Medicaid Behavioral Health Services Database Notes and Methods

The Kaiser Family Foundation (KFF) contracted with Health Management Associates (HMA) to survey Medicaid directors in all 50 states and the District of Columbia to identify those behavioral health services covered for adult beneficiaries in their programs. The survey instrument captured information about services covered, cost sharing requirements, and notable limits on those services as of July 1, 2018. A table summarizing the number of states covering each behavioral health service is included in this document below. The behavioral health services database tables reflect what the states reported on the survey; responses vary in level of detail and were not verified through another source.

The 2018 survey asked states to report coverage of services in their fee-for-service (FFS) programs for categorically needy (CN) traditional Medicaid adults ages 21 and older. The survey did not ask about service coverage for medically needy (MN) coverage groups, which may differ from the state's CN benefit package. Children were excluded from the survey because all children under age 21 enrolled in Medicaid through the categorically needy pathway are entitled to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires states to cover any medically necessary mandatory or optional service (regardless of whether the service is covered for adults). All but four states (Illinois, Iowa, New York, and South Carolina) submitted survey responses, and the territories are not included in the 2018 data.

The list of behavioral health services included in the survey was based on the services studied in the KFF report, "Adult Behavioral Health Benefits in Medicaid and the Marketplace." States selected from a yes/no dropdown menu on the survey to indicate whether the optional Medicaid behavioral health services are covered.

Note that while this survey focused on coverage in FFS, managed care organizations contracted in states to serve Medicaid beneficiaries sometimes offer services not available on a FFS basis to their adult enrollees. In addition, managed care contracts are often based on the state plan (FFS) benefit package but some services may be carved out of managed care. States had an opportunity on the survey to note differences in required minimum benefits for Medicaid managed care organizations (MCOs), as well as differences in benefit coverage under Alternative Benefit Plans (benefit plans that Medicaid expansion states are required to design, in line with federal guidelines, for newly eligible ACA expansion adults) or Section 1115 waiver programs. To the extent that they were reported, these notes are included in the tables as state-specific footnotes. However, the level of comprehensiveness of states' responses in capturing these differences varies, and the level of information provided is likely inconsistent across states. Therefore, while the state-specific footnotes may provide useful context about coverage in an individual state, they should not be taken as a complete list of differences in benefit coverage under managed care, Alternative Benefit Plans, or Section 1115 waiver programs nationally.

Although a particular service may not be identified on a table as covered, the state is also obligated to pay Medicare coinsurance and/or deductible amounts up to specified limits for certain enrollees who are dually eligible for Medicare and Medicaid (such as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), or Qualified Individual (QI) beneficiaries) and are receiving a service covered by Medicare, even if the Medicaid program does not otherwise cover it or the individual is not otherwise eligible for Medicaid benefits.

Federal rules generally preclude states from charging copayments for emergency services, pregnancy or family planning services, or for services rendered to beneficiaries residing in institutions, such as nursing facilities. American Indians are exempted from any state Medicaid copayment requirement for services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral from one of these entities to a contracted health services provider.

Additional information on Medicaid coverage of behavioral health services is available here and here.

Medicaid Behavioral Health Services National Summary Counts

Behavioral Health Service	Service Covered in State?			# States Requiring Copayments	# States with Limits on Services
	# Yes	# No	# NR		
INSTITUTIONAL CARE AND INTENSIVE SERVICES					
Inpatient Psychiatric Hospital	43	3	5	4	17
23-hour Observation	33	13	5	3	10
Psychiatric Residential Treatment	24	22	5	0	7
Adult Group Homes	12	33	6	1	3
Crisis Services	43	3	5	3	14
OUTPATIENT FACILITY SERVICES AND/OR PROVIDER SERVICES					
Case management	30	16	5	2	12
Day treatment	34	12	5	3	16
Partial Hospitalization	33	13	5	3	12
Psychosocial rehabilitation (e.g. "Clubhouse model")	29	17	5	3	10
Intensive outpatient	34	12	5	3	9
Mental health rehabilitation	37	8	6	2	12
ADL/Skills Training	29	17	5	1	11
Assertive Community Treatment	33	13	5	2	14
Psychiatric services - evaluation	46	0	5	10	17
Psychiatric services - testing	43	3	5	7	13
Medication evaluation, prescription, and management	45	1	5	9	18
Psychological testing	46	0	5	8	19
Individual therapy	45	1	5	9	20
Group therapy	45	1	5	9	20
Family therapy	46	0	5	9	20
OTHER SERVICES					
Mental health clinic services	43	2	6	9	12
Targeted Case Management for Chronic Mental Illness	32	13	6	4	11
Peer Support Services	32	14	5	2	11
SUD SERVICES					
Inpatient detoxification	43	2	6	4	15
Residential rehabilitation	33	12	6	1	15
Outpatient detoxification	31	15	5	1	10
Methadone for MAT	41	10	0	8	15
Buprenorphine for MAT	51	0	0	21	19
Oral naltrexone for MAT	51	0	0	21	14
Injectable naltrexone for MAT	51	0	0	18	15
Suboxone treatment	44	2	5	19	19
Intensive outpatient SUD	38	8	5	5	14
Smoking and tobacco use cessation counseling (excluding mandatory coverage for pregnant women)	37	9	5	4	10

NALOXONE					
Naloxone available in at least one formulation without prior authorization	46	1	4	23	9
Nasal spray covered without PA	43	3	5	22	12
Nasal spray atomizer covered without PA	25	19	7	13	8
Auto-injectors covered without PA	10	34	7	5	1
Coverage provided for family members or friends obtaining naloxone prescriptions on enrollee's behalf	19	25	7	8	4

Source: Kaiser Family Foundation Medicaid Benefits Survey conducted by Health Management Associates, data as of July 1, 2018. See the KFF Medicaid Behavioral Health Services Database for data by state and additional notes.