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Access to Children's Mental Health Services under Medicaid and SCHIP

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Medicaid and SCHIP agencies could play a larger role in assessing and coordinating mental health services for children.

At least one-tenth of children suffer from a serious mental health problem that causes impairment (U.S. Public Health Service 2000). Because parents and providers are often reluctant to label a child with a specific diagnosis, the general term serious emotional disturbance (SED) is commonly used for severe problems. Poor children have more mental health problems than other children (Costello et al. 2003). Since more low-income children are now eligible for public health insurance through the Medicaid "poverty expansions" and the new State Children's Health Insurance Program (SCHIP), half of all children are potentially eligible for public health insurance coverage (Dubay, Haley, and Kenney 2002). Consequently, such programs play a critical role in ensuring access to child mental health services.

This brief fills some of the knowledge gaps about the unique roles of Medicaid—the dominant payer for mental health services for poor children—and SCHIP, a newer program whose role is still evolving. The brief first reviews coverage policy for mental health services for Medicaid and SCHIP. It then provides new information on the prevalence of mental health problems for Medicaid and SCHIP children, and their use of mental health services. Together, this information will help guide Medicaid and SCHIP policy regarding how best to serve children.

Methods

To learn in detail about Medicaid and SCHIP policies for children's mental health coverage, we conducted telephone interviews with state officials in the 13 *Assessing the New Federalism* (ANF) focal states, a group of states whose social policies are monitored regularly by the Urban Institute (Kondratas, Weil, and Goldstein 1998).[1] The ANF states include 53 percent of the children enrolled in Medicaid and 63 percent of those enrolled in SCHIP, for the most recent years data are available. Semi-structured interviews were conducted from mid-August to mid-October 2003, using a standard protocol.

A new analysis of data from the 2002 round of the National Survey of America's Families (NSAF) provides recent information on the prevalence of emotional and behavioral problems (here called "mental health problems") and the use of mental health services among children nationwide, according to poverty level and insurance coverage. For children 6–17 years old, parents were asked how often their child felt worthless or inferior, had been nervous or tense, or acted too young for their age. Parents of children 12–17 years old were also asked how often their child had trouble sleeping, lied or cheated, or had trouble at school. Responses were combined into a scale from 1 (most severe problems) to

18 (no problems). Children with mental health problems are those with a score of 12 or lower. Parents were also asked whether their child "received mental health services, including mental health services from a doctor, mental health counselor, or therapist."[2]

Medicaid and SCHIP Coverage

Medicaid is widely considered the largest funder of mental health services for children, although comprehensive national-level data are not available to assess the issue thoroughly. Children are entitled to Medicaid because their family is low-income; their family receives cash assistance; they have a severe disability and receive Supplemental Security Income (SSI); they are in foster care; or because of medically needy or spend-down provisions. Consequently, children on Medicaid include both those who are entitled because of welfare receipt or poverty (the large majority), and a smaller group who have a high rate of mental health problems (such as those on SSI or in foster care).[3]

States have adopted a wide array of approaches to financing and delivering mental health services.

Through a combination of mandated benefits (inpatient care; outpatient care; and Early and Periodic Screening, Diagnosis, and Treatment, or EPSDT) and optional benefits (inpatient psychiatric care, prescription drugs, rehabilitation, and various types of case management), Medicaid provides very comprehensive coverage for mental health services, especially compared with most private insurance plans. This generosity is partly because a provision of the Omnibus Budget Reconciliation Act of l989 required states to cover all needed services identified in an EPSDT screen, even those not in a state's Medicaid benefit package. Lawsuits around EPSDT implementation have led to increased Medicaid coverage of services for children with severe mental health problems.

Each state develops a different "flavor" to its Medicaid-covered mental health benefits, and the "flavors" vary widely within states depending on local funding streams and service availability. In our interviews, we also heard that Medicaid is increasingly absorbing costs from other state- and locally financed sectors that had provided mental health services to children. The education, child welfare, and public mental health sectors in particular have enrolled more of their client children in Medicaid programs, to bring federal as well as state and local money into the financing for mental health services. Studies in selected states have shown that use of mental health services under Medicaid varies widely from state to state (Buck and Miller 2002; Sturm, Ringel, and Andreyeva 2003), undoubtedly a result of states' varied approaches to coverage and the varying roles of other sectors in providing services.

As states move to Medicaid managed care, they have adopted a wide array of approaches to financing and delivering mental health services. For example, a physical health managed care organization may be responsible for providing mental health benefits, while mental health is either "carved out" to fee for service (FFS) reimbursement or to a special mental health managed care organization. Special categories of people (such as children with SED) may be treated differently from others in these arrangements, either through carveouts to FFS or through special plans to manage their care.

Table 1 shows how the states manage Medicaid mental health services. The wide range of approaches in these states illustrates the variety of arrangements across the country. Among the 13 states, two have no Medicaid managed care. All the others have special managed care arrangements for children with mental health problems, either by carving out mental health to FFS reimbursement (three states); providing special treatment for children with SED or on SSI (three states); using separate managed care plans for mental health (one state); or some combination of these approaches, depending on geography or other factors (four states).

Under SCHIP, states can elect either to expand Medicaid (in which case they must adopt the same benefit structure as

TABLE 1. Key Features in Medicaid Managed Care for Children with Mental Health Problems in ANF States

	Medicaid managed care arrangements for children's mental health
Alabama	None
California	Mental health services carved out to FFS
Colorado	Mental health services carved out to FFS
Florida	Five counties have separate mental health managed care; for other counties, mental health services carved out to FFS
Massachusetts	Separate mental health managed care program for persons not enrolled in physical health HMO; HMO enrollees served through their HMO
Michigan	Mental health services carved out after 20 visits a year to county-operated system
Minnesota	SSI and foster care children are exempt
Mississippi	None
New Jersey	Mental health services carved out to FFS
New York	Stop loss for benefits in excess of limits; SSI and SED exempt from managed care
Texas	Mental health services carved out to separate mental health managed care plan in Dallas metro area; SSI children may elect FFS
Washington	Mental health services carved out to separate mental health managed care plan
Wisconsin	No carveout for mental health; SED children in special plans

Sources: Author correspondence with Neva Kaye of the National Academy for State Health Policy and state officials.
FFS = fee for service; HMO = health maintenance organization; SED = serious emotional disturbance; SSI = Supplemental Security Income.

Medicaid), establish a new program separate from Medicaid (with a potentially more limited benefit structure), or combine these approaches (for example, using different approaches for different income groups). Most separate programs use managed care to deliver services. When Rosenbaum et al. (2002) examined 33 separate state SCHIP programs in 2000, they found that 27 of them used managed care, and that most managed care contracts included visit and day limits for mental health.

Our interviews with state officials revealed how SCHIP's role in mental health coverage is changing in the 13 states (table 2). Two states (Minnesota and Wisconsin) have Medicaid expansion programs, and thus Medicaid-equivalent services. In four of the states with separate programs (Massachusetts, Michigan, New Jersey, and Washington), SCHIP children also have Medicaid-equivalent mental health services, because SCHIP children are included in the same managed mental health carveout arrangements as Medicaid children. In four other states (Alabama, California, Florida, and New York), children with SED are handled through special arrangements. In those cases, we were told that these children receive Medicaid-equivalent services with few limitations. Only three ANF states (Colorado, Mississippi, and Texas) do not have such arrangements, so children enrolled in SCHIP, regardless of the severity of their mental health problems, are subject to benefit limits that are closer to private plan coverage than to Medicaid.

As has occurred with Medicaid, SCHIP's role in covering mental health services will undoubtedly evolve. We were told that recent state budget pressures have led states to reexamine SCHIP coverage

TABLE 2. Key Features in SCHIP Mental Health Coverage in ANF States

	All have Medicaid-equivalent	SED have Medicaid-equivalent	Limits
Alabama		X	Non-SED: 20 visits or 30 days
California		X	Non-SED: 20 visits or 30 days
Colorado			20 visits or 45 days (converts to 90 days of day treatment)
Florida		X	Non-SED: 40 visits or 30 days
Massachusetts	X		
Michigan	X		
Minnesota	X		
Mississippi			52 visits or 30 days (converts to 60 days of day treatment)
New Jersey	X		
New York		X	Non-SED: 60 visits or 30 days
Texas			30 visits or 30 days
Washington	X[a]		
Wisconsin	X		

Source: Author correspondence with state officials.
Notes: Limits for non-SED children are expressed in visits to ambulatory care and days of institutional care.
a. Dual coverage: public system or in HMO up to 20 visits.

policy for mental health services. Indeed, Texas temporarily eliminated most mental health benefits from its SCHIP benefit package, but had reinstated them by the time of our interviews. It remains to be seen whether SCHIP will evolve toward a more limited program, more closely resembling private insurance coverage, or continue to provide relatively generous mental health benefits for enrollees.

The Prevalence of Mental Health Problems among Poor Children

Previous studies of mental health problems in poor children show widely varying estimates of the proportion of children who suffer from such problems (Howell, Buck, and Teich 2000; Costello et al. 1996; Glied and Cuellar 2003), and there is a lack of research reporting prevalence by income and health insurance status at the national level. Consequently, up to now it has been difficult to know how many children enrolled in public programs need mental health services.

New data are available from the 2002 NSAF, which used a survey of parents to measure the prevalence of men-tal health problems in children age 6–17. Table 3 shows the prevalence of such conditions by age, family income, and health insurance

TABLE 3. Children with Behavioral or Emotional Problems by Age, Family Income, and Health Insurance Status, 2002 (percent)

	Medicaid/SCHIP	Other insured	Uninsured	Total
Children age 6–11				
Poor	13.0 (1.5)	8.5 (2.0)	8.8 (3.1)	11.3 (1.1)
Near-poor	9.5 (1.6)	6.8 (1.2)	3.8 (1.9)	7.5 (0.9)
Nonpoor	9.5 (1.6)	5.1 (0.5)	11.1 (2.4)	5.8 (0.4)
All income levels	11.0 (1.0)	5.5 (1.5)	8.2 (3.0)	7.0 (0.8)
Sample size	2,526	7,266	861	10,653
Children age 12–17				
Poor	14.0 (1.9)	10.5 (3.4)	10.9 (2.5)	12.5 (1.2)
Near-poor	11.8 (1.6)	9.8 (1.5)	8.0 (2.0)	10.1 (1.0)
Nonpoor	18.2 (3.3)	6.2 (0.5)	7.9 (2.3)	7.0 (0.5)
All income levels	14.0 (1.0)	6.9 (0.5)	8.7 (1.4)	8.4 (0.4)
Sample size	1,986	7,889	1,023	10,898
All children age 6–17				
Poor	13.5 (1.1)	9.4 (1.9)	9.8 (1.8)	11.8 (0.7)
Near-poor	10.6 (1.2)	8.2 (0.9)	6.3 (1.5)	8.7 (0.7)
Nonpoor	13.5 (1.9)	5.7 (0.4)	9.4 (1.7)	6.4 (0.4)
All income levels	12.4 (0.8)	6.2 (0.4)	8.5 (0.9)	7.7 (0.3)
Sample size	4,512	15,155	1,884	21,551

Source: 2002 National Survey of America's Families.
Notes: Standard errors are in parentheses. Poor children are those living in families with incomes below the federal poverty level (FPL). Near-poor children are those living in families with incomes between 100 and 200 percent of FPL. Nonpoor children are those living in families with incomes at or above 200 percent of FPL.

status in 2002. In the table, Medicaid and SCHIP children are combined for analysis, because parents often have trouble distinguishing between the programs and SCHIP numbers are too small for precise analysis. Children living in families with incomes below the federal poverty level (FPL) are compared with near-poor children (children living in families with incomes between 100 and 200 percent of FPL), and nonpoor children (children living in families with incomes at or above 200 percent of FPL).

The highest prevalence of mental health problems among all children age 6–17 is observed among Medicaid-SCHIP children (12.4 percent), a rate significantly higher than for other insured children (6.2 percent) or uninsured children (8.5 percent). Poor children also have significantly higher prevalence (11.8 percent) than near-poor (8.7 percent) and nonpoor (6.4 percent) children. These patterns in prevalence by insurance status and family income hold for younger children (age 6–11) and adolescents (age 12–17), although differences are not always significant owing to small sample sizes. The overall prevalence for children age 6 to 17 (7.7 percent) is very similar to the 8.2 percent rate found for the same age group in the National Health Interview Survey disability supplement of l994–96, which used a more extensive screening instrument (Colpe 2001).

Table 3 reveals that nonpoor Medicaid/SCHIP children have significantly higher rates of behavioral or emotional problems (13.5 percent) than nonpoor children with other forms of insurance (5.7 percent). This is undoubtedly because some higher-income children are enrolled in Medicaid through various provisions to obtain more comprehensive benefits for their costly mental health problems.

Mental Health Service Use under Medicaid and SCHIP

Table 4 shows NSAF data on the proportion of all children age 6 to 17 who used a mental health service in 2002, as well as the proportion of children with a mental health problem who used services. Data are provided by income and insurance status. As shown in the final column, 8.8 percent of all children age 6–17 used a mental health service in 2002. The rate of use of mental health services for Medicaid and SCHIP children (13.1 percent) was significantly higher than for other insurance groups.

More telling in terms of access to care for those who need it most, 44.9 percent of Medicaid/SCHIP children with reported emotional or behavioral problems used a mental health service, about the same as children with other (mostly private) insurance (41.0 percent), but over three times as high as uninsured children (13.7 percent). These rates are not adjusted for the severity of the emotional or behavioral problem. It is likely that many children with severe mental health problems who are uninsured or have limits to their mental health insurance coverage become eligible for Medicaid because of such problems, thereby increasing the Medicaid use rate.

There is little separate information on use of mental health services for children enrolled in SCHIP. According to state representatives, use of mental health services so far has been moderate. Washington State reported that 6.2 percent of children ever enrolled in SCHIP in 2002 used mental health services, a rate substantially below the use rates reported for Medicaid.

Conclusions

Because of Medicaid's and SCHIP's relatively comprehensive coverage of mental health benefits, the two programs can clearly reduce disparities in use of mental health services between higher- and lower-income children. NSAF data provide new evidence of this important role. Uninsured children have dramatically lower use of mental health services than children with insurance. On the other hand, use rates for poor children with mental health problems in 2002 did not differ significantly from rates for nonpoor children with such problems.

While Medicaid and SCHIP appear to improve access to care for children with

TABLE 4. Children Using Mental Health Services, by Insurance Status and Income, 2002 (percent)

	Medicaid/SCHIP	Other insured	Uninsured	Total
All children age 6–17				
Poor	12.0 (1.2)	9.4 (2.1)	2.1 (0.7)	9.6 (0.9)
Near-poor	14.1 (1.4)	8.9 (1.0)	3.5 (1.1)	9.9 (0.8)
Nonpoor	13.3 (1.9)	8.0 (0.4)	7.1 (1.3)	8.3 (0.4)
All income levels	13.1 (0.8)	8.2 (0.4)	4.5 (0.6)	8.8 (0.4)
Sample size	4,644	15,897	1,940	22,481
Children age 6–17 with emotional or behavioral problems				
Poor	44.8 (5.4)	18.1 (5.8)	10.8 (4.9)	34.5 (3.9)
Near-poor	43.3 (5.3)	39.8 (5.9)	10.5 (4.2)	37.7 (3.4)
Nonpoor	47.7 (9.3)	43.8 (3.0)	17.8 (6.7)	42.0 (2.9)
All income levels	44.9 (4.1)	41.0 (2.6)	13.7 (3.4)	39.2 (2.2)
Sample size	597	936	171	1,704

Source: 2002 National Survey of America's Families.
Notes: Standard errors are in parentheses. Poor children are those living in families with incomes below the federal poverty level (FPL). Near-poor children are those living in families with incomes between 100 and 200 percent of FPL. Nonpoor children are those living in families with incomes at or above 200 percent of FPL.

mental health problems, most children with mental health problems nationwide, from all income and insurance groups, still do not use mental health services. Access to such services is lower than it should be for all children, regardless of income and insurance status.

State and local governments increasingly use Medicaid and SCHIP to finance the children's mental health services provided by other public sectors, such as the mental health and educational systems. Consequently, Medicaid and SCHIP agencies could play an increased role in assessing and coordinating the mental health services provided to the nation's most critical asset, its children.

Notes

1. The ANF states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

2. For more information on the NSAF or the child behavior checklist, see Ehrle and Moore (1999) or http://anf.urban.org.

3. In 2000, only 4 percent of Medicaid children under 18 were entitled through receipt of SSI cash assistance (special tabulations of data by the Urban Institute). The Social Security Administration (2003) reported that 38.7 percent of SSI children were disabled due to mental illness in 2003.

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Embry Howell is a principal research associate with the Urban Institute's Health Policy Center. Dr. Howell's research interests include maternal and child health policy, Medicaid, the health care safety net, and the role of community-based nonprofits.

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This series presents findings from the 1997, 1999, and 2002 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at **http://newfederalism.urban.org.**

The NSAF is part of *Assessing the New Federalism*, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Olivia A. Golden is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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State officials from *Assessing the New Federalism* states were interviewed and provided information about their Medicaid and SCHIP programs. Brigette Courtot of the Urban Institute participated in the interviews and obtained most of the written materials that were reviewed. Amy Davidoff, Ian Hill, and Genevieve Kenney of the Urban Institute provided helpful comments on a draft of the paper.