

State Advocacy Update

Medicaid 2002 Spotlight: State Action Under HIFA Sparks Concern

Proposed Waivers Threaten Services

Advocates across the country are closely watching state legislatures to safeguard access to services for Medicaid recipients following the recent implementation of the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative (see the December issue of *State Advocacy Update*). Although HIFA is designed to allow states to reduce services for some Medicaid recipients and extend a more modest benefit to the uninsured, the new regulation also allows states to simply reduce Medicaid expenses without expanding coverage.

To date, only a few states have initiated a waiver application under HIFA. Stakeholder groups attribute this lukewarm response to the absence of new federal funding for such expansions. NMHA remains concerned, however, that the benefit and cost-sharing changes proposed in some applications would directly affect services for individuals with mental illness.

Given budget constraints in state Medicaid programs, NMHA worries that states will use this waiver flexibility to balance

budgets on the backs of their most vulnerable citizens. With an anticipated Medicaid shortfall of more than \$38 billion across the 50 states in 2002, Medicaid officials are scrambling for ways to control costs. Mental health and other disability advocates must pay careful attention to HIFA and other waivers of federal law or state options to protect funding and access to needed treatment and services.

Some State Waivers Under HIFA Spell Trouble

Arizona was the first state to receive a waiver approval under HIFA. And Utah's recently approved proposal was the first to include benefit reductions for certain Medicaid enrollees in an effort to expand coverage to a wider group of uninsured individuals. Below are brief summaries of these waivers and other recent waiver applications that are pending or in development.

Arizona Reallocates SCHIP Funding To Expand Coverage

Arizona's waiver amends its existing section 1115 waiver for the Arizona Health Care Cost Containment System to use its

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Advocates Locked in Fierce Budget Battles

In the opening months of 2002, many state advocates across the country have been engaged in fierce budget battles to preserve funding for key mental health and Medicaid services. The National Conference of State Legislators (NCSL) said that 44 states were reporting revenues below forecasted levels as the 2002 fiscal year began a few months ago. NCSL also reports that the majority of states are considering cuts or holdbacks in 2002 budgets even as states begin work on 2003. With anticipated shortfalls in the state budgets now totaling more than \$38 billion, many advocacy coalitions are scrambling to preserve funding or just decrease the amount of the cuts under consideration.

In contrast to the economic wealth of just a few legislative sessions ago, states are now looking at a "perfect storm" headed toward budgets and needed resources for services. States are facing more than \$15 billion in shortfalls in the Medicaid program alone. And the events of September 11 have placed new stress on our nation's public health system and led to increased spending on homeland security.

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Winter Healthcare Reform State Advocacy Trainings Focus on *Olmstead*, Children, Funding

NMHA's Healthcare Reform Advocacy trainings continue to offer technical support to state mental health coalitions for the seventh consecutive year. Through collaboration with state and local affiliates, these trainings empower advocacy groups to effectively counter state legislative and regulatory policies that could threaten or reduce access to quality mental health care.

Trainings slated for 2002 will focus on a variety of timely issues, including: appropriations, Medicaid managed care, comprehensive parity, substance abuse, involuntary outpatient commitment, advance directives, *Olmstead* planning, consumer empowerment, access-to-medication, children's mental health, Partners in Care and coalition building.

Healthcare Reform Advocacy Trainings held this past fall in 2001, include:

Colorado—The MHA in Colorado met with members of the state's larger mental health coalition in November to analyze strategies for scaling back proposals to cut state appropriated resources for public mental health. Participants examined trends underway in neighboring localities and developed realistic alternatives to proposed cuts.

Michigan—In December, the MHA of Michigan brought together state advocates and stakeholders to call attention to the state's effort to limit access to prescription drugs for mental health consumers. Participants analyzed national trends regarding efforts to defeat restrictions to medication. The meeting concluded with a successful lobbying rally at the state capitol.

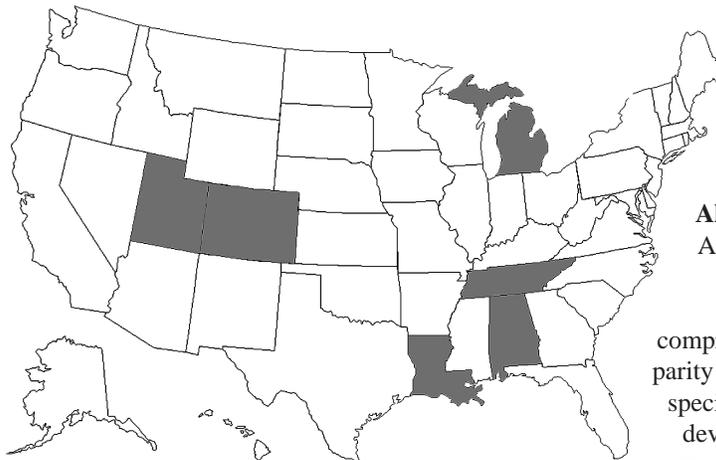
Healthcare Reform Advocacy trainings scheduled or already held for winter 2002 include:

Utah—In January, the MHA of Utah met with the state's larger mental health coalition to examine national and state trends in *Olmstead* planning. The coalition also explored

successful measures to strengthen support for consumer participation and leadership in state and local *Olmstead* planning. Participants developed strategies for improving consumer involvement in state *Olmstead* planning and increase the public's awareness of mental health through public education.

Louisiana—In February, the MHA of Louisiana hosted a meeting of state advocates and key stakeholders to explore national trends in *Olmstead* planning with a focus on cultural competence in community mental health.

Participants outlined a three-tier strategy for enhancing access to community-based mental health services, including: *Olmstead* planning, budget resources and access to prescription medication.



Alabama—The MHA of Alabama will host a meeting of state advocates to develop strategies for prioritizing comprehensive health insurance parity and children's mental health specific to a full constellation of developmental services (such as mental health, education, substance abuse and child welfare).

Tennessee—Also in the month of March, the MHA of Tennessee will gather mental health coalition members to address the importance of securing fiscal support to shore up the state's public mental health system in the wake of shortfalls, and efforts to reorganize Tennessee's TennCare Medicaid program. These reorganization efforts are based on the new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative rules (see related story on page 8-a).

If you anticipate problems regarding legislation or regulatory policy, or if you need to create or expand a mental health coalition, please feel free to contact us for assistance. NMHA is ready to help. For more information, please contact Terri Odom, director of Healthcare Reform Training, at 703-838-7554 or todom@nmha.org. **SAU**

We're Still Ready to Work

Congress's 1999 passage of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) gave states the opportunity to support people with disabilities in their efforts to get jobs.

One action of TWWIIA was to improve the Medicaid Buy-In Program and make it easier for states to provide healthcare coverage to individuals with disabilities who want to return to work. The Medicaid Buy-In Program gives states the option of extending healthcare coverage to this population by increasing the income and asset thresholds for Medicaid eligibility for beneficiaries of the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. A second component of the 1999 TWWIIA legislation is the Ticket to Work and Self-Sufficiency Program, which seeks to offer consumers more access to and more providers for employment services.

Medicaid Buy-In Program Sparks State Action

Since the Medicaid Buy-In program was established, only 25 states have passed legislation to implement a Buy-In program. Many more bills were introduced during the 2001 legislative session, and while they did not pass, they did lay the groundwork for future state action.

Ticket to Work Falls Short of Goals

The Ticket to Work and Self-Sufficiency Program has not started off as well as many had hoped. The proposed regulations were published in February 2001 but created great controversy among advocacy and provider networks. Final regulations were published on December 28, 2001. The program began phase one of a three-year implementation in January 2002, with the first "ticket" handed out in February to a Social Security beneficiary in Delaware. The first 13 states set to begin the program are Arizona, Colorado, Delaware, Florida, Illinois, Iowa, Massachusetts, New York, Oklahoma, Oregon, South Carolina, Vermont and Wisconsin.

Obstacles to Success

Although many expect that this new program will provide Social Security beneficiaries with access to appropriate and effective employment services, some aspects of the Ticket to Work program may keep it from reaching its potential. The greatest barrier to the program's success is the payment structure. Many provider groups are frustrated by payment systems that require them to cover costs upfront for an extended period of time and be reimbursed by Social Security for their services only after the ticket holder becomes employed. For some mental health consumers, reaching this goal could take up to five years. Many providers, therefore, are unwilling to participate in the program.

States that have passed Medicaid Buy-In legislation or are in the process of implementing a Medicaid Buy-In program include:

- Alaska
- Arkansas
- California
- Colorado
- Connecticut
- Illinois
- Iowa
- Indiana
- Kansas
- Maine
- Massachusetts
- Minnesota
- Mississippi
- Missouri
- Nebraska
- New Jersey
- New Mexico
- New York
- Oklahoma
- Oregon
- Pennsylvania
- South Carolina
- Vermont
- Washington
- Wisconsin
- Wyoming

Related Resources From NMHA

- *Ready to Work: Enacting State Work Incentives*
- Model legislative language and samples from other states
- Reports on cost projections from states implementing a Buy-In Program
- Contacts to state and national experts on these issues
- Research on supports and services that assist individuals with mental illness in their return to work

For research and other resources regarding the Medicaid Buy-In program, contact the NMHA Advocacy Resource Center at 800-969-NMHA (6642) and select option 6, or e-mail shcrinfo@nmha.org.

NMHA Pledges To Renew Parity Battle

Despite Setback, Last Year Produced Major Gains

Why did Congress permit mental health parity legislation to go down in flames? What could we have done differently to ensure passage of the Mental Health Equitable Treatment Act of 2001, which would have outlawed disparities in insurance coverage for mental and physical illnesses. Parity advocates are asking these questions following Congress' disappointing defeat of parity legislation last session.

Exactly what happened? On Dec. 18, when approximately 30 members of the House and Senate met to iron out differences between Senate and House-passed appropriations bills, members debated the issue of mental health parity. Because the NMHA-supported Domenici-Wellstone parity legislation was included in the Senate's appropriations bill but not the House version, the fate of parity hinged on a vote by House members at that meeting. Those members voted 10-7 along party lines to exclude the Senate-passed parity provision in the final funding bill.

The outcome certainly sparked bitter frustration given how close victory seemed. But if we consider our progress in this civil rights battle, we realize that we suffered a setback, not a defeat.

As a legislative matter, parity is anything but a dead issue. In fact, parity has advanced tremendously in less than a year. Parity remains "in play" in both the House and Senate as viable legislation that is being addressed in the current session of Congress. Our Senate sponsors and House supporters are poised to return to battle, and have gained strength and momentum since they started their campaign last spring. A majority of members of both houses of Congress have expressed their support for parity, including 66 senators. Only an isolated few senators have voiced opposition. And a majority of House members endorsed the Domenici-Wellstone measure.

It is also important to note that 10 conference committee members opposed parity due to procedural concerns over committee jurisdiction. That is, other committee chairmen had urged that parity legislation should be considered by their committees—and not decided by appropriations committee members. Two of those authorizing committee chairmen have already promised to hold a parity hearing this year.

A broad spectrum of national organizations—154 in all—representing millions of Americans have pressed Congress to enact parity. Editorial writers across the country supported parity. More and more people have come to appreciate the importance of mental health and the harsh inequity of insurance barriers to needed treatment. Legislation that is opposed by powerful, deep-pocketed interests is not won easily. But legislation that is so clearly right and supported by so many citizens and policymakers will not go away and cannot be disregarded. Advocates should be proud of all that was achieved this year. We lost this skirmish but will ultimately prevail in securing mental health parity for all insured Americans.

Advocates Locked in Fierce Budget Battles

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This dire situation has left many states with two primary targets for spending reductions. Discretionary programs such as mental health and other human services are often first in line to be cut. In addition, with Medicaid costs rapidly increasing, many states are looking at reducing Medicaid services or limiting access to needed medications. Because Medicaid now pays for more than half of public mental health spending, mental health consumers are disproportionately the targets of these cuts as well.

But mental health advocates can help improve this situation. Last year, facing growing budget pressures, many state coalitions successfully preserved or expanded key services. In addition, research shows that cuts in services and limitations on access to medications and services only serve to drive up overall spending in other areas. A recent example of this can be found in South Carolina, where the more than \$26 million cut from the state Department of Mental Health's budget last year has led to a reduction in the number of psychiatric beds available and resulted in an influx of mental health consumers receiving care in emergency rooms.

To support advocates in this year's funding and access battles, NMHA has produced a line of new resources. *A Call for Investment: Expanding Community-Based Mental Health Services* and *Penny-Wise & Pound Foolish: Restricting Access to Psychotropic Medications* are two new policy brochures intended to educate policymakers, the media, advocates and the general public. In addition, NMHA staff members are on call to provide state-specific training and technical assistance to MHAs and their coalitions.

To order the brochures (\$0.31 each for affiliates and \$0.35 each for non-affiliates), call NMHA at 800-969-NMHA (6642) and select option 4. For more information on state training or NMHA's technical assistance, e-mail Jennifer Bright, senior policy director, Healthcare Reform Department, at jbright@nmha.org. SAU

NMHA Affiliates Rally Community Support for Juvenile Justice

In the last few months, five NMHA affiliates have joined NMHA and the Children's Defense Fund (CDF) to take community leaders on tours of juvenile detention facilities for a first-hand look at the lack of mental health services provided there and related issues. The tours were intended to serve as a wake-up call for local policymakers to improve substandard conditions, increase community-based services and divert youth with mental health problems from the justice system into more appropriate treatment settings in the community.

The program is made possible by a one-year grant that the Annie E. Casey Foundation awarded NMHA to develop local coalitions that advocate for improved mental health services for youth in the juvenile justice system or at risk for becoming involved in the system.

The tours, a part of CDF's Child Watch Visitation program, took place recently in Vermont, with the Vermont Association for Mental Health; North Carolina, with the MHA in Orange County; Indiana, with the MHA in Indiana, Hamilton County; New York, with the MHA of the Southern Tier; and Louisiana, with the MHA of Southwest Louisiana.

New Coalitions

MHA sites spent months organizing their tours and developing advocacy coalitions with assistance from NMHA and CDF. The planning process for all sites followed this basic formula:

- Each site formed planning committees composed of community members, child advocates and representatives from their local juvenile detention center.
- NMHA provided technical assistance such as providing information about juvenile justice system reform and

issues related to conditions of confinement. NMHA also hosted conference calls with the sites to identify their most pressing issues and to offer guidance on improving the mental health of youth within juvenile justice facilities.

- CDF staff offered on-site training to introduce the Child Watch model to each site's planning committee.
- Administrators of local detention facilities were encouraged to be active participants in the coalitions. These administrators are an essential component in bringing about meaningful and lasting change in child-serving facilities and in the juvenile justice system.

Next Steps

Following the tours, the coalitions outlined ways to reach their long-term goal to improve conditions for youth, and develop an array of community-based alternatives to detention and incarceration. Their action plans include short- and long-term strategies such as raising awareness among parents about the benefits of community-based mental health services for at-risk youth; redirecting money designated for the construction of new facilities to support the development of community-based services; and providing mental health services to youth in short-term confinement.

NMHA will continue to provide on-going technical assistance and support the coalitions' efforts to develop community-based alternatives to detention and improve conditions for confined youth with mental health needs.

For more information, contact Hazel Moran, NMHA's program associate for Juvenile Justice Programs, at 703-837-4798. [SAU](#)

Advocacy Resources

NMHA is committed to providing mental health advocates and stakeholders with quality information that helps promote positive policy changes in states and communities. Below is a list of resources MHAs can use to help support their advocacy efforts. Most of these materials are available on the Internet. If you have problems accessing any of the following items online, contact the Advocacy Resource Center at 800-969-6642 and select option 6, or e-mail shcrinfo@nmha.org.

Health Disparities

From The Commonwealth Fund—"Race, Ethnic and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices" available at <http://www.cmwf.org/publist/publist2.asp?CategoryID=13>.

Olmstead and Community Services

From the Center for Health Care Strategies, Inc.—"Olmstead and Supportive Housing: A Vision for the Future" available at <http://www.chcs.org/publications/pdf/cas/olmsteadsupportive.pdf>.

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state Children's Health Insurance Plan (SCHIP) funds to expand coverage to 50,000 adults—25,000 of whom are uninsured. This population includes parents with children enrolled in KidsCare, Arizona's SCHIP plan, childless adults, and childless couples with incomes between 100 and 200 percent of the federal poverty level (FPL).

The waiver will be implemented in two phases: Childless adults (with family incomes up to the FPL, which is \$8,590 for an individual and \$11,610 for a couple) became eligible Nov. 1, 2001. Parents of SCHIP and Medicaid children (with family incomes between 100 and 200 percent of FPL, which is between \$17,650 and \$35,300 for a family of four) become eligible Oct. 1, 2002. Benefits and cost-sharing requirements will be identical to the state's acute care and SCHIP program benefit packages.

Utah's Approved Waiver Cuts Benefits To Expand Coverage

Approved in February, Utah's waiver extends Medicaid coverage to 25,000 uninsured residents by restructuring the Utah Medical Assistance Program (UMAP) into three benefits packages: traditional Medicaid, a plan based on the state employee plan, and a new package called the Primary Care Network. The waiver, which includes benefit cuts to certain Medicaid beneficiaries, is the first of its kind to be approved.

Under the waiver, Utah will be able to extend Medicaid coverage to uninsured adults with incomes of up to 150 percent of the federal poverty level, or about \$12,885 a year for an individual. Those newly eligible for UMAP will pay a \$50 enrollment fee and receive a benefits package that covers primary and preventive care services. The waiver also allows the state to provide full Medicaid coverage to about 150 "high-risk pregnant women" whose incomes exceed the state's eligibility limit. These women will not have to pay the enrollment fee or for any cost-sharing.

To cover the cost of the new enrollees, the state will reduce benefits for between 17,000 and 20,000 beneficiaries. Reductions will include a cap on the number of visits to physical therapists, chiropractors and psychiatrists; the elimination of transportation to doctor visits except in emergencies; and reductions in speech, vision and dental benefits. According to the announcement of the waiver approval, however, children, the elderly, pregnant women and beneficiaries with disabilities will be exempt from any benefit reductions.

Parents who receive Temporary Assistance to Needy Families (TANF) or who are eligible for transitional Medicaid, and "medically needy" adults would qualify for a plan based on the state's Public Employee Health Plan.

SCHIP eligible children would also receive benefits under the Public Employee Health Plan. All adults with incomes below 200 percent of the FPL, including childless adults who earn below 53 percent of the FPL and who are currently in the state-funded UMAP program, would be eligible for a new plan called the Primary Care Network.

The Public Employee Health Plan includes coverage for mental health and substance abuse benefits that is similar to the coverage provided in the regular Medicaid program. Mental health services would continue to have inpatient and outpatient visit limits of 30 days per year; however, the new plan would impose a new copayment of \$100 per day for inpatient stays and increase the copayment from \$2 to \$3 per visit for outpatient visits.

Under the Primary Care Network, no mental health or substance abuse benefits would be covered. Prescription drugs would be available under the new plans, but a \$2 copay per prescription would apply under the Public Employee Health Plan and a \$5 copay per generic drug or pre-approved brand name drug would apply under the Primary Care Network. Under the regular Medicaid program, the copay is only \$1 per prescription, with a monthly limit of five copays. Brand name drugs not on the approved formulary would have a 25 percent coinsurance rate. Emergency ambulance services are not covered under the Public Employee Health Plan or the Primary Care Network for psychiatric emergencies.

Michigan's MIFamily Includes Mental Health and Substance Abuse Benefits

Michigan Governor John Engler submitted a waiver March 1 seeking to expand the state's CHIP program, MICHild, to include more than 220,000 low-income adults. The program, called MIFamily, would cover outpatient care, prescription drugs, mental health and substance abuse services, and "limited" inpatient care for the following groups: 80,000 parents or guardians of MICHild enrollees with incomes between 51 percent and 100 percent of the FPL; disabled adults with incomes of up to \$31,188 per year; and 2,000 pregnant women with annual incomes between \$21,182 and \$23,980.

Under the proposal, full Medicaid benefits would be made available to pregnant women who earn up to 200 percent of the FPL and to individuals eligible under the Ticket to Work Act. Parents and children in families with incomes at or below 50 percent of the FPL would receive modified benefits with cost-sharing (\$5 copayment for generic medication/\$10 copayment for brand medications; \$25 emergency room copayment). This group would also receive mental health services through the state's regional community mental health centers.

Parents and children in families with incomes between 51 percent and 100 percent of the FPL would receive similar benefits, but their inpatient care benefits would be limited to \$500 per day for the first five days of a hospitalization. In addition, for children up to 100 percent of the FPL, the state proposes replacing Early, Periodic Screening, Diagnosis and Testing (EPSDT) benefits with services that meet the criteria of the National Academy of Pediatrics. The waiver proposal also seeks to expand eligibility for the County Health Plan—currently a seven-county pilot program of limited Medicaid services for medically needy individuals—to 40 counties. The Engler administration vows that services for mental health will be unchanged, and advocates note that upon initial review, optional mental health benefits appear to be intact. However, the proposal outlines a process to review the benefit and cost-sharing requirements annually, and preserves the state's ability to cap enrollment for new participants.

The state plans to use \$300 million in unused federal money earmarked for MICHild to finance the expansion. Advocates are skeptical that the proposal can be budget neutral, given that the state recently made cuts to Medicaid to wipe out a nearly \$1 billion budget deficit this year.

Oregon's Proposal Reprioritizes Benefits

The state wants to expand Oregon Health Plan (OHP) eligibility to approximately 42,000 working poor by cutting benefits for about one-quarter of the program's current beneficiaries. This proposal would increase eligibility to 185 percent of the FPL, which is \$17,600 for a family of four. Under a statute passed last summer, the state divides OHP members into two groups with different benefit packages: OHP Standard and OHP Plus. To cover the cost of expanding coverage, the state proposes to cut benefits for those who became eligible for Medicaid after it expanded the program in 1994. Pregnant women, children, and individuals with disabilities, however, would be exempt from the benefit cuts, and state officials say they intend to preserve coverage of mental health services and drug treatment.

Washington's Broad Changes Threaten EPSDT Services

The Washington state Department of Social and Health Services proposal seeks to achieve eligibility expansion by: (1) capping enrollment and proposing waiting lists, (2) implementing cost-sharing for optional services, and services accessed through EPSDT, (3) waiving mandatory service requirements, and specifically EPSDT requirements, for optional groups, (4) establishing a benefit floor, based on the state's Basic Health Plan, the "Buy-In" plan for working uninsured state residents and (5) using unspent SCHIP federal allotment to cover parents of Medicaid- and SCHIP-eligible kids and childless adults through the Basic Health Plan.

The proposal lacks detail about specific benefits changes, enrollment caps and cost-sharing requirements, raising

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NMHA Takes Center Stage at National Black Legislators' Conference

NMHA staff joined NMHA board member state Sen. Vincent Hughes, D-Penn., in November at the 25th Annual National Black Caucus of State Legislators (NBCSL) Conference in Atlanta to urge policymakers to join the fight against the stigma surrounding mental illness. The conference theme, "Our Destiny ... Our Legacy," challenged African American legislators to broaden their legislative scope, strengthen their coalitions and continue working to end healthcare disparities in communities of color in the wake of the September 11 attacks.

Hughes also introduced a new NMHA resource manual he helped develop that includes contact information for NMHA's 340-member nationwide affiliate network, and for affiliates of the National Association of Black Social Workers and the Association of Black Psychologists. The manual, "A Report on Coalition Building Opportunities on Mental Health in the African-American Community," also includes the executive summary of the recently released U.S. Surgeon General's report, "Mental Health: Culture, Race and Ethnicity."

Hughes delivered compassionate remarks regarding the mental health implications of September 11 for communities of color. "Among the many issues of priority awaiting your attention as you return to your districts, remember that mental health is paramount to one's ability to recover from any and all trauma," Hughes said. He also stressed to policymakers the importance of securing adequate resources to invest in comprehensive community mental health.

This five-day event featured a number of progressive plenaries, workshops and meetings on topics such as the September 11 attacks, state projected shortfalls for 2002, welfare reform, Medicaid managed care, and access to medication.

The "Report on Coalition Building Opportunities on Mental Health in the African-American Community" is the first of a series of culturally relevant public policy products NMHA plans to develop in collaboration with national, regional and local associations and organizations.

For more information, please contact Terri Odom, NMHA's director of Healthcare Reform Training, at 703-838-7554 or todom@nmha.org.

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concern among advocates about the blanket authority of the state to make changes that affect vulnerable populations. CMS responded to the state in January, requesting more detail about the proposed benefit design and cost-sharing requirements.

Tennessee Divides TennCare Into Service Tiers

Although the Center for Medicaid and Medicare Services (CMS) extended Tennessee's existing 1115 waiver until 2003, the state submitted a revised waiver amendment in mid-February. The proposal would divide TennCare, into three tiers:

- **TennCare Medicaid**—would provide coverage for individuals and families with mandatory eligibility for Medicaid; for pregnant women and infants with incomes of up to 185 percent of the FPL; and for women diagnosed with breast or cervical cancer.
- **TennCare Standard**—would provide coverage for uninsured residents with incomes under 250 percent of the FPL; for "medically eligible" children and adults of any income (as determined by the underwriter); and for uninsured children enrolled in TennCare as of Dec. 31, 2001, and with family incomes below 200 percent of the FPL. In addition, individuals enrolled in TennCare as "uninsurable" (in private insurance markets) as of Dec. 31, 2001, who have Medicare, will receive only pharmaceutical benefits under TennCare Standard.
- **TennCare Assist**—would provide premium assistance to low-income working people with access to group health coverage. Actual eligibility levels will be determined by annual budget appropriations.

TennCare Medicaid beneficiaries would receive current Medicaid benefits, except home health care visits would be limited to 125 per year and some services for adults (sitter services, adult cataract glasses, convalescent care and private duty nursing care) would be eliminated. All services would be provided without copayments or premiums. The state also wants to give dually eligible beneficiaries (people who are eligible for both Medicaid and Medicare) the option of receiving prescription drugs and other services through the state's managed care organization, TennCare Select. The dually eligible beneficiaries and the "uninsurable" adults who only receive a prescription drug benefit, would be assigned a primary care provider to authorize and monitor prescription drug use.

TennCare Standard beneficiaries would receive a package comparable to the state employees package and private sector basic HMO coverage. Beneficiaries with incomes of more than 100 percent of the FPL would pay premiums and

copayments (except for preventative care services for children and adults).

Behavioral healthcare coverage under TennCare Medicaid and TennCare Standard would be provided through the TennCare Partners behavioral health organization. Behavioral health prescription drugs would be available through the state pharmacy benefits program. Beneficiaries under TennCare Standard would pay a \$100 per admission copayment for inpatient services, a \$25 emergency room visit copayment (waived upon admission), and an outpatient visit copayment of \$10 for community mental health centers and \$25 for other facilities.

Substance abuse benefits for TennCare Standard beneficiaries and TennCare Medicaid beneficiaries over the age of 18 would be limited to 10 days of detoxification services and \$30,000 in lifetime benefits. TennCare Standard beneficiaries would pay a prescription drug copayment of \$5 for generic medications and \$15 for brand name medications and refills.

TennCare Assist would require an out-of-pocket maximum of \$2,000 per individual or \$4,000 per family per year. Employers would have to contribute at least 60 percent of the cost of family coverage. **SAU**

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The *State Advocacy Update* is a quarterly publication of the National Mental Health Association's Healthcare Reform program.

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