up visit provided by Title V providers of services to children with special needs, and to assure access to multidisciplinary clinics for those children determined to have serious physical conditions that make them eligible for the Title V program.[22] Although Utah's quality reporting requirements did not include any clinical effectiveness measures, they did call for utilization data on physician specialty, emergency room, inpatient hospital, mental health, ancillary therapy, home health, and vision services. In addition, the state required plans to identify children with special health care needs at the time of enrollment and provided the following definition: "Children with special health care needs are those who have or, are at risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally. Such conditions limit physical functioning, activities of daily living, or social role in comparison to age peers."

The approaches taken by the California and Connecticut non-Medicaid programs were substantially different from the one taken by Utah. Whereas Utah's S-CHIP officials expected children with extensive health care requirements to be eligible for Medicaid coverage through the program's medically needy spend-down provision,[23] officials in California and Connecticut determined that

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[21] In Maryland, managed care plans are not responsible for behavioral health services. These services are delivered by a separate managed care arrangement regulated by the Department of Health and Mental Hygiene.

[22] In Utah, children eligible for the Title V program are those determined to have one of the following conditions: spina bifida, sacral agenesis, cleft lip and palate, congenital heart defects, myelodysplasia, orthopedic defects, seizure disorder, cystic fibrosis, hemophilia, and metabolic disorders, osteogenesis imperfecta, phocomelia, phenylketonuria, galactosemia, cerebral palsy, and muscular dystrophy.

[23] Medicaid's medically needy program option allows states to extend eligibility to children born before September 30, 1983 in families with incomes that exceed the AFDC income eligibility but are not greater than 133 percent of that level, and also allows them to extend eligibility to all children with incomes above the Medicaid level if they incurred medical expenses that reduce their countable income to the Medicaid eligibility level. Some states require that families actually pay the medical expenses each month, while others require only the expenses be incurred. These programs are sometimes referred to as "spend-down" programs.

In Utah, the medically needy program allows children to qualify for Medicaid coverage if they have incurred medical expenses that bring their countable income down to 100 percent of the federal poverty level. If after deducting medical expenses, a family's countable income exceeds 100 percent of the poverty level, the family may elect to qualify either by paying the "excess income" amount towards their incurred medical expenses or by assigning the money to the Medicaid agency.

Table II

S-CHIP Program Features Benefitting Children with Special Health Care Needs in the Five Study States During the First Year of S-CHIP Implementation*

	States with Medicaid S-CHIP Programs		States with Non-Medicaid S-CHIP Programs		
	Maryland	**Missouri**	**California**	**Connecticut**	**Utah**
Network Requirements					
1. Primary Care Providers					
A. Specialists as PCPs	✓				✓
B. PCPs with Experience Treating Special Needs					✓
2. Medical Specialists with Pediatric Expertise	✓			✓	
3. Mental Health Providers with Pediatric Expertise				✓	
4. Ancillary Therapists with Pediatric Expertise	✓			✓	
Access Standards					
1. Appointment Standards					
A. Primary Care	✓	✓		✓	✓
B. Medical Specialty Care	✓	✓			✓
C. Mental Health Care	✓	✓			
D. Dental Care	✓			✓	
2. Distance Standards					
A. Medical Specialty Care					
B. Mental Health Care				✓	
C. Dental Care	✓	✓		✓	
D. Pharmacy Services	✓	✓			
3. Other Access Requirements					
A. Multidisciplinary Care	✓				✓
B. Title V Services for Special Needs	✓				✓
C. Time Limits on Authorization Decisions					
Other Plan Requirements					
1. Use of Special Care Coordinators	✓	✓			
2. Treatment Protocols	✓				
3. Specialty Care Referral Protocols	✓				
Quality Performance Measures					
1. Clinical Effectiveness	✓			✓	✓
A. Asthma	✓				✓
B. Diabetes	✓				✓
C. Sickle Cell Anemia	✓				✓

Continued on next page

Table II *(continued from previous page)*

S-CHIP Program Features Benefiting Children with Special Health Care Needs in the Five Study States During the First Year of S-CHIP Implementation*

	States with Medicaid S-CHIP Programs		States with Non-Medicaid S-CHIP Programs		
	Maryland	**Missouri**	**California**	**Connecticut**	**Utah**
2. Service Utilization	✓	✓		✓	✓
A. Physician Specialty Services					✓
B. Emergency Room Visits					✓
C. Pharmacy Services					✓
D. Inpatient Hospital Services	✓	✓		✓	✓
E. Mental Health Services	✓	✓		✓	✓
F. Chemical Dependency Services	✓	✓		✓	✓
G. Ancillary Therapy Services	✓				
H. Home Health Services		✓			✓
I. Vision Services		✓			✓
J. Case Management Services		✓			
Special Programs for Children with Special Needs					
1. Populations Exempt from MCO Enrollment					
A. Children with Severe Physical Problems	✓	✓			
B. Children with Severe Mental Health Problems		✓			
2. Supplemental Benefits					
A. Children with Severe Physical Problems			✓	✓	
B. Children with Severe Mental Health Problems			✓	✓	

Source: Information obtained by the MCH Policy Research Center through detailed on-site and follow-up telephone interviews and an analysis of the S-CHIP contracts in effect during the first year of S-CHIP implementation.

Note: *The programs were implemented in either July or August of 1998.

wrap-around benefit programs were needed to serve this population of children appropriately. California relied almost exclusively on the wrap-around strategy, establishing few if any protections for children with special needs in its general managed care contracts. Supplemental benefits were furnished through the California Children's Services (CCS) program and its network of approved pediatric providers and specialty care centers to children with selected chronic physical or developmental conditions[24] that require tertiary level, multidisciplinary, or multi-specialty care, and through the county mental health system and its community-based

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[24] These are children with serious illnesses in diagnostic categories that include: infectious diseases; neoplasms; endocrine, nutritional and metabolic diseases and immune disorders; diseases of blood and blood-forming organs; diseases of the nervous system; diseases of the eye and ear; diseases of the circulatory system; diseases of the respiratory system; diseases of the digestive system; diseases of the genitourinary system; diseases of the skin and subcutanaeous tissues; diseases of the musculoskeletal system and connective tissues; congenital anomalies; perinatal morbidity; and accidents, poisonings, violence, and immunization reactions.

provider networks to children with severe emotional disturbances[25] that cause substantial impairment or risk of harm. Children eligible for CCS received all diagnostic, outpatient treatment, hospital, rehabilitation, and follow-up care related to their condition, as well as case management services, through the CCS system.[26] Those eligible for county mental health services received all case management, outpatient therapy, day treatment, residential treatment and psychiatric hospital services—except for 30 days of inpatient care—from the county system.[27] Under both wrap-around arrangements, providers were paid on a fee-for-service basis.

Connecticut chose to impose some specialty care requirements on managed care plans related to the care of children with special needs in addition to operating two wrap-around benefit programs. Plans were required[28] to include in their networks mental health providers, social workers, and ancillary therapists with pediatric expertise as well as a significant number and mix of pediatric medical and surgical specialists. They also were mandated to meet distance standards for mental health services. Connecticut's wrap-around benefits were available through the Husky Plus Physical health plan to children with serious chronic physical conditions associated with some functional limitation,[29] and through the Husky Plus Behavioral health plan to children who are determined to have severe emotional disturbances or substance abuse problems characterized by functional impairment and limitation in the child's role in family, school, or community activities.[30] The state intended that to be eligible for supplemental services,

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[25] These are children who have a mental disorder other than a primary substance abuse disorder or developmental disorder and who meet one or more of the following criteria: 1) the child has impairments in at least two functional areas (self care, school functioning, family relationships, or ability to function in the community) and either has been removed or is at risk for removal from home or has a condition and impairments that have persisted for six months and are expected to continue a year or longer without treatment, 2) the child shows psychotic features or risk of suicide or violence due to a mental disorder, or 3) the child meets the special education eligibility requirements.

[26] CCS provides a comprehensive array of medically necessary services to promote or maintain optimum health and functioning and to prevent deterioration. Such services, provided by CCS-approved hospitals, physicians, and specialty care centers, include medical and surgical diagnoses and treatment, inpatient hospital care, therapies, home health care, audiology services, durable medical equipment and medical supplies, dental services, pharmaceuticals, and care coordination.

[27] The county mental health system provides a full continuum of specialty mental health care. Services include outpatient mental health services, medication support services, acute and non-acute psychiatric hospital services, inpatient therapeutic or rehabilitative services, day treatment services, crisis intervention and stabilization, crisis and non-crisis residential treatment services, and targeted case management.

[28] Connecticut established requirements for plans through its requests for proposals. As of May 2000, almost two years after the program began operating, the state had not developed an S-CHIP contract. Plans perceived that having a contract would have given them more specificity regarding the amount, duration, and scope of covered services such as ancillary therapies, home health care, and durable medical equipment.

[29] To become eligible for the Husky Plus Physical health plan, a determination is made by the medical staff at the Yale New Haven Hospital or the Connecticut Children's Medical Center. The child must be found to have one of the following: 1) a Title V eligible condition (i.e. cystic fibrosis, diabetes, hearing impairment, cerebral palsy, and congenital heart disease; 2) a problem with his brain, eyes, nerves, or muscles that makes it more difficult to move or learn than most other children the same age (except for behavioral or psychiatric conditions); 3) an ongoing physical problem (e.g., with heart, lungs, stomach, blood, arms, or legs) making it more difficult to do things most other children the same age can do; or 4) an ongoing need for special machines (e.g., respiratory equipment, monitors, or feeding pumps) or equipment (e.g., wheelchair or braces).

[30] To become eligible for the Husky Plus Behavioral health plan, a determination is made by a multidisciplinary committee of the Yale Child Study Center comprised of a child and adolescent psychiatrist, a clinical psychologist, a psychiatric nurse, and other specialists as necessary. The specific assessment instruments used are the Child Behavior Check List and the Child and Adolescent Functional Assessment Scale. The child must be found to have a diagnosable DSM-IV disorder, show evidence of severe psychiatric or substance abuse symptoms, experience marked and enduring impairment in functioning across multiple areas, and have been unresponsive or minimally responsive to intervention.

a child would have physical or behavioral health care needs that could not be met through the regular S-CHIP benefit package. The Husky Plus Physical health plan, operated by the Yale New Haven Hospital and the Connecticut Children's Medical Center, contracted with a network of Title V-approved providers to furnish a wide range of services including multidisciplinary team conferences, family support services, hearing aids, specialized medical equipment, and orthodontics as well as expanded coverage of many services included in the basic plan. The Husky Plus Behavioral health plan, operated by the Yale Child Study Center, provided case management, crisis intervention, in-home therapeutic services, and expanded coverage of outpatient and day treatment services through child guidance and hospital clinics. Providers in the two plans, as in California, were paid on a fee-for-service basis.

Neither California nor Connecticut had enrolled a significant number of children with special needs in their wrap-around programs by the end of their first year of operation. In fact, the number of participants in the two physical health wrap-around programs equaled 1.4 percent of California's total S-CHIP enrollment and 1 percent of Connecticut's. The participation rates in these two physical health programs are probably only about a quarter of the rates that might have been expected.[31] The number of participants in the two behavioral health wrap-around programs was even lower—.31 percent in California and .17 percent in Connecticut. The participation rates in these two mental health programs are probably 10 percent or less of the rates that might have been expected.[32] S-CHIP and wrap-around program officials in California and Connecticut offered several possible explanations for why their wrap-around benefit programs were not serving more children.[33] One was that the medically needy programs[34] (which were operating in both states) were enabling these children to participate in Medicaid. Another was that families

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[31] Based on the opinions of four national experts in the epidemiology of chronic childhood illness, we estimate that, using the states' own screening criteria, between 5 to 7 percent of children in California's S-CHIP program might have been eligible for wrap-around services and that between 3 to 5 percent of children in Connecticut's S-CHIP program might have been eligible. On the basis of these estimates, the 2,000 children participating in California would comprise 21 to 29 percent of the estimated eligible participation; the 37 children participating in Connecticut would comprise 21 to 35 percent of the estimated eligible participation. (The directors of Connecticut's physical health wrap-around program initially estimated that eight percent of S-CHIP participants might qualify for wrap-around services.)

[32] According to prevalence estimates developed by a group of technical experts for the Florida Mental Health Institute, among children ages 9 to 17, an estimated 9 to 13 percent have a serious emotional disturbance causing significant impairment, and an estimated 5 to 9 percent have a serious emotional disturbance causing extreme impairment. In Manderscheid RW and Henderson MJ (eds.) Center for Mental Health Services. *Mental Health, United States, 1998.* Washington, DC: Government Printing Office, 1998. Assuming 3 to 5 percent of children of all ages could meet SED criteria with functional impairment, the 425 S-CHIP children participating in California's mental health wrap-around program comprise only 6 to 10 percent of the estimated eligible population, and the six children participating in Connecticut's mental health wrap-around program comprise only 3 to 6 percent. (The director of Connecticut's behavioral health wrap-around program initially estimated that four percent of the state's S-CHIP participants might qualify for wrap-around services.)

[33] California's CCS program director was not concerned about the participation rate. She believed that the program was serving the expected population of S-CHIP children.

[34] Medicaid's medically needy program option allows states to extend eligibility to children born before September 30, 1983 in families with incomes that exceed the AFDC income eligibility but are not greater than 133 percent of that level, and also allows them to extend eligibility to all children with incomes above the Medicaid level if they incurred medical expenses that reduce their countable income to the Medicaid eligibility level. Some states require that families actually pay the medical expenses each month, while others require only the expenses be incurred. These programs are sometimes referred to as "spend-down" programs.

whose children had extensive service requirements were more likely than other families to purchase group health insurance coverage. In addition, children with severe behavioral health problems may have been receiving services through the juvenile justice system, child welfare, or special education. A lack of awareness among families and providers appeared also to have contributed to low participation. Plans only referred children to these programs when they identified the children on the basis of high-cost claims.

It is important to note that in Connecticut's enabling legislation for S-CHIP and in its request for proposals from managed care organizations, the state articulated that children meeting a very broad definition of children with special health care needs could be eligible for supplemental services from the Husky Plus Physical health plan. Both documents stated that eligible children are those who meet the clinical eligibility standard of the Title V program, and that the standard is based on diagnostic or acuity criteria and also on the approved definition of children with special needs. Children with special needs are defined in both documents, consistent with the federal Maternal and Child Health Bureau's definition, as those who "have or are at elevated risk for (biologic or acquired) chronic physical, developmental, behavioral, or emotional conditions and who also require health and related (not educational and not recreational) services of a type or amount not usually required by children of the same age." This definition, according to national estimates, includes as many as 18 percent of children,[35] counting only those with diagnosed conditions and not those "at elevated risk" for such conditions. Excluding children with behavioral or emotional conditions, the definition probably would encompass approximately 10–12 percent of children.[36,37] However in Connecticut, children could only become eligible for the Husky Plus Physical health plan if their service needs could not be met through the regular S-CHIP benefit package.

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[35] Newacheck PW, Strickland B, Shonkoff JM, Perrin JP, McPherson M, McManus M, Lauver C, Fox H, Arango P. Epidemiologic Profile of Children with Special Health Care Needs. *Pediatrics.* 102: 117–123, 1998.

[36] This estimate is based on the opinions of four national experts in the epidemiology of chronic childhood illness.

[37] There are now two new screening tools that have been extensively tested for use in identifying children who would meet this broad definition of special health care needs. They both measure functional limitations, elevated service needs, and reliance on compensatory mechanisms (e.g. medications). The tools are 1) the Questionnaire for Identifying Children with Chronic Conditions—Revised (QuiCCC-R), which is a set of 16 questions developed by researchers at the Albert Einstein College of Medicine, and 2) the Living with Illness Module (LWIM), which is a set of five questions developed by the Child and Adolescent Health Measurement Initiative of the Foundation for Accountability. Stein REK, Silver EJ, Bauman LJ. Shortening the Questionnaire for Identifying Children with Chronic Conditions (QuiCCC): What is the consequence? *Pediatric Research.* Vol. 47, No.2, April 2000. Bethel CM, Read D, Newacheck PW. *Toward a Common Approach to Identifying Children with Chronic Conditions.* Portland, OR: Foundation for Accountability, 2000.

Provider Networks

Pediatric Specialty Providers

Plan officials in the five S-CHIP programs we examined reported having a generally sufficient supply of pediatric subspecialists to serve the S-CHIP population, although in California and Utah they mentioned shortages of these providers in rural areas. Of the nine plans for which we could obtain information,[38] all but one in Connecticut subcontracted with a single children's hospital or other tertiary care center and relied on this facility almost exclusively to supply pediatric subspecialists. In their specialty provider directories, all plans included pediatric specialty areas, but none identified board-certified pediatric subspecialists. A few plans indicated some type of board certification,[39] but most simply allowed physicians to self-designate their interest in a pediatric specialty. This latter approach permitted board-eligible pediatric subspecialists, physicians board-certified in both pediatrics and an adult specialty area, and general pediatricians as well as adult medicine specialists to be listed. Still, only one plan in Connecticut listed all of the 14 pediatric specialty areas we examined[40] in their directories. Four plans were missing one or two specialty areas, while two plans were missing five or six.

Pediatricians and, in some instances, families in California, Maryland, and Missouri reported fairly extensive shortages in some S-CHIP subspecialty networks. Only in Connecticut and Utah did providers indicate that the hospital-based network included nearly all of the potentially available subspecialists and that out-of-network providers were approved when necessary. In the other three states we were told that community-based pediatric subspecialists were usually not participating in S-CHIP and that families faced long waits for particular types of subspecialists, most commonly pediatric neurologists and orthopedists. We heard also that one plan in Missouri was no longer contracting with a hospital in the central region of the state, causing families to travel long distances for subspecialty care.

Network shortages for physician specialty care apparently were caused by several factors. One was the very limited supply of certain types of board-certified pediatric subspecialists practicing in any setting. For example, according to the American Academy of Pediatrics, the number of practicing board-certified pediatric pulmonologists in our study states ranged from three in Utah to 26 in California.[41] Another factor was reimbursement rates, which, at least in California and Missouri, were characterized as being inadequate to attract the community-based pediatric subspecialty providers who could have served the S-CHIP special needs population, and in

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[38] We could not obtain pediatric specialty provider network information for one plan in Maryland because it subcontracted with numerous medical service organizations that had their own specialty care provider networks.

[39] Three plans indicated board certification but did not distinguish between those certified in an adult specialty area, an adult specialty area plus pediatrics, or a pediatric subspecialty area.

[40] These pediatric specialty areas are allergy, immunology, cardiology, emergency medicine, endocrinology, gastroenterology, genetics, hematology/oncology, infectious disease, neurology, nephrology, orthopedics, pulmonology, surgery, and urology.

[41] Cull WP. *Physician Workforce: Ratio for Child Health, 1998.* Elk Grove Village, Il: American Academy of Pediatrics, June 2000.

Maryland were too low to maintain specialty physician staff at network hospitals. A third factor, contributing directly to the waiting list problem, was the tendency of primary care providers treating children with complex physical conditions to make referrals to the same few participating subspecialists with board certification in pediatrics.

Among non-physician specialty care providers, ancillary therapists (physical therapists, occupational therapists, and speech and language therapists) were participating, according to plan officials, in adequate numbers to meet the needs of the S-CHIP population. All nine plans included a mix of hospital-based and office-based therapists, although the number of office-based therapists varied widely. For example, one plan in California listed no occupational therapists while another in the same state listed 119 privately operated centers. The types of centers plans contracted with typically offered only a single type of therapy.[42] It was usually difficult for families and providers to identify appropriate therapists in plans' directories. Only six listed ancillary therapists, and only one of these indicated which ones had pediatric expertise. Families in most study states tended to rely on hospital-based therapists. Providers in California, Maryland, and Missouri commented that there were either too few therapists or too few with pediatric training and experience in the networks, but in one of these states the problem appeared to be part of a more general provider shortage. No concerns were raised about network capacity in Connecticut and Utah.

The nine plans we interviewed also reported having an adequate supply of home health agencies and durable medical equipment vendors, but state officials in Connecticut and Utah reported home health agency shortages. The number of home health agencies that plans contracted with ranged from two in one Maryland plan to 73 in one Connecticut plan. Most plans included information about home health agencies and medical equipment vendors in their directories, but none specified whether participating home health agencies had any pediatric expertise. Overall, the supply of home health agencies and medical equipment vendors was considered adequate by the providers and families we interviewed.

Mental Health Providers

The composition of the behavioral health networks[43] in our five study states varied somewhat. The five plans in Connecticut, Maryland, and Missouri—all but one of which were organized for Medicaid and S-CHIP business—contracted primarily with community mental health centers and other clinics for outpatient services. The four plans in California and Utah—all of which operated to serve commercially insured populations—primarily used their existing panels of independent mental health practitioners. Clinics that applied to join these panels in Utah were often refused, which presented problems for children who prior to enrolling in S-CHIP were receiving subsidized care at a mental health clinic. Nevertheless, nearly all of the plans we

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[42] Centers were typically physical therapy centers or sports rehabilitation centers.

[43] Separate behavioral health plans were used to serve S-CHIP adolescents in all of the plans we interviewed except one in Utah. There was a total of nine plans providing behavioral health services in the five states we examined because Maryland had a single, state-regulated behavioral health plan that was not a subcontractor to the general managed care plans. The Utah and the Maryland plans were the only entities that assumed no financial risk for mental health services.

interviewed relied heavily on licensed clinical social workers and lesser trained therapists to treat S-CHIP participants. In the three states where plans contracted with clinics, licensed clinical social workers, family counselors, and bachelors-level therapists working under their supervision made up the vast majority of clinic staff. In each of the other two states, there was one plan with a panel comprised predominately of therapists with similar training.

Across all five S-CHIP programs, mental health providers reported a severe shortage of participating psychiatrists in all communities. In particular, they cited the lack of psychiatrists to serve Spanish-speaking children and those in rural areas. These problems were pervasive and resulted in long waits for psychiatric referrals, typically ranging from three to six months, and difficulties obtaining medication management services. Because of these shortages, primary care physicians and, in Connecticut, nurses were often relied upon to prescribe and manage psychotropic medications, which many felt were beyond the scope of their practice.[44] Despite the fact that plans may have appeared to have an adequate supply of psychiatrists identifying themselves as able to serve the child population, we heard repeatedly from several sources that network listings failed to account for the fact that psychiatrists severely restrict the number of S-CHIP participants they accept in their practices and may, in fact, see only one or two each year in order to remain on network lists. In California, Connecticut, and Missouri, for example, we were told that participating university-affiliated psychiatrists were refusing to accept S-CHIP patients. Although not as serious as the shortage of psychiatrists, we heard also that psychologists in four of the nine plans we interviewed were in short supply.

With respect to inpatient psychiatric care, plans' behavioral health networks showed more variation. We found that one California plan included 73 inpatient hospital facilities, while both plans in Utah and one in Connecticut included three to six, although we could not obtain the actual number of beds available to serve children from most plans. To varying degrees, mental health providers in Connecticut, Maryland, and Missouri reported concerns related to the supply, location, or pediatric capacity of inpatient mental health services. In two of these states providers attributed inpatient bed shortages to the insufficient number of residential treatment beds, citing waiting periods of six weeks in one state and six months in the other, and reported that children needing longer term services often were being treated in general acute hospitals or psychiatric facilities, while those needing short-term hospitalizations were backed up in emergency rooms.

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[44] A national survey of more than 12,000 physicians, conducted in 1996–1997, found that about a quarter of primary care physicians felt that the scope of care that they were expected to provide was greater than it should be. St. Peter RE, Reed MC, Kemper P, and Blumenthal D. Changes in the Scope of Care Provided by Primary Care Physicians. *The New England Journal of Medicine.* Vol 341, No. 26, December 1999.

Inadequate reimbursement, more than any other factor, was cited as the major reason for low participation by psychiatrists and inpatient facilities. Psychiatrists' refusal to participate in all types of managed care because of insufficient payment was identified as a serious problem in four out of five of our study states, although a general shortage of psychiatrists was reported in the fifth state (Utah). Psychiatrists in at least two states were paid rates significantly below those paid for commercially insured children,[45] and reportedly in all states were paid well below their charges. Moreover, rate structures for clinics frequently created a strong incentive for them to retain clinical social workers, family counselors, and bachelors' level therapists rather than psychologists or psychiatrists. Both plans in Connecticut and the one plan in Missouri paid a single rate for all clinic services regardless of the therapists' professional training.[46]

Managed care participation by psychiatric hospitals was reportedly also affected by low reimbursement rates. In Connecticut, one plan reported that psychiatric hospitals were very difficult to bring into its panel, preferring instead to be out-of-network facilities. In Missouri, providers mentioned that low reimbursement rates, along with shortened stays, caused several adolescent inpatient psychiatric units in the state to close.

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[45] S-CHIP rates paid to psychiatrists by the four plans in Connecticut and Missouri for an individual therapy session lasting 45-50 minutes were $35, $50, $55, and $84—between 71 and 86 percent of the rates the plans paid for their commercial enrollees. The rate paid by the Maryland Specialty Mental Health System for a 45–50 minute therapy session was $78 but it could not be compared to commercial rates because the system was organized only for Medicaid business.

[46] In Maryland, the clinic rate structure for the specialty mental health system did not distinguish between psychiatrists and psychologists.

Service Coverage and Access

Medical Necessity

States specify the covered benefits for S-CHIP participants in their managed care contracts but recognize that plans will make determinations about the amount and scope of coverage available to a given child based on medical necessity. Among our five study states, both Medicaid states and one non-Medicaid state specified in their contract documents medical necessity standards for plans to follow. Connecticut[47] and Missouri[48] defined medical necessity to include interventions to treat conditions and disabilities and correct functional impairments as well as interventions to treat illnesses and injuries. Maryland's definition[49] was more vague; it neither limited medically necessary treatment to illnesses or injuries nor expressly incorporated a broader purpose. All three states, however, required interventions for preventive purposes. None required that medically necessary services be the least costly available intervention, and none required that they demonstrate evidence of effectiveness based on well-controlled, peer-reviewed studies.

Moreover, two of the three states also specified a medical necessity standard for children's behavioral health services. Both Connecticut[50] and Missouri[51] provided a standard intended to assure that children receive behavioral health services based on an assessment of their individual needs. While Connecticut used language focusing on preventive interventions and linkages to social and medical services, Missouri's language emphasized practice standards among qualified mental health professionals.

The California and Utah S-CHIP programs provided no state guidance regarding medical necessity. Both non-Medicaid states left full discretion in medical necessity determinations to

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[47] Connecticut defined medical necessity as "health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or prevent a medical condition from occurring."

[48] Missouri's medical necessity definition stated that "It is the responsibility of the health plan to determine whether or not a service(s) furnished or proposed to be furnished is(are) reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered; and service(s) could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered; and service(s) is(are) furnished in the most appropriate setting."

[49] Maryland defined medical necessity as "what is medically necessary and appropriate." Medically necessary is defined as "directly related to diagnostic, preventive, curative, palliative, or rehabilitative treatment." Medically appropriate is defined as "an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any alternative services which could be used for the same purpose."

[50] Connecticut defined medical necessity for behavioral health services as those that include "coordination of and linkage to social and medical services which ensure child's health and safety; preventive health services that are designed to avoid need for future medically necessary services; services for chronic, long-term disorders which if left untreated will affect the physical or mental health of child; and duration of treatment provided by MCO for these children shall be based on child's individual needs."

[51] Missouri stated that medically necessary health services "shall be provided in accordance with a process of assessment that accurately reflects the clinical condition of the patient and acceptable standards of practice for such clinical conditions among the community of qualified mental health and substance abuse providers of the area in which services are provided."

plans, allowing them to rely on their commercial standards of medical necessity. Among the four plans we interviewed in these states, three used medical necessity definitions that covered interventions to treat medical conditions, illnesses, or injuries, and none specified coverage for preventive purposes. In addition, one plan that was silent with respect to the scope of health problems covered required that for a service to be medically necessary, it had to be the least costly available intervention and to show evidence of effectiveness based on well-controlled, peer-reviewed studies.

Pediatric Specialty Care

Specialty physician services were covered as a basic benefit without visit limits in the five S-CHIP programs and accessed by primary care referrals in eight of the nine plans we interviewed. Only one plan in California required prior authorization before a child could see a specialty physician.[52] Neither primary care referrals nor prior authorization requirements appeared to present any obstacles to care. However, due to inadequate participation by certain types of pediatric medical subspecialists and surgical specialists, children sometimes faced unnecessarily lengthy waiting times. For children in California and Connecticut with serious chronic physical conditions, specialty physician services were also available through the wrap-around programs. The California program, which provided all specialty physician care related to the child's eligible condition, reportedly had difficulties meeting children's needs in a timely fashion because of shortages associated with low payment rates.[53] The Connecticut wrap-around program only provided supplemental specialty care, primarily evaluations and consultations.

S-CHIP coverage for **ancillary therapies** differed substantially between the two Medicaid and three non-Medicaid programs. The Medicaid programs both provided a potentially unlimited number of medically necessary therapy services but paid for therapies furnished as part of an early intervention or special education program[54] outside of the managed care contract arrangement. The non-Medicaid programs, by contrast, each provided limited benefits, which would essentially be available only for three months or less: California covered each therapy for a 60 day period,[55] Connecticut covered each therapy on a short-term basis, and Utah covered a

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[52] One plan in Missouri also required prior authorization but only after the fourth visit.

[53] Even more important than the California program's low physician reimbursement rates were the low fees it paid to outpatient hospital-based special care centers, where most pediatric subspecialists practiced. As a result, the ability of hospitals to support special care centers and provide staffing and faculty support reportedly was deteriorating.

[54] The early intervention program was established by P.L. 99-457, the Education of the Handicapped Act Amendments of 1986. Now authorized under Part H of IDEA, it provides both evaluation services, including medical services that are necessary to make a diagnosis or conduct an evaluation, and treatment services. The covered treatment services include audiology and speech pathology; occupational and physical therapy; case management; nutrition; assistive technology; psychological services; home visits; family counseling and training; social work services; transportation; and health services that enable a child to benefit from the early intervention services. For children receiving services through this program, an individual family service plan (IFSP) is developed.

The special education program was established by P.L. 94-142, the Education of the Handicapped Act. Now called the Individuals with Disabilities Education Act (IDEA), it provides identification and assessment of disabling conditions; speech pathology and audiology services; psychological services; occupational and physical therapy; recreation, including therapeutic recreation; social work services, including rehabilitation counseling; medical services for diagnostic and evaluation purposes; and special transportation. For children receiving services through this program, an individual education plan (IEP) is developed.

[55] California's managed care contract specifies that additional visits may be provided if the child's condition will significantly improve.

total of 16 physical, occupational and speech therapy visits combined. Of the nine plans we interviewed, all but one in Utah[56] required prior authorization for ancillary therapies and used the process to implement guidelines established by industry consultants or developed by the plan itself. It appeared that, despite differences in states' benefit amounts and medical necessity standards, the guidelines all essentially provided access to ancillary therapies for children with impairments due to serious medical conditions or injuries that would improve significantly from therapy within a relatively short amount of time. Providers frequently commented that the prior authorization process was burdensome and required excessive persistence but that therapies were usually approved if the established criteria were met. Many remarked that they could not look to the plans to reimburse habilitative services or correct impairments due to congenital defects.

Consistent with their authorization policies, all plans reported that children with serious medical conditions—such as spina bifida, cerebral palsy, or cleft lip and palate—would receive ancillary therapies, although both plans in California and one in Connecticut reported that they would also refer these children to the supplemental benefit programs. Therapy services for those with less serious medical conditions such as scoliosis might not be approved by all plans. Children with developmental disabilities, including pervasive developmental disorder and autism, apparently would receive treatment only in two plans; in the others, they would be referred to schools or regional service centers. Children with developmental delay, motor planning dysfunction, oral motor dysfunction, or sensory integration disorder would receive therapies services up to age three in four plans.[57]

Coverage of **home health services** was available in the five S-CHIP programs in our study but, as with ancillary therapies, coverage was more generous in the Medicaid programs. The two Medicaid programs covered a potentially unlimited number of medically necessary home health visits, including private duty nursing, skilled care, and home health aide services as well as physical, occupational, and speech therapy. The three non-Medicaid states covered skilled nursing care without visit limits, and California and Connecticut also covered home health aide services. Only California allowed physical, occupational, and speech therapy to be covered under its home health benefit. All plans in our study required prior authorization for home health care services. The home health review criterion used by most of the plans we interviewed was that the child need skilled nursing care, but both California plans and one Utah plan also stipulated that home health services could only be authorized as a post-hospital service or a substitute for hospitalization. The California and Connecticut plans reported that children with ongoing home care needs would be referred to the wrap-around program. However, families in Connecticut were concerned that even in the wrap-around program, the amount of covered home health visits—one skilled nursing visit per day and one home health aide service per week—was inadequate. In only one state, Missouri, did providers report any difficulties obtaining authorization for home health care.

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[56] This one Utah plan, which was not at financial risk, only required prior authorization for therapy visits beyond the 16 covered visits. Using criteria similar to those used by the other plans, it allowed children to receive additional outpatient therapy visits by borrowing from the inpatient rehabilitation benefit.

[57] Two of these plans are in Connecticut where reimbursement of early intervention services is required by state law. As of July 1, 1996, insurance companies have been required to cover at least $5,000 of medically necessary early intervention services provided as part of an IFSP by the Birth to Three Program.

Durable medical equipment was also covered in the five study states and, again, the scope of the benefit was broader in the Medicaid programs. In both Maryland and Missouri coverage included, but was not limited to, hearing aids, eyeglasses, prosthetics, orthotics, motorized wheelchairs, and assistive technologies. Among the three non-Medicaid programs, all covered orthotics. California also covered hearing aids, eyeglasses, and prosthetics; Connecticut also covered eyeglasses and prosthetics; and Utah also covered hearing aids and motorized wheelchairs. While all of the nine plans we interviewed required prior authorization for medical equipment, some required it for almost all medical equipment and others required it only for equipment costing more than a specified amount (e.g., $100, $500, or $1,000). Authorizations by plans in the three non-Medicaid programs were generally limited to equipment needed for rehabilitative or restorative purposes, not for habilitative purposes. Plans in California and Connecticut referred children to the wrap-around programs for most medical equipment. In Maryland, Missouri, and Utah, authorizations were usually approved but, according to vendors and primary care physicians, completing the required documentation was difficult, and families often experienced delays. Still, in Maryland, one plan sought external advice on medical equipment authorizations from either the children's hospital or rehabilitation facility.

Specialty Program Access. For S-CHIP children with serious, chronic physical conditions in California and Connecticut, the wrap-around programs provided some or all of their specialty care services. California's program provided all services needed for the treatment of the child's eligible condition, whereas Connecticut's provided only services beyond the basic benefit package or the medical necessity criteria applied by the plans.[58] Potentially eligible children were referred to the programs by their plans—and in Connecticut, by families and providers as well. Eligibility determinations in California were made by county-level CCS staff on the basis of information obtained from medical records, including the results of physical examinations and laboratory and other tests. In Connecticut, eligibility was determined using a short screening tool, which included questions on eligible conditions, functional impairments, and need for medical equipment, administered by staff at Yale New Haven Hospital or Connecticut Children's Medical Center and reviewed by a multidisciplinary team, along with medical documentation.

The eligibility determination process for wrap-around services appeared to work more efficiently in Connecticut than in California. State officials in both California and Connecticut noted a lack of provider and family understanding of the wrap-around programs and a general confusion about the division of responsibility between plans and the wrap-around systems. In Connecticut, where only a few dozen children were in the physical health wrap-around program, eligibility determinations typically took one to two days, whereas in California officials reported that they could take only five days but sometimes took as long as six months. Delays in California were due to several

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[58] In addition to providing services that are explicitly of a type or amount not covered under the basic benefit package, the wrap-around program might provide services that plans consider outside the scope of their coverage and therefore deny on the basis of medical necessity. The kinds of services that might be subject to such denials are specialty evaluations, laboratory tests, and home health care.

factors: plans often failed to provide sufficient medical documentation with their referrals, and overall they referred far too many children in an effort to avoid financial risk;[59] the CCS program, on the other hand, had staffing shortages and lacked an automated management information system for processing applications. Another problem in California that affected families, plans, and providers was the frequency with which certain children gained and lost their CCS eligibility depending on whether their condition improved or deteriorated.[60] Although eligibility determinations in Connecticut happened quickly, plans apparently referred too few children, unsure about whether the wrap-around program was intended to serve children at the point of diagnosis—so that they could receive a multidisciplinary team evaluation and family support services—or at a latter point when their plan benefits had been exhausted.

Once in the wrap-around programs, children in California and Connecticut received their services as defined in a plan of care. Services were consistently viewed as being of high quality. However, problems were identified in both states regarding the coordination of services furnished by plans and wrap-around programs. Interestingly, plans reported that they would have preferred to assume full responsibility for the child's care or to have all of the child's services carved out of the managed care contract, as was done for a small child population in Maryland.

In Maryland, S-CHIP children with rare and expensive physical health conditions had the option to receive all of their covered health care services through a separate fee-for-service program. To participate in the program, the child's managed care plan had to complete a referral form providing a clinical history, the results of a physical examination and laboratory and other testing, and, for some diagnoses, subspecialty consultation notes. Eligibility determinations were made by staff at the University of Maryland's Center for Health Policy Development and Management. Although plans apparently have been encouraging providers to apply on behalf of their patients, pediatricians reported that they have few incentives to do so, since Medicaid fee-for-service reimbursement rates were much lower and bureaucratic hassles much greater than under managed care.

Children participating in the program were assigned a case manager whose job was to develop a plan of care and arrange for all necessary services. Providers' opinions of the program were mixed. Some appreciated the fact that the program enabled them to deliver comprehensive care at one site and to work with a familiar team of providers. Others, however, were concerned that there was a high turnover of case managers and that their skills were variable. Families and plans were generally satisfied, but plans would have preferred that the program accept children on the basis of a severity index that could capture children with additional diagnoses.

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[59] Often multiple referrals were submitted to the CCS program for the same child. Plans typically devoted substantial administrative resources reviewing their claims data daily to identify potentially eligible children. In the two plans we interviewed, a total of 12 staff were conducting these reviews.

[60] Severity was a factor used in determining CCS eligibility for children with diseases of the blood, benign neoplasms, asthma, burns, diabetes, hearing loss, scoliosis, seizure disorder, strabismus, fractures of the skull, spine, pelvis, or femur, primary hypertension, and cardiac dysrhythmias.

Mental Health Treatment

The amount of mental health services coverage provided to S-CHIP participants varied considerably across our five study states, as shown in Table III. The two Medicaid S-CHIP programs, as federally required, both offered a potentially unlimited package of medically necessary outpatient, inpatient, and specialty mental health services. The three non-Medicaid S-CHIP programs each specified visit and day limits. Connecticut covered 30 outpatient mental health visits[61] and 60 inpatient mental health days. California covered 20 outpatient mental health visits[62] and 30 inpatient mental health days, but only for conditions that would significantly improve with short-term therapy. Utah covered 30 outpatient visits and 30 inpatient days for mental health and substance abuse treatment combined, but excluded coverage for oppositional defiant disorder, conduct disorder, learning disabilities, situational disturbances, and stress disorder. However, both California and Connecticut provided an enriched service package for those children who qualified as having severe emotional disturbances—in California through a separate, comprehensive services program and in Connecticut through supplemental services that wrap around the basic benefit.

Regardless of the generosity of the benefit package, however, children's access to **outpatient mental health services** was often hampered by plans' gatekeeping and referral systems. Although none of the nine[63] plans[64] required service authorization by a primary care provider, only three plans enabled S-CHIP enrollees to seek care directly from participating mental health providers without first calling the plan. Both plans in Connecticut permitted one or two initial visits without plan authorization, and one plan in Utah, which assumed no financial risk and had no behavioral subcontractor, permitted the maximum 30 visits. Mental health providers in these plans were listed in the network directories. The remaining six plans required enrollees to telephone the plan for prior authorization or provider referrals, or both. Obtaining service authorization—which was for two to eight visits, depending on the plan—was apparently a routine matter. Finding a provider was often more difficult. In Maryland's specialty mental health system, two plans in Missouri, and one plan in Utah, mental health providers were not identified in the directories. In Maryland, the toll-free number for mental health services was not on the plan membership card, and some families were not even aware that S-CHIP provided mental health coverage.[65] In Utah, the toll-free number for mental health services was on the

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[61] Plans in Connecticut were permitted to convert one inpatient mental health day to three outpatient visits, two intensive outpatient visits, two day treatment services, or one residential treatment day. However, only up to 35 of the 60 inpatient days could be converted.

Connecticut has since passed mental health parity legislation that affects the mental health benefit and copayment requirements under S-CHIP. Now there are no inpatient day or outpatient visit limits for mental health services, and the copayment requirement for oupatient mental health services is $5—except for certain conditions: mental retardation; learning, motor skills, and communication disorders; relational problems; and V-codes. For these conditions, the inpatient benefit still is limited to 60 days and the outpatient benefit to 30 visits, and higher copays and coinsurance charges still apply.

[62] Plans in California were permitted to convert one inpatient mental health day to four outpatient visits, three day treatment services, or two residential treatment days.

[63] There was a total of nine plans providing behavioral health services in the five states we examined because Maryland had a single, state-regulated behavioral health plan that was not a subcontractor to the general managed care plans.

[64] Separate behavioral health plans were used to serve S-CHIP children in all of the plans we interviewed except one in Utah. This plan and the Maryland plan were the only entities that assumed no financial risk for mental health services.

[65] Information about the mental health system in Maryland was included in the plans' member handbooks, but families apparently did not always have ready access to this information.

Table III

Mental Health Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Outpatient Visits	Covered up to 20 visits/year, with additional visits available through conversion of inpatient mental health days (1:4). Additional visits available fee-for-service to wrap-around participants.	Covered up to 30 visits/year, with additional visits available through conversion of inpatient mental health days (1:3). Additional visits available to wrap-around participants.	Covered	Covered	Covered up to 30 visits/year in combination with outpatient substance abuse visits.
Inpatient Hospitalization	Covered up to 30 days/year. Additional days available fee-for-service to wrap-around participants.	Covered up to 60 days/year.	Covered	Covered	Covered up to 30 days/year in combination with inpatient substance abuse services.
Crisis Intervention	Services only available fee-for-service to wrap-around participants.	Services available only to wrap-around participants.	Covered	Covered, at plans' option.[2] Also available fee-for-service to severely emotionally disturbed participants.	Not covered
Intensive Outpatient Visits	Services only available fee-for-service to wrap-around participants.	Covered through conversion of inpatient mental health days (1:2). Additional services available to wrap-around participants.	Covered	Covered	Not covered
Intensive In-Home Services	Not covered	Services available only to wrap-around participants.	Covered	Covered, at plans' option.[2]	Not covered
Residential Treatment	Covered at plans' option through conversion of inpatient mental health days (1:2). Additional services available fee-for-service to wrap-around participants.	Covered through conversion of inpatient mental health days (1:1).	Covered	Covered, at plans' option.[2]	Covered through conversion of inpatient mental health days (1:1).
Exclusions for Plan Benefits	Conditions that will not improve with short-term therapy.	None	None	None	Oppositional defiant disorder, conduct disorder, learning disabilities, and situational disturbances.

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1] The programs were implemented in either July or August of 1998.

[2] Plans in Missouri were only encouraged to provide crisis intervention, intensive in-home, and residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

membership card, but enrollees who called were reportedly given only a few providers to contact, and these providers frequently were not taking S-CHIP patients.

All the S-CHIP plans we interviewed required mental health providers to submit detailed treatment plans with an acceptable diagnosis by the end of the initial therapy visits in order for treatment to continue. The number of additional visits authorized varied across the plans. Some approved visits based on the specifics of the diagnoses and treatment plans, while some routinely authorized a particular number of visits—most often four to six but, in one plan, 10 to 12—without regard to the severity of the problem. With the required paperwork completed, authorization did not appear to be a substantial barrier to outpatient care. Mental health providers did however express complaints that the documentation and authorization process was burdensome and time-consuming. Moreover, not all mental health diagnoses were considered acceptable. The majority of the nine plans we interviewed reported that therapy would not be authorized to treat pervasive developmental disorders and autism, personality disorders, or identity problems. A few plans would not authorize therapy for children with emotional problems associated with a complex physical condition, children with attention deficit hyperactivity disorder, or children with conduct disorder or oppositional defiant disorder (in Utah, these last two conditions were excluded from coverage). Providers reported that such plan policies were actually more common but that they usually could access benefits for these children by assigning an acceptable primary mental health diagnosis, such as depression or mood disorder.[66] Children with pervasive developmental disorder or autism, though, were thought to have more serious access problems because they had difficulty obtaining appropriate care from either the physical or mental health systems.

Plans' coverage of **psychotropic medications** was somewhat variable. Of the 11 plans we interviewed, including Maryland's two managed care plans[67] as well as its specialty mental health system, we found that only three plans—one Medicaid-only plan in Connecticut, one Medicaid-only plan in Missouri,[68] and the specialty mental health system in Maryland—had open formularies[69] permitting nearly all medications to be obtained by prescription. The other eight

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[66] A national survey of more than 1,000 physicians and 700 nurses conducted in 1999 found that 26 percent of physicians reported often or sometimes exaggerating the severity of a patient's condition in order to get approval for care they thought was necessary. The Henry J. Kaiser Family Foundation and Harvard University School of Public Health. Survey of Physicians and Nurses. Menlo Park, CA: The Henry J. Kaiser Family Foundation, July 1999.

[67] We included the formularies used by Maryland's two largest managed care plans in this analysis because Maryland's S-CHIP children were expected to receive primary mental health care from their primary care providers; many children, therefore, obtained psychotropic medications through managed care plans rather than the specialty mental health system.

[68] Of the ten plans we interviewed, four were Medicaid-only plans, six were commercial plans.

[69] Although plans often used a behavioral health plan subcontractor, all 10 had a single prescription drug formulary that included psychotropic medications.

plans had restricted formularies; for a given class of drugs, only certain generic and brand name drugs might be available.[70] Looking at coverage policies for several types of psychotropic medications, we found that among closed-formulary plans, both California plans and one Utah plan included fewer medications often considered most important for inclusion in a formulary[71] and, not surprisingly, the newer of these medications were less often covered.

- For attention deficit hyperactivity disorder (ADHD), depression, and anxiety, we analysed coverage of medications in the eight plans with closed formularies. Most of the plans covered the three important stimulant medications for ADHD,[72] sometimes requiring prior authorization; however, only one also provided coverage for both stimulant drugs available in sustained-release form[73] while most of the others did not cover either. Only two plans covered the four important selected serotonin reuptake inhibitors (SSRIs)[74] for the treatment of depression, and although all but one of the remainder covered three, they usually required prior authorization for certain drugs or particular doses.[75] Most of the eight plans covered both of the important atypical antidepressants,[76] and all but one of these covered the drugs in the sustained release form as well.[77] All of the plans covered the three important drugs for the treatment of anxiety.[78]

- For anti-psychotic and mood stabilizing medications, we analyzed coverage in only six plans with closed formularies—assuming that, in Maryland, children requiring these types of medications would receive them through the state's open formulary specialty mental health system, not through general plans. Only one of the six plans covered the five recommended anti-psychotic drugs, but all of the remainder covered four;[79] and nearly all plans covered the three important mood stabilizing drugs,[80] with four covering one or both of the mood stabilizing drugs available in sustained release form.[81]

Psychiatrists in states with more restrictive formularies voiced complaints about their inability to obtain specific medications for their patients, and cited in particular concerns about the lack of coverage for those drugs available in sustained release form.

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[70] Five plans also required automatic generic substitution for brand name drugs with a generic available.

[71] Members of the American Academy of Child and Adolescent Psychiatry recommended specific psychotropic medications that are most important to have on plans' formularies. Most stressed, however, that the broadest possible range of psychotropic medications should be available.

[72] These stimulant medications are Adderall, Ritalin, and Dexedrine. (The Surgeon General's report on mental health mentions Cylert, which was sometimes covered, but this drug requires frequent liver function tests. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.)

[73] The two drugs available in sustained-release forms are Ritalin SR and Dexedrine Spansule.

[74] These SSRI drugs are Celexa, Paxil, Prozac, and Zoloft.

[75] However, one of the two plans we interviewed that had an open formulary did have a step therapy requirement for two of the four SSRIs it covered.

[76] These atypical antidepressants are Effexor and Wellbutrin.

[77] The sustained-release forms of these drugs are Effexor XR and Wellbutrin SR.

[78] These anxiety drugs are Ativan, BuSpar, and Klonopin.

[79] These anti-psychotic drugs are Mellaril, Risperdal, Seroquel, Thorazine, and Zyprexa.

[80] These mood stabilizing drugs are Depakote, Lithium, and Tegretol.

[81] The sustained-release form of Lithium is Eskalith CR or Lithobid. The sustained-release form of Tegretol is Tegretol XR.

Access to **inpatient mental health services** in each of the plans we interviewed was conditioned on prior authorization. The criteria were essentially the same: the child was expected to demonstrate imminent suicidal or homicidal risk, presence of acute psychotic symptoms, pervasive functional deterioration, or potentially lethal self-abusive or risk-taking behaviors. Providers consistently expressed concern that authorized lengths of stay for children, particularly those who were suicidal, were too short, generally only three to five days. Because hospitalization required that the child's condition be in an acute and potentially dangerous phase, once it stabilized, the child was released. Providers in two states even reported that children brought to emergency rooms (apparently the only entry point for a psychiatric hospitalization) were medicated, held for less than 24 hours and then released when they no longer could be characterized as a danger to themselves or others. In both of these states, inpatient beds were reportedly in short supply.

For children needing **residential treatment care**, benefits were available in each of the five states—in California through the wrap-around program, in Maryland as part of regular S-CHIP coverage furnished by the state's specialty mental health plan,[82] and in the remaining three states as either a conversion or optional plan service.[83] For plan approval in four states, children had to meet a specific set of criteria. Plans generally required that the child be in a deteriorating psychiatric condition or have a history of failed hospitalizations, not be stable enough to be treated outside of a therapeutic environment, but be able to demonstrate a capacity to respond favorably to rehabilitation in a structured milieu. Providers expressed concerns that plans were not always authorizing residential treatment services to the extent that they were needed. In Utah, plans were able to deny service authorization for S-CHIP children diagnosed with conduct disorder or oppositional defiant disorder, since these conditions were excluded from coverage by the state, but in the other three states, plans reportedly were also excluding children with conduct disorder as well. In addition, except for Maryland's plan and one plan in Utah, neither of which was at financial risk, all plans were apparently denying residential treatment admission to other children with conditions they viewed as especially disruptive, violent, or difficult to treat, in some cases including those with substance abuse disorders. In at least one state, access problems were complicated by the fact that residential treatment centers could be selective about the children they would accept.[84] Authorization for residential treatment for children with severe emotional disturbances was easier to obtain under California's wrap-around program. Still this

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[82] In Maryland, residential treatment services were covered to the extent that they were determined to be medically necessary.

[83] Plans in Connecticut were permitted to convert one inpatient day to one residential treatment day, but only 35 of the available 60 inpatient days could be converted. Plans in Utah were permitted to convert one inpatient day to one residential treatment day up to the maximum of 30 days. Plans in Missouri were simply encouraged to provide residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

[84] However, S-CHIP children in Connecticut, Missouri, and Utah could sometimes receive residential treatment services from other state-funded programs. In Missouri, the state's mental health agency could finance residential treatment if funding was available. In Connecticut and Utah, the states' child welfare agencies could fund residential treatment services, but families often had to relinquish temporary custody of their children. The child welfare agency in Connecticut could also fund residential treatment for children in its voluntary services program whereby parents do not have to relinquish custody, but these placements reportedly represented less than 10 percent of all residential treatment placements in 1998–1999. Funding for residential treatment in Connecticut was also available through local school districts and the state education department, but these placements were usually out-of-district.

publicly supported system apparently had shortages of residential treatment facilities that caused delays in admissions similar to those in managed care plans. In all five states, overall shortages or shortages for particular levels of care or types of programs were reported. Capacity problems seemed particularly acute for children with mental retardation or developmental disabilities in addition to significant emotional disturbances.

Benefits for **specialty mental health services** such as intensive in-home therapy, intensive outpatient therapy, and crisis intervention were much more variable and complex. Benefits were available in California and Connecticut for children with severe emotional disturbances through the wrap-around programs, although California's program did not provide intensive home therapy, and Connecticut's provided intensive outpatient therapy only to extend coverage furnished by plans as a conversion benefit.[85] Benefits were available for crisis intervention services in Missouri for children with severe emotional disturbances through a separate state program reimbursed outside of the managed care contract,[86] and for all three specialized mental health services—intensive in-home and intensive outpatient, as well as crisis intervention—as an optional benefit furnished through the plans.[87] Maryland covered all three services as regular S-CHIP plan benefits, while Utah covered none.[88] According to plans' authorization criteria, children who would be approved to receive intensive in-home services are those who have serious mental disorders characterized by non-compliance and vulnerability and are at risk for out-of-home placement; children who would be approved to receive intensive outpatient services are those who are experiencing psychiatric symptoms that cause significant educational, social, or psychological impairment or require family therapy as part of treatment as a result of complex family dysfunction; and children who would be approved to receive crisis intervention services are those who are experiencing rapid deterioration of functioning, are a threat to themselves or others, and are unable or unwilling to receive care in a hospital. Plans in Connecticut and Missouri authorized these services only rarely and only as a substitute for more costly interventions. Moreover, not all plans actually provided them.[89] For the Maryland plan, no

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[85] Plans in Connecticut were permitted to substitute one inpatient day for two intensive outpatient therapy visits, but only 35 of the available 60 inpatient days could be converted.

[86] This carve-out arrangement is with the Community Psychiatric Rehabilitation Program, which is operated by the state's mental health agency and primarily serves adults.

[87] Plans in Missouri were encouraged to provide crisis intervention, in-home, and intensive outpatient services to avoid inpatient hospitalization.

[88] However, S-CHIP children in Utah could receive intensive in-home and crisis services from the state's child welfare agency, but only if family preservation were the primary goal. The state's multi-agency FACT (Families, Agencies, and Communities Together) program could serve as a payor of last resort for S-CHIP children requiring specialty mental health services, however, their budget was limited.

[89] However, S-CHIP children in Missouri could receive intensive in-home therapy services financed with state revenues through the state's mental health agency. Insufficient funding, however, sometimes caused provider shortages that led to waiting lists for services.

By contrast, S-CHIP children in Connecticut did not have access to the same specialized mental health services due to insufficient funding for an adequate community-based service infrastructure. A report to the state's General Assembly found that there were not enough community-based services to allow children in residential treatment centers to return to the community. Child Health and Development Institute of Connecticut for the Department of Social Services. *Delivering and Financing Children's Behavioral Health Services in Connecticut: A Report to the Connecticut General Assembly Pursuant to Public Act 99-279, Section 36,* February 2000.

authorization problems were reported, as was the case for the California and Connecticut wrap-around programs and the Missouri carve-out program. Still, we heard in California, Maryland, and Missouri that specialized mental health services were not available statewide. These services could not be established and sustained by reimbursement revenue alone; grant funding was required but not sufficiently available.[90] In addition, bureaucratic delays in California and Maryland slowed access to services, according to providers.

Specialty Program Access. Children needing wrap-around mental health services in both California and Connecticut were referred to the specialty programs for assessments by their behavioral health plans—and in California, by schools and a variety of public agencies as well. California's county mental health staff made a determination of whether the child met the diagnostic and functional criteria for a severe emotional disturbance and, although providers commented on the variable interpretations across counties, the determination process overall was fairly lenient. Connecticut's child guidance and hospital clinic staff made the same determination using various checklists and an assessment form, the results of which were reviewed by a three-member multidisciplinary team. Gaining access to either wrap-around program did not appear to be a problem. Plans in both states, however, referred very few children. Providers were not well informed about the programs, and plans relied on high-cost service utilization, primarily hospitalization, to identify children for referral. Wrap-around services in California were primarily being provided to children previously in the county mental health system; new referrals came largely from schools and other agencies.

Once in the programs, children could receive any covered service indicated in their treatment plans, and no concerns were reported regarding the quality of services in either program. California's mental health staff noted, however, that the inability to hire and maintain good therapists sometimes delayed treatment. Also, service coordination for children who required inpatient hospitalization, covered as a basic S-CHIP plan benefit, was sometimes a problem. Connecticut's wrap-around program staff (with only six enrollees) had too little experience to comment on whether separate financial responsibility for hospital services would be a problem, but they noted that other services were effectively coordinated with plans because most of their providers were child guidance clinics that participated in both networks. Wrap-around program providers in Connecticut commented that although there were currently no shortages of

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[90] In Maryland, for example, we heard from providers that only Baltimore City had sufficient grant funding to support the required 24-hour availability of crisis intervention staff.

[91] To participate in Connecticut's mental health wrap-around program, clinics had to demonstrate a capacity to provide the covered services. Half of the 12 child guidance and hospital clinics that were selected had existing staff providing specialized child mental health services whose salaries were paid in part by grant funds from the state's child welfare and mental health agency. All but one of the remainder either designated therapists who could expand the range of services they furnished to incorporate more specialized, intensive interventions or entered into subcontract arrangements for these services. Providers were concerned that with increasing demand, additional staff could not be hired without grant funds to support these positions, at least initially. Also, they worried that the lack of appropriately trained professionals willing to provide such services would be a barrier to new hiring. (In the second year of S-CHIP implementation in Connecticut, the one clinic that had hired new staff

Other Components of Health Care Access

Plan Selection

The amount of assistance and information that families were given to help them find an appropriate managed care plan for their children varied somewhat across the states. All five states had enrollment specialists[92] to provide families with information about plans' primary care, hospital, and specialty physician networks. In Connecticut, Maryland, and Missouri, enrollment brokers were available by phone to assist families once their children were determined eligible for S-CHIP,[93] and in California and Utah, they met with families in person at the time they applied for coverage. Maryland provided families with a listing of the plan affiliations of all participating primary care and specialty providers, except for mental health professionals. Connecticut provided hospital network information, and Missouri provided primary care provider network information. California gave applicants a handbook listing the available plans for each county, while Utah, which required an in-person meeting with an enrollment broker, provided no information in writing. Of the five states, California and Utah required families to select a plan at the time they applied for coverage; Maryland and Missouri auto-assigned eligible children whose families failed to make a plan selection.[94] Only Connecticut did not assign eligible children to a plan if none was selected, leaving them unable to receive services.

For families with children who had special health care needs finding an appropriate plan was difficult in all of the states. Families tended to select a plan either on the basis of its general reputation or as a result of calling their current providers to ascertain their network affiliations. Written information about the network was limited. Even in Maryland where S-CHIP participants received a list of providers from the state, the directory was criticized for containing inaccurate and out-of-date information. Moreover, enrollment specialists were unable to help families with information on mental health providers, medical equipment suppliers, ancillary therapists, and home health agencies; families would have had to call the plans directly. Enrollment brokers in Connecticut, Maryland, and Missouri were faulted for not having sufficient clinical experience and knowledge to help families select a plan with the necessary resources and network. Since providers in our study states were not always participating in more

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[92] In Connecticut, Maryland, and Missouri, the enrollment specialists were contracted companies. In Utah, these specialists were state workers, and in California, they were community-based individuals paid a per-application fee of $50 for each successful application.

[93] In Connecticut and Maryland, families had the option to apply for S-CHIP and select a plan at the same time.

[94] In Maryland, applicants determined to be eligible for S-CHIP had 21 days to select a plan. Before assigning eligible children randomly, the state tried to assign enrollees to historical providers. Maryland could not provide separate information for its S-CHIP population; its auto-assigned rate for the whole population was 15.8 percent. In Missouri, applicants determined to be eligible for S-CHIP had 15 days to select a plan. The state tried to assign eligible children to the same plan as another family member. Failing that, the state assigned them based on an algorithm that gives a larger proportion of enrollees to plans with the highest evaluation score from the competitive bidding process and number of signed contracts with safety net, acute care hospitals. The algorithm assignment rates for S-CHIP children in Missouri was 5.8 percent, slightly lower than the rate for traditional Medicaid enrollees (6.5 percent).

than one plan, it was particularly important for families to receive comprehensive and accurate information about plans' provider networks if they were to avoid having to change plans subsequent to enrollment.[95]

Health Risk Assessments

Identifying new enrollees with special health care needs can assist plans in anticipating their service needs. Both the Medicaid states and one non-Medicaid state (Utah) had health risk assessment requirements for their S-CHIP programs. Although each of the three baseline screening tools included different questions, all asked about the presence of specific chronic conditions, such as asthma, diabetes, and heart disease, and all asked about the use of certain types of primary and specialized services, such as physician services, prescriptions, mental health and substance abuse counseling, and home health care. In Maryland and Missouri, health risk assessments were part of the application process. Responses to health status questions either were given directly by families who mailed in their applications or obtained by enrollment brokers.[96] In Utah, plans were required to conduct a health risk assessment within ten days of plan enrollment, but only one of the two Utah plans we interviewed had actually implemented this requirement.

Plans in the two Medicaid states reported that the health risk assessment forms were sometimes incomplete and inaccurate, but generally helpful. In addition, plans in Maryland reported problems in expediting appointments for those identified with special health care needs[97] because of difficulties locating all new enrollees and scheduling the initial visit. None of the providers in the three states were informed of the health risk assessment results.

Neither California nor Connecticut had health risk assessment requirements, which likely contributed to the low participation of children with special health care needs in the wrap-around programs. If properly designed, a health risk assessment could have identified a significant number of children potentially eligible for the wrap-around programs. Questions could have been asked as part of the application process about the presence of serious medical or emotional conditions or specific qualifying conditions, functional impairments, or the need for certain specialty physical or mental health services.[98]

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[95] In Missouri, for example, hospital-based pediatric subspecialists in the Central region of the state participated in only one of the three plans operating in that area and reportedly many families whose children have special needs frequently had to transfer to this plan after realizing that the one they chose had a specialty network limited to the Eastern region of the state.

[96] In addition, one Maryland plan reported conducting welcome calls in which families were asked whether their children had diabetes or asthma and whether they used home health services.

[97] In Maryland, plans were required to schedule primary care visits for those identified as having special needs within 15 days of enrollment.

[98] One Connecticut plan conducted welcome calls in which families were asked a few general questions about health service needs. These questions were useful to the plan but not designed with enough specific detail to identify children who might be eligible for the wrap-around programs.

Case Management

Families whose children require services from multiple sources—including plan and out-of-network providers; behavioral health plan providers; and early intervention, special education, and other community programs—may benefit from having an identified person to help them obtain services, advocate, and coordinate their multiple sources of care. Among our five study states, Maryland, Missouri, and Utah specified in their contracts that case management services be furnished to children with special needs to assist families in accessing needed plan services as well as linking to early intervention, special education, and family support services and that health risk assessments of new members be conducted for the purpose of identifying those needing case management services. Both the Maryland and Missouri contracts also required plans to employ special needs coordinators to act as a source of information and coordination.[99] Neither California nor Connecticut[100] had any special requirements for case management for children with special needs other than coordination with the wrap-around programs.[101]

For the most part, the plans we interviewed determined case management eligibility on the basis of high cost claims, particular types of service utilization, or the presence of certain serious conditions, which usually resulted in their furnishing case management services to a very small minority of children.[102] In one Missouri plan, however, eligibility for case management services appeared to be more lenient. Primary care providers were able to access case management services for any child they regarded as needing greater assistance and service coordination.

All but one of the plans we interviewed in these three states reported helping families obtain services outside the scope of their financial responsibility as well as coordinating their plan services. In the two Medicaid states, plans were involved in assisting children with special needs obtain early intervention and special education services, which were carved out of the capitated contracts, and case managers reported attending IEP meetings. One Medicaid plan even addressed social service problems. In Utah, one plan sought to link children with community resources, such as the visiting nurses association and a home health program, when the S-CHIP benefit was not adequate to the child's needs. Importantly though, the families we interviewed were generally unaware of the availability of case management services; they tended to rely on their providers or their own resources to piece together an appropriate array of services. Providers appeared to know about the case management service but seldom used it.

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[99] In Maryland, the special needs coordinator functions are to serve as a point of contact for health services information and referral as well as a resource to plan providers and enrollees on the Americans with Disabilities Act requirements, and to maintain a log of denials for treatment and the outcomes of utilization reviews. In Missouri, the special programs coordinator functions are to coordinate with state agencies, serve as the point of contact for beneficiaries, providers, and state and local agencies, and ensure that services listed on an IEP or IFSP are provided in a timely manner.

[100] California's contract included no specifications on case management and Connecticut's RFP asked plans to describe available processes, including case management, for managing catastrophic or chronically ill cases.

[101] California required that plans' memoranda of understanding with the wrap-around programs include procedures for providing care continuity between the plans and the wrap-around programs. Connecticut required plans to convene case management teams made up of a case manager from the wrap-around program, a health plan representative, the child's parents, and the child's provider to develop a care plan and coordinate care.

[102] One Utah plan, for example, provided case management services to only six children.

In California and Connecticut, where case management services were available from the wrap-around programs, and in Maryland, where they were available through the carve-out arrangement for children with rare and expensive conditions and also through the state-administered mental health program, families were very pleased with the case management services they received. Yet, the California and Connecticut wrap-around programs offered substantially different case management services. Although case managers in both programs focused largely on coordinating specialty services and negotiating respective financial responsibilities with plan staff, Connecticut's providers worked more closely with primary care providers and incorporated family support services. In California, where the ratio of case managers to families was exceptionally high, primary care providers voiced concerns that they were not usually informed about the specialty services furnished to their patients unless they happened to have an established relationship with the CCS provider. In Connecticut, families expressed satisfaction that case managers not only coordinated their medical care but also served as advocates for plan services on their behalf. Although Maryland's providers and families found case management provided by the carve-out program invaluable, they commented about the variability in the quality of case management staff and the high turnover rates.

Multidisciplinary Care

Children with complex chronic conditions often need a plan of care and coordinated interventions from a multidisciplinary team of health professionals. Among the five S-CHIP programs in our study, two states included multidisciplinary care requirements in their managed care contracts. Maryland required plans to convene multidisciplinary teams to review and develop a plan of care for complex cases involving multiple interventions or social services, and Utah required plans to provide access to coordinated, multidisciplinary clinics for children with certain conditions, when medically necessary. Utah's contract also specified that plans must waive any prior authorization requirements for one outpatient team evaluation and one follow-up visit provided through the Title V program. In addition, multidisciplinary care was required under the California wrap-around, Connecticut wrap-around, and Maryland carve-out programs. Only Missouri had no provisions for the financing of multidisciplinary care.

Although most of the plans that we interviewed mentioned convening multidisciplinary teams to develop plans of care for children receiving case management services, it appeared that only the two Utah plans had a mechanism for specialty clinics to bill for multidisciplinary care using negotiated case rates or team medical conference codes. However, the wrap-around and carve-out programs in California, Connecticut, and Maryland also allowed specialty clinics to bill under designated codes. Still, providers in the three states complained that payment rates were inadequate to maintain a comprehensive team of professionals at clinic sites. In one of these states, psychologists, social workers, and special educators had been eliminated from the team conferences because of low reimbursement rates.

Reimbursement for individual providers to participate in multidisciplinary care for the purposes of developing a plan of care was less available. Two plans in Utah and one Maryland plan reported having a mechanism for reimbursing individual providers who participated in team conferences, but the other plans did not approve payment for same-day billing by multiple providers. Moreover, plans and providers alike commented that multidisciplinary care was difficult to support because payment for physical and mental health services was separately financed. Primary care providers or ancillary therapists could not be reimbursed for participating in conferences for children with a primary mental health diagnosis, and mental health providers could not be reimbursed for participating in conferences for children with a primary physical health diagnosis. This bifurcated payment system created the greatest hardship for children with dual diagnoses, who reportedly often fell through the cracks. For example, treating adolescents with eating disorders was repeatedly mentioned as a problem, despite the efforts of plans to negotiate payment responsibilities between the general managed care plan and the behavioral plan, to share at least some treatment information between the two systems, and to offer case management services.

Cost Sharing

Because of their more frequent use of health care, families whose children have special needs can be especially burdened by cost-sharing requirements. Among the five S-CHIP programs in our study, Maryland was the only state that did not require cost-sharing charges at the time of service, although the California and Connecticut wrap-around programs also had no cost-sharing requirements. Copayments, which were used by plans in the four states, varied according to family income and type of service. The charge for most services was usually $5 but in Connecticut was $25–$50 for outpatient mental health.[103] For prescription drugs, charges ranged from $2 to $6.[104] Coinsurance requirements were applied only in Utah for children in families with incomes between 151 and 200 percent of poverty and ranged from 10 percent for lab, x-ray, and inpatient services to 20 percent for medical equipment to 50 percent for outpatient mental health services.[105] California, Missouri, and Utah all had cost-sharing requirements for ancillary

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[103] California required all S-CHIP enrollees to pay $5 for most services; vision services carried higher copayments, $10 for optometry services and $25 for eyeglasses. Connecticut required all S-CHIP enrollees to pay payments ranging from $5 for a physician visit to $25–$50 for an outpatient mental health visit. Missouri required S-CHIP enrollees with family incomes between 186 and 225 percent of poverty to pay $5 for all services and S-CHIP enrollees with family incomes between 226 and 300 percent of poverty to pay $10. Utah required S-CHIP enrollees with family incomes between 100 and 150 percent of poverty to pay $5 for most services and S-CHIP enrollees with family incomes between 151 and 200 percent of poverty to pay payments ranging from $10 for physician visits to $30 for emergency room visits.

[104] California required all S-CHIP enrollees to pay $5 for prescription drugs, with the exception of FDA-approved contraceptive drugs and devices. Connecticut required all S-CHIP enrollees to pay $3 for prescribed generic drugs and $6 for prescribed brand name drugs. Utah required S-CHIP enrollees with incomes between 100 and 150 percent of poverty to pay $2 for generic and brand name drugs on their managed care plan's prescription drug formulary and for brand name drugs not included on their plan's formulary; the state required S-CHIP enrollees with incomes between 151 and 200 percent of poverty to pay $4 for generic and brand name drugs on their plan's formulary. Missouri required S-CHIP enrollees with incomes above 225 percent to pay $5 for prescription drugs.

[105] Utah also required a 50 percent coinsurance payment for brand name drugs that are not on a plan's prescription drug formulary.

therapy services, but only Utah required cost sharing for medical equipment, and only Missouri required it for home health.

Cost sharing's impact on access to care reportedly was most significant in Utah. Providers expressed concern that some families whose children had chronic health care needs elected not to enroll in the S-CHIP program because of cost-sharing requirements, choosing instead to spend down to the medically needy eligibility level and obtain Medicaid coverage.[106] In addition, Utah families whose children had severe mental health problems reported that without the reduced-fee services available from community mental health centers not in S-CHIP plans' networks, they would be unable to obtain mental health services for their children. In California, Connecticut, and Missouri, cost-sharing requirements apparently were not a problem for families. In California, copayments were collected but providers and families perceived that they were nominal and did not constitute a barrier to care. In Connecticut and Missouri, however, families were unaffected because providers were regularly foregoing copayment collection, concerned that S-CHIP families were unable to pay. Mental health clinic providers in Connecticut, for example, routinely used their sliding fee schedules to assist S-CHIP participants unable to meet their cost-sharing obligations. Other providers in Connecticut failed to charge copayments because they found collection a burden, or, as in Missouri, were unsure about the copayment requirement.[107]

Conclusions

Children with chronic behavioral, emotional, or developmental conditions appeared to have faced more difficulties accessing care than children with chronic physical conditions in our five study states. Difficulties for children with mental health conditions stemmed from service denials, but more significantly from the lack of providers, particularly child and adolescent psychiatrists and inpatient and residential treatment facilities. For children with developmental problems, access difficulties were due both to service denials and shortages of ancillary therapists. While there were shortages of pediatric subspecialists for children with chronic physical conditions, it did not appear that these children had to forego care as a result. Delays were common, but care was eventually obtained. It is clear that states and plans need to consider ways to facilitate access to mental health and developmental services and expand pediatric provider networks. Increasing provider reimbursement rates in several states would likely be necessary.

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[106] This issue was also mentioned by the state Medicaid directors in Connecticut and Missouri with regard to the deterrent effect of premium requirements. In Connecticut, the state said that because it has no for-profit hospitals and a mandate that hospitals provide care, regardless of ability to pay, some families are likely not to apply for S-CHIP because of the upfront premium requirements. In Missouri, the state's own focus groups found that families would prefer a $30 monthly premium instead of a $65 premium, and it reported that some families completed the application process but failed to make the first premium payment.

[107] Missouri's two largest plans paid providers the Medicaid reimbursement rate, regardless of whether copayments were collected, and providers were forbidden from denying services to an enrollee who was unable or unwilling to pay.

Two of the five study states had wrap-around programs that provided additional benefits for children with special health care needs. Providers and families spoke highly of the services these programs provided. However, low enrollment and plans' confusion about eligibility and benefits indicated that the wrap-around programs could benefit from increased outreach and education to plans, providers, and families. Moreover, both S-CHIP programs should further clarify the division of responsibility between plans and wrap-around programs and consider whether it would be appropriate to expand their target population to include certain underserved groups of children. In California, administrative problems should be addressed as well.

APPENDIX

Overview of the Five Study States' S-CHIP Programs

California

California structured its S-CHIP program as a private initiative but also included a small S-CHIP expansion of Medicaid. Concerns that the stigma of Medicaid's association with welfare would discourage enrollment, former Governor Wilson (R) insisted that the S-CHIP program not be affiliated with Medicaid, either in terms of benefits or administration. The state implemented its new program, known as Healthy Families, in July 1998, with the expectation that 328,000 children would be eligible. At the end of the first year, 138,869 children were participating.

Eligibility. California provides S-CHIP eligibility under Medicaid to uninsured adolescents ages 16 to 19 in families with incomes up to 100 percent of the federal poverty level and S-CHIP eligibility under Healthy Families to all uninsured children in families with incomes up to 250 percent of the federal poverty level. During the first year of implementation, however, S-CHIP eligible children ages 14 to 19 in families with incomes up to 100 percent of poverty were covered under Medicaid and under Healthy Families at family income levels up to 200 percent of poverty.[1] To qualify as uninsured, participants must not have had insurance for three months prior to applying, although they can qualify immediately if they have reached the maximum benefit limits offered under employer-sponsored coverage.

Cost sharing is required for all Healthy Families enrollees. Families pay small monthly premiums that vary slightly depending on family income and are charged standard, private sector copayments for certain services.

Coverage. Healthy Families coverage is modeled after CalPERS, the benefit package available through the health insurance program for state employees and retirees. In addition to hospital and physician services, prescription drugs, vision services, and dental care, the benefits include various services offered with specific limitations. These are: skilled nursing care up to 100 days per benefit year; ancillary therapy services up to 60 consecutive calendar days per condition; outpatient mental health services up to 20 visits; inpatient mental health services up to 30 days; outpatient substance abuse crisis intervention and services up to 20 visits; inpatient detoxification; durable medical equipment that primarily serves a medical purpose; and home health care services with the exception of custodial care and long-term physical therapy and rehabilitation.

Enrollees who meet the medical eligibility criteria for California Children's Services (CCS), the Title V program for Children with Special Needs, or who are determined to be seriously emotionally disturbed by the county mental health system receive additional services outside of their managed care plan. Among CCS' benefits are physician subspecialty services, hospital services, ancillary therapy services, prescription drugs, durable medical equipment, medical nutrition therapy, specialty care center services, care coordination, and nonemergency transportation. The county mental health systems offer outpatient services, residential treatment

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[1] Prior to S-CHIP, California's Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

services, intensive day treatment, medication support services, crisis intervention services, and targeted case management.

Managed Care Arrangements. Healthy Families is a statewide managed care program that requires all participants to enroll in a health maintenance organization (HMO) or exclusive provider organization (EPO), in addition to separate vision and dental plans. Carved out of the managed care contracts are all wrap-around services as well as dental and vision contracts. Rates for the capitated services vary by region but not age or gender. In most counties, enrollees have a choice of at least two plans, although seven counties have only one EPO available, and three have nine plans from which to choose.

Enrollees eligible for wrap-around benefits receive these services through different arrangements. The CCS programs in each county have their own providers that have met board certification and experience requirements, and the county mental health systems have their own providers—community agencies that contract with or are operated by the counties. In the program's first year, the CCS program received an annual appropriation of $9.7 million and the county mental health systems received an annual appropriation of $9.8 million.

Connecticut

Connecticut's non-Medicaid S-CHIP initiative, known as HUSKY Part B, was implemented in July 1998, along with an S-CHIP expansion of Medicaid, renamed HUSKY Part A. Governor Rowland (R) exerted considerable influence over the program, promoting a primarily private option because of concerns about the scope of EPSDT benefits, the inequity of imposing only nominal cost-sharing charges, and the unpredictability of long-term federal funding. As of June 30, 1999, 3,787 of the estimated 36,700 eligible children were participating in HUSKY B.

Eligibility. Using income disregards, Connecticut's S-CHIP program establishes HUSKY A eligibility for all uninsured adolescents ages 14 to 19 in families with incomes up to 185 percent of the federal poverty level and HUSKY B eligibility for uninsured children up to age 19 in families with incomes between 186 percent and 300 percent of the federal poverty level.[2] To qualify as uninsured, participants must not have had insurance for six months prior to applying for coverage, although there are certain exceptions to this rule, most notably self-employment. Monthly premiums are charged for children in families above 226 percent of poverty. In addition, families with incomes above 300 percent of poverty may purchase HUSKY B coverage for their children at the full group rate negotiated by the state. All HUSKY B participants, regardless of income, are required to pay copayments comparable to the private sector's for most services but higher than usual coinsurance for extended outpatient mental health services.[3]

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[2] Prior to S-CHIP, Connecticut's Medicaid eligibility levels were set at 185 percent of poverty for children up to age 15 and 100 percent of poverty for children ages 15 to 19.

[3] Connecticut has since passed mental health parity legislation that affects the mental health benefit and copayment requirements under S-CHIP. Now there are no inpatient day or outpatient visit limits for mental health services, and the copayment requirement for oupatient mental health services is $5—except for certain conditions: mental retardation; learning, motor skills, and communication disorders; relational problems; and V-codes. For these conditions, the inpatient benefit still is limited to 60 days and the outpatient benefit to 30 visits, and higher copays and coinsurance charges still apply.

Coverage. Children enrolled in HUSKY B receive the state employees' benefit package. In addition to hospital and physician services, skilled nursing, home health, prescription drugs, dental care, and durable medical equipment, the package provides other benefits on a short-term or limited basis. These include: short-term rehabilitation and physical, occupational, and speech therapies; inpatient mental health services up to 60 days; outpatient mental health services up to 30 visits with an option to convert inpatient days; inpatient substance abuse services up to 60 days and for alcohol abuse, 45 days; and outpatient substance abuse services up to 30 visits.

Enrollees who meet certain medical eligibility criteria may receive additional benefits that are limited or not included under the HUSKY B benefit package. These benefits are available through two supplemental "Plus" plans, with no cost-sharing obligations. Children eligible for these benefits remain enrolled in their managed care plans, which continue to be responsible for covered HUSKY B benefits. HUSKY Plus Behavioral offers in-home psychiatric services, mobile crisis services, care coordination, and extended outpatient and day treatment services. HUSKY Plus Physical covers multidisciplinary team consultations, orthodontics, nutritional therapy, hearing aids, specialized medical equipment and supplies, family support services, and extended ancillary therapy, home health, and physician consultation services.

Managed Care Arrangements. During HUSKY B's first year, Connecticut required all children participating in HUSKY B to enroll in one of five managed care plans, all of which are health maintenance organizations and operate statewide. These plans are capitated to provide all services included in the HUSKY B benefit package. The rates they receive vary by plan but not age or other risk factors.

The state has separate contractual arrangements for the Plus programs. Children qualifying for HUSKY Plus Physical receive services from the existing administrators of the Title V program for children with special health care needs. Those who qualify for HUSKY Plus Behavioral receive services from one of 12 child guidance and hospital clinics that contract with the Yale Child Study Center. In the program's first year, the HUSKY Plus programs each received an annual appropriation of $2.5 million.

Maryland

Maryland chose to implement a Medicaid expansion to cover its S-CHIP population because state advocates supported it, and the state Medicaid agency had only recently put into place a section 1115 demonstration waiver program and did not want to start anew with a non-Medicaid approach to S-CHIP. As a condition of approval by the House of Delegates, however, the agency was required to examine the feasibility of eventually developing a private health insurance option for S-CHIP children in families with higher incomes.[4] The state estimated that 60,000 children would become eligible for Medicaid, known as HealthChoice, as a result of S-CHIP and began enrolling the expansion population in July 1998. One year later, 57,000 S-CHIP children had HealthChoice coverage, under the Maryland Children's Health Insurance Program (MCHIP).

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[4] The private option has not been implemented, and although the Medicaid agency concluded in December 1998 that the option was not feasible, the House of Delegates required the agency to reconsider its evaluation.

Eligibility. In Maryland, all uninsured children in families up to 200 percent of the federal poverty level are eligible for HealthChoice as S-CHIP participants.[5] However, the level at which S-CHIP eligibility begins, and therefore the size of the S-CHIP population, is viewed differently by the state and the federal government.[6] Prior to the implementation of S-CHIP, Maryland operated a limited-benefit health insurance program, known as KidsCount, under a section 1115 demonstration waiver program for children up to age 15 with family incomes up to 185 percent of poverty. KidsCount ended with the advent of S-CHIP, and participants became eligible for HealthChoice and the full range of Medicaid benefits. The state considers these children to be part of the S-CHIP population. However, despite KidsCount's limited benefits, HCFA does not consider any HealthChoice enrollee with a family income below 185 percent of poverty to be an S-CHIP participant. As a result, the state receives the enhanced matching rate only for enrollees with incomes between 185 and 200 percent of poverty.

Coverage. As HealthChoice participants, MCHIP children receive the full range of Medicaid benefits to which regular Medicaid beneficiaries are entitled. No cost-sharing obligations are imposed.

Managed Care Arrangements. HealthChoice operates as a mandatory, statewide managed care program, and nearly all S-CHIP participants are required to enroll in one of eight managed care organizations. These plans are health maintenance organizations that do not generally operate statewide. Plans contract to provide most Medicaid services. Personal care, early intervention services, and health-related special education services are carved out of capitated contracts and paid for on a fee-for-service basis. In addition, all mental health services are also carved out and paid for under a separate managed care arrangement, called Maryland Health Partners, which the state mental health agency regulates. Beginning in year two, the state also carved out all ancillary therapy services.

Each plan receives the same capitation rate, and the rates vary by enrollees' age, gender, and region. In addition, for S-CHIP participants for whom the state has six months of Medicaid fee-for-service data from 1997—approximately 20 percent of the S-CHIP population—the state uses Adjusted Clinical Groups (ACGs) to adjust rates by diagnosis. Maryland Health Partners is not at financial risk.

The only children excluded from managed care enrollment are those who qualify for the Rare and Expensive Case Management Program (REM).[7] For these children, all care is furnished on a fee-for-service basis.

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[5] Prior to S-CHIP, Maryland's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, 100 percent of poverty for children ages 6 to 16, and 34 percent of poverty for children ages 16 to 19.

[6] Because we were interested in states' perspectives on S-CHIP implementation, we adopted the view of the state government. In our Maryland interviews we inquired about the experiences of newly enrolled children up to age 16 in families with incomes between 100 and 185 percent of the federal poverty level, as well as children in families with incomes between 185 and 200 percent of poverty. Enrollment of S-CHIP participants for whom the state received the enhanced matching rate was 14,975 in July 1999.

[7] REM covers 33 diagnoses, the majority of which are severe physical health problems, such as HIV, spina bifida, hemophilia, ventilator dependent conditions, cystic fibrosis, brain injury, and aplastic anemia.

Missouri

Missouri's S-CHIP program is part of a larger Medicaid expansion covering uninsured adults as well as children. The state had included its current S-CHIP population in a section 1115 demonstration waiver application to HCFA in 1994, although it was never implemented. With the availability of enhanced federal support under S-CHIP, Missouri expanded its Medicaid program, now known as MC+, in September 1999. Eligibility determinations were started several months earlier, and by July 1999, 42,251 of the projected 90,000 children were participating.

Eligibility. Missouri uses income disregards to make all uninsured children in families with incomes up to 300 percent of the federal poverty level eligible for MC+.[8] To qualify as uninsured, participants must not have had insurance for six months prior to the date of application.

Coverage. Children eligible under the expansion are entitled to the complete package of Medicaid benefits, with the exception of nonemergency transportation.[9] However, because S-CHIP participants technically are part of a demonstration waiver, Missouri has been able to require cost sharing greater than what would otherwise be permitted for Medicaid recipients. Beginning in January 1999, families with incomes between 226 percent and 300 percent of poverty are required to pay monthly premiums, identical to those for state employees, and all S-CHIP families are required to pay copayments for office visits and prescription drugs, although the amount varies depending on family income.

Managed Care Arrangements. Missouri does not require all S-CHIP participants to select a managed care organization. Children meeting SSI disability criteria are exempt, as are children living in certain areas of the state. These children, who comprise slightly more than half of the MC+ population, receive Medicaid services on a fee-for-service basis. All other S-CHIP children are required to enroll in one of the three or four managed care organizations that may operate in their region; there are nine operating in the state. All of these plans are health maintenance organizations, and most are provider-sponsored. The plans are capitated to provide nearly all Medicaid benefits; only early intervention services, health-related special education services, certain mental health services for children with severe emotional disturbances, and substance abuse services offered through the state's Comprehensive Substance Abuse and Rehabilitation Program (C-STAR) are carved out of their contracts.

Capitation rates for S-CHIP participants vary according to an enrollee's age, gender, and region, as they do for other Medicaid beneficiaries. The rates are slightly lower than the regular Medicaid rates, however, because the S-CHIP benefits do not include non-emergency transportation.

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[8] Prior to S-CHIP, Missouri's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 19.

[9] The state excluded this benefit for two reasons: one, it did not want to encourage crowd-out by offering a benefit package that was wholly unlike any offered in the commercial market and two, it reasoned that higher income enrollees would not have the same need for transportation as lower income enrollees.

Utah

Utah implemented a non-Medicaid S-CHIP program in August 1998. Reflecting Governor Leavitt's (R) philosophy that publicly subsidized health insurance should be comparable to private insurance otherwise available to families with similar incomes, the state modeled its program after the private plan for state employees. At the end of the program's first year of operation, the state had 10,729 children participating, more than half of the anticipated 20,000.

Eligibility. Eligibility for S-CHIP is open to all uninsured children up to age 19 in families with incomes at or below 200 percent of the federal poverty level.[10] To qualify as uninsured, a child must not have had insurance during the prior three-month period. Children in families with incomes between 100 and 150 percent of poverty participate in Plan A, and children in families with incomes between 151 and 200 percent of poverty participate in Plan B. Although benefits for both plans are the same, cost-sharing requirements differ. Under Plan A, families are subject to basic copayments for most services. Under Plan B, families are subject to more substantial copayments for office visits and prescription drugs as well as standard, private sector coinsurance for hospital and mental health services. However, neither group is required to pay premiums.

Coverage. Utah provides S-CHIP benefits that are actuarially equivalent to those given to state employees. In addition to hospital and physician services and prescription drugs, the benefit package includes: outpatient mental health treatment up to 30 visits per year for most diagnoses and inpatient mental health treatment up to 30 days per year for most diagnoses;[11] ancillary therapy services up to 16 visits per year to restore speech loss or correct impairments due to congenital defects or injury or sickness; durable medical equipment to assist medical recovery; home health services provided by registered nurses or licensed practical nurses other than custodial care, private duty nursing, and home health aide services; and a limited set of dental services.

Managed Care Arrangements. Children living in urban counties are required to enroll in one of four managed care organizations, each of which is a health maintenance organization. Children living in rural areas must enroll in a single preferred provider organization (PPO), established as one of the plan options for public employees. The PPO also provides dental services to S-CHIP enrollees statewide.

All S-CHIP-covered services, with the exception of dental care, are included in the capitation rate paid to managed care plans for S-CHIP participants. Utah pays a single, average monthly rate for each S-CHIP child, although it has separately negotiated a risk corridor arrangement with each of the five plans to provide a measure of stop-loss protection.

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[10] Current Medicaid eligibility in Utah is set at 133 percent of poverty for children up to age six and 100 percent of poverty for children up to age 19.

[11] Diagnoses excluded from mental health coverage are learning disabilities, conduct disorder, and oppositional defiant disorder.

Appendix Table I

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	**Connecticut**	**Maryland**	**Missouri**	**Utah**
Program Name	Healthy Families	HUSKY B	Maryland Children's Health Insurance Program	MC+for Kids	CHIP
Program Type	Non-Medicaid[1]	Non-Medicaid[2]	Medicaid	Medicaid	Non-Medicaid
Implementation Date	7/1/98	7/1/98	7/1/98	7/1/98	8/1/98
Income Eligibility Levels					
Infants	200–250%	185–300%	185–200%	185–300%	133–200%
Children Ages 1–6	133–200%	185–300%	133–200%	133–300%	133–200%
Older Children	100–200%	185–300%	100–200%	100–300%	100–200%
First Year Enrollment	138,869	3,787	57,000	42,251	10,729
Benefit Package	Benchmark Plan (state employees)	Benchmark Plan (state employees)	Medicaid	Medicaid	Benchmark Plan (state employees)
Populations Excluded from MCO Participation	None	None	Children with rare and expensive physical conditions	Children meeting SSI disability criteria and all children in some areas of the state	None
Services Excluded from MCO Contract	Dental, vision, specialty services for children with severe physical health conditions, and non-hospital specialty services for children with severe emotional disturbances	None	Personal care, early intervention, health-related special education, and all mental health	Early intervention, health-related special education, substance abuse, and crisis intervention for children with severe emotional disturbances	Dental

Continued on next page

Appendix Table I *(continued from previous page)*

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	**Connecticut**	**Maryland**	**Missouri**	**Utah**
Wrap-around Program Services	All specialty services (supplemental and basic) for children with severe physical health conditions, and all non- hospital specialty services (supplemental and basic) for children with severe emotional disturbances	Supplemental specialty services for children with severe physical health conditions (HUSKY Plus Physical), and supplemental specialty services for children with severe emotional disturbances (HUSKY Plus Behavioral)	Not applicable	Not applicable	None
Cost-Sharing Requirements					
Monthly Premiums	Yes	Yes	No	Yes	No
Copayments	Yes	Yes	No	Yes	Yes
Coinsurance	No	No	No	No	Yes
Number of Managed Care Plans	26 MCOs 4 dental plans 1 vision plan	5 MCOs	8 MCOs	9 MCOs	5 MCOs 1 dental plan

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1] California had a small expansion of its Medicaid program to include adolescents ages 16 to 19 up to 100 percent of the federal poverty level.

[2] Connecticut had a small expansion of its Medicaid program to include adolescents ages 14 to 19 up to 185 percent of the federal poverty level.

Appendix Table II

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Physician Services	Covered	Covered	Covered	Covered	Covered
Lab and X-ray Services	Covered	Covered	Covered	Covered	Covered
Preventive Care	Covered	Covered	Covered	Covered	Covered
Prescription Drugs	Covered	Covered	Covered	Covered	Covered
Family Planning Services	Covered except for abortion.	Covered except for abortion.	Covered	Covered except for abortion.	Covered except for routine HIV testing, Norplant, and abortion.
Outpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Inpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Outpatient Mental Health Services	Covered up to 20 visits/year for conditions that will significantly improve with short-term therapy, with additional visits available through conversion of inpatient mental health days (1:4).	Covered up to 30 visits/year, with additional visits available through conversion of inpatient mental health days (1:3).	Covered	Covered	Covered up to 30 visits/year (in combination with outpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities.
Inpatient Mental Health Services	Covered up to 30 days/year for conditions that will significantly improve with short-term therapy.	Covered up to 60 days/year.	Covered	Covered	Covered up to 30 days/year (in combination with inpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities.
Residential Treatment Facilities	Covered by converting inpatient mental health days (1:2) for conditions that will significantly improve with short-term therapy.	Covered by converting inpatient mental health days (1:1).	Covered	Covered, at plans' option.[2]	Covered by converting inpatient mental health days (1:1), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities.

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Appendix Table II *(continued from previous page)*

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Outpatient Substance Abuse Treatment Services	Covered up to 20 visits/year.	Covered up to 60 visits/year.	Covered	Covered	Covered up to 30 visits/year in combination with outpatient mental health.
Inpatient Substance Abuse Treatment Services	Covered for detoxification.	Covered for drug abuse up to 60 days/year and for alcohol abuse up to 45 days/year.	Covered	Covered	Covered up to 30 days/year in combination with inpatient mental health.
Physical, Occupational, and Speech Therapy	Each therapy covered up to 60 consecutive days/condition, additional visits available if condition will improve significantly.	Covered on a short-term basis.	Covered	Covered	Covered up to 16 visits/year, but excluding therapies for children with developmental delay, and excluding speech therapy not required to treat an injury, sickness, or surgically corrected congenital condition.
Optometry Services	Covered	Covered	Covered	Covered	Not covered
Eyeglasses	Covered	Covered	Covered	Covered	Not covered
Home Health Services	Covered for skilled nursing services and home health aide services, including PT, OT, and ST.	Covered for skilled nursing services and home health aide services.	Covered	Covered	Covered for skilled nursing services.
Durable Medical Equipment and Other Devices	Covered except for therapeutic footwear and motorized wheelchairs.	Covered except for hearing aids and motorized wheelchairs.	Covered	Covered	Covered except for eyeglasses and therapeutic footwear.
Dental Services	Covered except for orthodontia.	Covered	Covered	Covered	Covered except for replacement restorations for other than decay or fracture, orthodontia, sealants except when placed on permanent molars through age 17.

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs.

Notes: [1] The programs were implemented in either July or August of 1998.

[2] Plans in Missouri were only encouraged to provide residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

Appendix Table III

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

Monthly Premiums	**California**	**Connecticut**	**Maryland**	**Missouri**		**Utah**	
101–150% FPL	$7 for 1 child[2] $14 for ≥2 children	Not applicable	None	None		None	
151–200% FPL	$9 for 1 child; $18 for 2 children; $27 for ≥3 children	None	None	None		None	
200–300% FPL	Not applicable	above 235% FPL: $30 for 1 child; $50 for ≥2 children	Not applicable	above 225% FPL: $65 per family		Not applicable	
>300% FPL	Not applicable	$113.87–$194.37, depending on plan selected	Not applicable	Not applicable		Not applicable	
Copayments/Coinsurance	**101–200%**	**>185%**	**None**	**186–225%**	**226–300%**	**101–150%**	**151–200%**
Physician Visits	$5	$5		$5	$10	$5	$10
Prescription Drugs	$5	$3 generic; $6 brand		—	$5	$2	$4; 50% nonformulary
Lab/X-ray	—	—		$5	$10	—	10%
Emergency Room Services	$5	$25		–	–	$5–$10	$30
Inpatient Hospital Services	—	—		$5	$10	—	10%
Outpatient Hospital Services	—	—		$5	$10	—	10%
Mental Health Services							
Outpatient Visits	$5	11–20 visits $25; 21–30 visits $50 or 50%		$5	$10	$5	50%
Inpatient Hospital Services	—	—		$5	$10	—	1–10 days, 10%; 11–30 days, 50%
Substance Abuse Services						$5	
Outpatient Visits	$5	–		–	—	—	50%
Inpatient Hospital Services	—	–		–	—	—	1–10 days, 10%; 11–30 days, 50%

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Appendix Table III *(continued from previous page)*

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri		Utah	
Copayments/Coinsurance	**101–200%**	**>185%**	**None**	**186–225%**	**226–300%**	**101–150%**	**151–200%**
PT, OT, ST Services	$5	–		$5	$10	$5	$10
Audiology Services	—	$5 hearing exams		$5	$10	—	—
Optometry	$10	$5		$5	$10	—	—
Home Health	—	—		$5	$10	—	—
DME	—	—		—	—	—	20%
Eyeglasses	$25	lenses covered and up to $50 for frames		—	—	—	—
Dental	varies	varies		$5	$10	—	varies

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1] The programs were implemented in either July or August of 1998.

[2] California's Healthy Families participants who enroll in a community provider plan receive a discounted premium of $3 per child.

NOTES

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