Chapter II: Medicaid Benefits

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HIGHLIGHTS
MEDICAID BENEFITS

States that choose to participate in Medicaid must cover a minimum set of benefits for certain groups. States may, at their option, cover additional types of services and receive federal matching funds for the costs of those benefits. Because states have flexibility to design their own benefits packages (subject to federal minimum requirements), these vary significantly from state to state.

Services that states must cover. Most Medicaid beneficiaries are entitled to coverage for the following basic services, if the services are medically necessary:

- hospital care (inpatient and outpatient)
- nursing home care
- physician services
- laboratory and x-ray services
- immunizations and other early and periodic screening, diagnostic, and treatment (EPSDT) services for children
- family planning services
- health center (FQHC) and rural health clinic (RHC) services
- nurse midwife and nurse practitioner services

Services that states may cover. States have the option of covering additional services and receiving federal matching funds for those services, which include:

- prescription drugs
- institutional care for individuals with mental retardation
- home- and community-based care for the frail elderly, including case management
- personal care and other community-based services for individuals with disabilities
- dental care and vision care for adults

Services must be adequate in amount, duration, and scope. States have discretion to vary the amount, duration, or scope of the services that they cover, but in all cases the service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." For example, a state may not limit coverage for inpatient hospital care to 1 day per year.

Services must be offered throughout the state. States may not vary the amount, duration, or scope of covered services based on the individual's residence. For example, a state may not offer coverage for 30 hospital days per year to residents of urban areas but only 20 hospital days per year to residents of rural counties.

States may not vary the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, types of illness, or condition." For example, states may not exclude Medicaid beneficiaries with AIDS from coverage for prescription drugs, or Medicaid beneficiaries with Alzheimer's disease from coverage for nursing home care.

States may impose nominal cost-sharing on some services for some groups of beneficiaries. States may impose nominal cost-sharing on most non-emergency services, including prescription drugs. However, they may not impose any copayments (or other cost-sharing) upon children, pregnant women, and nursing home residents.

MEDICAID BENEFITS

INTRODUCTION

THE MEDICAID BENEFITS PACKAGE is broad and flexible. Its breadth reflects the differing needs of the various populations that Medicaid serves, who have more serious health needs than the general population. The types of benefits a state may cover range from prenatal and hospice care to preventive services and long-term care. The federal Medicaid program also allows states substantial flexibility to design their own benefits packages subject to certain minimum requirements. States also have the flexibility to contract with managed care plans to deliver Medicaid benefits, to use a traditional fee-for-service approach, or to use both.

The purpose of this chapter is to explain the basics of Medicaid benefits policy at the federal level.[1] It begins with a discussion of the need for services on the part of Medicaid beneficiaries and an overview of Medicaid spending on benefits. It then sets forth the federal requirements that apply to states, as well as the federal law options available to them, in establishing a Medicaid benefits package. The chapter then explains the issues raised by Medicaid managed care contracting as it relates to Medicaid services. The chapter concludes by comparing the federal Medicaid benefits package with a typical commercial product and the Medicare benefits package.[2]

I. OVERVIEW

Medicaid benefits are a defining element of Medicaid's individual entitlement. Under federal law, if a state chooses to participate in Medicaid (as all states do), then every resident of the state who meets the state's Medicaid eligibility requirements is entitled to have payment made on his or her behalf for covered services. This is a fundamentally different approach to health care coverage than a block grant to states like the State Children's Health Insurance Program (SCHIP), under which states are entitled to federal matching funds up to a specified amount, but no individual child is entitled to have payment made on his or her behalf for a specified package of benefits. The Medicaid entitlement also differs fundamentally from a defined contribution program, under which a fixed dollar amount is contributed on behalf of an individual, regardless of the scope of benefits that the dollar amount will enable the individual to purchase in the marketplace.

There is no single Medicaid benefits package. This is because states, subject to minimum federal requirements, have broad discretion to determine which categories of benefits their Medicaid programs will cover. They also have discretion to impose nominal cost-sharing on certain groups of eligible individuals with respect to certain services. The result of this broad discretion is wide variation from state to state in the scope and content of the Medicaid coverage offered to beneficiaries. This chapter does not attempt to describe Medicaid benefits policy in each state. Instead, the chapter sets forth the federal guidelines that structure the policy choices states make with respect to the Medicaid coverage they offer.

Medicaid benefits are as diverse as the population that Medicaid serves. They range from preventive services (e.g., immunizations and prenatal care), to acute care services (e.g., inpatient hospitalization and diagnostic tests), to behavioral health services (e.g., psychiatric hospitalization and counseling), to long-term care services (e.g., nursing home care and medical equipment), to supportive services that enable individuals with disabilities to work or remain in the community (e.g., personal attendant care and prescription drugs). They include both institutional and non-institutional services as well as services that are relatively inexpensive (e.g., well-child visits) and those that are extremely costly (e.g., organ transplants).

Benefits packages are shaped in part by the financing arrangements under which they are delivered. Even if they are identical on paper, benefits that are paid for on a fee-for-service basis can differ significantly in scope, quality, and accessibility from those that are delivered by managed care organizations (MCOs). The effect of managed care on Medicaid benefits can be both positive and negative. On the one hand, Medicaid beneficiaries

enrolled in Medicaid MCOs may receive more preventive and primary care services than they would in traditional fee-for-service Medicaid. Medicaid MCOs may also improve beneficiary access to services in general by providing care coordination through a clearly identifiable health care provider. In addition, Medicaid MCOs may apply any savings they achieve through efficient management of services to the provision of additional services to enrollees. On the other hand, capitation payments can create financial incentives for Medicaid MCOs to withhold approval for services that are medically necessary. In addition, the "carving out" of certain benefits categories from contracts with MCOs has the potential to create confusion on the part of Medicaid enrollees as to whether a service is covered and, if so, who is responsible for providing it.[3]

The decision by a state to cover a particular service category has important implications not just for Medicaid beneficiaries who need that service, but also for the state or local jurisdictions that are paying for (or providing) the service to their low-income residents. Because the average nominal federal matching rate is 57 percent, a state can partially refinance the costs of services its own agencies have traditionally provided at the state's expense simply by adding these services to the list of its covered Medicaid benefits.[4] A number of Medicaid service categories share this dual purpose of meeting beneficiary needs and securing partial federal financing for their costs.

Medicaid benefits have been, and continue to be, the focus of major policy debates at both the state and national level. Perhaps the most divisive of these debates concerns the circumstances, if any, under which Medicaid should cover abortion services. Issues have also arisen with respect to the administration of psychotropic drugs to Medicaid-eligible residents in nursing facilities and whether Medicaid should cover services for residents of large state facilities for individuals with mental retardation. Oregon is currently operating its Medicaid program under a highly-debated demonstration waiver in which it is testing an approach of ranking Medicaid benefits for specific medical conditions and excluding benefits for conditions considered lower priority.

II. THE NEED FOR MEDICAID BENEFITS

The Medicaid benefits package is broad. As Table 2-1 shows, there are some 30 statutory categories of services for which federal Medicaid matching funds are available. Some of these categories are "mandatory," meaning states must cover them if they choose to participate in Medicaid. Other categories are "optional," meaning states may cover them if they so choose. This breadth of Medicaid benefits reflects the diversity of the Medicaid beneficiary population and its health care needs.

In 1998, Medicaid covered 20.7 million low-income children, 8.6 million low-income adults (mostly women) in families with children, over 4 million elderly individuals (age 65 and over), and nearly 7 million individuals with disabilities. Each of these four major population groups has different health care needs, and there is also considerable variation within each group. For example, the disabled population includes individuals with physical impairments and limitations like blindness and quadriplegia; severe mental or emotional conditions, including mental illness; and other specific disabling conditions such as autism, cerebral palsy, cystic fibrosis, Downs Syndrome, HIV/AIDS, mental retardation, muscular dystrophy, and spina bifida.

A program designed to provide health care coverage to individuals with such diverse health needs will necessarily have to cover a wide range of services. Pregnant women will require prenatal and maternity care. Their children will require immunizations, lead screening, well-child care, and primary care services. If these children have disabilities, they may need appropriate specialty care, home-based care, medical equipment, or even institutional care. Working individuals with disabilities may need personal attendants, prescription drugs, and other supportive services to remain independent. Frail elderly individuals may require home health care or nursing home care. A traditional commercial insurance benefits package would not accommodate many of these needs.

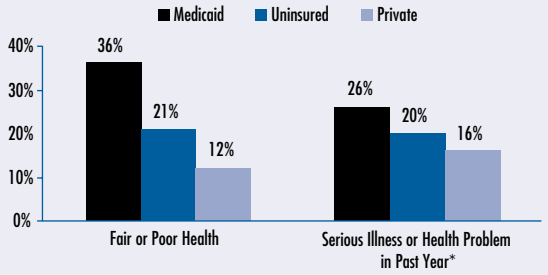
These needs are great. Medicaid beneficiaries tend to have poorer health status and greater health care needs than other individuals. As shown in Figure 2-1, Medicaid beneficiaries in general are about three times more likely to report that they are in fair or poor health than individuals with private health insurance. They are also more likely to report a serious illness or health problem within the past year than individuals with private health insurance or individuals with no coverage at all.

Not only are Medicaid beneficiaries generally in poorer health than other Americans, but aged and disabled individuals insured by Medicaid are also substantially more impaired than are other aged or disabled individuals. For example, almost 60 percent of Medicaid beneficiaries with a chronic disability are limited in their major life activity (e.g., for children, going to school and for adults, working) because of the disability, compared to 37 percent of privately insured disabled persons.

Table 2-1: Medicaid Statutory Benefits Categories[5]

Mandatory Items and Services	Optional Items and Services
Acute care	
Physicians' services	Medical care or remedial care furnished by licensed practitioners under state law
Laboratory and x-ray services	Prescribed drugs
Inpatient hospital services	Diagnostic, screening, preventive, and rehabilitative services
Outpatient hospital services	
Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	
Family planning services and supplies	Clinic services
Federally-qualified health center (FQHC) services	
Rural health clinic (RHC) services	
Nurse midwife services	
Certified nurse practitioner services	
	Primary care case management services
	Dental services, Dentures
	Physical therapy and related services
	Prosthetic devices, Eyeglasses
	TB-related services
	Other specified medical and remedial care
Long-term care	
Institutional Services	
Nursing facility (NF) services for individuals 21 or over	Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental diseases (IMD)
	Intermediate care facility for individuals with mental retardation (ICF/MR) services
	Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services	
Home health care services (for individuals entitled to NF care)	Home health care services
	Case management services
	Respiratory care services for ventilator-dependent individuals
	Personal care services
	Private duty nursing services
	Hospice care
	Services furnished under a PACE program
	Home- and community-based (HCBS) services (under waiver, subject to budget neutrality requirements)

Figure 2-1: Health Status by Insurance Coverage, 1997

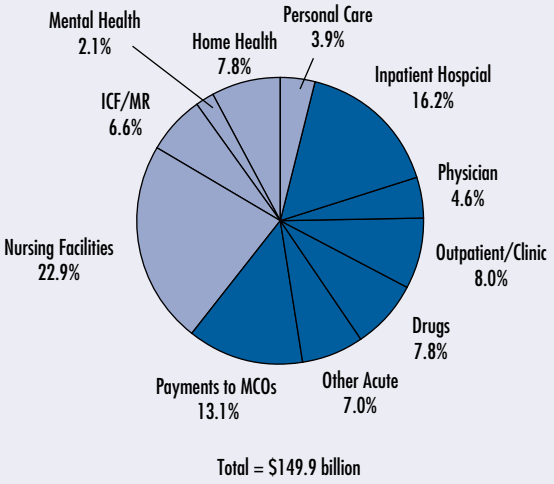


*Respondent or family member

SOURCE: The Kaiser/Commonwealth 1997 National Survey of Health Insurance

Similarly, low-income elderly people who are enrolled in Medicaid are in poorer health than higher income elderly people. Over 40 percent of poor and near-poor (income below 200% of the federal poverty level) elderly people perceive their health to be fair or poor, compared to 20 percent of elderly people with incomes above 200 percent of the poverty level. Poor and near-poor elderly people are also more likely to suffer from chronic conditions that require on-going medical treatment, including arthritis, hypertension, and diabetes.

Figure 2-2: Medicaid Spending on Services, 1998



Note: Does not include DSH payments or payments to Medicare. Lab and X-ray services included in site of receipt of service.

SOURCE: Urban Institute estimates, 2000, based on HCFA-2082 and HCFA-64 reports.

III. MEDICAID SPENDING ON BENEFITS

From the standpoint of federal and state expenditures, all Medicaid benefits categories are not created equal. As Figure 2-2 illustrates, more than one fifth of all Medicaid dollars spent on services in 1998 was used to purchase nursing facility care, and about one sixth was used to buy inpatient hospital care. Payments to MCOs (13 percent) and prescription drugs, home health services, and outpatient/clinic services (each about 8 percent) were the next largest expenditure categories.

Spending on Medicaid benefits can also be examined by distinguishing acute services from long-term care services. Of the $150 billion that the federal and state governments spent on Medicaid benefits in 1998, just over 43 percent was spent on long-term care services, primarily nursing facility care and home health services. The remaining 57 percent was spent on acute care services such as hospital care, physician services, and prescription drugs (Figure 2-2).

When viewed from the perspective of national health expenditures, Medicaid spending on benefits is significant. In 1998, the program paid for nearly 16 percent of what the U.S. spent on personal health services. However, Medicaid's role varies from service to service. For example, Medicaid (including both federal and state outlays) paid for about 7 percent of all physician services, 16 percent of all hospital care, and 46 percent of all nursing home services in 1998.[6]

These national data mask substantial variation in benefits spending trends from state to state. As shown in the Exhibit on pages 73–75, which contains state-by-state Medicaid benefits expenditure data for 1998, the breakdown of spending on particular benefits in some states departed significantly from the national pattern shown in Figure 2-2. For example, in Connecticut, over 29 percent of Medicaid spending was for nursing facility care, while in Oregon, the corresponding figure was only about 10 percent. Similarly, Alaska spent over 11 percent of its Medicaid dollar on physician, lab, and x-ray services, while Maryland, Rhode Island, and Tennessee each spent less than 1 percent.

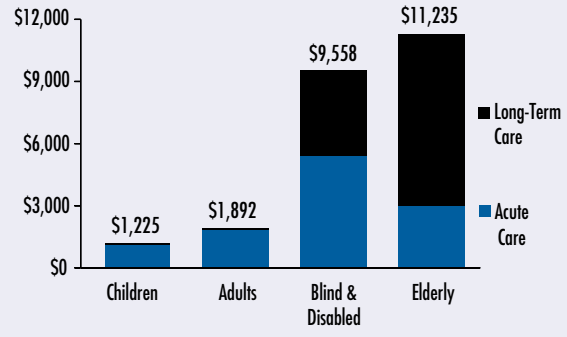
Medicaid spending on services reflects a number of different factors that vary in importance from state to state. As discussed below, states have substantial (but not absolute) discretion as to which benefits to cover and how broadly to define the scope of each benefit covered. States also have considerable discretion in determining how much to pay for a service and whether to pay for it on a fee-for-service or capitated basis. In addition, states, through their licensure authority, can try to control spending by limiting the supply of providers (such as nursing homes) that are qualified to furnish covered services to program beneficiaries.[7] Finally, the

mix of Medicaid beneficiaries may differ significantly from state to state, with some states having a greater proportion of relatively higher-cost beneficiaries (such as elderly or disabled individuals needing expensive nursing home care).

As a group, the elderly tend to be the most expensive of the four major Medicaid beneficiary groups on a per enrollee basis. In 1998, per capita spending on elderly Medicaid beneficiaries was over nine times as great as per capita spending on children (Figure 2-3). Similarly, Medicaid spending per enrollee for adults with disabilities was over five times as large as that for non-disabled adults. Figure 2-3 makes clear that much of the difference in per enrollee spending among the four population groups is based on the greater need for, and use of, long-term care services by the elderly and disabled.[8]

Note that over 13 percent of all Medicaid benefits spending in 1998 is classified as payments to MCOs (Figure 2-2). Most Medicaid MCOs receiving payments from states assume responsibility for providing a range of acute care services to enrolled Medicaid beneficiaries, including physician services, diagnostic services, inpatient hospital services, and prescription drugs. However, the data are not available to determine what portion of the payments made to MCOs is spent on benefits (as opposed to administration, marketing, and other purposes), much less what portion is spent on the various benefits categories. Under current reporting practices, as more Medicaid beneficiaries are enrolled in MCOs and more Medicaid benefits dollars flow to those organizations, policy makers and analysts will have less and less national (or state-level) data on Medicaid spending by benefits category.

Figure 2-3: Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 1998



Note: Expenditures do not include DSH, adjustments, or administrative costs.

SOURCE: Urban Institute estimates, 2000, based on HCFA-2082 and HCFA-64 Reports.

There are three types of Medicaid expenditures that are related to benefits expenditures. The first, payments to Medicaid disproportionate share (DSH) hospitals, is closely linked to Medicaid's inpatient hospital benefit. Another involves payments to public hospitals or public nursing homes made under upper payment limits (UPLs) and transferred to state governments through intergovernmental transfers (IGTs). Both of these types of payments are made to providers of covered services, but do not represent payment for a specific service on behalf of a particular beneficiary. (See Chapter 3: Medicaid Financing)

The other type of Medicaid expenditure related to benefits is the payment that state Medicaid programs make on behalf of certain low-income Medicare beneficiaries to defray the costs of Medicare's monthly Part B premiums and, in some cases, Medicare's deductible and coinsurance requirements. These payments reduce the financial burden of the Medicare program's premium and cost-sharing requirements on low-income Medicare beneficiaries.[9] However, they are not spending for benefits in and of themselves.

IV. MEDICAID SERVICE CATEGORIES

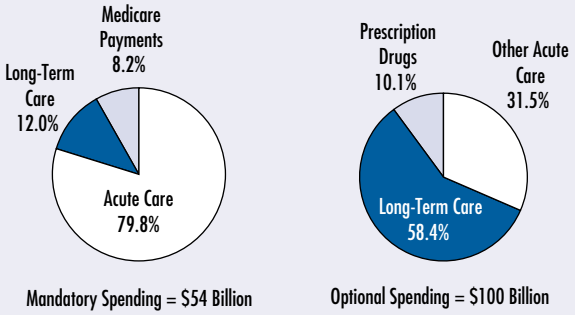
Medicaid services fall into one of two broad statutory groups: "mandatory" and "optional." The services that a participating state *must* cover are known as "mandatory" services; the others, which they may also cover, are referred to as "optional" services. Since state participation in the Medicaid program is voluntary, no state is required to cover any of the 30 or so federal statutory categories of Medicaid benefits. However, if a state wants federal Medicaid matching funds to help it pay for the costs of acute care services for its low-income residents, and for the costs of long-term care and behavioral health services for its low-income disabled and elderly residents, it must cover specific categories of services for certain groups of Medicaid beneficiaries.[10]

Most of the spending on Medicaid benefits is for optional services. As shown in Figure 2-4, of $154 billion in federal and state Medicaid spending on benefits in 1998, $100 billion, or 65 percent, was spent on optional services. Over half of optional spending went toward the purchase of nursing facility and other long-term care. Of the remaining $54 billion in spending for mandatory services, 80 percent covered hospital, physician, and other acute care services.[11]

The distinction between "mandatory" and "optional" services is purely a matter of the terms on which federal Medicaid matching funds are available to the states for the costs they incur in paying for the service. The

distinction has nothing to do with whether a beneficiary needs a particular service or whether one service is of greater medical importance than another. For example, the Medicaid statute treats prescription drugs as an "optional" benefit, even though they are obviously integral to the treatment of many of the illnesses or conditions that Medicaid beneficiaries experience, and even though every state covers them. Similarly, the distinction has nothing to do with the rate at which

Figure 2-4: Mandatory and Optional Medicaid Spending by Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

federal Medicaid matching funds are available to a state; each state can claim federal matching dollars at its regular rate (the average nominal federal matching rate is 57 percent) for the costs of services, whether the service is "mandatory" or "optional."[12]

"Mandatory" Services

The following 12 service categories are "mandatory" in all states participating in Medicaid (Table 2-1):

- Physicians' services—services furnished by or under the personal supervision of a physician or osteopath within the scope of practice under state law, whether in the practitioner's office, a hospital, or elsewhere.
- Laboratory and x-ray services—professional and technical laboratory and radiological services (1) ordered and provided by or under the direction of a physician or other licensed practitioner, or ordered by a physician and provided by a referral laboratory and (2) furnished by a laboratory that meets the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- Inpatient hospital services—services that are (1) ordinarily furnished in a hospital for the treatment of inpatients, (2) furnished under the direction of a physician or a dentist, and (3) furnished in an institution that is licensed by the state and meets the requirements for participation in Medicare as a hospital.
- Outpatient hospital services—preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished (1) to outpatients, (2) by or under the direction of a physician or dentist, and (3) by an institution that is licensed by the state and meets the requirements for participation in Medicare as a hospital.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under age 21—(1) screening services at periodic intervals (including a comprehensive health and development history, physical exam, appropriate immunizations, laboratory tests including lead blood level assessments, and health education); (2) vision services, including eyeglasses; (3) dental services; (4) hearing services, including hearing aids; and (5) other necessary health care, diagnostic services, and treatment necessary to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not these "follow-up" services are otherwise covered under the state's Medicaid program.
- Family planning services and supplies—no federal statutory or regulatory definition.
- Federally-qualified health center (FQHC) services—ambulatory care services (including physicians' services, physician assistant and nurse practitioner services, and preventive primary health services) furnished by an entity that is receiving a federal grant as a community health center under section 330 of the Public Health Service Act, or meets the requirements for receiving such a grant.
- Rural health clinic (RHC) services—ambulatory care services (including physicians' services and physician assistant and nurse practitioner services) furnished by an entity certified as a rural health clinic for Medicare purposes.
- Nurse-midwife services—services furnished by a nurse-midwife within the scope of practice under state law, whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider (unless required under state law).
- Certified pediatric nurse practitioner or family nurse practitioner services—services furnished as authorized

under state law by a registered professional nurse who meets a state's advanced educational and clinical practice requirements, whether or not the practitioner is under the supervision of, or associated with, a physician or other health care provider.

- Nursing facility (NF) services for individuals 21 or over—services provided in a facility that is licensed by the state and is certified as meeting the requirements applicable to nursing facilities under the federal Medicaid statute and regulations.

- Home health care services (for individuals entitled to NF care)—services provided to a beneficiary at his or her place of residence on his or her physician's orders as part of a written plan of care, including at a minimum: (1) part-time or intermittent nursing services furnished by a home health agency that meets Medicare participation requirements; (2) home health aide services provided by a home health agency that meets Medicare participation requirements; and (3) medical supplies, equipment and appliances suitable for use in the home.

Transportation services are not formally a statutory benefits category. However, states are required to ensure necessary transportation for beneficiaries to and from providers. In addition, as part of the EPSDT benefit, states are required to offer to eligible children and their families "necessary assistance with transportation" to and from providers. Federal Medicaid matching funds are available for transportation expenses, which include the costs of ambulance, taxicab, or bus or subway, as well as the cost of an attendant if necessary. States may treat some transportation services as administrative costs that are matched at the general 50 percent administrative matching rate, rather than at the state's regular rate for services.

"Optional" Services

No state offers only mandatory services in its Medicaid program. All states also cover several, if not most, of the optional service categories. In some states, Medicaid fee-for-service expenditures for optional services in 1998 were greater than such expenditures on mandatory services (Delaware, Kansas, Maine, New Hampshire, Oregon, Utah, Vermont, and Washington).[13]

A full listing of the statutory optional service categories may be found in Table 2-1. The principal optional services, covered by virtually every state, are:

- Prescription drugs—simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are (1) prescribed by a physician or other licensed practitioner, (2) dispensed by licensed pharmacist and licensed authorized practitioners, and (3) dispensed on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

- Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR) services—items and services furnished in an ICF/MR if certain conditions are met, including (1) the facility fully meets the requirements for a state license to provide services that are above the level of room and board, (2) the primary purpose of the facility is to furnish health or rehabilitative services to persons with mental retardation or persons with related conditions, and (3) the facility meets federal regulatory conditions of participation.

- Personal care services—services furnished to an individual who is not an inpatient that are (1) authorized for the individual by a physician in accordance with a plan of treatment, (2) provided by an individual who is qualified to provide such services and is not a member of the beneficiary's family, and (3) furnished in a home or, at state option, in another location.

- Targeted case management services—services which will assist beneficiaries in gaining access to needed medical, social, educational, and other services.

Waiver Services

Every state covers home- and community-based (HCBS) services for frail elderly or disabled individuals at risk of institutional care.[14] (These services are also known as "1915(c) waiver" services, after the section of the Social Security Act that authorizes federal Medicaid matching funds.) These services are optional for the states—that is, states are not required, as a condition of participation in Medicaid, to cover them for any group of beneficiaries. However, there is an important legal and administrative difference between waiver services and the optional services described above.

In the case of non-waivered optional services, states may elect to cover them and receive federal matching payments for their costs of coverage without demonstrating to the Centers for Medicare & Medicaid Services (CMS, formerly known as the Health Care Financing Administration, or HCFA) that coverage would be budget neutral to the federal government. In contrast, a state that wants to offer home- and community-based services must obtain a waiver from CMS by showing that the average per capita Medicaid expenditure estimated by

the state with respect to individuals covered by the waiver each fiscal year will not exceed the average per capita expenditure that the state would make in the absence of the waiver.[15] These section 1915(c) waivers should not be confused with section 1115 waivers, described below.

HCBS services include a wide range of non-institutional, long-term care services. Some of these, notably case management services and personal care services, overlap with existing optional service categories. States that wish to cover these services only with respect to frail elderly or individuals with disabilities at risk of institutionalization may do so under a section 1915(c) waiver.

Other HCBS services do not overlap with any mandatory or optional service categories. For these services, federal Medicaid matching funds are available only under a section 1915(c) waiver and only for those individuals covered under the waiver. These services include homemaker/home health aide services, adult day health services, habilitation services, and respite care. Habilitation services are defined in the federal statute as "services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings." These include prevocational, educational, and supported employment other than those available under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973. For individuals with chronic mental illness, HCBS services include day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

Targeted Benefits

As one might expect from a program that reaches so many different populations, not all Medicaid benefits categories are conventional in their structure and function. Some categories are population-specific, while others are applicable to most of the populations served by the program. Some benefits categories are, in effect, mechanisms to ensure the participation of certain classes of providers or to apply minimum quality standards. Finally, some benefits categories are subject to Congressionally-directed exclusions.

Population-specific Benefits. A number of Medicaid benefits categories are population-specific. For example, the EPSDT benefit, which covers among other things preventive services, is limited to children under 21. While there is policy logic for the coverage of preventive services for individuals 21 or older, there is no such mandatory benefit category. States may, however, elect to cover preventive services under one of the optional benefits categories for their entire Medicaid population.[16]

The EPSDT benefit is special in another way. If an eligible child is discovered, through an EPSDT screening, to need diagnostic or treatment service in order to correct or ameliorate defects, physical and mental illnesses, or conditions, the child is entitled to have payment made for the services "whether or not such services are covered" under the state's Medicaid program, so long as the service is in one of the 30 or so statutory categories summarized in Tables 2-1. For example, if as a result of an EPSDT screen it is determined that a child needs extensive physical therapy services, and those services are not covered under the state's Medicaid program, the child is still entitled to coverage for those services.[17]

Family planning services and supplies are another benefit targeted to a specific population. Though this mandatory benefit category has never been defined in regulation, CMS has issued guidelines clarifying that states may cover "counseling services and patient education, examination and treatment by medical professionals in accordance with applicable state requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals."[18] This benefit is key to ensuring access to reproductive health services needed by low-income women and teens eligible for Medicaid.[19] Medicaid accounts for half of all public dollars spent for family planning in the United States.[20]

Yet another example of a population-specific benefit is "TB-related" services. This benefit is specific to individuals infected with tuberculosis who meet certain income and resource requirements but are not otherwise eligible for Medicaid. A state can elect to cover such individuals as an optional eligibility group. For this population, TB-related services are: prescribed drugs, physicians' services, outpatient hospital services, clinic services, FQHC services, RHC services, laboratory and x-ray services, case management services, and services "designed to encourage completion of regimens of prescribed drugs by outpatients, including services to directly observe the intake of prescribed drugs."

"Targeted" case management services is another example of a population-specific benefit. This optional benefit category covers services "which will assist [Medicaid beneficiaries] in gaining access to needed medical, social, educational, and other services." Although case management services are applicable to most if not all of the populations served by Medicaid, states have the

option to limit or "target" this benefit to particular subpopulations, including individuals with AIDS or AIDS-related conditions and individuals with chronic mental illness. In addition, states may, without a waiver from the Secretary of Health and Human Services (HHS), limit case management services to particular subpopulations residing in certain cities, counties, or regions within the state. States may also receive federal matching funds for covering case management services under other benefits categories or as administrative costs.[21]

Provider-specific Benefits. Some Medicaid benefits categories have the function of ensuring participation by, or direct payment to, certain types of providers. For example, the mandatory FQHC and RHC benefits categories require state Medicaid programs to cover and pay for ambulatory services furnished to Medicaid beneficiaries by those particular providers, even if those ambulatory care services could also be provided by office-based physicians or hospital outpatient departments. Similarly, the mandatory benefits categories for nurse-midwife services and certified pediatric and family nurse practitioner services require that state Medicaid programs cover and pay for services of those practitioners directly, rather than through a physician, clinic or hospital by whom they may be employed.

Benefits Tied to Quality Standards. Some Medicaid benefits categories are designed to improve the quality of covered services. As a general rule, most practitioners or institutional providers that wish to participate in Medicaid must be licensed under state law. In some instances, however, meeting state licensure standards is not sufficient to receive federal Medicaid matching funds for serving Medicaid beneficiaries. For example, the mandatory nursing facility benefit incorporates into the definition of "nursing facility" an extensive set of requirements relating to the provision of services, residents' rights, and facility administration that are intended to improve the quality of care and the quality of life for Medicaid beneficiaries and other residents. Similarly, CMS by regulation has prohibited psychiatric residential treatment facilities receiving Medicaid payments from using drug or physical restraints or involuntary seclusion against children and adolescents except in emergency circumstances.[22]

Sterilization is another example. Generally, sterilizations and hysterectomies are reimbursed as physicians' services. However, abuses of these procedures led to the issuance in 1978 of federal regulations banning federal Medicaid matching payments for sterilization of mentally incompetent or institutionalized individuals. In the case of other eligible individuals, federal matching funds are only available for sterilizations and hysterectomies if specified procedures regarding voluntary, informed consent are followed.[23]

Congressionally-directed Exclusions. The mandatory benefits category of physicians' services illustrates how Congress can exclude certain services from the Medicaid benefits package. As discussed above, physicians' services are "services furnished by or under the personal supervision of a physician or osteopath within the scope of practice under state law …" In general, abortion services are within the scope of practice for a physician under state law.[24] Since 1977, however, Congress, in annual appropriations bills, has barred the payment of federal Medicaid matching funds for the costs of abortions except under the circumstances specified in the Hyde Amendment. The version of this Amendment that is applicable during Fiscal Year 2001 specifies two exceptions to the prohibition: "(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."[25] Under the Hyde Amendment, states are permitted to spend their own funds on abortions for which federal matching funds are not available because they do not fall into one of the two exceptions. However, all abortions that do fall into either of these exceptions "are medically necessary services and are required to be provided by states participating in the Medicaid program."[26] CMS has also extended the Hyde Amendment restrictions to coverage of Mifepristone (Mifeprex, or RU-486).[27]

V. STATE FLEXIBILITY

Each state's Medicaid benefits package is unique. In part, this is because states make different choices about placing limitations on the services they are required to cover. This is also because states make different choices among the services that they are allowed to cover. This section discusses the federal requirements within which states can make these benefits design decisions.[28]

Flexibility to Limit Benefits

Discretion to limit the scope of services is available to states without a waiver from the Secretary of HHS and applies to both mandatory and optional services. This discretion is not absolute; it is subject to statutory and regulatory protections for beneficiaries under Medicaid law. These protections are the requirements relating to

"amount, duration, and scope;" "comparability;" and "statewideness."[29] However, these protections are subject to waiver for demonstration purposes by the Secretary, as discussed below. State discretion in benefits design is also subject to the requirements of other applicable federal laws, such as the Americans with Disabilities Act (ADA).

Amount, Duration, and Scope. Each service category that a state covers under its Medicaid program must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." This requirement applies to both mandatory and optional service categories. There is no precise federal regulatory definition of this requirement; as a result, disputes over "sufficiency" may find their way into the courts. For example, federal courts have upheld state limits on the number of covered physician visits (e.g., 3 per month) and hospitalizations (e.g., 14 days per year).

There is one Medicaid benefit that is not subject to amount, duration, or scope limitations: EPSDT services for children under 21. As discussed above, "follow-up" diagnostic and treatment services are covered for children who are determined to need them as a result of an EPSDT screening, regardless of whether the state's Medicaid plan otherwise covers the service. For example, in a state that limits coverage of physician services to three visits per month, a child who was determined through an EPSDT screening to require four visits per month would be entitled to have payment made on her behalf for all four visits.[30]

Comparability: No Discrimination Based on Diagnosis, Type of Illness, or Condition. Medicaid benefits must not only be "sufficient" in amount, duration, and scope, they must also be comparable. More specifically, the package of services that the state makes available to an individual who is eligible as a "categorically needy" individual—e.g., poverty-level children—must be equal to that offered to any other "categorically needy" individual—e.g., disabled SSI recipients. In addition, these services may not be less in amount, duration, and scope than the services available to any other "categorically needy" individual. Thus, if a state Medicaid program covers all medically necessary physician services for one "categorically needy" individual—e.g., an elderly SSI recipient—it must also cover all medically necessary physician services for all other individuals in this category (i.e., elderly and disabled SSI recipients) as well as individuals in other categorically needy groups, i.e., poverty-level children. The state is not, however, required to cover all medically necessary physician services for any "medically needy" group, whether elderly, disabled, or children. (See Chaper 1: Medicaid Eligibility)

Note that the comparability requirement applies to all "categorically needy" eligibility groups—those who are "optional categorically needy," such as children under age six with a family income above 133 percent of the federal poverty level, as well as those who are "mandatory categorically needy," such as a children under age six with a family income at or below 133 percent of the federal poverty level. Thus, a state must cover EPSDT services for all "categorically needy" children enrolled in its Medicaid program, whether those children are in an optional or mandatory eligibility group.

An important corollary to this comparability rule is the prohibition against discrimination based on diagnosis with respect to mandatory services. Specifically, Medicaid agencies "may not arbitrarily deny or reduce the amount, duration, or scope of a required service … to an otherwise eligible [beneficiary] solely because of the diagnosis, type of illness, or condition." Thus, a state could not, for example, deny coverage for inpatient hospital services to disabled SSI recipients with HIV infection (as opposed to some other disability) or deny coverage of nursing facility services to elderly SSI recipients with Alzheimer's disease (as opposed to some other chronic condition). Note that this prohibition applies even in the case of Medicaid beneficiaries whose eligibility depends upon a particular diagnosis, such as women in need of treatment for breast or cervical cancer.[31]

Statewideness. In general, states are required to make their Medicaid benefits package available to all eligible individuals, regardless of the location of their residence within the state. This rule applies to both mandatory and optional benefits. For example, a state that covers optional prescription drugs must make that coverage effective in both its rural and its urban areas.

There are, of course, exceptions to this general rule. As noted above, the "targeted" case management services benefit allows a state to limit its coverage not just to particular subpopulations like the chronically mentally ill, but also to particular geographic areas within the state. Similarly, the HCBS waiver services can be restricted to target populations residing in particular areas within the state. Finally, states may obtain waivers of this "statewideness" requirement in order to conduct demonstrations under section 1115 of the Social Security Act, as evidenced by the waiver in place in Los Angeles County.[32]

"Medical Necessity." Medicaid beneficiaries are entitled to have payment made on their behalf for covered services that are "necessary." In the case of Medicaid eligibles who are under age 21, the federal Medicaid statute, as part of the EPSDT benefit, requires the

coverage of services that are necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the [EPSDT] screening services." However, there is no federal statutory or regulatory definition of "medical necessity" for benefits other than EPSDT.[33]

State definitions of "medical necessity" vary widely. One of the more restrictive definitions is that adopted by California during the mid-1980s and upheld by the state courts. This definition limits Medicaid benefits to those services necessary "to protect life, to prevent significant disability or illness, or to alleviate severe pain." In contrast, commercial health insurance products have traditionally defined medically necessary services as those that are "in accordance with generally accepted standards of medical practice."[34] This commercial standard would commonly allow payment to be made for physician or hospital services to prevent disability, even if the disability is not "significant," or to alleviate pain, even if the pain is not "severe."

State discretion to define "medical necessity" was recently addressed in the context of coverage for medical equipment (ME), which is a component of the mandatory home health services benefit. The issue was prompted by Connecticut's use a of list of pre-approved items of medical equipment. Medicaid beneficiaries seeking an item of ME not on the list had to establish not that the item was medically necessary for them individually, but that the absence of the item rendered the list unreasonable and inadequate with respect to the needs of the Medicaid population of the state. The State's approach was upheld by the United States Court of Appeals for the 2nd Circuit in 1998, which noted that "an individual with a rare condition or unusual needs, who must have a costly item of [ME] that Connecticut has not chosen to cover and that is needed by a handful of the Medicaid population, will have to look for other sources of assistance."[35] Subsequent to this ruling, CMS issued an interpretive guidance to State Medicaid agencies contrary to that of the 2nd Circuit: "In evaluating a request for an item of ME, a State may not use a 'Medicaid population as a whole' test, which requires a beneficiary to demonstrate that, absent coverage of the item requested, the needs of 'most' Medicaid recipients will not be met. This test, in the ME context, establishes a standard that virtually no individual item of ME can meet."[36]

The enrollment of Medicaid beneficiaries in managed care organizations (MCOs) has added a further level of complexity to the "medical necessity" limitation. The definition of "medical necessity" used by an MCO is often, but not always, specified in the risk contract between the state Medicaid agency and the MCO.[37] In those cases where it is not, there is a potential that the MCO may use a more restrictive definition of "medical necessity" than that in use by the state Medicaid agency in its fee-for-service program. Because MCOs operate under financial incentives to reduce the provision of services, the application of a more restrictive definition of "medical necessity" by an MCO could result in the denial of covered services to Medicaid enrollees that might not occur to Medicaid fee-for-service beneficiaries with similar medical illnesses or conditions. Because Medicaid is an individual entitlement program, states remain responsible "for all benefits in the state Medicaid plan not offered by [the MCO]."[38]

"Experimental." States have the discretion to deny payment for services that are otherwise covered and "medically necessary" if the service is "experimental." Again, there is no federal statutory or regulatory definition of "experimental;" however, many states have established criteria for identifying experimental services or procedures. The application of this allowable limitation for denial of coverage for items and services such as organ transplants and AIDS drugs has resulted in litigation, with federal courts both sustaining and rejecting the denials of coverage in individual instances. With respect to organ transplants, the federal Medicaid statute does not require that states cover such procedures, but if they elect to do so, states must have written standards under which "similarly situated individuals are treated alike."

One new technology that states are not able to exclude as "experimental" is FDA-approved prescription drugs. Under the federal Medicaid drug rebate program, a state that opts to cover outpatient prescription drugs must cover, for their medically-accepted indications, almost all FDA-approved prescription drugs of manufacturers that have entered into drug rebate agreements with the Secretary of HHS.[39] For this reason, for example, CMS has advised state Medicaid agencies that their programs are required to extend coverage to include FDA-approved protease inhibitors[40] and Viagra when medically necessary.[41] (States may impose prior authorization requirements on these and other covered outpatient prescription drugs.)[42]

Waivers. Under section 1115 of the Social Security Act, the Secretary of HHS has broad authority to waive statutory and regulatory provisions in federal Medicaid law to enable states to engage in demonstrations while continuing to receive federal matching funds.[43] For example, effective December 1, 1999, the Secretary approved a five-year demonstration project to extend only family planning services to men and women of child-bearing age residing in California who have family

incomes no greater than 200 percent of the federal poverty level and who would otherwise not be eligible for Medicaid coverage. Under the waiver, family planning services will be matched at the standard 90 percent rate by the federal government, while follow-up diagnostic tests, treatment for sexually transmitted infections (STIs) and complication services delivered in a family planning setting (e.g., not on an inpatient hospital basis) will be matched at California's regular matching rate (currently about 50 percent).

In one instance, the Secretary has waived the basic "comparability" requirement and allowed a state to limit Medicaid benefits on the basis of diagnosis. Under the Oregon waiver, first approved in 1993 and extended for an additional three years in 1998, the Medicaid benefits package has been rearranged into a listing of 743 "condition/treatment" pairs, ranked by priority.[44] For example, the pair with the highest ranking is severe/moderate head injury/medical and surgical treatment. The state covers only those condition/treatment pairs that are "above the line"—i.e., above the threshold set by the state subject to budget considerations, which was set at pair number 574 in 1999. A recent review of the initial experience under the waiver concluded, "Oregon decided to ration services rather than ration people in its design of the [Medicaid waiver]. In the face of budget shortfalls, the state reduced benefit scope rather than restrict eligibility."[45]

In August 2001, the Secretary issued a new set of guidelines for section 1115 waivers that would give states additional flexibility with respect to Medicaid benefits design. Through this Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, the Administration "strongly encourages State proposals that would further integrate, or at a minimum coordinate, Medicaid and SCHIP funding with private health insurance options."[46] Among other things, the HIFA waivers would allow states to reduce both the mandatory and optional services offered to any optional eligibility groups and to increase the cost-sharing requirements imposed on those groups. HIFA waivers have potentially far-reaching implications for Medicaid coverage, since optional eligibility groups account for more than two-fifths of all Medicaid spending on benefits.[47]

No Discrimination on the Basis of Disability. The allowable limitations on benefits discussed above all derive from the federal Medicaid statute. However, because Medicaid is a form of federal financial assistance, other cross-cutting federal laws apply. Among these is the Americans with Disabilities Act (ADA) of 1990. Because over seven million Medicaid beneficiaries, accounting for about 40 percent of all Medicaid spending, are individuals with disabilities, the ADA has important implications for the design of Medicaid benefits packages and the individual service categories.

The ADA prohibits a public entity, such as a state Medicaid program, from discriminating against a qualified individual with a disability "by reason of such disability." Federal regulations implementing the ADA require that public entities administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." These regulations also require public entities to make "reasonable modifications" to avoid discrimination on the basis of disability; however, the entity is not required to make changes that would "fundamentally alter" its programs.

The application of these ADA requirements to Medicaid benefits is still evolving. When Oregon initially applied for its waiver in 1991, CMS conditioned its approval in part on a showing that the state's listing of condition/treatment pairs would meet ADA requirements. More recently, the Supreme Court, in *Olmstead v. L.C.,* 119 S. Ct. 2176 (June 22, 1999), ruled that the ADA's "most integrated setting requirement" may require states to place persons with mental disabilities in community settings rather than in institutions, if certain conditions are met.[48] The Court held that "States must adhere to the ADA's non-discrimination requirement with regard to the services they in fact provide," but that the ADA did not require states to provide a certain level of benefits to individuals with disabilities. Depending on how the lower federal courts, CMS, and the Office for Civil Rights (OCR) interpret *Olmstead,* states that already cover some HCBS waiver services may be required to offer that coverage to Medicaid-eligible individuals with mental disabilities residing in institutions so they can return to the community.[49] However, states that do not cover any HCBS waiver services may not be required to offer them. CMS and OCR have issued guidance to State Medicaid Directors on the implementation of the *Olmstead* decision recommending that states develop comprehensive, effective working plans to strengthen community service systems.[50]

The ADA's requirements are also being applied in the context of particular Medicaid benefits categories. For example, New York has elected to cover personal care services, including assistance with personal hygiene, dressing, feeding, and other activities of daily living. New York's personal care services benefit does not include "safety monitoring," i.e., payment for a caregiver in the beneficiary's home to ensure that the beneficiary does not injure herself. The absence of coverage of safety monitoring as a service was challenged by Medicaid beneficiaries with cognitive impairments such as Alzheimer's disease. They argued that, without "safety

monitoring," they are unable to receive other personal care services or remain in their homes. In *Rodriguez v. City of New York,* 197 F.3rd 611 (2nd Cir. 1999), the Second Circuit Court of Appeals ruled that the ADA does not require New York to include "safety monitoring" in its Medicaid personal care service benefit. The Second Circuit reasoned that because New York does not cover "safety monitoring" services for any groups of Medicaid beneficiaries, it does not discriminate against those with mental disabilities.[51]

Flexibility to Expand Benefits

Medicaid offers states the opportunity to cover a wide range of services with federal matching funds. First, as discussed above, states can elect to cover over 20 different statutory categories of optional services. Further, many of these optional categories (e.g., "diagnostic, screening, preventive, and rehabilitative services") are themselves quite broad and could accommodate multiple benefits.

Some states have drawn on the breadth of Medicaid benefits definitions to incorporate additional services into their Medicaid programs. For example, many states have implemented Assertive Community Treatment (ACT) programs for beneficiaries with schizophrenia. These programs use interdisciplinary treatment teams with shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment in clients' own environment, and individualized treatment, including medication, rehabilitation, and support services, and, as CMS noted in a letter to state Medicaid directors, "can be supported under existing Medicaid policies."[52] In another example, Rhode Island's Medicaid program covers the cost of replacing windows in the homes of children diagnosed with lead poisoning during EPSDT blood lead level screenings.[53]

The flexibility in Medicaid benefit design also allows states to adopt new standards of care without requiring a change in Medicaid law as those standards are developed. In some instances, CMS has notified states that newly-available services may be covered under existing optional benefit categories and has encouraged states to include them in their Medicaid programs. For example, CMS alerted states to the fact that federal matching funds are available for HIV viral load tests[54] and HIV resistance testing[55] as Medicaid benefits. CMS has also made it clear that disease management programs for conditions such as asthma qualify for federal matching funds under the optional "medical or other remedial care" benefits category.[56] In addition, CMS has explained that, although telemedicine is not a distinct Medicaid benefit, federal Medicaid matching funds are available at state option for "services furnished through telemedicine applications," such as physician consultation.[57]

In other instances, these benefits fall under mandatory service categories, and CMS informs states of the expanded definition of a benefit. For example, CMS informed states of new guidelines on treating tobacco use and dependence, advising states to incorporate the new Agency for Healthcare Research and Quality (AHRQ) smoking cessation drug therapy and counseling programs into their Medicaid program and reminding them that such services fall under the mandatory EPSDT and pregnancy-related care categories.[58]

VI. COST-SHARING OPTIONS

From an actuarial standpoint, the benefits package of a private or public insurer is the combination of two elements: the services covered and the cost-sharing requirements applicable to those services. Cost-sharing refers to out-of-pocket payments that Medicaid beneficiaries are required to make in connection with the receipt of a covered service.[59] These payments take three main forms: (1) deductibles, or specified dollar expenditures that must be incurred before the program begins to pay for a covered service; (2) copayments, or fixed amounts that beneficiaries must pay when they receive a service; and (3) coinsurance, or amounts that beneficiaries must pay at the point of service that are based on a fixed percentage (e.g., 20 percent) of the amount that the program recognizes as payment for the particular service. Note that premiums are not technically cost-sharing, even though they involve out-of-pocket payments by beneficiaries toward the cost of their coverage. That is because premium requirements govern whether an individual is eligible for coverage; deductibles and copayments, in contrast, govern an individual's financial liability for a service for which the individual has established coverage.

The amount that a Medicaid beneficiary pays toward a covered service may not exceed whatever allowable cost-sharing requirements (such as deductibles and copayments) a state has imposed. However, if the state Medicaid program does not cover an item or service, beneficiaries would generally be liable for the costs. For example, in a state that limits payment for inpatient hospital care to 14 days per year, a beneficiary would be liable for the costs of any additional inpatient hospital care the beneficiary elected to receive, unless some exception were to apply. (As noted above, under the EPSDT benefit a beneficiary under 21 would not be subject to the 14-day limitation.)

Under current Medicaid law, hospitals, physicians, and other providers that elect to participate in Medicaid must agree to "accept assignment"—that is, accept the state's (or Medicaid MCO's) payment as payment in full for the covered service. They may not "balance bill" the beneficiary for the difference between what Medicaid (or a Medicaid MCO) pays them and what they usually charge for their services.[60]

Exempt Categories of Beneficiaries

Federal Medicaid law prohibits states from imposing any cost-sharing requirements on the following groups of beneficiaries with respect to most or all services:

- eligible children under 18 with respect to any service;
- pregnant women with respect to any services relating to pregnancy or any other medical condition which may complicate the pregnancy;[61]
- terminally ill individuals receiving hospice care with respect to any service; and
- inpatients in hospitals, nursing facilities, or ICFs/MR who as a condition of eligibility are required to apply most of their income to the cost of care.

Exempt Categories of Services

Federal Medicaid law prohibits states from imposing any cost-sharing requirements on the following services with respect to any Medicaid beneficiary:

- emergency services, as defined by CMS,[62] and
- family planning services and supplies.

Nominal Cost-Sharing

In the case of beneficiary groups and services other than those discussed above, states have the option under federal Medicaid law to impose "nominal" cost-sharing. States may also, but are not required to, limit cumulative cost-sharing charges imposed on any beneficiary to a particular amount. Under CMS regulations:

- a "nominal" deductible is $2 per month per family;
- a "nominal" copayment may range from $0.50 to $3.00, depending on the amount of the state's payment for the item or service; and
- a "nominal" co-insurance requirement is five percent of the state's payment rate for the item or service.

There is one exception to the "nominal" limitation on allowable cost-sharing. In the case of nonemergency outpatient services furnished in a hospital emergency room, a state may impose a deductible or copayment up to twice the "nominal" amount if the state shows that beneficiaries "have actually available and accessible to them alternative sources of nonemergency, outpatient services."

Provider Obligations

Providers are not required by Medicaid to participate in the program. As discussed above, hospitals, physicians, and other providers that choose to participate in Medicaid must accept the amounts that Medicaid pays for a service as payment in full. For example, in 1999, CMS had received reports of incidents "where an anesthesiologist would not provide an epidural to a Medicaid patient in childbirth unless she paid in advance, with her own funds, for the procedure." This practice violates the Medicaid requirement that a provider who has agreed to participate in a state's Medicaid program cannot require a Medicaid patient to pay for a covered service that is medically necessary, e.g., an epidural during labor and delivery, either in the form of a cash advance or through a subsequent bill.[63]

When a Medicaid patient is subject to a "nominal" deductible or copayment with respect to the service the provider furnishes, the provider may collect this allowable cost-sharing from the beneficiary. However, if the beneficiary is unable to pay the cost-sharing, the provider may not deny care or services to the beneficiary. Although the provider may not withhold services, the beneficiary remains liable to the provider for the allowed cost-sharing. To the extent that beneficiaries do not meet cost-sharing requirements, the practical effect of imposing cost-sharing requirements on Medicaid beneficiaries, therefore, may be a reduction in the providers' actual reimbursement.

Waivers

Unlike most federal Medicaid statutory provisions, the beneficiary cost-sharing provisions described above cannot be waived by the Secretary of HHS under section 1115.[64] The Secretary may waive these protections only under a separate statutory authority that provides for a narrow set of conditions: the Secretary has to find, after public notice and opportunity for comment, that the waiver will "test a unique and previously-untested use of copayments;" that it will provide benefits which "can reasonably be expected to be equivalent to the risks;" and that it will test a reasonable hypothesis "in a

methodologically-sound manner," including the use of control groups. The waiver would have to be limited to no more than two years and, if participation is not voluntary, would have to "make provision for assumption of liability for preventable damage to the health of beneficiaries."[65]

VII. BENEFITS ISSUES IN MEDICAID MANAGED CARE

States have the option of offering covered benefits on a fee-for-service basis, through managed care plans, or both. As of June 2000, 43 states and the District of Columbia had more than one-quarter of their Medicaid population enrolled in managed care plans.[66] In some cases, the managed care plans are Primary Care Case Management (PCCM) organizations that contract with state Medicaid agencies and are not at financial risk for care. In most cases, however, the managed care plans are managed care organizations, or MCOs, that assume much of the financial risk of providing hospital, physician, and other covered Medicaid services to the beneficiaries who are enrolled in them. The coverage of Medicaid benefits through MCOs (and in the case of mental health services, through specialized Behavioral Health Organizations, or BHOs) raises issues relating to definition of benefits and utilization management, among others.[67]

Specification of Covered Services

States that opt to purchase benefits on a risk basis from MCOs must do so through a contract with the MCO that meets certain minimum federal requirements. However, there is no federally-defined Medicaid managed care benefits package. The federal Medicaid statute requires only that each risk contract "specify" the benefits for the provision of which the MCO is responsible. Thus, states may determine which services to purchase through the MCO and which to "carve out," either by continuing to pay for the service (e.g., prescription drugs) directly on a fee-for-service basis or by purchasing the services (e.g., mental health care) from another MCO or BHO under a separate risk contract.

Accordingly, state risk contracts with MCOs vary widely in the scope and specificity of their covered benefits. Some states have added benefits to their risk contracts that go beyond the scope of federal Medicaid benefit requirements. For example, South Carolina includes in its risk contracts coverage for "sickle cell anemia services" and "diabetes education and counseling services." Other states cover less through their risk contracts than the full scope of benefits they offer under their fee-for-service Medicaid program.[68] A state Medicaid program remains responsible for paying for services that are covered by the state's Medicaid program but are not included in the risk contract with the MCO.[69]

"Medical Necessity" Criteria

As discussed previously, the fact that a service is specified as covered in a risk contract with a Medicaid MCO does not ensure that a Medicaid enrollee who needs that service will receive it. MCOs, like Medicaid fee-for-service programs and other insurers, make separate determinations as to whether a service that is covered for all of its Medicaid enrollees will be paid for in the case of an individual enrollee.

As in the case of Medicaid fee-for-service programs, there is no federal statutory definition of "medical necessity" for purposes of Medicaid risk contracts with MCOs.[70] As a result, there is great variation among the states in their risk contract provisions. Some contracts allow the MCO to establish and apply its own definition of "medical necessity;" others specify a restrictive standard like that adopted by California (described above); still others embody the traditional approach that the service is "in accordance with the standards of good medical practice." In addition, some contracts specify different "medical necessity" standards for enrollees generally, for children, and for mental health or substance abuse services.[71]

VIII. MEDICAID AND COMMERCIAL INSURANCE: A COMPARISON

Comparing Medicaid's benefits package with those of private health insurers is not straightforward. As discussed above, there is no single Medicaid benefits package; the services covered vary significantly from state to state. Moreover, Medicaid cost-sharing requirements differ from group to group, with eligible children being protected entirely from any cost-sharing on any service. Thus, the Medicaid benefits package can vary significantly depending on the beneficiary group at issue. Finally, Medicaid covers populations to which private health insurers do not market, so the products that the insurers offer will not be designed to meet the needs of those populations. Medicaid serves individuals with poorer health status and greater health care needs than the general population, including ten million disabled and low-income elderly individuals.

To further complicate matters, private health insurers and managed care plans offer numerous benefits and cost-

sharing packages that vary substantially from market to market and from employer to employer.[72] Even among state CHIP programs, the benefit packages vary widely.[73] Selecting a representative private health insurance product from among these multiple offerings is difficult. Moreover, in those markets where providers more readily accept privately-insured than Medicaid patients, benefits that appear comparable on paper may have quite different value in the real world from the standpoint of accessibility. In addition, even where the service categories covered may appear to overlap—for example, prescription drugs—each state Medicaid plan may have its own limits on amount, duration, or scope (e.g., seven prescriptions per month) or its own formularies that result in important differences from the commercial coverage. Finally, the working definition of "medical necessity" used by the commercial insurance product may differ significantly from that used by the Medicaid program in the state, so that coverage for physicians' services or hospital care, which appear to be the same, may in fact be different.

Table 2-2 compares Medicaid's federal statutory service categories with those of a representative private product: the Blue Cross/Blue Shield Standard PPO offered under the Federal Employees Health Benefits Program (FEHBP), a popular, nationwide plan offered to federal employees and annuitants. Of the nine million people covered through the FEHBP, almost half (46%) pick this plan.[74] This comparison is useful for the limited purpose of isolating the major differences that one is likely to find between the two products in any given state or market.

It is important to understand what Table 2-2 does not do. It does not compare the Medicaid benefits actually offered to program eligibles in any given state with those available under the Blue Cross/Blue Shield Standard PPO in that state. It does not provide a basis for judging the value of Medicaid coverage against that of the Blue Cross/Blue Shield product in any particular market.[75] And it does not provide a basis for concluding that Medicaid is superior or inferior to the Blue Cross/Blue Shield Standard PPO coverage, either nationally or in any particular state.

As shown in Table 2-2, there are four mandatory Medicaid benefits categories that are not found in the Blue Cross/Blue Shield product: EPSDT, FQHC/RHC services, nursing facility (NF) services for individuals over 21, and transportation services. This does not necessarily mean that the Blue Cross/Blue Shield package does not cover any of the services in these Medicaid benefits categories. For example, the Blue Cross/Blue Shield product covers some if not all of the childhood immunizations covered through EPSDT; it may pay for some of the physician or other services that FQHCs or RHCs provide; and it covers emergency ambulance services.

There are also four major optional benefits categories that are offered by many state Medicaid programs that have no corresponding coverage in the Blue Cross/Blue Shield product: ICF/MR services, home and community-based waiver services, case management services, and personal care services. The absence of these benefits categories from the Blue Cross/Blue Shield product in large measure reflects Medicaid's role as a long-term care financing program for its elderly and disabled beneficiaries, a role that the Blue Cross/Blue Shield product does not play in the FEHBP program for federal employees and annuitants.

Finally, note that there are some benefits categories specified under the Blue Cross/Blue Shield product that have no corresponding category under Medicaid. For example, the commercial product covers "mental conditions/substance abuse benefits." Medicaid also covers behavioral health services, but the coverage falls into several different benefits categories among those listed in Table 2-1. Inpatient behavioral health services are covered under "inpatient hospital services for individuals 65 years of age or over in an IMD" and "inpatient psychiatric hospital services for individuals under age 21," among others. Outpatient behavioral health services may be covered under "physicians' services," "prescribed drugs," "case management services," and "HCBS services," among others.

Table 2-3 compares the cost-sharing requirements that states may incorporate into their Medicaid benefits design with those under the Blue Cross/Blue Shield Standard PPO coverage for some of the major overlapping benefits categories. As Table 2-3 makes clear, Medicaid's potential cost-sharing requirements (which are not imposed by all states) are substantially lower than those under the Blue Cross/Blue Shield coverage. This reflects not only the low incomes of the populations Medicaid covers but also the public health objective of eliminating barriers to access for low-income children, pregnant women, and other low-income populations at high risk. Note that providers participating in Medicaid must accept Medicaid reimbursement as payment in full and cannot withhold services in the event that a beneficiary cannot pay cost-sharing obligations. Similarly, participating and preferred providers in the BC/BS program may not balance bill patients. However, if a patient goes to a non-participating provider, the provider may bill the patient for the difference between the BC/BS payment and the

Table 2-2: Services Covered by Medicaid and Private Insurance, 2001

Mandatory Medicaid services	Medicaid	Private*
Inpatient hospital services	✓	✓
Outpatient hospital services	✓	✓
Physicians' services	✓	✓
Laboratory and x-ray services	✓	✓
Early and periodic screening, diagnostic, and treatment (EPSDT) services	✓	Not specified
Family planning services and supplies	✓	✓
FQHC/RHC services	✓	Not specified
Nurse midwife services	✓	✓
Certified nurse practitioner services	✓	✓
Nursing facility (NF) services	✓[1]	[2]
Home health services, including durable medical equipment (DME)	✓[3]	✓[4]
Transportation services	✓	[5]
Optional Medicaid services**		
Prescription drugs (inpatient and outpatient)	✓	✓
Care furnished by state-licensed chiropractors, psychologists, and podiatrists	✓	✓[6]
Diagnostic, screening, and preventive services	✓	✓
Rehabilitative services	✓	✓
Clinic services	✓	✓
Dental services and dentures	✓	✓[7]
Physical therapy and related services	✓	✓[8]
Prosthetic devices, including eyeglasses	✓	✓[9]
Inpatient hospital services for mental health/inpatient psychiatric hospital care	✓[10]	✓
Intermediate care facility for individuals with mental retardation (ICF/MR) services	✓	Not covered
Home- and community-based services (HCBS) (under waiver authority)	✓	Not covered
Case management services	✓	Not covered
Personal care services	✓	Not covered
Hospice care	✓	✓

* Private insurance benefits based on Blue Cross/Blue Shield Standard PPO offered under the Federal Employees Health Benefit Program (FEHBP) for 2001. See text for explanation of this benchmark.

** Includes optional services offered by most states in 2001.

[1] Medicaid law mandates coverage of NF services for beneficiaries age 21 and older; states may also opt to also provide NF services to other beneficiary groups.

[2] NF services only covered if enrollee also has Medicare Part A coverage. Benefit limited to 30 days of payment.

[3] Medicaid law mandates coverage of home health services for any individual entitled to NF care; states may also opt to provide home health services to additional populations. The majority of states extend home health benefits to other groups.

[4] Plan does not cover 24-hour home health care; covers home nursing visits at 25 visits per year for 2 hours per day; DME coverage limited to certain devices.

[5] Emergency and transport ambulance services only.

[6] Does not cover chiropractor services or routine foot care.

[7] Plan does not cover dentures, orthodontia, or services for periodontal disease.

[8] Physical therapy limited to 50 visits per year; occupational and speech therapy (combined) limited to 25 visits per year.

[9] Eyeglasses provided only following intra-ocular surgery or injury; hearing aids not covered.

[10] Medicaid law provides states with the option of covering inpatient hospital care for beneficiaries age 65 and up in an institution for mental disease (IMD) and with the option of covering inpatient psychiatric hospital services for individuals under age 21.

TABLE 2-3: MEDICAID AND PRIVATE INSURANCE COST-SHARING REQUIREMENTS FOR COMMON SERVICES, 2001

	Medicaid		Private[1]
	Adults	*Children/Pregnant Women*	
Deductible			
	At state option, up to $2 per month	None	$250 per year individual limit[2] $500 per year family limit
Coinsurance & Copayments			
Inpatient hospital services	At state option, charge per admission up to 50% of the state's payment for first day of care	None	$100 per admission
Outpatient hospital services	At state option, copayments of $0.50 to $3 per visit[3]	None	10% of allowable charges coinsurance *Physical/occupational therapy:* all charges after 50/25 visits
Physician services	At state option, copayments of $0.50 to $3 per visit[3]	None	$15 per physician office visit 10% of allowable charges coinsurance for all other physician charges[4] *Physical/occupational therapy:* all charges after 50/25 visits
Prescription drugs	At state option, copayments of $0.50 to $3 per prescription[3]	None	25% coinsurance for drugs obtained from a retail pharmacy[5]
Well-child care	Not applicable	None	None
Maternity services	None	None	None

[1] Private insurance based on Blue Cross/Blue Shield Standard PPO offered under the Federal Employees Health Benefits Program (FEHBP). Cost-sharing assumes use of PPO Providers; higher deductibles, coinsurance, and out-of-pocket maximums are in place for non-PPO Provider utilization. Premiums for standard coverage are $74 per month for individual coverage and $175 per month for family coverage. Private coverage also has a $3,000 per year out-of-pocket maximum for deductibles, coinsurance and copayments (some exceptions apply).

[2] Deductible does not apply to some services, such as inpatient hospital care, charge for office visit, preventive services, and diagnostic cancer tests.

[3] States may alternatively opt to impose coinsurance up to 5% of the state's payment rate for that item or service.

[4] No coinsurance for preventive services and diagnostic cancer tests.

[5] $12/$20 copayment for generic/brand name drugs obtained through prescription drug mail-in service.

actual charge. BC/BS does not require that contracted providers treat patients who do not pay their cost-sharing.

IX. MEDICAID AND MEDICARE: A COMPARISON

Medicaid and Medicare are both public payers, and they both include among their beneficiary populations low-income elderly and disabled individuals. As discussed in Section III above, Medicaid plays an important role in supplementing Medicare coverage for many low-income Medicare beneficiaries. Medicaid pays the premiums and, to some extent, the cost-sharing requirements imposed under Medicare. In the case of Medicare beneficiaries who are eligible for the full Medicaid benefits package, Medicaid covers additional benefits, notably outpatient prescription drugs and long-term care, that Medicare does not cover. Although low-income elderly and disabled individuals never have to choose between Medicare and Medicaid coverage, it is instructive to compare the benefits packages of the two programs.

Medicare actually has two benefits packages: (1) the basic "traditional Medicare" fee-for-service benefits as enacted in 1965 and modified somewhat since then; and (2) the benefits offered by Medicare+Choice plans. As Merlis has noted, the "traditional Medicare" benefits package was "comparable to standard employer group policies at the time of enactment," but it is now "considerably less generous than many private plans," due to its high inpatient deductible ($792 per benefit period in 2001), 20 percent coinsurance on most Part B services, and unlimited beneficiary out-of-pocket liability.[76] Medicare+Choice plans must cover most of the "traditional Medicare" benefits (other than hospice care), and most also offer supplemental services, such as routine physicals, eye exams, ear exams, and outpatient drugs.

Table 2-4 compares benefits categories covered under the federal Medicaid statute with benefits categories covered by "traditional Medicare."[77] The same caveats that apply to comparisons between Medicaid and private insurance products also apply to comparisons between Medicaid and Medicare. Table 2-4 does not justify any inferences about the relative merits or benefit values of the two programs. Instead, it is presented for the limited purpose of identifying the major differences between the two, which in turn should improve an understanding of each.

As is evident from Table 2-4, Medicare does not cover benefits categories that correspond to the following Medicaid mandatory categories: EPSDT, family planning services and supplies, and non-emergency transportation. This divergence reflects the differences in the populations covered by the two programs. In addition, Medicare's skilled nursing facility (SNF) benefit is considerably more limited in scope than Medicaid's nursing facility (NF) benefit for individuals over 21.

With respect to optional Medicaid benefits, Medicare does not cover outpatient prescription drugs; this difference makes Medicaid coverage particularly important for the "dual eligible" low-income elderly and disabled Medicare beneficiaries.[78] In addition, Medicare, like the Blue Cross/Blue Shield Standard PPO, does not cover a number of the long-term care benefits categories that most states offer through their Medicaid programs: ICF/MR services, HCBS services, case management services, and personal care services.

Table 2-5 compares Medicare and Medicaid cost-sharing requirements for some of the major overlapping benefits categories with respect to three different groups of elderly or disabled individuals: those eligible for Medicaid only, those eligible for Medicare only, and those eligible for both programs. The "Medicaid Only" column shows the cost-sharing requirements that state Medicaid programs have the flexibility to impose under current law with respect to their aged and disabled adult Medicaid beneficiaries who are not institutionalized. The "Medicare" column shows the cost-sharing requirements under "traditional Medicare." The "Medicaid-Medicare Dual Eligibles" column shows the interaction between the two programs' cost-sharing requirements. As noted above, Medicaid pays the premium and cost-sharing obligations of many low-income Medicare beneficiaries who are dually eligible for both programs. In these cases, when Medicare covers a benefit that Medicaid also covers (e.g., inpatient hospital care) Medicare pays for the benefit, and Medicaid pays the Medicare cost-sharing requirements for that service. For this reason, the column shows no Medicaid cost-sharing for these services, since whatever cost-sharing requirements states could generally impose on such services do not apply (because Medicare is paying for the benefit, not Medicaid).

However, Table 2-5 does make clear that Medicaid's potential cost-sharing requirements (which are not imposed by all states) are substantially lower in design than those applicable under "traditional Medicare." It also underscores how crucial a role Medicaid plays for many low-income elderly and disabled Medicare beneficiaries in protecting them from the burden of most or all of the "traditional Medicare" cost-sharing requirements.

TABLE 2-4: SERVICES COVERED BY MEDICAID AND MEDICARE, 2001

Mandatory Medicaid services	Medicaid	Medicare
Inpatient hospital services	✓	✓
Outpatient hospital services	✓	✓
Physicians' services	✓	✓
Laboratory and x-ray services	✓	✓
Early and periodic screening, diagnostic, and treatment (EPSDT) services	✓	Not specified
Family planning services and supplies	✓	Not covered
FQHC/RHC services	✓	✓
Nurse midwife services	✓	✓
Certified nurse practitioner services	✓	✓
Nursing facility (NF) services	✓[1]	✓[2]
Home health services, including durable medical equipment (DME)	✓[3]	✓
Emergency and non-emergency transportation services	✓	[4]
Optional Medicaid services*		
Prescription drugs (inpatient and outpatient)	✓	[5]
Care furnished by state-licensed chiropractors, psychologists, and podiatrists	✓	✓
Diagnostic, screening, and preventive services	✓	✓[6]
Rehabilitative services	✓	✓[7]
Clinic services	✓	✓
Dental services and dentures	✓	Not covered
Physical therapy and related services	✓	✓
Prosthetic devices, including eyeglasses	✓	✓[8]
Inpatient hospital services for mental health/inpatient psychiatric hospital care	✓[9]	✓[10]
Intermediate care facility for individuals with mental retardation (ICF/MR) services	✓	Not covered
Home- and community-based services (HCBS) (under waiver authority)	✓	Not covered
Case management services	✓	Not covered
Personal care services	✓	Not covered
Hospice care	✓	✓

*Includes optional services offered by most states.

[1] Medicaid law mandates coverage of NF services for beneficiaries age 21 and older; states may opt to also provide NF services to other beneficiary groups.

[2] Benefit limited to 100 days.

[3] Medicaid law mandates coverage of home health services for any individual entitled to NF care; states may opt to also provide home health services to additional populations. The majority of states extend home health benefits to other groups.

[4] Covers limited ambulance services only.

[5] Generally covers inpatient prescription drugs only.

[6] Restrictions apply.

[7] Restrictions apply.

[8] Eyeglasses excluded.

[9] Medicaid law provides states with the option of covering inpatient hospital care for beneficiaries age 65 and up in an institution for mental disease (IMD) and with the option of covering inpatient psychiatric hospital services for individuals under age 21.

[10] Medicare does not recognize IMDs as a provider category.

Table 2-5: Medicaid and Medicare Cost-Sharing Requirements for Common Services for Elderly and Disabled Adults, 2001

	Medicaid Only	Medicaid-Medicare Dual Eligibles*	Medicare
Deductible			
	At state option, up to $2 per month	*	$792 per inpatient hospital stay up to 60 days $100 per year for outpatient services
Coinsurance & Copayments			
Inpatient hospital services	At state option, charge per admission up to 50% of the state's payment for first day of care	*	*Days 1–60:* no cost *Days 61–90:* $198 per day copayment *60 lifetime reserve days:* $396 per day copayment
Outpatient hospital services	At state option, copayments of $0.50 to $3 per visit[1]	*	At least 20% of Medicare payment rate
Physician services	At state option, copayments of $0.50 to $3 per visit[1]	*	20% coinsurance[2] *Outpatient mental health:* 50% coinsurance *Physical/occupational therapy:* all charges after $1,500
Prescription drugs	At state option, copayments of $0.50 to $3 per prescription[1]	Copayments $0.50 to $3 per prescription[1]	Generally, 100% of outpatient drug costs
Home health	At state option, copayments of $0.50 to $3 per visit[1]	*	None
Nursing facility services	Most of beneficiary's income applied to cost of care	Most of beneficiary's income applied to cost of care after Medicare coverage is evaluted	*Days 1–20:* no cost *Days 21–100:* $99/day copayment *Days 100+:* all costs
Hospice care	None	*	Small payment for drugs and inpatient respite care

*In the case of individuals eligible for both programs, Medicare pays first for any service that both programs cover. As a result, the Medicare cost-sharing requirements apply. Medicaid pays some or all of the Medicare cost-sharing for these individuals.

[1] States alternatively have the option of imposing a coinsurance rate up to 5% of the state's payment rate for that item or service.

[2] If physician does not accept assignment, beneficiary pays 20% coinsurance plus up to 15% over Medicare-approved fee.

X. CONCLUSION

Medicaid pays for comprehensive, guaranteed benefits with little or no cost-sharing to some of the nation's most vulnerable populations: low-income families, the disabled, and the elderly. Because the population served has a wide range of significant health needs, the services that states can cover range from basic health services for those for whom private coverage is unavailable or unaffordable to long-term care services for those with chronic health needs. Though each state's Medicaid benefits package differs in the type and scope of covered services, every eligible individual entitled to Medicaid coverage is guaranteed a minimum set of benefits. As state Medicaid programs move to new models of service delivery and medical advances make new technologies available, states are challenged to adjust benefits packages to address these new developments while continuing to ensure beneficiaries' access to needed care.

Exhibit: Medicaid Expenditures by State, 1998 (millions of dollars)

		Acute Care Spending						Long-Term Care Spending						Other Spending		
State	Total Medicaid*	Total Acute	Inpatient	Physician, Lab, & X-ray	Outpatient	Prescription Drugs**	Other Acute Care***	Total LTC	Nursing Facilities	ICF-MR	Mental Health	Home Health	Personal Care Support Services****	Payments to Medicare	Managed Care & Other Prepaid	DSH
U.S. Total	**$169,315.5**	**$65,375.0**	**$24,306.2**	**$6,909.2**	**$11,945.8**	**$11,673.1**	**$10,540.7**	**$64,986.9**	**$34,352.7**	**$9,987.7**	**$3,104.4**	**$11,657.7**	**$5,884.4**	**$4,419.1**	**$19,572.7**	**$14,961.8**
Alabama	2,330.2	914.9	417.4	121.4	121.6	198.7	55.7	787.5	532.4	56.7	26.2	140.6	31.5	77.5	156.7	393.7
Alaska	369.9	255.8	59.9	41.6	88.1	27.9	38.3	92.4	49.3	0.3	7.7	30.8	4.3	6.3	0.0	15.4
Arizona	1,858.2	209.2	85.7	24.5	25.0	1.5	72.5	17.4	16.1	0.0	0.0	1.1	0.3	29.3	1,478.8	123.4
Arkansas	1,416.3	755.2	202.0	128.3	174.7	127.5	122.6	598.1	304.5	109.2	48.2	64.9	71.4	53.0	8.3	1.7
California	18,382.8	7992.7	3,172.8	931.4	1,144.1	1,340.1	1,404.3	5,089.4	2,138.9	525.9	940.6	571.5	912.6	729.3	2,120.7	2,450.7
Colorado	1,590.2	538.2	201.1	71.9	123.7	89.0	52.4	636.7	337.0	22.3	5.3	265.5	6.6	23.4	252.9	139.1
Connecticut	2,895.4	513.6	161.0	30.6	66.0	155.3	100.7	1,505.7	854.5	204.2	25.4	409.7	11.9	128.0	378.0	370.1
Delaware	422.2	121.4	15.2	4.2	23.1	34.7	44.2	164.3	84.2	32.6	9.1	37.8	0.7	6.8	121.8	8.0
District of Columbia	741.7	357.6	196.3	18.0	89.0	31.0	23.2	251.5	154.2	69.2	14.7	13.0	0.4	11.5	88.3	32.9
Florida	6,616.8	3118.9	996.4	430.4	467.9	729.0	495.3	2,070.1	1,344.2	256.0	14.5	356.1	99.4	384.8	672.5	370.5
Georgia	3,598.0	1964.4	691.0	391.0	404.8	316.3	161.3	1,033.7	623.1	106.8	20.7	180.4	102.7	105.4	85.0	409.6
Hawaii	594.4	153.8	56.1	26.8	26.1	31.7	13.2	181.7	140.5	10.0	0.0	27.1	4.1	22.6	236.2	0.0
Idaho	448.9	255.0	84.6	36.1	33.3	46.1	54.8	183.8	92.9	46.8	0.3	20.6	23.2	7.5	0.4	2.2
Illinois	6,648.0	3708.9	2,095.7	270.0	266.4	493.4	583.5	2,350.2	1,353.4	610.1	60.4	290.8	35.5	93.4	225.9	269.6
Indiana	2,600.3	1030.6	372.8	122.9	112.1	263.6	159.2	1,214.4	686.5	300.9	129.6	96.9	0.5	40.2	120.4	194.7
Iowa	1,447.4	585.4	209.0	59.2	63.6	131.0	122.6	649.9	316.7	177.5	19.1	118.8	17.8	74.3	117.9	19.8
Kansas	1,070.1	417.5	135.1	35.6	20.4	94.4	132.0	563.5	236.7	84.8	15.0	211.2	15.7	23.1	21.0	45.0
Kentucky	2,614.6	1251.7	290.1	194.0	317.7	267.7	182.1	818.8	491.0	79.4	44.0	183.3	21.2	69.9	279.5	194.7
Louisiana	3,200.2	1446.6	558.5	249.3	206.2	301.3	131.3	932.5	502.8	323.9	11.1	89.1	5.6	82.3	0.5	738.3
Maine	1,112.4	531.0	132.2	30.6	101.4	94.8	172.0	399.7	188.3	38.8	32.6	113.9	26.0	55.5	3.9	122.4
Maryland	2,667.3	666.7	298.9	23.9	63.5	110.7	169.8	929.9	559.0	55.6	80.4	207.5	27.3	60.4	874.4	136.0
Massachusetts	5,600.5	1884.9	614.8	208.1	374.9	416.7	270.3	2,450.6	1,330.0	252.9	40.7	491.7	335.3	128.9	638.8	497.3
Michigan	5,662.5	2208.7	758.2	174.0	843.7	308.2	124.6	2,173.6	1,129.8	242.9	155.1	312.5	333.3	124.6	836.2	319.3
Minnesota	2,937.9	706.5	213.6	98.7	53.5	142.2	198.4	1,692.1	847.4	223.8	16.2	434.8	169.8	45.5	437.6	56.3
Mississippi	1,689.2	761.3	284.9	105.9	125.5	191.7	53.2	514.6	315.0	131.5	18.2	22.6	27.4	205.9	23.6	183.9
Missouri	3,320.5	993.6	319.7	56.2	179.5	326.6	111.6	1,211.8	696.5	146.2	7.9	226.1	135.2	105.6	343.3	666.1
Montana	405.3	167.5	50.4	24.4	31.3	36.2	25.2	168.4	99.5	12.1	0.5	27.9	28.4	15.1	54.1	0.2
Nebraska	847.1	298.6	96.9	50.1	31.5	79.2	41.0	433.7	284.1	43.0	5.8	91.1	9.7	34.6	74.3	5.9
Nevada	527.8	275.2	115.1	40.6	26.4	27.3	65.8	128.5	70.2	25.4	11.3	19.2	2.3	12.4	38.0	73.6
New Hampshire	768.1	290.7	35.9	19.3	111.2	45.0	79.2	333.8	207.8	1.5	1.9	107.0	15.6	3.3	11.9	128.4
New Jersey	5,451.4	1577.5	455.3	91.3	477.5	370.3	183.1	2,145.5	1,195.1	347.2	85.7	336.7	180.8	96.9	611.2	1,020.4
New Mexico	1,019.1	326.5	115.8	40.4	57.6	30.8	81.8	291.4	138.7	16.3	2.1	117.4	17.0	18.8	372.9	9.4
New York	26,993.2	11235.9	4,612.0	388.3	2,748.8	1,396.9	2,089.9	12,328.0	5,792.3	2,047.5	421.1	2,294.7	1,772.3	196.5	1,372.4	1,860.4
North Carolina	4,688.6	2408.6	842.5	396.5	561.0	391.8	216.8	1,745.1	778.9	380.2	27.5	346.0	212.6	146.4	34.4	354.1
North Dakota	339.7	130.1	35.0	18.1	33.8	22.8	20.4	203.8	111.7	44.3	4.1	38.8	5.0	3.1	1.5	1.2
Ohio	6,728.7	2450.5	908.7	284.5	486.2	536.6	234.5	3,089.0	1,968.9	534.9	224.8	321.5	39.0	101.4	430.7	657.0
Oklahoma	1,339.1	519.3	164.6	62.5	57.7	120.2	114.3	629.8	316.0	106.4	38.9	136.7	31.8	46.6	120.6	22.7
Oregon	1,728.9	300.1	77.5	39.1	22.1	80.6	80.8	651.0	183.6	76.4	33.1	275.1	82.8	26.1	724.8	27.0
Pennsylvania	8,522.1	1611.5	503.2	147.4	192.7	419.2	349.0	4,329.3	2,910.9	554.6	196.0	590.2	77.7	161.5	1,873.4	546.3
Rhode Island	973.1	400.7	161.4	9.2	20.7	50.4	158.9	390.4	219.9	5.9	11.9	149.8	2.8	11.2	115.0	56.0
South Carolina	2,318.9	1095.5	357.3	167.0	224.1	188.5	158.6	713.7	307.2	172.5	29.0	144.2	60.7	59.7	4.4	445.7
South Dakota	360.2	171.3	62.8	26.0	38.1	26.4	18.0	173.6	102.4	20.5	3.2	46.7	0.8	9.8	4.5	1.1
Tennessee	3,758.1	398.9	295.3	23.2	29.9	29.5	21.0	1,127.1	706.2	243.6	0.6	86.6	90.1	122.3	2,109.8	0.0
Texas	9,752.4	4259.6	1,670.3	688.4	432.7	677.4	790.8	2,990.5	1,394.3	646.6	34.4	418.8	496.4	342.0	721.4	1,438.9
Utah	687.8	298.8	92.8	22.1	98.6	59.0	26.3	214.2	86.7	44.0	8.6	65.2	9.7	13.7	157.1	4.1
Vermont	401.4	148.5	20.1	14.4	18.3	38.3	57.4	158.8	75.4	1.6	0.1	69.7	12.1	7.9	63.9	22.3
Virginia	2,324.5	1005.5	342.2	161.1	157.1	235.3	109.8	893.1	415.1	160.2	106.8	204.8	6.1	68.9	196.3	160.7
Washington	3,344.6	1180.1	259.7	135.9	327.5	209.2	247.8	1,209.2	544.2	127.0	48.6	312.2	177.2	54.8	567.7	332.8
West Virginia	1,278.5	656.9	155.8	116.6	119.7	123.6	141.3	503.8	262.1	48.7	27.6	122.2	43.3	37.7	58.2	21.9
Wisconsin	2,719.4	737.6	223.7	38.4	109.1	192.5	173.9	1,508.9	809.8	202.5	37.3	369.0	90.3	130.3	331.4	11.2
Wyoming	201.4	85.6	28.9	19.6	16.6	14.7	5.8	112.5	47.0	16.6	0.4	48.0	0.4	3.2	0.0	0.1

Source: Urban Institute estimates (2000) based on data from HCFA-64 reports.

* "Total Medicaid" includes all expenditures for medical services and DSH; it does not include administrative costs or accounting adjustments.

** "Prescription Drugs" includes only out patient fee-for-service spending and is net of rebate. Other spending on prescription drugs occurs under managed care plans and in institutional settings.

*** "Other Care" includes EPSDT, dental, vision, other practitioners' services, case management, and all other unspecified care services.

**** "Personal Care Support Services" includes personal care, home and community-based services for the functionally disabled elderly, hospice, and targeted case management.

Exhibit: Medicaid Expenditures by State, 1998 (percent of total Medicaid spending)

		Acute Care Spending						Long-Term Care Spending						Other Spending		
State	Total Medicaid*	Total Acute	Inpatient	Physician, Lab, & X-ray	Outpatient	Prescription Drugs**	Other Acute Care***	Total LTC	Nursing Facilities	ICF-MR	Mental Health	Home Health	Personal Care Support Services****	Payments to Medicare	Managed Care & Other Prepaid	DSH
U.S. Total	**$169,315.5**	**38.6%**	**14.4%**	**4.1%**	**7.1%**	**6.9%**	**6.2%**	**38.4%**	**20.3%**	**5.9%**	**1.8%**	**6.9%**	**3.5%**	**2.6%**	**11.6%**	**8.8%**
Alabama	2,330.2	39.3%	17.9%	5.2%	5.2%	8.5%	2.4%	33.8%	22.8%	2.4%	1.1%	6.0%	1.4%	3.3%	6.7%	16.9%
Alaska	369.9	69.2%	16.2%	11.2%	23.8%	7.6%	10.4%	25.0%	13.3%	0.1%	2.1%	8.3%	1.2%	1.7%	0.0%	4.2%
Arizona	1,858.2	11.3%	4.6%	1.3%	1.3%	0.1%	3.9%	0.9%	0.9%	0.0%	0.0%	0.1%	0.0%	1.6%	79.6%	6.6%
Arkansas	1,416.3	53.3%	14.3%	9.1%	12.3%	9.0%	8.7%	42.2%	21.5%	7.7%	3.4%	4.6%	5.0%	3.7%	0.6%	0.1%
California	18,382.8	43.5%	17.3%	5.1%	6.2%	7.3%	7.6%	27.7%	11.6%	2.9%	5.1%	3.1%	5.0%	4.0%	11.5%	13.3%
Colorado	1,590.2	33.8%	12.6%	4.5%	7.8%	5.6%	3.3%	40.0%	21.2%	1.4%	0.3%	16.7%	0.4%	1.5%	15.9%	8.7%
Connecticut	2,895.4	17.7%	5.6%	1.1%	2.3%	5.4%	3.5%	52.0%	29.5%	7.1%	0.9%	14.2%	0.4%	4.4%	13.1%	12.8%
Delaware	422.2	28.8%	3.6%	1.0%	5.5%	8.2%	10.5%	38.9%	19.9%	7.7%	2.1%	9.0%	0.2%	1.6%	28.8%	1.9%
District of Columbia	741.7	48.2%	26.5%	2.4%	12.0%	4.2%	3.1%	33.9%	20.8%	9.3%	2.0%	1.8%	0.0%	1.5%	11.9%	4.4%
Florida	6,616.8	47.1%	15.1%	6.5%	7.1%	11.0%	7.5%	31.3%	20.3%	3.9%	0.2%	5.4%	1.5%	5.8%	10.2%	5.6%
Georgia	3,598.0	54.6%	19.2%	10.9%	11.2%	8.8%	4.5%	28.7%	17.3%	3.0%	0.6%	5.0%	2.9%	2.9%	2.4%	11.4%
Hawaii	594.4	25.9%	9.4%	4.5%	4.4%	5.3%	2.2%	30.6%	23.6%	1.7%	0.0%	4.6%	0.7%	3.8%	39.7%	0.0%
Idaho	448.9	56.8%	18.9%	8.1%	7.4%	10.3%	12.2%	41.0%	20.7%	10.4%	0.1%	4.6%	5.2%	1.7%	0.1%	0.5%
Illinois	6,648.0	55.8%	31.5%	4.1%	4.0%	7.4%	8.8%	35.4%	20.4%	9.2%	0.9%	4.4%	0.5%	1.4%	3.4%	4.1%
Indiana	2,600.3	39.6%	14.3%	4.7%	4.3%	10.1%	6.1%	46.7%	26.4%	11.6%	5.0%	3.7%	0.0%	1.5%	4.6%	7.5%
Iowa	1,447.4	40.4%	14.4%	4.1%	4.4%	9.1%	8.5%	44.9%	21.9%	12.3%	1.3%	8.2%	1.2%	5.1%	8.1%	1.4%
Kansas	1,070.1	39.0%	12.6%	3.3%	1.9%	8.8%	12.3%	52.7%	22.1%	7.9%	1.4%	19.7%	1.5%	2.2%	2.0%	4.2%
Kentucky	2,614.6	47.9%	11.1%	7.4%	12.2%	10.2%	7.0%	31.3%	18.8%	3.0%	1.7%	7.0%	0.8%	2.7%	10.7%	7.4%
Louisiana	3,200.2	45.2%	17.5%	7.8%	6.4%	9.4%	4.1%	29.1%	15.7%	10.1%	0.3%	2.8%	0.2%	2.6%	0.0%	23.1%
Maine	1,112.4	47.7%	11.9%	2.7%	9.1%	8.5%	15.5%	35.9%	16.9%	3.5%	2.9%	10.2%	2.3%	5.0%	0.4%	11.0%
Maryland	2,667.3	25.0%	11.2%	0.9%	2.4%	4.1%	6.4%	34.9%	21.0%	2.1%	3.0%	7.8%	1.0%	2.3%	32.8%	5.1%
Massachusetts	5,600.5	33.7%	11.0%	3.7%	6.7%	7.4%	4.8%	43.8%	23.7%	4.5%	0.7%	8.8%	6.0%	2.3%	11.4%	8.9%
Michigan	5,662.5	39.0%	13.4%	3.1%	14.9%	5.4%	2.2%	38.4%	20.0%	4.3%	2.7%	5.5%	5.9%	2.2%	14.8%	5.6%
Minnesota	2,937.9	24.0%	7.3%	3.4%	1.8%	4.8%	6.8%	57.6%	28.8%	7.6%	0.6%	14.8%	5.8%	1.5%	14.9%	1.9%
Mississippi	1,689.2	45.1%	16.9%	6.3%	7.4%	11.3%	3.2%	30.5%	18.6%	7.8%	1.1%	1.3%	1.6%	12.2%	1.4%	10.9%
Missouri	3,320.5	29.9%	9.6%	1.7%	5.4%	9.8%	3.4%	36.5%	21.0%	4.4%	0.2%	6.8%	4.1%	3.2%	10.3%	20.1%
Montana	405.3	41.3%	12.4%	6.0%	7.7%	8.9%	6.2%	41.5%	24.5%	3.0%	0.1%	6.9%	7.0%	3.7%	13.4%	0.1%
Nebraska	847.1	35.2%	11.4%	5.9%	3.7%	9.3%	4.8%	51.2%	33.5%	5.1%	0.7%	10.8%	1.1%	4.1%	8.8%	0.7%
Nevada	527.8	52.1%	21.8%	7.7%	5.0%	5.2%	12.5%	24.4%	13.3%	4.8%	2.1%	3.6%	0.4%	2.4%	7.2%	13.9%
New Hampshire	768.1	37.8%	4.7%	2.5%	14.5%	5.9%	10.3%	43.5%	27.1%	0.2%	0.2%	13.9%	2.0%	0.4%	1.6%	16.7%
New Jersey	5,451.4	28.9%	8.4%	1.7%	8.8%	6.8%	3.4%	39.4%	21.9%	6.4%	1.6%	6.2%	3.3%	1.8%	11.2%	18.7%
New Mexico	1,019.1	32.0%	11.4%	4.0%	5.7%	3.0%	8.0%	28.6%	13.6%	1.6%	0.2%	11.5%	1.7%	1.8%	36.6%	0.9%
New York	26,993.2	41.6%	17.1%	1.4%	10.2%	5.2%	7.7%	45.7%	21.5%	7.6%	1.6%	8.5%	6.6%	0.7%	5.1%	6.9%
North Carolina	4,688.6	51.4%	18.0%	8.5%	12.0%	8.4%	4.6%	37.2%	16.6%	8.1%	0.6%	7.4%	4.5%	3.1%	0.7%	7.6%
North Dakota	339.7	38.3%	10.3%	5.3%	10.0%	6.7%	6.0%	60.0%	32.9%	13.0%	1.2%	11.4%	1.5%	0.9%	0.4%	0.4%
Ohio	6,728.7	36.4%	13.5%	4.2%	7.2%	8.0%	3.5%	45.9%	29.3%	7.9%	3.3%	4.8%	0.6%	1.5%	6.4%	9.8%
Oklahoma	1,339.1	38.8%	12.3%	4.7%	4.3%	9.0%	8.5%	47.0%	23.6%	7.9%	2.9%	10.2%	2.4%	3.5%	9.0%	1.7%
Oregon	1,728.9	17.4%	4.5%	2.3%	1.3%	4.7%	4.7%	37.7%	10.6%	4.4%	1.9%	15.9%	4.8%	1.5%	41.9%	1.6%
Pennsylvania	8,522.1	18.9%	5.9%	1.7%	2.3%	4.9%	4.1%	50.8%	34.2%	6.5%	2.3%	6.9%	0.9%	1.9%	22.0%	6.4%
Rhode Island	973.1	41.2%	16.6%	0.9%	2.1%	5.2%	16.3%	40.1%	22.6%	0.6%	1.2%	15.4%	0.3%	1.1%	11.8%	5.8%
South Carolina	2,318.9	47.2%	15.4%	7.2%	9.7%	8.1%	6.8%	30.8%	13.2%	7.4%	1.3%	6.2%	2.6%	2.6%	0.2%	19.2%
South Dakota	360.2	47.6%	17.4%	7.2%	10.6%	7.3%	5.0%	48.2%	28.4%	5.7%	0.9%	13.0%	0.2%	2.7%	1.2%	0.3%
Tennessee	3,758.1	10.6%	7.9%	0.6%	0.8%	0.8%	0.6%	30.0%	18.8%	6.5%	0.0%	2.3%	2.4%	3.3%	56.1%	0.0%
Texas	9,752.4	43.7%	17.1%	7.1%	4.4%	6.9%	8.1%	30.7%	14.3%	6.6%	0.4%	4.3%	5.1%	3.5%	7.4%	14.8%
Utah	687.8	43.4%	13.5%	3.2%	14.3%	8.6%	3.8%	31.1%	12.6%	6.4%	1.2%	9.5%	1.4%	2.0%	22.8%	0.6%
Vermont	401.4	37.0%	5.0%	3.6%	4.6%	9.5%	14.3%	39.6%	18.8%	0.4%	0.0%	17.4%	3.0%	2.0%	15.9%	5.5%
Virginia	2,324.5	43.3%	14.7%	6.9%	6.8%	10.1%	4.7%	38.4%	17.9%	6.9%	4.6%	8.8%	0.3%	3.0%	8.4%	6.9%
Washington	3,344.6	35.3%	7.8%	4.1%	9.8%	6.3%	7.4%	36.2%	16.3%	3.8%	1.5%	9.3%	5.3%	1.6%	17.0%	10.0%
West Virginia	1,278.5	51.4%	12.2%	9.1%	9.4%	9.7%	11.1%	39.4%	20.5%	3.8%	2.2%	9.6%	3.4%	2.9%	4.6%	1.7%
Wisconsin	2,719.4	27.1%	8.2%	1.4%	4.0%	7.1%	6.4%	55.5%	29.8%	7.4%	1.4%	13.6%	3.3%	4.8%	12.2%	0.4%
Wyoming	201.4	42.5%	14.3%	9.7%	8.2%	7.3%	2.9%	55.8%	23.3%	8.3%	0.2%	23.9%	0.2%	1.6%	0.0%	0.1%

Source: Urban Institute estimates (2000) based on data from HCFA-64 reports.

* "Total Medicaid" includes all expenditures for medical services and DSH; it does not include administrative costs or accounting adjustments.

** "Prescription Drugs" includes only outpatient fee-for-service spending and is net of rebate. Other spending on prescription drugs occurs under managed care plans and in institutional settings.

*** "Other Care" includes EPSDT, dental, vision, other practitioners' services, case management, and all other unspecified care services.

**** "Personal Care Support Services" includes personal care, home and community-based services for the functionally disabled elderly, hospice, and targeted case management.

Exhibit: Medicaid Expenditures by State, 1998

State	Fee-for-Service: Mandatory Services (millions)	Fee-for-Service: Mandatory Services %	Fee-for-Service: Optional Services (millions)	Fee-for-Service: Optional Services %	Managed Care and Other Prepaid (millions)	Managed Care and Other Prepaid %	Payments to Medicare (millions)	Payments to Medicare %	Total Expenditures (millions)
United States	**$76,518.1**	**49.6%**	**$53,843.9**	**34.9%**	**$19,572.7**	**12.7%**	**$4,419.1**	**2.9%**	**$154,353.7**
Alabama	1,185.7	61.2%	516.6	26.7%	156.7	8.1%	77.5	4.0%	1,936.5
Alaska	192.7	54.4%	155.5	43.9%	0.0	0.0%	6.3	1.8%	354.5
Arizona	148.9	8.6%	77.8	4.5%	1,478.8	85.2%	29.3	1.7%	1,734.8
Arkansas	712.0	50.3%	641.3	45.3%	8.3	0.6%	53.0	3.7%	1,414.6
California	7,353.3	46.2%	5,728.9	36.0%	2,120.7	13.3%	729.3	4.6%	15,932.2
Colorado	727.8	50.2%	447.1	30.8%	252.9	17.4%	23.4	1.6%	1,451.1
Connecticut	1,205.6	47.7%	813.7	32.2%	378.0	15.0%	128.0	5.1%	2,525.3
Delaware	129.1	31.2%	156.6	37.8%	121.8	29.4%	6.8	1.6%	414.2
District of Columbia	422.7	59.6%	186.4	26.3%	88.3	12.5%	11.5	1.6%	708.8
Florida	3,336.2	53.4%	1,852.8	29.7%	672.5	10.8%	384.8	6.2%	6,246.3
Georgia	2,085.0	65.4%	913.1	28.6%	85.0	2.7%	105.4	3.3%	3,188.4
Hawaii	250.4	42.1%	85.2	14.3%	236.2	39.7%	22.6	3.8%	594.4
Idaho	241.6	54.1%	197.2	44.2%	0.4	0.1%	7.5	1.7%	446.7
Illinois	4,042.6	63.4%	2,016.6	31.6%	225.9	3.5%	93.4	1.5%	6,378.4
Indiana	1,336.2	55.5%	908.8	37.8%	120.4	5.0%	40.2	1.7%	2,405.6
Iowa	697.7	48.9%	537.6	37.7%	117.9	8.3%	74.3	5.2%	1,427.5
Kansas	454.7	44.4%	526.3	51.3%	21.0	2.0%	23.1	2.3%	1,025.1
Kentucky	1,323.4	54.7%	747.2	30.9%	279.5	11.6%	69.9	2.9%	2,419.9
Louisiana	1,519.2	61.7%	859.9	34.9%	0.5	0.0%	82.3	3.3%	2,461.9
Maine	437.8	44.2%	492.8	49.8%	3.9	0.4%	55.5	5.6%	990.0
Maryland	989.2	39.1%	607.4	24.0%	874.4	34.5%	60.4	2.4%	2,531.3
Massachusetts	2,503.6	49.1%	1,831.8	35.9%	638.8	12.5%	128.9	2.5%	5,103.2
Michigan	2,553.4	47.8%	1,829.0	34.2%	836.2	15.6%	124.6	2.3%	5,343.2
Minnesota	1,266.3	43.9%	1,132.2	39.3%	437.6	15.2%	45.5	1.6%	2,881.7
Mississippi	836.7	55.6%	439.1	29.2%	23.6	1.6%	205.9	13.7%	1,505.3
Missouri	1,289.0	48.6%	916.5	34.5%	343.3	12.9%	105.6	4.0%	2,654.4
Montana	208.4	51.4%	127.5	31.5%	54.1	13.4%	15.1	3.7%	405.1
Nebraska	476.2	56.6%	256.1	30.4%	74.3	8.8%	34.6	4.1%	841.2
Nevada	262.1	57.7%	141.6	31.2%	38.0	8.4%	12.4	2.7%	454.2
New Hampshire	297.6	46.5%	326.9	51.1%	11.9	1.9%	3.3	0.5%	639.7
New Jersey	2,192.5	49.5%	1,530.5	34.5%	611.2	13.8%	96.9	2.2%	4,431.0
New Mexico	347.3	34.4%	270.7	26.8%	372.9	36.9%	18.8	1.9%	1,009.6
New York	13,118.0	52.2%	10,445.9	41.6%	1,372.4	5.5%	196.5	0.8%	25,132.8
North Carolina	2,423.5	55.9%	1,730.2	39.9%	34.4	0.8%	146.4	3.4%	4,334.5
North Dakota	191.0	56.4%	143.0	42.2%	1.5	0.4%	3.1	0.9%	338.5
Ohio	3,477.2	57.3%	2,062.3	34.0%	430.7	7.1%	101.4	1.7%	6,071.7
Oklahoma	598.7	45.5%	550.5	41.8%	120.6	9.2%	46.6	3.5%	1,316.3
Oregon	323.1	19.0%	628.0	36.9%	724.8	42.6%	26.1	1.5%	1,701.9
Pennsylvania	4,015.5	50.3%	1,925.3	24.1%	1,873.4	23.5%	161.5	2.0%	7,975.7
Rhode Island	415.7	45.3%	375.3	40.9%	115.0	12.5%	11.2	1.2%	917.2
South Carolina	933.0	49.8%	876.1	46.8%	4.4	0.2%	59.7	3.2%	1,873.2
South Dakota	223.5	62.2%	121.4	33.8%	4.5	1.2%	9.8	2.7%	359.1
Tennessee	1,039.6	27.7%	486.4	12.9%	2,109.8	56.1%	122.3	3.3%	3,758.1
Texas	4,317.9	51.9%	2,932.1	35.3%	721.4	8.7%	342.0	4.1%	8,313.5
Utah	225.5	33.0%	287.4	42.0%	157.1	23.0%	13.7	2.0%	683.7
Vermont	127.8	33.7%	179.5	47.4%	63.9	16.9%	7.9	2.1%	379.1
Virginia	1,057.8	48.9%	840.7	38.9%	196.3	9.1%	68.9	3.2%	2,163.8
Washington	1,048.7	34.8%	1,340.6	44.5%	567.7	18.8%	54.8	1.8%	3,011.8
West Virginia	657.6	52.3%	503.2	40.0%	58.2	4.6%	37.7	3.0%	1,256.6
Wisconsin	1,190.5	44.0%	1,056.0	39.0%	331.4	12.2%	130.3	4.8%	2,708.2
Wyoming	108.6	54.0%	89.4	44.4%	0.0	0.0%	3.2	1.6%	201.2

Source: Urban Institute estimates (2000) based on data from HCFA 64 reports.

Notes: Does not include disproportionate share hospital payments, administrative costs, or accounting adjustments. Figures may not sum to totals due to rounding.

Mandatory services are those that states are required to offer to participate in Medicaid. They include inpatient, physician, lab/x-ray, outpatient hospital, rural clinic, EPSDT, home health, nursing facility, family planning services, and federally-qualified health center services. Optional services are additional services that states are not required to offer, but may do so and receive federal reimbursement. They include prescription drugs, ICF-MR, mental health services, clinic services, home and community-based waiver, case management, dental, vision, other practitioner, and other care services. Payments to Medicare and to managed care organizations generally include coverage for both mandatory and optional servies.

Endnotes

1 Other major aspects of the Medicaid program are discussed in Chapter 1: Eligibility, Chapter 3: Financing, and Chapter 4: Administration.

2 For a discussion of the federal and state case law that has developed around Medicaid benefits issues, see Perkins, J., and Somers, S., *An Advocate's Guide to the Medicaid Program,* June 2001, National Health Law Program, sections 4.3–4.10, www.healthlaw.org. Accessed April 18, 2002.

3 For a review of the impact of Medicaid Managed Care, see *Medicaid Managed Care: Evidence and Experiences,* The Kaiser Commission on Medicaid and the Uninsured, July 2000.

4 For a discussion of state efforts to increase federal funding for public health and mental health services, see Coughlin, Zuckerman, Wallin, and Holahan, "A Conflict of Strategies: Medicaid Managed Care and Medicaid Maximization," *HSR,* 34, April 1999, pp. 281, 284.

5 Transportation services are not a statutory benefits category. However, states are required to ensure necessary transportation for beneficiaries to and from providers, 42 C.F.R. 431.53, and federal Medicaid matching funds are available for transportation expenses, 42 C.F.R. 440.170(a).

6 Health Care Financing Administration. 1998 National Health Expenditures. www.hcfa.gov/stats/nhe-oact/. Accessed April 18, 2002.

7 For a discussion of state efforts to rely on certificate of need (CON) and reimbursement policies—rather than on limits on eligibility—to control nursing home costs, see: Feder, J. and W. Scanlon. *Washington Report: The Shortage of Nursing Home Beds.* The Urban Institute, p. 2.

8 Total average annual health expenditures for the elderly and disabled populations are higher than indicated in Figure 2-3, as Medicare pays for most acute care services and limited long-term care for these groups. Medicaid provides "wrap-around" acute care and comprehensive long-term care for low-income Medicare beneficiaries. For more information, see: O'Brien, E., Rowland, D., and Keenan, P. "Medicaid and Medicare for the Elderly and Disabled Poor." The Kaiser Commission on Medicaid and the Uninsured, May 1999.

9 Nemore, P. *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update.* Prepared for the Henry J. Kaiser Family Foundation by the National Senior Citizens Law Center, December 1999, www.kff.org/content/2000/1566/. Accessed April 18, 2002.

10 These eligibility categories are known as the "mandatory categorically needy." States have the option of covering other groups, including the "medically needy," but they are not required to offer the same benefits—mandatory or optional—to the "medically needy" as they must offer to the "categorically needy." For example, all states (and the District of Columbia) cover the optional prescription drug benefit for their "categorically needy" population, but only 27 (and D.C.) offer the benefit to their "medically needy" eligibles. Westmoreland, T. *Medicaid & HIV/AIDS Policy: A Basic Primer:* The Henry J. Kaiser Family Foundation, July 1999, www.kff.org.

11 The Kaiser Commission on Medicaid and the Uninsured. *Medicaid "Mandatory" and "Optional" Eligibility and Benefits.* July 2001, www.kff.org/content/2001/2256. Accessed April 18, 2002.

12 The only exception is family planning services and supplies, which the federal government matches at 90 percent in every state.

13 Urban Institute estimates based on HCFA 64 data, 2000, prepared for the Kaiser Commission on Medicaid and the Uninsured.

14 As of December 1999, all states except Arizona have at least one HCBS waiver in effect. Arizona covers home and community-based services under a different waiver authority. www.hcfa.gov.

15 The regulatory criteria for demonstrating budget neutrality showing were liberalized in 1994 (59 *Fed. Reg.* 37717, July 25, 1994, revising 42 C.F.R. 441.302(e), (f)).

16 CMS has by regulation defined "preventive services" as "services provided by a physician or other licensed practitioner … under state law to: (1) Prevent disease, disability, and other health conditions or their progression, (2) Prolong life; and (3) Promote physical

and mental health and efficiency." 42 C.F.R. 440.130(c).

17 Note that Federal Medicaid matching funds are available for physical therapy services, which are an optional category under section 1905(a)(11) of the Social Security Act. CMS recently clarified that "under EPSDT requirements, a state must cover any medically necessary services that could be part of the basic Medicaid benefit if the state elected the broadest benefits permitted under federal law …" (Letter to State Medicaid Directors, January 10, 2000, Attachment 4-B, www.hcfa.gov/medicaid/letters/smd11001.pdf). Accessed April 18, 2002.

18 Section 4270 *State Medicaid Manual,* www.hcfa.gov/pubforms/p2192ch4.htm. Accessed April 18, 2002.

19 The Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Women,* November 2000, www.kff.org/content/2000/2205/Medicaidwomenfs.PDF. Accessed April 18, 2002.

20 Benson Gold, R. and Richards, C. L. *Medicaid Support for Family Planning in the Managed Care Era.* Prepared for The Kaiser Commission on Medicaid and the Uninsured by The Alan Guttmacher Institute, 2001, www.kff.org/content/2001/6001/. Accessed April 18, 2002.

21 Other benefits categories through which federal matching funds are available for case management include: EPSDT, HCBS waiver services, and tuberculosis-related services. States may also treat case management services as administrative costs that are matched at the general 50 percent administrative matching rate, rather than at the state's regular rate for services.

22 42 C.F.R. 483.350 et seq., 66 *Fed. Reg.* 7148 (January 22, 2001).

23 42 C.F.R. 441.250–441.259.

24 According to the NARAL Foundation/NARAL, as of 1999, 44 states provide that only a physician may perform an abortion. *Who Decides? A State-by-State Review of Abortion and Reproductive Rights, 2000.* NARAL Foundation/NARAL, p. xiv.

25 Section 509(a) of the Labor/HHS/Education Appropriations Act for FY 2001, H.R. 5656, enacted as section 1(a)(1) of the Consolidated Appropriations Act, 2001, P.L. 106–554.

26 As of December 1999, 32 states funded abortions for Medicaid beneficiaries only under the circumstances required by federal law; 16 states used their own funds to cover other "medically necessary" abortions; and 3 states further extended coverage for abortion services in cases of fetal anomaly or grave physical health danger. Two states—Mississippi and South Dakota—did not cover abortion services in cases of rape or incest. The Alan Guttmacher Institute, www.agi-usa.org/pubs/abort_law_status.html#5. Accessed April 18, 2002.

27 Letter to State Medicaid Directors, March 30, 2001, www.hcfa.gov/medicaid/letters/smd33001.htm. Accessed April 18, 2002.

28 While most requirements outlined were intended to prevent states from restricting Medicaid benefits, states may perceive these requirements as limitations on their ability to *expand* benefits. For example, under these requirements, it is difficult for states to vary benefits to target special populations or areas. If the cost of providing the service to the state's entire Medicaid population is prohibitive for the state, the state must either apply for and receive a waiver to target the benefit or simply not provide the service to any of its Medicaid beneficiaries.

29 The federal Medicaid statute also establishes the right of Medicaid beneficiaries to choose to receive covered benefits from a practitioner or clinic from among the providers that are willing to accept Medicaid patients. This is an important patient protection, particularly with respect to such services as family planning, which some practitioners and institutions will not, as a matter of conscience, provide. However, the "freedom of choice" provision is only meaningful if sufficient providers elect to participate in Medicaid so that beneficiaries have more than a theoretical choice. In addition, the "freedom of choice" provision has frequently been waived by the Secretary of HHS. For information on freedom-of-choice waivers, see: CMS, www.hcfa.gov/medicaid/hpg3.htm. For information on freedom of choice and family planning, see: Rosenbaum, S., Shin, P., Mauskopf, A., and Zuvekas, A. "Medicaid Managed Care and the Family Planning Free-Choice Exemption: Beyond the Freedom to Choose." *Journal of Health Politics, Policy and Law.* 22(5): October 1997.

30 "While States may limit the services provided under an HCBS waiver …, States may not limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid." Letter to State Medicaid Directors,

January 10, 2000, Attachment 4-B, www.hcfa.gov/medicaid/letters/smd11001.pdf. Accessed April 18, 2002.

31 The Breast and Cervical Cancer Treatment and Prevention Act (P.L. 106-354), which was signed into law in October 2000, established a new optional eligibility group of women who have been screened under the Centers for Disease Control's early detection program and who need treatment for breast or cervical cancer. These women are eligible for the full range of services covered under a state's Medicaid plan, not just those services related to breast or cervical cancer. Letter to State Health Officials, January 4, 2001, www.hcfa.gov/medicaid/sho01041.htm; Question 17, Frequently Asked Questions, March 28, 2001, www.hcfa.gov/medicaid/bccpt/bccptfaq.htm. Accessed April 20, 2002.

32 See Long, S. and Zuckerman, S., "Urban Health Care in Transition: Challenges Facing Los Angeles County," *Health Care Financing Review,* Fall 1998, pp. 45–58; www.hcfa.gov/medicaid/1115/lacnfact.htm. Accessed April 18, 2002.

33 42 C.F.R. 440.230(d) permits state Medicaid agencies to "place appropriate limits on a service based on such criteria as medical necessity. …" However, neither the federal regulations nor the statute define the term. For federal and state court cases discussing "medical necessity," see Perkins, J., and Somers, S., *op. cit.,* footnote 78.

34 Rosenblatt, R., Law, S., and Rosenbaum, S. *Law and the American Health Care System* (1998), Foundation Press, p. 237.

35 *DeSario v. Thomas* 139 F.3d. 80 (2nd Cir. 1998). The Supreme Court vacated the judgment and remanded the case to the Second Circuit for further consideration in light of the interpretive guidance issued by HCFA on September 4, 1998. *Slekis v. Thomas,* 525 U.S. 1098 (January 19, 1999).

36 Letter to State Medicaid Directors, September 4, 1998, www.hcfa.gov/medicaid/letters. Accessed April 19, 2002.

37 A recent national survey of state Medicaid MCO contracts found that, in nine of 40 states reviewed, the contracts or RFPs did not contain provisions defining the "medical necessity" standards an MCO should use in making coverage decisions. George Washington Center for Health Services Research and Policy. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Ed,* June 1999, Table 2.7 (Medical Necessity Standards) www.gwhealthpolicy.org. Accessed April 18, 2002.

38 Letter to State Medicaid Directors, December 17, 1997, www.hcfa.gov/medicaid/bba97//bba4704.htm. Accessed April 18, 2002.

39 For more information on Medicaid coverage of prescription drugs and the Medicaid drug rebate program, see: Bruen, B. *Medicaid and Prescription Drugs: An Overview.* The Kaiser Commission on Medicaid and the Uninsured, October 2000; Schneider, A. and Elam, L. *Medicaid: Purchasing Prescription Drugs.* The Kaiser Commission on Medicaid and the Uninsured, December 2001.

40 Letter to State Medicaid Directors, June 19, 1996, www.hcfa.gov/medicaid/hiv/hiv61996.htm. Accessed April 18, 2002.

41 Letter to State Medicaid Directors, November 30, 1998, www.hcfa.gov/medicaid/smd11308.htm. Accessed April 18, 2002.

42 Section 1927(d)(5) of the Social Security Act.

43 See Lambrew, J., *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview,* The Kaiser Commission on Medicaid and the Uninsured, July 2001, www.kff.org/content/2001/4001/. Accessed April 18, 2002.

44 Oregon's Prioritized List of Health Services (October 1, 1999) is available at www.ohppr.state.or.us/.

45 J. Mittler, M.Gold, and B. Lyons. *Managed Care and Low-Income Populations: Four Years' Experience with the Oregon Health Plan,* Kaiser/Commonwealth Low-Income Coverage and Access Project, May 1999, p. 46, www.kff.org. Accessed April 18, 2002.

46 Centers for Medicare & Medicaid Services, *Health Insurance Flexibility and Accountability Demonstration Initiative,* August 2001, www.hcfa.gov/medicaid/hifademo.htm. Accessed April 18, 2002.

47 Mann, C., *The New Medicaid and CHIP Waiver Initiatives,* The Kaiser Commission on Medicaid and the Uninsured, February 2002, www.kff.org.

48 The Court held that an ADA violation would occur "when the State's treatment professionals have

determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." 119 S. Ct. at 2181. See Rosenbaum, S. *The Olmstead Decision: Implications for Medicaid.*

49 See The Kaiser Commission on Medicaid and the Uninsured. *The Olmstead Decision: Implications for Medicaid,* March 2000, www.kff.org/content/2000/2185/. Accessed April 18, 2002.

50 Letter to State Medicaid Directors, January 14, 2000 (OlmsteadUpdate No. 1), www.hcfa.gov/medicaid/letters/smd1140a.htm; Accessed April 18, 2002. Letter to State Medicaid Directors, July 25, 2000 (Olmstead Update #2) www.hcfa.gov/medicaid/letters/smd72500.htm; Letter to State Medicaid Directors, July 25, 2000 (Olmstead Update No. 3) www.hcfa.gov/medicaid/letters/smd725a0.htm; Letter to State Medicaid Directors, January 10, 2000 (Olmstead Update No.4) www.hcfa.gov/medicaid/letters/smd11001.pdf; Letter to State Medicaid Directors, January 10, 2000 (Olmstead Update No. 5) www.hcfa.gov/medicaid/letters/smd110a1.pdf. Accessed April 18, 2002.

51 The U.S. Supreme Court denied the beneficiaries' petition for certiorari, allowing the Court of Appeals ruling to stand in the 2nd Circuit. Cert. den. 121 U.S. 156 (2000).

52 Letter to State Medicaid Directors, June 7, 1999, www.hcfa.gov/medicaid/letters/smd60799.htm. Accessed April 18, 2002.

53 Rhode Island covers this service as part of its Section 1115 Waiver.

54 Letter to State Medicaid Directors, June 11, 1997, www.hcfa.gov/medicaid/hiv/hiv61197.htm. Accessed April 18, 2002.

55 Letter to State Medicaid Directors, January 8, 2001, www.hcfa.gov/medicaid/hiv/hiv01081.htm. Accessed April 18, 2002.

56 Letter to State Medicaid Directors, January 19, 2001, www.hcfa.gov/medicaid/smd01191.pdf. Accessed April 18, 2002.

57 CMS, *Medicaid and Telemedicine,* www.hcfa.gov/medicaid/telemed.htm. Accessed April 18, 2002.

58 Letter to State Medicaid Directors, January 5, 2001, www.hcfa.gov/medicaid/letters/smd01051.htm. Accessed April 18, 2002. In addition, a recent survey of state Medicaid directors found that 25 states did not cover any treatments for tobacco dependence in 1998. Schauffler, H. H., Barker, D., and Orleans, C., "Medicaid Coverage for Tobacco-Dependence Treatments." *Health Affairs.* 20(1): January/February 2001.

59 Hudman, J. and O'Malley, M. *Cost-Sharing in Medicaid and CHIP Programs: A Look at the Research, State Policies, and Implementation Issues.* The Kaiser Commission on Medicaid and the Uninsured, forthcoming; Dallek, G., *A Guide to Cost-Sharing and Low-Income People.* Families USA Foundation, October 1997.

60 In 1999, HCFA reaffirmed that providers are prohibited from requiring patients to make cash payments for Medicaid-covered services. Letter to State Medicaid Directors, January 27, 1999, www.hcfa.gov/medicaid/letters/smd12799.htm. Accessed April 18, 2002.

61 These services include "routine prenatal care, labor and delivery, routine post-partum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the post-partum period for conditions or complications related to the pregnancy." 42 C.F.R. 447.53(b)(2).

62 For this purpose, emergency services are "services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—(i) Placing the patient's health in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part. 42 C.F.R. 447.53(b)(4).

63 According to CMS, "where epidurals are a covered benefit under a state's Medicaid program and the service is determined to be medically necessary, a pregnant Medicaid beneficiary is entitled to receive the service from a provider who has accepted her as a patient without the imposition of deductibles, cost-sharing, or similar charges." Letter to State Medicaid Directors, January 27, 1999, www.hcfa.gov/medicaid/letters/smd12799.htm. Accessed April 18, 2002.

64 The cost-sharing protections can be waived for "expansion populations," or populations that are eligible for Medicaid only under a section 1115 waiver. See "Table 3: *Cost-Sharing in Section 1115 Demonstrations" in Hudman, J. and O'Malley, M. Cost-Sharing in Medicaid and CHIP Programs: A Look at the Research, State Policies, and Implementation Issues.* The Kaiser Commission on Medicaid and the Uninsured, forthcoming.

65 Section 1916(f) of the Social Security Act.

66 Centers for Medicare & Medicaid Services, 2000 Medicaid Managed Care Enrollment Report, www.hcfa.gov/medicaid/omc2000.htm. Accessed April 18, 2002.

67 For a review of the literature on the Medicaid managed care experience, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Managed Care: Annotated Bibliography, Evidence and Experiences,* December 2000.

68 See G.W. Center for Health Services Research and Policy, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Ed.* June 1999, Table 2.1 (General Services), Table 2.2 (Mental Health and Substance Abuse Services), Table 2.3 (Reproductive Health Services), Table 2.4 (EPSDT Services), Table 2.5 (Communicable Disease Services), Table 2.6 (Urgent Care and Emergency Care Services), Table 3.9 (Drug Formularies), pp. 4–7, and pp. 2–333; 2–334 www.gwhealthpolicy.org. Accessed April 18, 2002.

69 Letter to State Medicaid Directors, December 17, 1997, www.hcfa.gov/medicaid/bba4704.htm.

70 CMS has advised states that these contracts "must include provisions that address the responsibility of the [MCO] to furnish care and services when medically necessary in sufficient detail to ensure that beneficiaries receive needed services to which they are entitled under the contract." Letter to State Medicaid Directors, December 17, 1997, www.hcfa.gov/medicaid/bba97/bba4704.htm. Accessed April 18, 2002.

71 See G.W. Center for Health Services Research and Policy. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Ed.,* June 1999, Table 2.7 (Medical Necessity Standards), www.gwhealthpolicy.org. Accessed April 18, 2002.

72 Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999, www.kff.org. Accessed April 18, 2002.

73 See Forum for State Health Policy Leadership, National Conference of State Legislatures, *State Children's Health Insurance Program Chartbook, 2000* (March 2001), Tables 3, 4, 5, 6, and 9; and Hudman, J. and O'Malley, M. *Cost Sharing in Medicaid and CHIP Programs: A Look at the Research, State Policies, and Implementation Issues.* The Kaiser Commission on Medicaid and the Uninsured, forthcoming.

74 Personal Communication with Carolyn Hicks, Director, Legislative and Regularly Affairs, Blue Cross Blue Shield Association Federal Employee Program, March 30, 2001.

75 For an example of an estimate of the benefit value of the Blue Cross/Blue Shield product in comparison with the benefit values of other FEHBP plans offered in the Washington D.C. area, see M. Merlis. *Medicare Restructuring: The FEHBP Model.* Institute for Health Policy Solutions for The Henry J. Kaiser Family Foundation, February 1999, Table 9, p. 17, and Appendix B.

76 Merlis, M. *Medicare Restructuring: The FEHBP Model.* Institute for Health Policy Solutions for the Henry J. Kaiser Family Foundation, February 1999, pp. 12–13. For information about Medicare, see Kaiser Family Foundation, *Medicare at a Glance,* June 2001, www.kff.org/content/archive/1066/. Accessed April 18, 2002.

77 In May 2000, CMS announced its intent to establish national coverage decision procedures for determining if services are "reasonable and necessary" under the *Medicare* program. The goal of the new rule is "to facilitate timely and expanded access for Medicare beneficiaries to appropriate new technologies." According to the notice, HCFA anticipates applying two criteria in making national and local coverage decisions: (1) the item or service must demonstrate a medical benefit, and (2) the item or service must demonstrate added value to the Medicare population. The notice also states that cost is not a factor if a new item or treatment "provides a clearly superior result" and that the new rules do not apply to individual determinations of medical necessity. HCFA has not issued similar rules for Medicaid benefits. Notice of Intent to Publish a Proposed Rule, 65 *Fed. Reg.* 31124, May 16, 2000.

78 The Kaiser Family Foundation, *Medicare and Prescription Drugs,* February 2001. www.kff.org. Accessed April 18, 2002.