Chapter 11: A Description of Medicaid-Covered Services

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This chapter describes the services covered by Medicaid. The law [Social Security Act 1902(a)(10)(A), 1905(a)], along with Federal regulations [42 Code of Federal Regulations (CFR) 440], specifies which medical services must be provided (mandatory) and which services may be provided (optional) to persons eligible to receive Medicaid. For purposes of this article, these general eligibility groups include: the mandatory eligibility groups; the optional eligibility groups; and the medically needy. The mandatory eligibility groups include:

- Families with children receiving Aid to Families with Dependent Children (AFDC) or linked in specific ways to assistance through the AFDC program.
- Pregnant and/or postpartum women and children under 6 years of age (including infants) whose family incomes do not exceed standards related to Federal poverty guidelines. States are also required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983, in families at or below the Federal poverty level (FPL).
- Aged, blind, and disabled individuals receiving assistance under the Federal Supplemental Security Income (SSI) program or whose eligibility for Medicaid is determined under State standards that are more restrictive than the standards for SSI.
- Medicare-eligible individuals whose incomes do not exceed a specified percent of FPL and whose resources are below twice the standard allowed under the SSI program. For this group, coverage is generally limited to payment of Medicare premiums, deductibles, and coinsurance for services.
- Special protected groups (these are usually individuals who lose cash assistance because of the cash program's rules but who may keep Medicaid for a period of time).

The optional eligibility groups include additional groups related to the mandatory eligibility groups. The broadest optional groups include:

- Infants up to 1 year of age and pregnant women not covered under the mandatory rules whose family incomes are more than 133 percent but not more than 185 percent of FPL (the percent to be set by each State).
- Certain aged or disabled adults who have incomes above those requiring mandatory coverage but below FPL.
- Children under 21, 20, 19, or 18 years of age or reasonable groups of these children who meet income and resource requirements for AFDC but who are not otherwise eligible for AFDC or children under 19 years of age who were born after a State-chosen date prior to September 30, 1983, who meet the income and resource requirements of AFDC.
- Institutionalized individuals with incomes and resources below specified limits.
- Caretaker relatives whose incomes and resources meet the AFDC income and resource requirements.
- Persons receiving care under home and community-based waivers.
- Recipients of State supplementary payments.
- Pregnant women during a period of presumptive eligibility.

The medically needy program is also an optional State program. Individuals who qualify are those who would be eligible for Medicaid under one of the mandatory or optional groups covered by their State except that their income and/or resources are between the standards for those groups and the medically needy standards set by the State. Persons may become eligible for Medicaid coverage under the medically needy provision after they have incurred medical expenses that cause their resources and/or income to drop below the medically needy levels.

The Federal Medicaid law and regulations provide that the Federal Government will share in paying for mandatory and optional services [Social Security Act 1903(a), 1903(g), 1905(h); 42 CFR 433.10, 433.15]. A delineation of the services covered by Medicaid and a brief discussion of service limitations are presented in more detail below. The citations of the relevant Social Security law and Code of Federal Regulations are not meant to be exhaustive but, rather, to give a minimum reference base.

Mandatory services

A State's Medicaid program is required to provide the following services to the mandatory and optional eligibility groups [Social Security Act 1902(a)(10)(A), 1905(a); 42 CFR 440.210]:

1. *Inpatient hospital services* (other than services in an institution for mental diseases) are services ordinarily furnished in a hospital for the care and treatment of inpatients. Except for nurse-midwife services, they are furnished under the direction of physicians or dentists [Social Security Act 1905(a)(1); 42 CFR 440.10].

2. *Outpatient hospital services* must be provided under the direction of a physician or a dentist. Preventive, diagnostic, therapeutic, rehabilitative, and palliative services are included; they may include various types of organized outpatient programs for psychiatric treatment. The institution must meet the requirements for participation in Medicare and be licensed or approved as a hospital by State authority [Social Security Act 1905(a)(2)(A); 42 CFR 440.20(a)].

The text for this chapter came in part directly from the following sources: Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*, Washington: U.S. Government Printing Office, 1988, and Commerce Clearing House, *Topical Law Reports, Medicare and Medicaid Guide, Volume 4*, Chicago: Commerce Clearing House, Inc.

3. *Rural health clinic (RHC) services* are provided in a facility in a rural area determined to have a shortage of health services or primary medical care providers. RHCs must be under the medical direction of physicians and must have at least one nurse practitioner or physician assistant on staff. The services that a State has to cover in RHCs include the professional services of physicians, physician assistants, nurse practitioners, nurse-midwives or other specialized nurse practitioners, clinical psychologists, and clinical social workers employed by RHCs. States also are required to cover any other ambulatory services provided by RHCs that are otherwise available under a State's Medicaid program. Under certain conditions, part-time or intermittent visiting nurse care and related medical supplies can be included [Social Security Act 1905(a)(2)(B), 1905(l)(1); 42 CFR 440.20(b)]. As of March 1992, the District of Columbia, Hawaii, and New Jersey did not include coverage for RHC services (Health Care Financing Administration, 1992).

4. *Federally qualified health center* (FQHC) services were mandated as part of the Omnibus Budget Reconciliation Act (OBRA) 1989 (Public Law 101-239) [Social Security Act 1905(a)(2)(C), 1905(l)(2)]. FQHC is an entity that is receiving a grant, has a contract with a grantee and is qualified to receive a grant, or is determined by the Secretary to meet the requirements for receiving a grant under sections 329 (Migrant Health Centers), 330 (Community Health Centers), or 340 (Health Care for the Homeless) of the Public Health Service Act. It also includes outpatient health programs or facilities operated by a tribe or tribal organization. Covered services for FQHCs are the same as for RHCs. Medicaid FQHC regulations have not been published yet.

5. *Other laboratory and X-ray services* encompass professional and technical laboratory and radiological services ordered and provided by or under the direction of a licensed medical practitioner [Social Security Act 1905(a)(3); 42 CFR 440.30, 441.16]. Independent laboratories must be certified under the Clinical Laboratory Improvement Act.

6. *Nursing facility services* (other than in an institution for mental diseases) for individuals 21 years of age or over (optional services for individuals under 21) includes services received in an institution or part of an institution that provides skilled nursing care; rehabilitative services; or health-related care on a daily basis to individuals who are injured, disabled, or sick. Services include those that are given to an individual who needs daily basic nursing care or other rehabilitative services that practically can be provided only in a nursing facility on an inpatient basis. These include nursing and related services; specialized rehabilitative services; medically related social services; and activities to attain or maintain, to the fullest extent possible, the physical, mental, and psychosocial well-being of each resident. Other services include pharmacy and dietary services, dental services (to the extent covered under the State plan), and treatment and services required by mentally ill and mentally retarded residents not otherwise provided [Social Security Act 1905(a)(4)(A), 1905(c), 1905(f), 1919(a); 42 CFR 440.40(a), 483].

7. *Early and periodic screening, diagnosis, and treatment* (EPSDT) services for individuals under 21 years of age consist of: a comprehensive health and development history, including physical and mental assessments; physical examination; immunizations; laboratory tests, including blood lead levels; and health education. Vision services that at a minimum include diagnosis and treatment of defects in vision, including eyeglasses; dental services that at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health; and hearing services that at a minimum include diagnosis and treatment of hearing defects, including hearing aids, must also be provided. EPSDT services also encompass other health care, diagnostic services, treatment, and other measures that are coverable under Medicaid and medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered through screening. These additional services must be provided whether or not they are covered in the State's Medicaid plan. States must establish distinct periodicity schedules for screening, vision, dental, and hearing services. In addition, interperiodic screens must be available based on medical necessity. Individuals must be made aware of EPSDT services, and arrangements must be made for EPSDT screening when it is requested.

Qualified providers may furnish full or partial screens. The State may not limit providers of EPSDT services only to those providers who are qualified to furnish all services nor may a State prevent a provider who is qualified to furnish only one service from being qualified as an EPSDT provider. States are encouraged to promote close coordination among the providers, especially if responsibilities for screening services are shared [Social Security Act 1902(a)(43), 1905(a)(4)(B), 1905(r); 42 CFR 440.40(b), 440.250(b), 441 Subpart B].

8. *Family planning services and supplies* must be provided to individuals of childbearing age (including minors) who desire such services and supplies. Although Federal financial participation is available for abortions and sterilizations under certain circumstances (as described in 42 CFR 441 Subparts E and F), these are not considered family planning services [Social Security Act 1905(a)(4)(C); 42 CFR 440.40(c), 440.250(c), 441.20].

9. *Physicians' services* must be provided by a licensed doctor of medicine or osteopathy or under his or her personal supervision. Physician services may be provided in the physician's office, patient's home, hospital, nursing facility, or elsewhere [Social Security Act 1905(a)(5)(A); 42 CFR 440.50(a)].

10. *Medical and surgical services furnished by a dentist* are covered: (1) to the extent such services may be performed under State law either by a physician or by a doctor of dental surgery or dental medicine; and (2) if they would be covered as a physician's service if furnished by a physician [Social Security Act 1905(a)(5)(B); 42 CFR 440.50(b)].

11. *Nurse-midwife services* encompass services performed by certified nurse-midwives and authorized

under State law or regulations. Generally, these services include management of pregnant women and newborn infants. Nurse-midwives do not need to be under the supervision of or associated with a physician or other health care provider to perform these services [Social Security Act 1905(a)(17); 42 CFR 440.165, 441.21].

12. *Certified pediatric nurse practitioner and certified family nurse praetitioner services* furnished within the scope of practice as authorized by State law or regulations must be covered. The services do not have to be performed under the supervision of or associated with a physician [Social Security Act 1905(a)(21)].

13. *Home health services* include nursing, home health aide, and medical supplies, equipment, and appliances suitable for use at home. Services must be prescribed by a physician and reviewed every 60 days. A State's Medicaid plan must cover these services for all individuals 21 years of age or over in the mandatory and optional eligibility groups and for individuals in the mandatory and optional eligibility groups under 21 years of age if the plan provides nursing facility services for that age group. These services must be provided at the recipient's place of residence. States also have the option to include physical therapy, occupational therapy or speech pathology, and audiology services [Social Security Act 1905(a)(7); 42 CFR 440.70, 441.15].

Finally, each State's Medicaid program must assure transportation of any Medicaid-eligible individual to and from providers of medical care (42 CFR 431.53).

Optional services

In addition to the medical services that must be provided, States may provide the following services to the mandatory and optional eligibility groups:

14. *Medical or remedial care* recognized by State law and furnished by licensed practitioners within the scope of their practice as defined by the State may be covered. Examples of frequently covered practitioners include: podiatrists, optometrists, chiropractors, psychologists, medical social workers, and nurse anesthetists [Social Security Act 1905(a)(6); 42 CFR 440.60].

15. *Private duty nursing services* are for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or nursing facility. The services must be provided by a registered nurse or a licensed practical nurse under the direction of the recipient's physician. Services can be rendered, at the State's option, in a hospital, nursing facility, or at the patient's home [Social Security Act 1905(a)(8); 42 CFR 440.80].

16. *Clinic services* are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services rendered to outpatients by a facility that is not part of a hospital. All services must be provided under the direction of a physician, dentist, or nurse-midwife [Social Security Act 1905(a)(9); 42 CFR 440.90]. As of October 1, 1991, all States, including the territories, with the exception of Rhode Island, covered this service.

17. *Dental services* are comprised of diagnostic, preventive, or corrective procedures that treat: (1) the teeth and other structures of the oral cavity and (2) disease, injury, or impairment that may affect the oral or general health of the recipient [Social Security Act 1905(a)(10); 42 CFR 440.100].

18. *Physical therapy and occupational therapy* must be prescribed by a physician and performed by or under the direction of a qualified therapist. Coverage includes all necessary supplies and equipment [Social Security Act 1905(a)(11); 42 CFR 440.110(a), 440.110(b)].

19. *Services for persons with speech, hearing, and language disorders* must be provided by or under the direction of a speech pathologist or audiologist to whom a patient is referred by a physician. Services include diagnostic, screening, preventive, or corrective procedures. Coverage includes all necessary supplies and equipment [Social Security Act 1905(a)(11); 42 CFR 440.110(c)].

20. All jurisdictions, except Puerto Rico and the Virgin Islands, covered outpatient *prescribed drugs* for the mandatory and optional eligibility groups as of October 1, 1991 [Social Security Act 1903(i)(5), 1905(a)(12); 42 CFR 440.120(a)]. OBRA 1990 (Public Law 101-508) introduced a new financing mechanism for prescribed drugs, the Medicaid Drug Rebate Program, and changed coverage, limitation, and exclusion provisions.

In order for States to receive Federal reimbursement for outpatient drugs, the manufacturer must have in effect a rebate agreement with the Secretary of the U.S. Department of Health and Human Services (DHHS) on behalf of the States or an individual agreement with a State as approved by the Secretary. Currently, there are approximately 400 such agreements. There are limited cases in which medications not covered under rebate agreements may be covered by the Medicaid program [Social Security Act 1927(a)(3)]. The rebate program is discussed more fully in Chapter 14. The coverage, limitation, and exclusion provisions of OBRA 1990, as well as some in place before then, are discussed below.

A State may subject to prior authorization any covered outpatient drug [Social Security Act 1927(d)]. The only exception is the first 6 months following approval by the Food and Drug Administration (FDA) of a new drug product. Under prior authorization, the State must provide a response to the request for the drug within 24 hours; and in an emergency situation, the pharmacy must provide at least a 72-hour supply of a covered outpatient prescription drug.

States may exclude an outpatient drug or otherwise restrict its coverage if: the prescribed use is not for a medically accepted indication, the drug is restricted in an individual agreement between a manufacturer and a State, or the drug is contained in the list of drugs subject to restriction or is restricted by the government in another manner [Social Security Act 1927(d)(1)(B)].

Exclusion of selected groups of drugs from a State benefit program is allowable. These groups include benzodiazepines; barbiturates; drugs used to promote fertility, smoking cessation, or weight gain; drugs used to treat anorexia; drugs used for symptomatic relief of coughs and cold; agents used for cosmetic purposes or hair growth; prescription vitamins and minerals (except for prenatal vitamins and fluoride preparations); any or all over-the-counter (nonprescription) drugs; drugs for which a manufacturer requires the purchase of monitoring equipment or supplies when the drug is dispensed; and any FDA-approved drug without established efficacy (i.e., drug efficacy study implementations (DESI) drugs) but not subject to a Notice of Opportunity for Hearing by FDA [Social Security Act 1927(d)(2)].

A State can no longer exclude a drug of a participating manufacturer because it is a brand name or a generic substance. This new requirement is an effort to provide open access to brand name and generic drugs (in contrast to closed formularies that some States maintained) and achieve cost savings on drugs, which are a significant portion of Medicaid expenditures.

A State may impose limitations on the minimum or maximum quantities per prescription or the number of refills, provided that the limitations are in place to discourage waste [Social Security Act 1927(d)(7)]. Limits on amount, duration, and scope of services already in law also apply.

21. States may provide any or all of the following benefits: *dentures, prosthetic devices*, and *eyeglasses* [Social Security Act 1905(a)(12); 42 CFR 440.120(b), 440.120(c), 440.120(d)].

22. *Other diagnostic, screening, preventive, and rehabilitative services* may be covered [Social Security Act 1905(a)(13); 42 CFR 440.130].

23. *Inpatient hospital and nursing facility services for individuals 65 years of age or over in an institution for mental diseases* may be covered as long as specific conditions are met regarding the types of institutions providing the services and the care rendered to the patient [Social Security Act 1905(a)(14); 42 CFR 440.140, 441 Subpart C].

24. *Services in an intermediate care facility for the mentally retarded* (ICF/MR) may be provided if certain stipulations concerning the types of institutions and care provided are met [Social Security Act 1905(a)(15); 42 CFR 440.150].

25. *Inpatient psychiatric facility services for individuals under 21 years of age* continue for an eligible patient who is receiving them at age 21 until the services are no longer needed or until the patient's 22nd birthday, whichever occurs first. These services must involve active treatment, i.e., services based on an individual plan of care that is professionally developed and supervised by a team qualified to assess mental health conditions and treatment [Social Security Act 1905(a)(16), 1905(h)(1); 42 CFR 440.160, 441 Subpart D].

26. *Hospice care* is provided for terminally ill individuals who have elected to use hospice care instead of using other benefits covered under Medicare. Hospice coverage must be available for at least 210 days and may be subdivided into two or more periods at the State's option. In general, no more than 20 percent of hospice care days may be used for inpatient care in order to control pain or palliate symptoms. This limit, however, is not binding for patients with acquired immunodeficiency syndrome (AIDS) [Social Security Act 1905(a)(18)].

27. *Case-management services* are services that assist Medicaid-eligible individuals to gain access to medical, social, educational, and other services. States have the option of providing these services without regard to the requirements of statewideness and comparability of services. Thus, States may target these services to individuals by age, type or degree of disability, or by illness or condition. States may also limit the case-management services provided to individuals with developmental disabilities or chronic mental illness [Social Security Act 1905(a)(19), 1915(g); 42 CFR 440.180(c)].

28. *Respiratory care services* are provided on a part-time basis in the individual's home by a respiratory therapist or other health care professional trained in respiratory therapy. These services may be covered only if: (a) they are not included as part of some other item or service in the State's Medicaid plan; (b) the care is provided as an alternative to covered care in a hospital, nursing facility, or ICF/MR; (c) the recipient is medically dependent on a ventilator for at least 6 hours per day; (d) the recipient had been dependent as an inpatient in a hospital, nursing facility, or ICF/MR for the lesser of 30 consecutive days or the maximum number of days specified in the State's Medicaid plan; (e) there is adequate social support for the individual to be cared for in the home; and (f) the individual wishes to be cared for at home [Social Security Act 1902(e)(9)(A), 1902(e)(9)(C), 1905(a)(20)].

29. *Home and community care for functionally disabled elderly individuals* generally is defined as care provided to financially eligible people 65 years of age or over who require substantial human assistance in performing two out of three specified activities of daily living (ADLs). Individuals with Alzheimer's disease may qualify for the program under somewhat more liberal eligibility criteria (assistance in two out of five specified ADLs or sufficiently cognitively impaired as to require substantial supervision because of inappropriate behaviors that pose serious health or safety hazards to themselves or others). Home and community care includes homemaker, home health aide, chore, and personal care services; nursing care services provided by or under the supervision of a registered nurse; respite care; training for family members in managing the individual; adult day care; and for the chronically mentally ill, day treatment, partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). States may also furnish other home- and community-based services (other than room and board) as the Secretary may approve [Social Security Act 1905(a)(22), 1929].

30. *Community-supported living arrangement (CSLA) services* are designed to assist developmentally disabled individuals in ADLs necessary to permit them to live in their own home, apartment, family home, or rental unit. The services consist of one or more of the following: personal assistance; training and habilitation; 24-hour emergency assistance; assistive technology; adaptive equipment; support services necessary to aid an individual to participate in community activities; and other services approved by the Secretary of DHHS. No Federal financial participation is allowed for room and board or for the cost of prevocational, vocational, or supported employment [Social Security Act 1905(a)(23), 1930; 42 CFR 441.400]. Eight States have been selected to provide CSLA services: California, Colorado, Florida, Illinois, Maryland, Michigan, Rhode Island, and Wisconsin (Intergovernmental Affairs Office, Medicaid Bureau, HCFA Pub. No. 02155-92).

31. *Any other medical care or remedial care* recognized under State law as specified by the Secretary of DHHS may be covered. This includes Christian Science nurses' services, Christian Science sanatoria services, nursing facility services for individuals under 21 years of age, emergency hospital services, and personal care services in a recipient's home [Social Security Act 1905(a)(24); 42 CFR 440.170].

Figure 11.1 presents the Medicaid-covered optional services by State, as of October 1, 1991.

Services for the medically needy

If a State's Medicaid program covers the medically needy, it must provide certain minimal services. These services include: (a) prenatal care and delivery services for pregnant women; (b) ambulatory services, as defined in the State's Medicaid plan, for individuals under 18 years of age (and at the State's option up to age 19, 20, or 21) and for individuals entitled to institutional services; and (c) home health services for any individual entitled to nursing facility services. If the program offers any group of medically needy individuals services in institutions for mental diseases (services numbered 23 and 25 above) or in an ICF/MR (service number 24), then the program must provide individuals in that group, at a minimum, services numbered 1 through 11 above or any 7 from services numbered 1 through 28. Any service provided to the medically needy must be provided also to the mandatory and optional eligibility groups. If a State chooses to provide EPSDT to any medically needy group, it must provide the entire package of EPSDT services [42 CFR 440.220].

Coverage for poor pregnant and postpartum women

Benefits to women eligible under the poverty income levels are limited to services related to pregnancy. These include prenatal, delivery, postpartum, and family planning services, as well as services for other conditions that may complicate pregnancy [Social Security Act 1902(a)(10)(E)(iii)(VII)].

General requirements

Each Medicaid State plan must specify the amount, duration, and scope of services provided to the mandatory and optional eligibility groups and, if applicable, to each covered group of medically needy individuals [42 CFR 440.230]. The services provided to the mandatory and optional eligibility groups may not be less in amount, duration, and scope than the services provided to the medically needy. Each service also must be in sufficient amount, duration, and scope to reasonably achieve its purpose. A State's Medicaid agency may not arbitrarily deny or decrease the amount, duration, or scope of a mandatory service solely because of a recipient's diagnosis, type of illness, or condition. However, the agency may place appropriate limits on a service based on criteria such as medical necessity or utilization control procedures. A State may place tentative limits on EPSDT services, but any service determined to be medically necessary by the State must be provided to EPSDT recipients.

In addition, the following requirements apply:

- Statewideness—A State's Medicaid plan must be in effect throughout the entire State. With a few exceptions, the services covered in one part of a State cannot be different from those covered in another part of the State [Social Security Act 1902(a)(1); 42 CFR 431.50].
- Freedom of choice—Generally, recipients may obtain covered services from any provider qualified to provide the needed service. This requirement does not apply to Puerto Rico, the Virgin Islands, and Guam [Social Security Act 1902(a)(23); 42 CFR 431.51].
- Comparability of services—Amount, duration, and scope of services must be equal for all individuals within the mandatory and optional eligibility groups. The same is true for all individuals within each covered group of medically needy individuals [Social Security Act 1910(a)(10)(B); 42 CFR 440.240].

The Secretary of DHHS can grant a waiver of these requirements under certain circumstances. Such waivers are called freedom-of-choice waivers and home and community-based service waivers. In order to be granted, the waiver must be cost effective, efficient, and consistent with Medicaid program objectives. An example of a waiver would be a request to provide specifically defined home and community-based care to certain foster-care children under 5 years of age who test positive for AIDS who would otherwise need to be in a hospital or nursing facility [Social Security Act 1915(b), 1915(e)].

For more specific information on coverage and service limitations see Health Care Financing Administration (1992).

Figure 11.1
Medicaid Services State by State: October 1, 1991

Basic Required Medicaid Services

Medicaid recipients receiving federally-supported financial assistance must receive at least these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic (including federally-qualified health center) services
- Other laboratory and x-ray services
- Nurse Practitioners' services
- Nursing facility (NF) services and home health services for individuals age 21 and older
- Early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under age 21
- Family planning services and supplies
- Physicians' services
- Nurse-Midwife services

Optional Services in State Medicaid Programs*

• CN[1]
+ Both CN and MN[2]

Key to Medicaid Determination column:
1634 State
SSI-criteria State
209 (b) State
Not applicable

FMAP[3]	Basic Required Medicaid Services See Above	Key		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorders	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services
72.93	•		Alabama		•		•		•					•		•	•	
50.00	•		Alaska		•	•			•	•	•	•	•	•		•	•	
50.00	+		American Samoa[4]			+	+	+	+	+	+	+	+	+	+	+	+	+
62.61	•		Arizona[5]	•	•		•	•	•	•	•	•	•	•	•	•	•	
75.66	+		Arkansas		+	+	+	+	+	+	+	+	+	+	+	+	+	
50.00	+		California	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
54.79	•		Colorado	•	•		•	•	•					•		•	•	
50.00	+		Connecticut	+	+	+	+		+	+	+		+	+	+	+	+	+
50.12	•		Delaware	•	•		•	•	•					•		•	•	•
50.00	+		D.C.	+	+		+	+	+	+	+	+	+	+	+	+	+	+
54.69	+		Florida	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
61.78	+		Georgia	+	+		+		+	+				+	+	+	+	
50.00	•		Guam		•				•	•			•	•			•	
52.57	+		Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+
73.24	•		Idaho	•	•	•	•		•		•			•				
50.00	+		Illinois	+	+	+		+	+	+	+	+	+	+	+	+	+	+
63.85	•		Indiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
65.04	+		Iowa	+	+	+	+		+	+	+	+	+	+	+	+	+	
59.23	+		Kansas		+		+	+	+	+	+	+	+	+	+	+	+	
72.82	+		Kentucky	+	+		+		+	+	+	+	+	+		+		+
75.44	+		Louisiana	•	+		•		+					+	+	+		
62.40	+		Maine	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
50.00	+		Maryland	+	+		+	+	+	+	+		+	+	+	+	+	
50.00	+		Massachusetts	+	+		+	•	+	+	+	+	+	+	+	+	+	+
55.41	+		Michigan	+	+		+		+	+	+	+	+	+	+	+	+	+
54.43	+		Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
79.99	•		Mississippi				•		•	•	•	•	•	•		•	•	•
60.84	•		Missouri	•	•				•	•				•	•	•	•	
71.70	+		Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+
64.50	+		Nebraska	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
50.00	•		Nevada	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
50.00	+		New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+
50.00	+		New Jersey[6]	+	+	+	+		+	+	+	+	+	+	+	+	+	+
74.33	•		New Mexico	•	•		•		•	•	•	•	•	•	•	•	•	
50.00	+		New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+
66.52	+		North Carolina	+	+	+		+	+	+				+	+	+	+	+
72.75	+		North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+
50.00	+		N. Mariana Islands[4]				+		+	+	+	+	+	+	+	+	+	+
60.63	•		Ohio	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
70.74	+		Oklahoma	+	+		+		+	+				+		•	•	
63.55	+		Oregon[6]	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
56.84	+		Pennsylvania	+	+	+			+	+				•	+	+	+	
50.00	+		Puerto Rico[7]						+									
53.29	+		Rhode Island	•	+					+				+	+	+	•	
72.66	+		South Carolina	+	+		+		+	+	•	•		+		+	+	
72.59	•		South Dakota	•		•			•	•	•		•	•	•	•		
68.41	+		Tennessee	+	+		+		+	+				+		+		
64.18	+		Texas[6]	+	+	+	+		+		+			+		+	+	+
75.11	+		Utah	+	+		+	+	+	+	+		+	+	+	+	+	+
61.37	+		Vermont	+	+	+	+		+	+	+	+	+	+	+	+	+	
50.00	+		Virgin Islands[7]						+									
50.00	+		Virginia	+	+		+		+	+	+	+	+	+		+	+	
54.96	+		Washington	+	+	•	+	+	+	+	+	+	+	•	+	+	+	•
77.68	+		West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+	
60.38	+		Wisconsin	+	•	•	•	•	+	•	+	+	+	+	•	+	•	•
89.10	•		Wyoming		•		•		•	•	•		•	•		•	•	
•	15		•	12	14	8	13	8	15	12	11	8	11	16	8	14	16	5
+	41		+	33	36	19	32	20	40	36	31	26	29	38	31	38	33	21
	56		Total	45	50	27	45	28	55	48	42	34	40	54	39	52	49	26

[1] Categorically Needy (CN): Individuals receiving federally-supported financial assistance.
[2] Medically Needy (MN): Individuals who are eligible for medical but not for financial assistance.
[3] Federal Medical Assistance Percentage (FMAP): Rate of Federal Financial Participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1991 through September 30, 1992 (Fiscal Year 1992).
[4] American Samoa and the Northern Mariana Islands operate special Medicaid waivered programs.

The data shown were supplied by individual Regional Offices and compiled by the Intergovernmental Affairs Office, Medicaid Bureau

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Figure 11.1
Medicaid Services State by State: October 1, 1991

Basic Required Medicaid Services

Federal financial participation (FFP) is also available to States electing to expand their Medicaid programs to cover additional services, and individuals eligible for medical but not for financial assistance.

Although States must assure the availability of necessary transportation, they may seek FFP as an optional service and/or administrative cost.

Definitions and limitations on eligibility and services vary from State to State.

Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in agreement or the EPSDT program are not shown on this chart.

Optional Services in State Medicaid Programs*

Screening Services	Preventive Services	Rehabilitative Services	Age 65 or Older in IMDs[4]: A. Inpatient Hospital Services	Age 65 or Older in IMDs[4]: B. NF Services	ICF Services for Mentally Retarded	Inpatient Psychiatric Services for Under Age 21	Christian Science Nurses	Christian Science Sanitoriums	NF Services for Under Age 21	Emergency Hospital Services	Personal Care Services	Transportation Services	Case Management Services	Hospice Care Services	Respiratory Care Services	Total Additional Services		
		•		•	•	•			•			•	•	•		14	AL	
			•		•	•			•	•	•	•				17	AK	
+	+	+										+				17	AS	
					•				•	•	•	•		•	•	20	AZ	
		+	+	•	•	+			•	+	•	+	+			23	AR	
+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	30	CA	
		•	•	•	•	•			•	•		•	•	•		18	CO	
+	+	+	+	+	+	+		+	+			+	+			24	CT	
		•	•		•				•	•		•		•		16	DE	
+	+	+	+	+	+	+				+	+					23	DC	
		+	•		•				•	+	+	+	+	+	+	24	FL	
					+				+			+	+	+		14	GA	
										•						7	GU	
+	+	+			+	+			+	+		+	+	+	+	24	HI	
		•		•	•				•	•	•	•	•	•		16	ID	
	+	+	+	+	+	+		+	+	+		+		+		25	IL	
•	•	•	•		•	•	•	•	•	•		•	•		•	28	IN	
			•	•	•	•			•			+	+	+		21	IA	
		+	+	+	+	+			+	+	+	+	+	+		23	KS	
+	+	+	+	+	+	+			+	+		+	+	+		23	KY	
		+	•		•	•			•			+	+			14	LA	
+	+	+	+			+	+	+	+		+	+	+			26	ME	
			+	+	+	+			+	+	+	+	+	+		22	MD	
+	+	+	+	+	+	+			+	+	+	+	+	+		27	MA	
		+	+	+	+	+		+	+	+	+	+	+	+	+	26	MI	
+	+	+	+	+	+	+		+	+	+	+	+	+	+		29	MN	
•	•	•						•	•	•		•	•			18	MS	
		•	•		•	•			•		•	•	•	•		17	MO	
+	+	+	+	+	+	+			+	+	+	+		+		26	MT	
+			+	+	+	+			+	+	+	+	+			24	NE	
		•	•	•	•	•			•	•	•	•	•		•	25	NV	
+	+	+	+	+	+	+			+	+	+	+	+			26	NH	
+	+	+	•	•	•	•		•	•	•	•	•				26	NJ	
				•	•				•	•		•	•	•		19	NM	
+	+	+	+		+	+			+	+	+	+	+	+		26	NY	
+	+	+	+	+	+	+			+		+	+	+	+		23	NC	
+	+	+	+		+	+			+	+		+	+	+		25	ND	
+	+	+										+				15	MMI	
		•		•	•			•	•	•		•	•	•		23	OH	
•		+	•		•	+			•		+	+	+			17	OK	
+	+	+	+		+	+		+	+	+	+	+	+		+	28	OR	
		+	+	+	+	+			+	+		+	+	+		19	PA	
																1	PR	
		+	+	+	+	+			+			+	+	+		16	RI	
		+	+	+	+	+			+	+		+	+			19	SC	
		•		•	•				•	•	•		•			16	SD	
		+	+	+	+	+		+	+	+		+	+	+	+	19	TN	
		+			+			+	+	+	+	+	+	+	+	20	TX	
+	+	+	+	+	+	+			+	+	+	+	+	+		26	UT	
		+	+	+	+	+			+	+		+	+	+		23	VT	
															+	2	VI	
		+	•	•	•			+	+	+		+	+	+		21	VA	
	+	+	+	+	+	+			+	+	•	+	+	•	+	28	WA	
					+	+			+	+	+	+	+		+	21	WV	
•	•	•	•	+	•	•		+	+	+	+	+	+	+	+	30	WI	
		•	•		•				•	•		•				15	WY	
4	3	12	14	11	21	10	1	4	20	14	9	14	10	9	3			
19	20	33	26	22	28	29	2	11	30	28	19	37	33	24	11			
23	23	45	40	33	49	39	3	15	50	42	28	51	43	33	14			

[5] Arizona operates a federal assistance program under a Section 1115 Demonstration Project.
[6] Services indicated as available to the Medically Needy are not available to all Medically Needy groups.
[7] All services are provided through public health facilities.
[8] IMDs – Institutions for Mental Diseases
[9] ICF – Intermediate Care Facilities

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Reference

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