Chapter 14: Payment, Administration, and Financing of the Medicaid Program

by Paul Gurny, David K. Baugh, and Thomas W. Reilly

This chapter presents information on the administration, payment for services, and financing of the Medicaid program. It begins by providing a general description of the administrative structure of the program. It describes the methodologies by which States pay providers for services rendered to Medicaid recipients. Finally, it describes how program and administrative costs are financed.

Administrative structure

State agencies administer the Medicaid program overseen by the Health Care Financing Administration's (HCFA) Medicaid Bureau. Each State must designate a single agency that is responsible for program operations (Social Security Act 1902[a][5]; 42 CFR 431.10[b]). The basic administrative functions that must be fulfilled by a State Medicaid agency include:

- Eligibility determination. The agency must determine which individuals are eligible to receive services (42 CFR 431.10[c]-[d] and 431.11[d]).
- Provider certification. The agency must develop agreements with providers to qualify them to receive Medicaid payments. Federal law provides standards and certification procedures for institutional providers such as hospitals and nursing facilities. State certification agencies, which are different from the Medicaid agencies, survey and certify institutional providers. States generally apply their own standards for non-institutional providers such as physicians. These usually rely on the determinations of the applicable State licensing board (Social Security 1902[a][9], 1902[a][22], and 1902[a][33]; 42 CFR 431.610[b] and 431.610[f]-[g]).
- Claims processing. The State agency is responsible for processing claims submitted by providers for services rendered to Medicaid recipients. However, it may use a fiscal agent to perform this task (Social Security Act 1902[a][4]; 42 CFR 434.1 and 434.2).
- Program control. Three activities help ensure that the program is properly administered. First, the agency must maintain quality control systems, particularly for eligibility determination and claims processing. Federal payments may be reduced if errors exceed a certain level. Second, the agency must produce information on program utilization and expenditures, including reports required by HCFA. Third, the agency must review the adequacy and appropriateness of the services delivered to Medicaid recipients (Social Security Act 1902[a][19], 1902[a][26], 1902[a][30], 1902[a][31], 1902[a][33], 1919[g]; 42 CFR 431.800, 433.110, 45 CFR Part 75, 95.601 et seq.).
- Program integrity. The agency must have a system for identifying and investigating potential cases of fraud and abuse. The State typically utilizes its claims processing system to identify unusual utilization patterns by providers or recipients. Cases of apparent abuse are often handled through re-education or sanction of the offending provider or recipient. Possible cases of fraud can be referred to Medicaid fraud control units. These units operate outside the Medicaid agency and are responsible for investigating and prosecuting such cases (Public Law 100-93; 42 CFR 455.13).

Payment

As a vendor payment program, Medicaid pays providers directly. Payment levels are subject to conditions that all State Medicaid plans and agencies must satisfy. First, payments must be sufficient to enlist enough providers so that services under the plan are available to recipients to the extent that those services are available to the general population. Second, participating providers must accept Medicaid payment as payment in full. Third, payments made to providers must be consistent with efficiency, economy, and quality of care standards. Finally, States must maintain payment records, provide a description of payment methodologies and policies, and notify providers of changes in them (Social Security Act 1902[a][30]; 42 CFR 447.15, 447.200 through 447.205).

Despite these requirements, States have considerable leeway in determining payment rates. Payment methodologies may include nominal deductibles, coinsurance, or copayments. However, these may not be imposed on categorically or medically needy individuals or on qualified Medicare beneficiaries when:

- Services are provided to individuals under 18, 19, 20, or 21 years of age as decided by the State.
- Services are provided to pregnant women if (a) the services are related to the pregnancy or any other medical condition that may complicate the pregnancy, or (b) the State chooses not to impose such charges for any services provided to pregnant women.
- The individual is expected to spend most of his or her income for medical care provided in a hospital, nursing home, or other medical institution services.
- Emergency services are provided.
- Individuals of childbearing age receive family planning services and supplies.
- Services are furnished by a health maintenance organization (HMO), except that such charges may be imposed on medically needy HMO enrollees.
- Hospice services are provided. (Social Security Act 1916[a] and [b]; 42 CFR 447.53).

Methods of provider payment

This section discusses payment methods used by States for inpatient hospital services, long-term care facility services (including nursing facilities [NF] and intermediate care facility-mental retardation [ICF-MR] services), physician services, outpatient services, and prescription drugs. These services constitute a large share of Medicaid payments. The section concludes with a brief description of prepaid risk contracts in Medicaid.

Institutional services payment

Institutional services encompass inpatient hospital services and long-term care. States pay institutional services using retrospective and prospective methods.

In a retrospective system, payments are determined after services are rendered, and are based on the costs incurred by the provider in furnishing those services. Under this method, Medicaid makes interim payments throughout the year. At the end of the fiscal year (FY), there is a reconciliation between the interim payments and the institution's costs.

In a prospective system, payment amounts are determined in advance. Under this method, the State typically establishes a rate for a base year using cost-based data. For future years, the base-year rate is projected to reflect inflation. The provider receives a specific rate for each unit of service, regardless of whether the provider's costs were more or less than the pre-determined rate.

Medicaid agencies use three types of prospective methods—rate-of-increase control systems, case-mix systems, and negotiated systems. In a rate-of-increase control system, the provider is paid a fixed rate per day or per case. This rate is typically based on the institution's average costs in a base year, adjusted for inflation. Most States using this method also impose a ceiling on the rates based on factors such as type of facility or location.

In a prospective case-mix system, the payment rate is based on the patient's diagnosis. Each case is classified into one of a set of diagnosis-related groups (DRGs). Each DRG is assigned a weighing factor that represents the relative resources required by a typical patient with a given condition, as compared with all patients. Payment for each case in a given DRG is determined by multiplying the weighing factor for the DRG by a predetermined rate. The predetermined rate may vary by hospital or class of facility (defined by factors such as size or location).

Finally, under a negotiated prospective system, the State uses a competitive bid or negotiation process to select providers. The bidding or negotiation process establishes the payment rates. Except in emergency cases, Medicaid patients are required to obtain inpatient services from the selected providers. States choosing this option typically obtain waivers of the "freedom of choice" requirements (Social Security Act 1915; 42 CFR 431.50, 431.55, 435.217, 435.726, 435.735, 440.1, 440.180, 440.200, 440.250, and 441.300, et seq.).

Generally, Medicaid agencies may pay no more in the aggregate for the services than what would have been paid under Medicare's principles of payment. Medicaid payments also must meet the costs of "efficiently and economically operated" facilities. Finally, State Medicaid hospital payment policies must take into account hospitals serving a disproportionate number of low-income recipients with special needs. Disproportionate share payments may exceed the Medicare-related ceilings that apply to other hospital payments (Social Security Act 1902[a][13][A], 1902[a][30], 1902[h]; Public Law 96-499 sec. 962, Public Law 97-35 sec. 2173; Public Law 100-203 sec. 4112; 42 CFR 405.460, 405.463, 405.470, 447.253, and 447.271). Tables 14.1 to 14.3 present the general methods used by States for institutional payment.

Physician services payment

States have wide latitude in determining how to pay for physician services; Federal financial participation is available for any payment method as long as it meets the criteria of Federal laws and regulation (Social Security Act 1902[a][30] and 1903[i]; 42 CFR 447.200, 447.300, 447.302, and 447.304).

Methods used by the States for physician payment can be broken roughly into two broad categories—fee schedules and reasonable charge methods. Table 14.4 lists the types of payment method used by each State to pay physicians for their services.

States choosing fee schedules specify a flat maximum payment for each service. In 1989, 42 States used some form of fee schedule to pay for physician services. Some of these States used a relative value scale (RVS) to set the fee schedule. With an RVS, each service is given a specific weight based on the relative value of the service. This relative value, for example, may be based on an assessment of resource cost of the service (such as physician time, complexity, and level of training required). The specific weight for the service is multiplied by a standard dollar amount to arrive at the fee for the service. Other States used historical cost or charge data to set the fee schedule.

States choosing reasonable charge methods often limit payments for physician services to the lowest of the physician's actual charge, the physician's customary charge for comparable services (for example, the physician's median charge in a recent prior period), or the prevailing charge in the area (for example, the 75th percentile of the customary charges of all providers in the area). In 1989, 8 States used some form of the reasonable charge method to determine payment levels for physician services.

States differ widely in the actual level of payment provided for specific services. Table 14.5 illustrates this variation across States by presenting the minimum and maximum payments for 54 physician services commonly provided to Medicaid recipients; Table 14.6 presents actual payments by State for several of these services. For example, the average payment across all States for an intermediate office visit with an established patient was $21.91 in 1990. However, payments for this service ranged from a minimum of

$10.00 in West Virginia to a maximum of $41.00 in Massachusetts. The average payment for an intermediate hospital visit for subsequent hospital care was $22.58, but ranged from $6.75 in New York to $57.00 in Alaska. On the average, States paid $542.86 for a vaginal delivery, but payments ranged from $291.20 in Hawaii to $901.00 in Georgia. The fee paid to a physician for performing a total hysterectomy ranged from $240.00 in New York to $2,079 in Alaska. The average payment made by States for reading a chest X-ray was $27.67, but ranged from $10.58 to $58.00. Fees for a routine urinalysis ranged from $1.20 to $8.26.

There is also wide variation across States in how Medicaid payments for physician services compares with Medicare. Table 14.7 presents information on the ratio of maximum Medicaid fees to Medicare-allowed charges for the common physician services previously noted. Some States pay well by the standards of Medicare; others do not. For example, on the average across all States, Medicaid paid 87 percent of what Medicare paid for an intermediate office visit for an

Table 14.1

Medicaid inpatient hospital payment methods, by State: 1992

State	Retrospective cost-based	Prospective			
		Rate of increase controls	Case-mix diagnosis-related groups	Negotiated	Other
Alabama					X
Alaska		X			
Arizona[1]					
Arkansas	X				X
California	X	X			X
Colorado			X		X
Connecticut	X				
Delaware	X			X	X
District of Columbia	X				X
Florida		X			
Georgia	X	X			
Hawaii		X			
Idaho	X				
Illinois		X	X		X
Indiana	X				X
Iowa					X
Kansas			X		
Kentucky		X			
Louisiana	X	X			X
Maine					X
Maryland					X
Massachusetts	X				X
Michigan			X		
Minnesota			X		X
Mississippi		X			
Missouri		X			
Montana			X		
Nebraska		X			
Nevada					X
New Hampshire			X		
New Jersey			X		
New Mexico	X	X	X		X
New York			X		
North Carolina					X
North Dakota			X		
Ohio	X	X	X		
Oklahoma		X			
Oregon			X		
Pennsylvania			X		
Rhode Island					X
South Carolina	X	X	X		X
South Dakota	X		X		X
Tennessee	X	X			
Texas	X		X		X
Utah			X		
Vermont		X			
Virginia		X			X
Washington			X		X
West Virginia	X				X
Wisconsin		X	X		
Wyoming	X				

[1]Arizona operates under a Medicaid waiver. For additional information see Laguna Research Associates, 1991.

SOURCES: Health Care Financing Administration, Medicaid Bureau, State Program Data.

established patient in 1990. However, Medicaid fees ranged from a minimum of 35 percent of Medicare-allowed charges to a maximum of 28 percent above what Medicare paid.

Outpatient services payment

States employ many methods to pay for clinic and outpatient hospital services. States choosing retrospective payment methods pay providers for reasonable costs incurred for the service. Other States use different methods, including fee schedules and negotiated rates. As with institutional services payment, aggregate payments for outpatient services may not exceed what would have been paid under Medicare to all providers for furnishing comparable services under similar circumstances (42 CFR 447.321).

Prescription drug payment

Payment for prescription drugs involves (1) a payment system for individual pharmacies and (2) a rebate system from the manufacturer to the Medicaid

Table 14.2

Medicaid nursing facility payment methods, by State: 1992

State	Retrospective cost-based	Prospective		Other
		Rate of increase controls	Case-mix per diem	
Alabama		X		
Alaska		X		
Arizona[1]				
Arkansas		X		
California		X		X
Colorado	X			
Connecticut	X			
Delaware		X		X
District of Columbia		X		
Florida		X	X	
Georgia		X		
Hawaii		X		X
Idaho	X			
Illinois	X	X	X	
Indiana		X		X
Iowa		X		
Kansas		X		
Kentucky			X	
Louisiana	X	X		
Maine		X		
Maryland	X	X		X
Massachusetts	X			
Michigan		X		
Minnesota		X		
Mississippi		X		
Missouri		X		
Montana		X		
Nebraska	X			
Nevada				X
New Hampshire	X	X		
New Jersey		X	X	
New Mexico		X		
New York		X		
North Carolina	X	X		X
North Dakota			X	
Ohio		X		X
Oklahoma		X		
Oregon		X		
Pennsylvania	X			
Rhode Island		X		
South Carolina	X	X		X
South Dakota		X		
Tennessee	X	X		
Texas		X	X	
Utah		X		
Vermont		X		
Virginia			X	X
Washington		X		
West Virginia	X	X		
Wisconsin		X		
Wyoming		X		

[1]Arizona operates under a Medicaid waiver. For additional information see Laguna Research Associates, 1991.

SOURCES: Health Care Financing Administration, Medicaid Bureau, State Program Data.

agency and the Federal government. States reimburse pharmacies for covered drugs by combining the State Medicaid dispensing fee with an allowable dollar value for drugs dispensed. For prescription drugs provided during hospital or nursing home stays, payment for the drugs may be included in the facility payment rate. Determination of the dollar value that Medicaid can pay for drugs must, on the average, not exceed the Federal upper dollar limits (Social Security Act, section 1927[d] through [f]).

The Medicaid Drug Rebate Plan requires that a pharmaceutical manufacturer have a rebate agreement with the U.S. Department of Health and Human Services (DHHS) Secretary, or a State Medicaid agency with the Secretary's permission (Social Security Act, section 1927[a] through [c]). This program requires that each pharmaceutical manufacturer rebate all drugs covered under Medicaid unless a drug meets one of the exceptions cited in the amendment. The chapter on Medicaid services in this supplement lists groups of drugs that a State agency may elect to exclude.

The rebate plan requires that each manufacturer or wholesaler report to the DHHS Secretary the average manufacturer price for multiple source drugs. For

Table 14.3

Medicaid intermediate care facilities for the mentally retarded payment methods, by State: 1992

State	Retrospective cost-based	Prospective		Other
		Rate of increase controls	Case-mix per diem	
Alabama		X		
Alaska		X		
Arizona[1]				
Arkansas	X	X		
California		X		X
Colorado	X			
Connecticut	X			
Delaware		X		
District of Columbia		X		
Florida		X		
Georgia		X		
Hawaii		X		
Idaho	X			
Illinois	X	X	X	
Indiana		X		
Iowa		X		
Kansas	X	X		
Kentucky			X	
Louisiana		X		
Maine		X		
Maryland	X			
Massachusetts		X		
Michigan	X			
Minnesota	X	X		
Mississippi		X		
Missouri		X		
Montana	X			
Nebraska		X		
Nevada	X			
New Hampshire	X			
New Jersey	X			
New Mexico		X		
New York	X			
North Carolina	X	X		X
North Dakota	X			
Ohio		X		X
Oklahoma	X	X		
Oregon	X			
Pennsylvania	X			
Rhode Island	X			
South Carolina	X			X
South Dakota	X	X		
Tennessee		X		
Texas		X		
Utah		X		X
Vermont		X		
Virginia	X			
Washington		X		
West Virginia	X	X		
Wisconsin	X			X
Wyoming		X		

[1]Arizona operates under a Medicaid waiver. For additional information see Laguna Research Associates, 1991.

SOURCES: Health Care Financing Administration, Medicaid Bureau, State Program Data.

Table 14.4

Medicaid physician payment methods, by State: Calendar year 1989

State	Payment method	Fee schedule source
Alabama	Fee schedule	90 percent of 75th percentile of submitted charges, 1981
Alaska	Reasonable charges	
Arizona	Negotiated rate	
Arkansas	Fee schedule	Charges
California	Fee schedule	1969 and 1974 California relative value studies
Colorado	Fee schedule	1976 Colorado relative value study
Connecticut	Fee schedule	Charges
Delaware	Fee schedule	Charges
District of Columbia	Fee schedule	Charges
Florida	Fee schedule	
Georgia	Fee schedule	Charges
Hawaii	Reasonable charges	
Idaho	Fee schedule	1974 California relative value study
Illinois	Fee schedule	Charges
Indiana	Reasonable charges	
Iowa	Fee schedule	Charges
Kansas	Fee schedule	1974 California relative value study
Kentucky	Reasonable charges	
Louisiana	Fee schedule	Charges
Maine	Fee schedule	1974 California relative value study
Maryland	Fee schedule	1974 California relative value study
Massachusetts	Fee schedule	
Michigan	Fee schedule	Michigan relative value study, Medicare prevailing charges
Minnesota	Fee schedule	Charges
Mississippi	Fee schedule	1964 California relative value study
Missouri	Fee schedule	Charges
Montana	Fee schedule	Charges
Nebraska	Fee schedule	
Nevada	Fee schedule	1974 California relative value study
New Hampshire	Reasonable charges	
New Jersey	Fee schedule	Charges, 1973 New Jersey Blue Shield 500 Plan
New Mexico	Fee schedule	1986 Colorado relative value study
New York	Fee schedule	1965 New York Medical Society relative value study
North Carolina	Fee schedule	Charges
North Dakota	Fee schedule	Charges
Ohio	Fee schedule	Charges
Oklahoma	Fee schedule	Lower of 75th percentile of Medicare and Medicaid charges, 1986
Oregon	Fee schedule	
Pennsylvania	Fee schedule	Charges
Rhode Island	Fee schedule	1967 Rhode Island Medical Society negotiated rates
South Carolina	Fee schedule	1974 California relative value study
South Dakota	Fee schedule	Charges
Tennessee	Reasonable charges	Percentage of usual, customary or prevailing charges
Texas	Reasonable charges	
Utah	Fee schedule	Utah Medical Association relative value study
Vermont	Fee schedule	1988 McGraw-Hill relative value scale
Virginia	Fee schedule	15th percentile of charges
Washington	Fee schedule	1974 California relative value study
West Virginia	Fee schedule	
Wisconsin	Fee schedule	Charges
Wyoming	Reasonable charges	

SOURCE: Physician Payment Review Commission: *Physician Payment Under Medicaid.* U.S. Government Printing Office, 1991.

Table 14.5

Medicaid fees for selected physician services: Fiscal year 1990

Physician service	Average across all States	Maximum State value	Minimum State value
Primary care:			
Intermediate office visit, new patient (90015)	$31.68	$69.00	$10.00
Comprehensive office visit, new patient (90020)	49.10	113.00	10.00
Brief office visit, established patient (90040)	15.34	32.00	7.00
Limited office visit, established patient (90050)	18.47	34.00	10.00
Intermediate office visit, established patient (90060)	21.91	41.00	10.00
Extended office visit, established patient (90070)	28.77	66.00	10.00
Nursing home visit, limited (90450)	21.68	74.00	8.00
Intermediate emergency department visit, new patient (90515)	33.88	118.00	8.50
Limited emergency department visit, established patient (90550)	20.96	59.00	8.50
Preventive medicine, healthy infant (90764)	24.41	45.00	7.50
Psychotherapy, 20-30 minutes (90843)	30.32	51.00	11.79
Psychotherapy, 45-50 minutes (90844)	51.86	93.00	18.00
Ophthalmological visit, new patient (92004)	37.45	70.30	12.00
Tympanometry (92567)	11.55	35.00	4.50
Electrocardiogram (93000)	24.69	57.00	10.00
Hospital visits:			
Initial hospital care, intermediate (90215)	46.55	112.00	13.13
initial hospital care, comprehensive (90220)	59.06	150.00	14.38
Initial hospital care, normal (90225)	46.50	110.00	11.25
Subsequent hospital care, limited (90250)	18.75	47.00	6.75
Subsequent hospital care, intermediate (90260)	22.58	57.00	6.75
Subsequent hospital care, normal infant (90282)	20.70	58.00	6.75
Consultation (90620)	67.96	148.00	15.00
Critical care, visit (99174)	49.09	194.00	10.50
Obstetrical care:			
Total obstetric care and vaginal delivery (59400)	833.45	1,359.00	468.00
Vaginal delivery only (59410)	542.86	901.00	291.20
Cesarean section (59500)	713.25	1,230.00	387.11
Total obstetric care/Cesarean section (59501)	1,029.28	1,781.00	598.00
Surgery:			
Tonsillectomy and adenoidectomy (42820)	209.93	496.00	60.00
Upper G.I. endoscopy (43235)	226.42	411.00	80.00
Appendectomy (44950)	415.70	1,299.00	160.00
Cholecystectomy (47605)	690.02	2,049.00	270.00
Repair inguinal hernia, under 5 (49500)	383.26	1,157.00	140.00
Dilation and curettage (58120)	190.35	473.00	60.00
Total hysterectomy (58150)	722.18	2,079.00	240.00
Tubal ligation (58605)	336.78	943.00	120.00
Laparoscopy (58980)	299.22	881.00	60.00
Cataract removal/lens implant (66984)	1,121.20	3,023.00	440.00
Destruction of retinopathy (67228)	498.13	1,228.00	160.00
Tympanostomy (69437)	204.14	416.67	52.50
Imaging:			
CAT scan, head or brain (70450)	186.73	352.04	48.00
CAT scan, head or brain (70470)	256.75	484.18	75.00
MRI, brain (70551)	422.77	765.00	55.00
X-ray, chest, single view (71010)	19.49	40.00	7.87
X-ray, chest, two views (71020)	27.67	58.00	10.58
Mammography, bilateral (76091)	54.09	115.00	28.83
Echography, abdominal (76700)	92.50	193.00	37.25
Echography, pregnant uterus (76805)	79.52	171.90	35.34
Echography, pelvic, non-obstetric (76856)	77.66	150.00	26.00
Laboratory tests:			
Urinalysis, routine (81000)	4.31	8.26	1.20
Glucose test (82947)	5.44	10.31	0.35
Blood count, hematocrit (85014)	3.14	6.19	0.80
Culture, bacterial, definitive (87060)	9.34	20.19	1.30
Culture, bacterial, screening only (87081)	7.31	16.95	1.30
Surgical pathology (88305)	56.95	200.00	9.36

NOTES: Values in parentheses are *Current Procedural Terminology, Fourth Edition* codes. Each State provided the maximum fee that was paid for each procedure on the last day of its fiscal year. G.I. is gastrointestinal. CAT is computerized axial tomography. MRI is magnetic resonance imaging.

SOURCE: (Holahan, 1991).

Table 14.6

Medicaid fees for selected physician services, by State: Fiscal year 1990

State	Intermediate office visit, established patient (90060)	Intermediate hospital visit, subsequent hospital care (90260)	Vaginal delivery only (59410)	Total hysterectomy (58150)	Chest X-ray, two views (71020)	Routine urinalysis (81000)
Alabama	$22.50	$19.80	$700.00	$765.00	$23.40	$4.79
Alaska	34.00	57.00	599.00	2,079.00	58.00	5.00
Arkansas	24.75	30.75	397.08	993.75	30.00	4.88
California	18.40	27.60	480.60	810.72	22.92	4.56
Colorado	26.20	26.20	487.65	532.10	21.21	4.88
Connecticut	22.65	22.00	609.70	828.00	20.70	3.30
Delaware	17.94	27.50	500.00	648.83	33.23	3.58
District of Columbia	20.00	18.00	900.00	675.00	25.00	3.75
Florida	25.00	32.00	500.00	1,094.00	38.50	4.50
Georgia	25.00	35.00	901.00	1,337.50	23.00	4.89
Hawaii	23.02	33.56	291.20	980.00	33.60	4.82
Idaho	21.84	21.84	700.00	649.60	24.17	3.98
Illinois	18.00	14.65	550.00	715.40	10.58	3.45
Indiana	27.11	29.93	591.60	1,050.98	35.22	4.89
Iowa	20.63	20.87	644.32	835.35	30.62	4.70
Kansas	25.00	8.40	450.00	500.00	42.00	4.83
Kentucky	18.90	19.38	650.00	660.00	23.00	4.20
Louisiana	27.00	32.00	760.00	724.42	32.90	4.82
Maine	21.25	20.25	500.00	376.00	16.20	3.80
Maryland	21.00	10.50	895.00	356.00	15.50	4.08
Massachusetts	41.00	26.00	592.00	787.00	25.00	4.00
Michigan	19.48	12.65	380.79	470.85	20.41	2.83
Minnesota	30.00	30.00	457.93	900.00	35.00	4.92
Mississippi	15.00	10.00	531.20	472.50	26.00	2.54
Missouri	17.00	14.00	390.00	360.00	16.50	3.00
Montana	19.22	28.80	419.20	623.58	28.81	4.80
Nebraska	23.31	23.55	440.00	646.01	41.58	4.89
Nevada	29.38	29.38	824.73	1,161.60	44.53	6.00
New Hampshire	25.00	10.00	810.00	400.00	16.00	4.18
New Jersey	15.50	8.50	320.00	332.00	15.00	1.20
New Mexico	22.72	23.34	476.39	748.94	40.30	1.73
New York	11.00	6.75	679.00	240.00	15.00	2.08
North Carolina	21.88	22.92	550.00	594.40	23.03	4.40
North Dakota	16.70	20.00	400.00	621.75	29.80	4.89
Ohio	18.91	18.91	400.00	543.53	24.85	4.89
Oklahoma	17.50	25.00	525.00	750.00	29.10	4.89
Oregon	19.84	19.84	611.33	724.14	23.03	4.15
Pennsylvania	18.00	17.00	312.50	518.50	30.00	3.00
Rhode Island	—	—	—	—	—	—
South Carolina	20.00	20.00	700.00	663.00	30.36	3.88
South Dakota	18.90	28.40	346.50	869.40	33.00	4.89
Tennessee	27.00	18.47	362.50	765.68	39.75	4.83
Texas	28.36	28.25	692.20	1,153.62	41.46	8.26
Utah	19.65	32.75	325.16	518.71	18.47	3.89
Vermont	16.00	20.00	625.00	374.00	23.00	4.80
Virginia	23.00	32.00	670.00	1,100.00	24.00	4.92
Washington	24.37	17.82	424.68	525.60	23.50	4.78
West Virginia	10.00	10.00	330.00	383.00	13.50	4.83
Wisconsin	16.88	19.69	371.99	727.22	30.09	4.97
Wyoming	28.00	25.00	525.00	800.00	34.93	4.89

NOTES: Values in parentheses are *Current Procedural Terminology, Fourth Edition* codes. Each State provided the maximum fee that was paid on the last day of its fiscal year.

SOURCE: (Holahan, 1991).

Table 14.7

Ratio of Medicaid fees to Medicare-allowed charges, by selected physician services: Fiscal year 1990

Physician service	Average across all States	Maximum State value	Minimum State value
Primary care:			
Intermediate office visit, new patient (90015)	0.90	1.56	0.26
Comprehensive office visit, new patient (90020)	0.78	1.43	0.18
Brief office visit, established patient (90040)	0.89	1.45	0.28
Limited office visit, established patient (90050)	0.90	1.54	0.37
Intermediate office visit, established patient (90060)	0.87	1.28	0.35
Extended office visit, established patient (90070)	0.88	1.60	0.35
Nursing home visit, limited (90450)	1.03	3.70	0.31
Intermediate emergency department visit, new patient (90515)	0.94	2.48	0.21
Limited emergency department visit, established patient (90550)	1.10	4.97	0.34
Preventive medicine, healthy infant (90764)	—	—	—
Psychotherapy, 20-30 minutes (90843)	1.06	2.53	0.30
Psychotherapy, 45-50 minutes (90844)	1.07	1.90	0.39
Ophthalmological visit, new patient (92004)	0.94	1.56	0.29
Tympanometry (92567)	0.91	3.06	0.28
Electrocardiogram (93000)	0.73	1.30	0.27
Hospital visits:			
Initial hospital care, intermediate (90215)	0.77	1.78	0.22
Initial hospital care, comprehensive (90220)	0.73	1.40	0.20
Initial hospital care, normal (90225)	1.00	1.40	0.49
Subsequent hospital care, limited (90250)	0.76	1.32	0.21
Subsequent hospital care, intermediate (90260)	0.75	1.26	0.20
Subsequent hospital care, normal infant (90282)	0.55	0.99	0.35
Consultation (90620)	0.75	1.50	0.15
Critical care, visit (99174)	0.92	2.93	0.15
Surgery:			
Tonsillectomy and adenoidectomy (42820)	—	—	—
Upper G.I. endoscopy (43235)	0.80	1.46	0.21
Appendectomy (44950)	0.98	2.24	0.32
Cholecystectomy (47605)	1.04	2.54	0.30
Repair inguinal hernia, under 5 (49500)	0.70	1.32	0.26
Dilation and curettage (58120)	0.84	1.71	0.19
Total hysterectomy (58150)	1.04	2.08	0.23
Tubal ligation (58605)	—	—	—
Laparoscopy (58980)	0.76	1.51	0.16
Cataract removal/lens implant (66984)	0.76	1.60	0.31
Destruction of retinopathy (67228)	0.73	1.44	0.12
Tympanostomy (69437)	1.45	2.90	0.66
Imaging:			
CAT scan, head or brain (70450)	0.85	4.16	0.22
CAT scan, head or brain (70470)	0.79	3.19	0.22
MRI, brain (70551)	0.96	4.04	0.27
X-ray, chest, single view (71010)	0.72	1.29	0.23
X-ray, chest, two views (71020)	0.76	1.16	0.27
Mammography, bilateral (76091)	0.86	4.52	0.34
Echography, abdominal (76700)	1.40	2.74	0.53
Echography, pregnant uterus (76805)	1.16	2.36	0.49
Echography, pelvic, non-obstetric (76856)	1.23	2.45	0.39
Laboratory tests:			
Urinalysis, routine (81000)	0.90	1.64	0.25
Glucose test (82947)	0.92	1.65	0.06
Blood count, hematocrit (85014)	0.87	1.67	0.22
Culture, bacterial, definitive (87060)	0.92	1.98	0.13
Culture, bacterial, screening only (87081)	0.86	1.80	0.14
Surgical pathology (88305)	0.90	2.11	0.21

NOTES: Values in parentheses are *Current Procedural Terminology, Fourth Edition* codes. Ratios are Medicaid fees for the service divided by the Medicare-allowed charge. For Medicaid fees, each State provided the maximum fee that was paid for each procedure on the last day of its fiscal year. G.I. is gastrointestinal. CAT is computerized axial tomography. MRI is magnetic resonance imaging.

SOURCE: (Holahan, 1991).

single source and innovator multiple source drugs, the manufacturer best price must be reported. Once the Secretary receives the prices, HCFA calculates the rebate dollar amount per dosage unit of a drug and forwards it to the State agency. Each State agency must report the total units dispensed to the manufacturer and to HCFA. The manufacturer then sends the calculated rebate amount to the State agency.

Capitation payment

The payment methods described above pertain to fee-for-service (FFS) payment methods. States also have the opportunity to participate in coordinated care programs which require the formulation of a risk contract with HMOs, prepaid health plans (PHPs), or comparable entities. In a coordinated care program, the organization agrees to provide a specific set of services to a Medicaid enrollee in return for a fixed periodic payment. The periodic payment is referred to as a capitation payment or premium. For example, the organization may agree to provide access to all necessary inpatient hospital, physician, clinical, laboratory, and X-ray services to Medicaid enrollees in the plan for a fixed, monthly premium paid by the State. Payments under the risk contract may not exceed the cost to the State's Medicaid agency of providing those same services on an FFS basis to an actuarially equivalent non-enrolled population group (42 CFR 447.58 and 447.361).

Coordinated care programs in Medicaid

On a limited basis, a few States began to contract with HMOs or similar entities during the early days of Medicaid (Congressional Research Service, 1988). The earliest initiatives occurred with the HMO-like Health Insurance Plan of Greater New York in 1967, Group Health of Puget Sound (the State of Washington) in 1970, and Kaiser Permanente (3 States) in 1972. The first significant effort began in California in the early 1970s. The State entered into numerous prepaid contracts with HMOs in order to contain rising program costs. However, there were reports of serious problems with HMOs in California and other States. These problems included unscrupulous marketing practices, failure to furnish the full scope of Medicaid services, and financial insolvency which left Medicaid enrollees with the liability for their medical bills. These and other problems led to congressional action. Provisions in the HMO amendments of 1976 (Public Law 94-460) specified the first Federal requirements for Medicaid contracts with HMOs or comparable organizations. Then, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) gave States additional flexibility to contract with HMOs and pursue other forms of managed care. As a result of these provisions and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Public Law 97-248), States have three major managed care options (see Technical note for definitions):

- Voluntary enrollment in HMOs or health-insuring organizations (HIOs).
- Voluntary or mandatory enrollment in primary care case management (PCCM) programs.
- Mandatory enrollment in an HIO or a multiple HMO system (where a Medicaid enrollee can choose among a group of HMOs).

Related initiatives have included social/health maintenance organizations (S/HMOs) which are modeled after HMOs. These programs assume financial risk for some long-term care services in addition to acute care which has traditionally been provided by HMOs. Medicare, Medicaid, and private funds have been used to enroll a mix of healthy to significantly impaired persons in S/HMOs.

Much of the early interest in coordinated care was related to cost containment. However, recently the focus of concern has been on access, continuity, and quality of care.

The following sections will present national trends in Medicaid enrollment in coordinated care, statistics on the number and types of coordinated care plans serving Medicaid enrollees by State, comparative statistics on Medicaid enrollment in coordinated care by State, and brief profiles of Medicaid coordinated care programs in selected States.

Trends in coordinated care enrollment

Figure 14.8 presents the growth in Medicaid enrollment in coordinated care programs between 1983-92. In 1983, there were only 750,000 Medicaid enrollees covered under coordinated care. By 1992, the number had increased to 3.6 million, representing an increase of 385 percent during this time period or an average annual rate of 19.2 percent. In contrast, the number of total Medicaid users grew by only 31 percent, or 3.5 percent per year, between 1983-91 (HCFA Form-2082). Since 1983, the proportion of all Medicaid enrollees who were covered under coordinated care increased from 3.5 percent to 12 percent (based on an estimate of 31,100,000 Medicaid enrollees in 1992).

Although Medicaid enrollment in coordinated care programs grew steadily over the entire study period, enrollment in HMOs and prepaid health plans (PHPs) grew rapidly between 1983-85 and at a slower rate after 1985. However, overall growth was sustained because of the introduction of PCCMs in 1986 and steady growth of Medicaid enrollment in PCCMs after 1986. From 1991 to 1992, the number of enrollees in coordinated care plans increased by 938,000, a much larger single year increase than for any other year during the study period.

Coordinated care plans serving Medicaid

Table 14.9 presents the number of Medicaid coordinated care plans by type of plan and State as of June 30, 1992 (Health Care Financing Administration, 1992a). At that time, there were a total of 235 plans

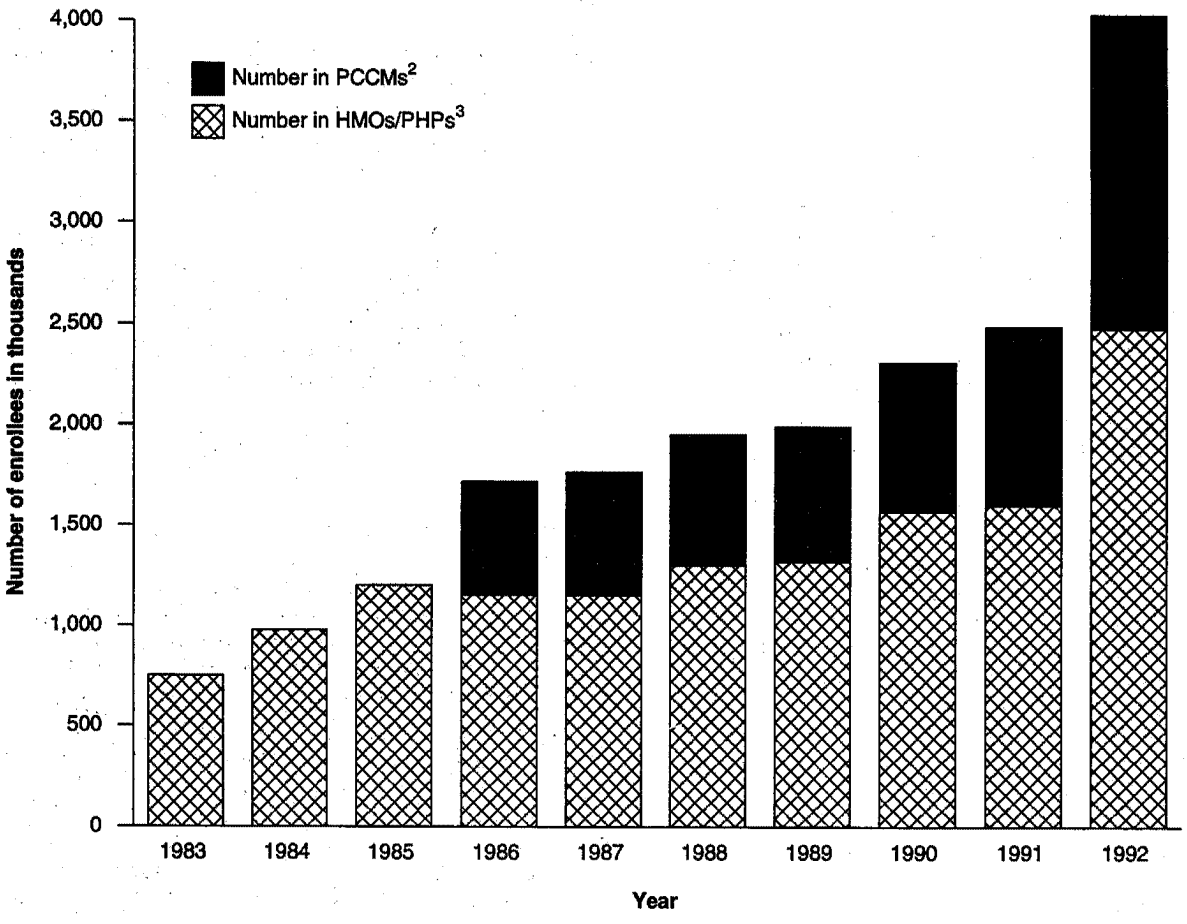
serving Medicaid enrollees in 34 States and the District of Columbia. The distribution of plans by State was not proportional to Medicaid enrollment across the States. Although there were no plans serving Medicaid enrollees in 16 States, there were 8 States that had 10 or more plans. These States had 159 plans (68 percent of the total) and more than one-half of all enrollees covered under coordinated care. In contrast, these 8 States accounted for only 40 percent of all Medicaid users in fiscal year (FY) 1991. In addition, 12 States had only one plan.

Across all jurisdictions, 80 plans (more than one-third of all plans) were State plan defined HMOs. In addition, there were 76 PHPs, 52 Federally qualified HMOs, and 22 PCCMs. Nationally, there were only 5 HIOs serving Medicaid enrollees. The two largest States in terms of Medicaid users and expenditures, California and New York, also had the largest number of plans. Oregon ranked third in number of plans despite the size of its Medicaid program (ranked 31st in number of users during FY 1991).

Enrollment in coordinated care across States

Table 14.10 presents the number of Medicaid enrollees in coordinated care plans by type of plan and State as of June 30, 1992 (Health Care Financing Administration, 1992a). At that time, there were more than 3.6 million Medicaid enrollees covered under coordinated care. More than 950,000 of these individuals were covered in just two States, Arizona and California. As was previously noted for the distribution of plans across States, the distribution of enrollees in these plans was not proportional to distribution of Medicaid users across the States. For example, New York, which had the second largest number of Medicaid users among all States in FY 1991, enrolled less than 4 percent of the State's Medicaid users in coordinated care as of June 1991. The number of Medicaid enrollees in coordinated care was higher in nine other States. In four States, a substantial percent

Figure 14.8
Medicaid enrollment in coordinated care programs: 1983-92[1]



[1]Data are reported for calendar years, except that enrollment for 1992 is as of June 30.
[2]PCCMs are primary care case management programs.
[3]HMOs are health maintenance organizations and PHPs are prepaid health plans. This category includes Health Insuring Organizations.
SOURCE: Health Care Financing Administration, Medicaid Bureau.

Table 14.9

Number of Medicaid coordinated care plans, by State[1]: June 30, 1992

State or jurisdiction	All plan types	Type of plan				
		Federally qualified HMOs	State-defined HMOs	Prepaid health plans	Health insuring organizations	Primary care case management
Alabama	1	0	0	0	0	1
Arizona	14	0	0	14	0	0
California	30	7	3	18	2	0
Colorado	3	2	0	0	0	1
District of Columbia	1	0	0	1	0	0
Florida	15	0	14	0	0	1
Georgia	1	0	0	0	0	1
Hawaii	1	1	0	0	0	0
Indiana	1	1	0	0	0	0
Illinois	4	1	3	0	0	0
Iowa	2	0	1	0	0	1
Kansas	1	0	0	0	0	1
Kentucky	1	0	0	0	0	1
Maryland	5	0	2	1	0	2
Massachusetts	16	9	7	0	0	0
Michigan	12	6	1	4	0	1
Minnesota	9	3	5	0	1	0
Missouri	5	1	1	2	0	1
Nevada	2	0	0	1	0	1
New Hampshire	1	1	0	0	0	0
New Jersey	2	0	2	0	0	0
New Mexico	1	0	0	0	0	1
New York	34	4	19	9	0	2
North Carolina	2	1	0	0	0	1
Ohio	12	0	12	0	0	0
Oregon	26	2	1	23	0	0
Pennsylvania	6	3	1	1	1	0
Rhode Island	1	1	0	0	0	0
South Carolina	3	0	0	1	0	2
Tennessee	2	0	1	0	0	1
Utah	4	2	0	1	0	1
Virginia	1	0	0	0	0	1
Washington	6	3	2	0	1	0
West Virginia	1	0	0	0	0	1
Wisconsin	9	4	5	0	0	0
United States	235	52	80	76	5	22

[1]The following jurisdictions did not have any active coordinated care plans serving Medicaid enrollees as of June 30, 1992: Alaska, Arkansas, Connecticut, Delaware, Idaho, Louisiana, Maine, Mississippi, Montana, Nebraska, North Dakota, Oklahoma, Puerto Rico, South Dakota, Texas, Vermont, Virgin Islands, and Wyoming.

NOTE: HMO is health maintenance organization.

SOURCE: (Health Care Financing Administration, 1992a).

of all Medicaid users were covered in coordinated care in 1991. These States were Utah (58.8 percent), Colorado (49.4 percent), New Mexico (48.1 percent), and Kentucky (37.5 percent). Two of these States, Colorado and Kentucky, which ranked relatively low among all States in terms of total Medicaid users during FY 1991 (33rd and 16th, respectively), had more than 100,000 Medicaid enrollees in coordinated care.

Of the 3.6 million Medicaid enrollees in coordinated care in 1992, more than 1.1 million were in PCCMs, more than 728,000 were in Federally qualified HMOs, 752,000 were in PHPs, and nearly 850,000 were in State-defined HMOs. A much smaller proportion of the total were covered in HIOs. In 6 States (Alabama, Kansas, Kentucky, New Mexico, South Carolina, and Virginia), a substantial number of Medicaid enrollees were covered in coordinated care exclusively through PCCM programs.

Profiles of selected States[1]

Arizona

The Arizona Health Care Cost Containment System (AHCCCS), which began October 1, 1982, has functioned as a Medicaid 1115 demonstration project. Until recently, it served primarily mothers, children, and elderly persons.[1]As of January 1989 services were added for persons who qualify under the Arizona Long Term Care System, a major program for the developmentally disabled, elderly, and physically disabled. Service delivery is through 14 PHPs (McCall et al., 1985; Laguna Research Associates, 1991).

[1]The material presented in this section was drawn from Health Care Financing Administration, 1992b.

Table 14.10

Medicaid enrollment in coordinated care plans, by State[1]: June 30, 1992

State or jurisdiction	All plan types	Type of plan				
		Federally qualified HMOs	State defined HMOs	Prepaid health plans	Health insuring organizations	Primary care case management
Alabama	15,399	0	0	0	0	15,399
Arizona	394,352	0	0	394,352	0	0
California	561,645	234,256	97,620	157,082	72,687	0
Colorado	119,682	9,226	0	0	0	110,456
District of Columbia	14,989	0	0	14,989	0	0
Florida	278,871	0	198,905	0	0	79,966
Georgia	0	0	0	0	0	0
Hawaii	3,572	3,572	0	0	0	0
Indiana	733	733	0	0	0	0
Illinois	113,496	71,000	42,496	0	0	0
Iowa	46,358	0	8,304	0	0	38,054
Kansas	51,962	0	0	0	0	51,962
Kentucky	296,372	0	0	0	0	296,372
Maryland	230,880	0	43,189	21,862	0	165,829
Massachusetts	69,267	36,530	32,737	0	0	0
Michigan	287,955	153,791	8,406	15,069	0	110,689
Minnesota	74,580	3,367	67,861	0	3,352	0
Missouri	37,536	7,134	15,147	8,376	0	6,879
Nevada	9,443	0	0	1,306	0	8,137
New Hampshire	3,950	3,950	0	0	0	0
New Jersey	18,000	0	18,000	0	0	0
New Mexico	78,000	0	0	0	0	78,000
New York	109,064	8,612	64,932	32,379	0	3,141
North Carolina	53,188	2,891	0	0	0	50,297
Ohio	132,007	0	132,007	0	0	0
Oregon	64,938	9,516	0	55,422	0	0
Pennsylvania	181,263	108,981	4,343	3,499	64,440	0
Rhode Island	361	361	0	0	0	0
South Carolina	11,980	0	0	0	0	11,980
Tennessee	29,645	0	26,445	0	0	3,200
Utah	126,096	18,096	0	48,000	0	60,000
Virginia	12,549	0	0	0	0	12,549
Washington	34,597	7,167	18,077	0	9,353	0
West Virginia	51,599	0	0	0	0	51,599
Wisconsin	120,187	48,872	71,315	0	0	0
United States	3,634,516	728,055	849,784	752,336	149,832	1,154,509

[1]The following jurisdictions did not have any active coordinated care plans serving Medicaid enrollees as of June 30, 1992: Alaska, Arkansas, Connecticut, Delaware, Idaho, Louisiana, Maine, Mississippi, Montana, Nebraska, North Dakota, Oklahoma, Puerto Rico, South Dakota, Texas, Vermont, Virgin Islands, and Wyoming.

NOTE: HMO is health maintenance organization.

SOURCE: (Health Care Financing Administration, 1992a).

California

The State of California contracts with a number of PHPs that provide Medicaid-covered services. Enrollment in a PHP is voluntary, and disenrollment is granted upon an enrollee's request. PHP enrollment is concentrated in Southern California, with San Diego and Los Angeles Counties representing the majority of PHP enrollees. California also contracts with two HIOs, one in Santa Barbara County and the other in San Mateo County. Under these contracts, Medicaid enrollees either choose or are assigned to a primary care physician who serves as a case manager. The HIO assumes financial risk for providing health services for a fixed capitation fee.

Colorado

Colorado contracts with two Federally qualified HMOs which serve AFDC, SSI, and foster care and child welfare enrollees in selected counties. Colorado also implemented the Primary Care Physician Program statewide in 1983 as one of the first PCCMs operating under a section 1915(b) freedom-of-choice waiver.

Florida

The primary focus of the coordinated care effort in Florida has been on contracts with State-defined HMOs which serve Medicaid enrollees in four major areas of the State—Northeast (Jacksonville area), West Central (Tampa and St. Petersburg area), Central (Orlando area), and Southeast (Miami, Ft. Lauderdale and Palm Beach area). Florida also has a PCCM known as the "Florida Physician Access System" (MediPass), authorized under a 1915(b) waiver, which began providing services in four counties in the Tampa and St. Petersburg area on October 1, 1991.

Kentucky

Kentucky implemented a major PCCM initiative, known as the Kentucky Patient Access and Care Program (KenPAC), on February 1, 1986. For Medicaid families with children, this program identifies a primary care physician who will provide primary medical care, and refer and authorize other specialty care services. This program operates in 111 out of 120 counties.

New Mexico

New Mexico has implemented its Primary Care Network, a PCCM program, under a 1915(b) waiver. The program is statewide for all Medicaid enrollees. Each enrollee chooses a primary care physician (or clinic) and a primary pharmacy. The primary care physician is the patient's first resource in obtaining health care. The primary pharmacy is the enrollee's source for non-emergency pharmacy services.

New York

Of the 34 plans in New York, the majority (19) are State-defined HMOs. Most plans serve only Aid to Families with Dependent Children (AFDC) enrollees in specific county or sub-county areas. The State also had 9 PHPs.

Ohio

The State has awarded contracts with State-defined HMOs to provide services to AFDC enrollees. Each contract is limited to one or two counties.

Pennsylvania

Pennsylvania has negotiated agreements with four HMOs to provide coverage to all Medicaid enrollee groups in selected counties. HMO enrollment is voluntary. The State has also received a section 1902 waiver to implement case management through an HIO. The program, known as HealthPASS, covers all Medicaid enrollees in selected eligibility groups and in limited areas of the State.

Utah

Since 1982, Utah has operated a section 1915(b) freedom of choice waiver for a PCCM program, called the Choice of Health Care Delivery. The program is mandatory in urban areas and optional in the remaining rural counties. In the urban areas, Medicaid enrollees choose between an HMO or a primary care physician to manage their care. Utah also has two HMOs serving Medicaid enrollees and a PHP for mental health services.

Financing

This section describes Federal and State participation in Medicaid financing. It also highlights coordination between the Medicaid and the Medicare programs. The section concludes with some information on third-party liability.

Federal financing

The costs of the Medicaid program are financed jointly by the Federal Government and the States. The Federal Government pays States a percentage of their Medicaid expenditures for providing services and for administering their programs. Payments are made to the States on the basis of the Federal medical assistance percentage (FMAP) (Social Security Act 1903[a][1]). The formula for calculating FMAP values (42 CFR 433.10) is as follows:

$$FMAP = 100 \text{ percent} - \text{State share}$$

where State share $=$

$$\frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 45 \text{ percent}$$

The formula sets higher rates of Federal matching for States with relatively low per capita incomes and lower matching rates for States with relatively high per capita incomes. Federal regulations limit FMAP values to a maximum of 83 percent and a minimum of 50 percent. An exception to the FMAP rules requires a 100-percent Federal share of State expenditures for services provided through Indian Health Service Facilities (Social Security Act 1905[b]; 42 CFR 433.10[2]). Federal payments may be reduced if a State is spending inordinate amounts because of inaccurate eligibility determinations.

Table 14.11 presents the FMAP values in effect for FY 1980-91. No State received the maximum Federal match in 1991 (Mississippi received the highest match at 79.99 percent), whereas 12 States received the minimum match of 50 percent. The matching rate for territories is set at 50 percent with limits on the total Federal dollar amount (Social Security Act 1108[c]; 42 CFR 433.10[b]).

FMAP values pertain only to Federal matching for medical vendor payments. The Federal Government also provides matching payments for administrative costs as follows:

- Administration of family planning services and supplies is matched at 90 percent.
- Design, development, or installation of mechanized claims processing and information retrieval systems is matched at 90 percent, and the operation of such systems is matched at 75 percent.
- Compensation and training of skilled professional and medical personnel, and staff directly supporting those personnel are matched at 75 percent.
- Funds expended for the performance of medical and utilization review by a peer review organization are matched at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency are matched at 90 percent for the first 3 years of their operation and at 75 percent thereafter.
- All other activities the Secretary finds necessary for proper and efficient administration of the program are matched at 50 percent (Social Security Act

1903[a][2] et seq., 1903[b][3], 1903[r]; Public Law 92-603 sec. 299E; 42 CFR 433.110 et seq., 433.115 and 45 CFR 95.601 et seq.).

State financing

State participation in Medicaid financing includes the non-Federal portion of medical vendor payments and the non-Federal portion of program administrative costs. The non-Federal share of medical vendor payments may be provided from State or local revenues. However, the State must bear at least 40 percent of the non-Federal share. It also must guarantee that a lack of local funds will not result in reduced amounts, duration, scope, or quality of care provided to Medicaid enrollees. The State is solely responsible for the costs of services to State-only eligibles and for additional services it offers that do not qualify for Federal financial participation (Social Security Act 1902[a][2]; 42 CFR 433.33). Recently, States have been utilizing tax and donation programs to help fund their share of costs. (A more thorough discussion of these financing mechanisms and their effects on Medicaid expenditures is provided in the chapter by Buck and Klemm, 1993.)

Coordination with the Medicare program

Many aged and disabled persons are enrolled in both Medicare and Medicaid. These persons are known as dual enrollees. Because Medicaid is the payer of last resort, Medicare-covered services provided to these individuals may be financed by Medicare rather than Medicaid.

Medicare coverage is comprised of two parts. Part A, hospital insurance, includes coverage of inpatient hospital, SNF, hospice, and some home health services. Part B, supplemental medical insurance (SMI), incorporates coverage of physician, hospital outpatient, home health care, and ancillary services. Part A coverage is automatic for all persons entitled to Medicare benefits. Part B coverage is optional and is obtained through an enrollee-paid premium.

For the dually enrolled population, Medicaid pays Part B premiums (and in some instances Part A premiums), and Part A and Part B coinsurance and deductibles. States have buy-in agreements with HHS to pay for Part B premiums. Buy-in agreements are arrangements between the Federal Government and State Medicaid programs for the payment of Part B premiums. The buy-in agreements can also be modified to include payment for Part A premiums. As of January 1, 1992, only the territories of Puerto Rico and the Northern Mariana Islands did not have buy-in agreements for Part B coverage.

The payments made by the Medicaid program for Medicare premiums, coinsurance, and deductibles generally are split between the Federal Government and the State based on the Federal matching percentage. There are exceptions, however. For example, Part B premiums for the medically needy are paid entirely by the State.

Third-party liability

In some circumstances, services provided to Medicaid enrollees may be covered by other sources: For example, hospital services required because of an automobile accident may be covered by another driver's insurance. Because Medicaid is the payer of last resort, States are required to pursue such third-party liability. There are two basic options for dealing with third-party liability. First, the State can deny payment for the service and instruct the provider to bill the third party (cost avoidance method). Under the second option, the State can pay the claim and then seek payment from the third party (pay and chase method). HCFA regulations generally require cost avoidance, but provide some exceptions where the pay and chase method may be used.

Technical note

HMO—Health Maintenance Organization. An entity that contracts on a prepaid capitated risk basis to provide comprehensive health services to enrollees.

PHP—Prepaid Health Plan. An entity that either contracts on a prepaid capitated risk basis to provide services that are not comprehensive or contracts on a non-risk basis. Additionally, some entities that meet the above definition of HMOs are treated as PHPs, through special statutory exemption.

HIO—Health Insuring Organization. An entity that either provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services. HIOs that merely assume risk and process or pay claims are not considered to be coordinated care providers. HIOs that assume risk and provide or arrange for delivery of services are generally treated the same as HMOs.

PCCM—Primary Care Case Management. A freedom-of-choice waiver program, under the authority of section 1915(b) of the Social Security Act (the Act). States contract directly with primary care providers (PCP), who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently most PCCM programs pay the PCP a monthly case management fee in addition to receiving FFS payment (Health Care Financing Administration, 1992a).

Table 14.11

Federal Medicaid assistance percentages, by State: Fiscal years 1980-91

State or jurisdiction	1980-81	1982-83	1984-85	1986	1987	1988	1989	1990	1991
Alabama	71.32	71.13	72.14	72.30	72.41	73.29	73.10	73.21	72.93
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona	61.47	59.87	61.21	62.28	62.13	62.12	62.04	60.99	62.61
Arkansas	72.87	72.16	73.65	73.03	74.02	74.21	74.14	74.58	75.66
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	53.16	52.28	50.00	50.00	50.00	50.00	50.00	52.11	54.79
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	50.00	51.90	52.60	50.00	50.12
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	58.94	57.92	58.41	56.16	55.54	55.39	55.18	54.70	54.69
Georgia	66.76	66.28	67.43	66.05	64.54	63.84	62.78	62.09	61.78
Guam	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	50.00	50.00	50.00	51.00	51.29	53.71	53.99	54.50	52.57
Idaho	65.70	65.40	67.28	69.36	71.08	70.47	72.71	73.32	73.24
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	57.28	56.73	59.93	62.82	62.92	63.71	63.71	63.76	63.85
Iowa	56.57	55.35	55.24	58.90	60.39	62.75	62.95	62.52	65.04
Kansas	53.52	52.50	50.67	50.00	51.39	55.20	54.93	56.07	59.23
Kentucky	68.07	67.95	70.72	70.23	70.75	72.27	72.89	72.95	72.82
Louisiana	68.82	66.85	64.45	63.81	65.77	68.26	71.07	73.12	75.44
Maine	69.53	70.63	70.63	68.86	68.07	67.08	66.68	65.20	62.40
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	51.75	53.56	50.13	50.00	50.00	50.00	50.00	50.00	50.00
Michigan	50.00	50.00	50.70	56.79	56.88	56.48	54.75	54.54	55.41
Minnesota	55.64	54.39	52.67	53.41	52.98	53.98	53.07	52.74	54.43
Mississippi	77.55	77.36	77.63	78.42	78.50	79.65	79.80	80.18	79.99
Missouri	60.36	60.38	61.40	60.62	59.85	59.27	59.96	59.18	60.84
Montana	64.28	65.34	64.41	66.38	67.44	69.40	70.62	71.35	71.70
Nebraska	57.62	58.12	57.13	57.11	58.06	59.73	60.37	61.12	64.50
Nevada	50.00	50.00	50.00	50.00	50.00	50.25	50.00	50.00	50.00
New Hampshire	61.11	59.41	59.45	54.92	53.28	50.00	50.00	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	69.03	67.19	69.39	68.94	69.68	71.52	71.54	72.25	74.33
New York	50.00	50.88	50.00	50.00	50.00	50.00	50.00	50.00	50.00
North Carolina	67.64	67.81	69.54	69.18	68.40	68.68	68.01	67.46	66.52
North Dakota	61.44	62.11	61.32	55.12	56.41	64.87	66.53	67.52	72.75
Ohio	55.10	55.10	55.44	58.30	58.27	59.10	58.98	59.57	60.63
Oklahoma	63.64	59.91	58.47	57.60	59.86	63.33	66.06	68.29	70.74
Oregon	55.66	52.81	57.12	61.54	62.47	62.11	62.44	62.95	63.55
Pennsylvania	55.14	56.78	56.04	56.72	57.28	57.35	57.42	56.86	56.84
Puerto Rico	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Rhode Island	57.81	57.77	58.17	56.33	55.38	54.85	55.88	55.15	53.29
South Carolina	70.97	70.77	73.51	72.70	72.23	73.49	73.08	73.07	72.66
South Dakota	68.78	68.19	68.31	67.82	67.45	70.43	71.02	70.90	72.59
Tennessee	69.43	68.53	70.66	70.20	70.26	70.64	70.17	69.64	68.41
Texas	58.35	55.75	54.37	53.56	55.16	56.91	59.04	61.23	64.18
Utah	68.07	68.64	70.84	72.62	73.21	73.73	73.86	74.70	75.11
Vermont	68.40	69.37	68.59	67.06	67.37	66.23	63.92	62.77	61.37
Virgin Islands	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Virginia	56.54	56.74	56.53	53.14	51.86	51.34	51.20	50.00	50.00
Washington	50.00	50.00	50.00	50.06	52.52	53.21	53.06	53.88	54.98
West Virginia	67.35	67.95	70.57	71.53	72.59	74.84	76.14	76.61	77.68
Wisconsin	57.95	58.02	56.87	57.54	57.58	58.98	59.31	59.28	60.38
Wyoming	50.00	50.00	50.00	50.00	54.20	57.96	62.61	65.95	69.10

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of State Agency Financial Management.

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