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KCMU Medicaid Benefits Database: State-Specific Notes

Alabama: This State imposes its copayment requirements on dually eligible Medicare and Medicaid beneficiaries for services for which the State is asked to pay the coinsurance and/or deductible amount. The State does not require a copayment for physician office visits during which surgical procedures are performed. Any identified copayment requirements are applicable to beneficiaries age 18 and older.

Alaska: Any identified copayment requirements are applicable to beneficiaries age 18 and older.

Arizona: This State has an approved Section 1115 Waiver from CMS under which it provides services in a program called the Arizona Health Care Cost Containment System (AHCCCS). The program includes an Acute Care program and a companion program for long-term care services (in institutional and alternative residential settings as well as home and community-based care) called the Arizona Long-Term Care System (ALTCS). All Acute Care program members, whether receiving care on a fee for service basis or through enrollment in a managed care organization, are eligible for the same array of acute care services. All ALTCS members, whether receiving care on a fee for service basis or through enrollment in a managed care organization, are eligible for the same array of acute and long-term care services. The majority of the State's Medicaid beneficiaries are enrolled in contracted managed care organizations through which they receive health care services. Providers are required to obtain prior approval from the AHCCCS Administration for specified services for the fee for service populations or from the State's contracted managed care organizations for the managed care populations. Major differences in coverage limitations between the Acute Care program and the ALTCS program are noted on the tables.

Any identified copayment requirements are applicable to beneficiaries age 19 and older unless otherwise exempt. The copayment requirements shown on the tables apply to the traditional Medicaid population as permitted in federal law. Copayment requirements for the Transitional Medical Assistance (TMA) and AHCCCS waiver populations are higher, for a few additional services and not reflected on the tables; these groups may be denied non-emergency services for failure to pay the required copayments.

The tables reflect that Home and Community-Based Services (HCBS) Waivers are not covered. This does not mean that such services are not offered by the State, only that they are not covered through a Section 1915(c) waiver and are instead covered through Arizona's Section 1115 waiver.

Arkansas: This State has added the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA). Beneficiaries in this group are required to make a copayment for most services received. These copayment amounts are not reflected on the tables but are generally \$10 per service or a percentage of the program's payment for a particular service.

This State also has an approved Section 1115 Waiver from CMS under which it provides a safety net health benefit package in partnership with employers to parents and spouses of Medicaid and CHIP children and to childless adults and spouses. The information provided in the tables does not reflect policies applicable to this limited benefit program. This population receives a limited benefit package under a plan called ARHealthNetworks (also called ARHealthNet), which places limits on services, such as the number of covered prescriptions per month and the number of covered physician office visits and hospital services per year. There is a \$100 annual deductible, copayments are set at 15 percent of allowed charges for each covered service and there is a maximum annual benefit of \$100,000. The maximum out of pocket cost per year is \$1,000.

California: Irrespective of the amounts shown on the tables, copayments are not required for any service for beneficiaries younger than age 19 or for which the program's payment is \$10.00 or less. This State has an approved Section 1115 Waiver through which health care coverage, in advance of health care reform requirements in 2014, will be extended to two groups of low-income adults otherwise ineligible for Medicaid at the option of each county. The information provided in the tables does not reflect policies applicable to this limited benefit waiver, called Bridge to Reform.

Colorado: Any identified copayment requirements are applicable to beneficiaries age 19 and older. Providers may collect multiple copayments, if applicable, on the same date of service, e.g., a hospital could collect a copayment for both an outpatient visit and a laboratory service. Substance abuse treatment for pregnant women can extend up to 12 months postpartum if services were initiated prior to delivery.

Connecticut: HUSKY Health is this state's public health coverage program. There are multiple components. HUSKY A is the Medicaid program for children, parents, relative caregivers and pregnant women; the State provides full benefits to parents and caregivers of Medicaid eligible children with income at or below 185 percent of the federal poverty level (FPL) and to pregnant women with income at or below 250 percent of the FPL. HUSKY B is the non-Medicaid Children's Health Insurance Program for children under age 19 in families with income higher than Medicaid limits. HUSKY C is the Medicaid program for the elderly and individuals age 18 through 64 with disabilities. The HUSKY C group includes the optional Medicaid buy-in group of disabled and formerly disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA) who are allowed to continue Medicaid coverage and receive full benefits if their income is at or below \$75,000 per year and they pay an income-based monthly premium when their income exceeds 200 percent of the FPL. HUSKY D is the state's program for low-income adults without dependent children. Although income limits vary for HUSKY A, HUSKY C and HUSKY D the benefits are comparable and reflected on the tables.

Delaware: This State has an approved Section 1115 Waiver from CMS under which it extends Medicaid eligibility to additional low-income adults through savings achieved by implementing a managed care program called the Diamond State Health Plan. This statewide managed care program utilizes both a capitated plan and an enhanced fee for service plan, the latter administered by the State and called Diamond State Partners. Most Medicaid beneficiaries, including the expansion population of adults age 19 and older with income at or below 100 percent of the federal poverty level (FPL), are required to enroll in one of the State's contracted managed care plans. The expansion population is not entitled to coverage of any services until the effective date of such enrollment. In addition to services provided through the managed care plans, beneficiaries receive certain

wrap-around services on a fee for service basis. The wrap-around services covered for the expansion population are generally the same as those available to the Traditional Medicaid population. The tables reflect services available through both the managed care plans and as a wrap-around benefit. The capitated plan may also provide additional services for its members. Delaware does not offer Rural Health Clinic services as there are no such clinics located in the state.

District of Columbia: The District has an approved Section 1115 Waiver from CMS under which it provides full Medicaid benefits to childless adults between the ages of 21 and 64 with income at or below 200 percent of the federal poverty level (FPL); those individuals with income below 133 percent of the FPL receive benefits through the District's implementation of the childless adult coverage option available under the ACA. The District has extended Medicaid eligibility to working disabled adults with HIV/AIDS, permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA); qualified beneficiaries must have income at or below 300 percent of the FPL. The benefit package, managed care delivery system and cost sharing requirements for these beneficiaries are the same as for the Traditional Medicaid population. The District does not offer Rural Health Clinic services as there are no such clinics located there.

Florida: This State has an approved Section 1115 Waiver from CMS under which certain Medicaid eligibility groups are required to enroll in and receive health care services from specified health plans. At this time, the waiver is limited to selected counties. The health plans are paid a risk-adjusted premium and are required to provide all mandatory and most optional Medicaid benefits, but covered services may vary in amount, duration and scope. The tables reflect services available on a fee for service basis for the Medicaid population not yet included under the waiver.

Hawaii: This State has an approved Section 1115 Waiver from CMS, funded by both Title XIX and Title XXI, under which it extends Medicaid eligibility to a number of previously uninsured individuals and through which care is delivered by managed care organizations. The waiver program, commonly called QUEST Expanded, has multiple components, including QUEST, QUEST Expanded Access (QExA), QUEST-ACE (Adult Coverage Expansion) and QUEST-Net, for different populations at different income levels and with different health care needs. The QUEST-Net and QUEST-ACE components cover adult expansion populations. The benefit package is the same for all groups. All dental care is provided on a fee for service basis outside of the QUEST Expanded health plans. Copayments are not required from any beneficiaries.

Idaho: Idaho has implemented its Medicaid Basic Plan with services designed for healthy children and adults; this plan does not include long-term care, organ transplants or intensive mental health treatment, and most beneficiaries are enrolled in the State's Primary Care Case Management model of managed care called Healthy Connections. The Medicaid Enhanced Plan provides services designed for beneficiaries with more complex health care needs such as the elderly and disabled and includes long-term care in institutional and community settings, organ transplants and intensive mental health treatment. A third plan, the Medicare-Medicaid Coordinated Plan, provides integrated care for beneficiaries dually eligible for Medicare and Medicaid. The tables do not reflect all coverage variances across plans but do identify those benefits covered by at least one of the plans.

Indiana: This State has an approved Section 1115 waiver from CMS through which it operates two distinct health insurance products: the Hoosier Healthwise Program for current Medicaid eligible beneficiaries and the Healthy Indiana Plan (HIP) for uninsured adults not currently eligible for Medicaid. The Hoosier Healthwise program provides coverage for children, pregnant women and low-income families. The Traditional Medicaid Program serves primarily beneficiaries dually eligible for Medicare or eligible for Medicaid through satisfaction of a spend-down as well as beneficiaries receiving care in an institution. The majority of Hoosier Healthwise enrollees as well as beneficiaries in the Traditional Medicaid and Care Select Programs receive full and comparable benefits; only these benefits are reflected on the State's tables. Benefits related to the HIP are not reflected on the tables. Any identified copayment requirements on the tables are applicable to beneficiaries age 18 and older.

Iowa: The Medicaid program in this state is administered through the Iowa Medicaid Enterprise (IME), which is a collection of approved contracts with proven specialty providers of administrative support services. The contracts are overseen by Medicaid agency staff.

Iowa also has an approved Section 1115 Waiver from CMS to operate the IowaCare program, which covers a limited benefit package and restricts beneficiaries to select providers for service. They are also subject to copayments for services. The information provided in the tables does not reflect this limited benefit package.

This State imposes a \$1 copayment requirement on dually eligible Medicare and Medicaid beneficiaries for each date of service for which the State is asked to pay the coinsurance and/or deductible amount on a Medicare Part B benefit.

Kansas: This State imposes a \$2 copayment requirement on dually eligible Medicare and Medicaid beneficiaries for each date of service for which the State is asked to pay the coinsurance and/or deductible amount.

Kentucky: Kentucky's KyHealth Choices initiative customizes beneficiaries' benefits to meet their specific needs. There are four plans included in the initiative and most beneficiaries are enrolled in capitated managed care organizations to receive their care. The plan's designated letter on the tables notes distinctions in coverage.

- **Global Choices ("A" on the tables)** includes the standard benefit package with more extensive cost sharing and benefit caps and does not include long-term care; it targets pregnant women and parents, caretaker relatives, recipients of cash assistance through SSI or the state's TANF (KTAP) program, women with breast or cervical cancer, medically fragile children and children in foster care.
- **Optimum Choices ("B" on the tables)** includes the standard benefit package as well as institutional (ICF/MR) and community-based long-term care; it targets persons with developmental disabilities.
- **Comprehensive Choices ("C" on the tables)** targets the elderly and disabled in need of institutional or community-based long-term care; it includes the standard benefit package as well as long-term care services, and also relies on authority in a Section 1915(c) waiver.

Irrespective of the plan, members are subject to copayments for certain services and have both a medical and a pharmacy out of pocket maximum of \$225 per year. Any identified copayment requirements are applicable to beneficiaries age 18 and older and do not apply to preventive services; beneficiaries eligible for both Medicare and Medicaid are exempt from cost sharing.

A fourth plan, Family Choices, targets children, including those eligible for Traditional Medicaid and those covered by CHIP. It includes the standard benefit package with no cost sharing for the Medicaid-covered children. This plan is not referenced on the tables because the covered population does not include adults.

Louisiana: Currently most of this State's Medicaid beneficiaries receive their physical health care services through a risk-based managed care system called Bayou Health, however the tables generally reflect fee for service policies. Specialized behavioral health services are provided through the Louisiana Behavioral Health Partnership's contracted vendor.

Maine: MaineCare is the name of the health care program in this State that provides coverage for residents living below 100 percent of the federal poverty level (FPL) as well as others with low-income. The Medicaid program is a part of MaineCare. Most MaineCare beneficiaries receive their care through a Primary Care Case Management model of managed care but may voluntarily enroll in DirigoChoice, a managed care entity, if they work for an eligible business. The State has an approved Section 1115 Waiver from CMS under which it extends Medicaid eligibility to childless adults with income at or below 100 percent of the FPL. This population receives a limited benefit package that is not referenced on the tables.

Maryland: This State has an approved Section 1115 managed care waiver from CMS under which it extends Medicaid eligibility to a number of different populations not otherwise eligible for Medicaid in a program called HealthChoice. Services for HealthChoice members are provided primarily through managed care organizations. Under this waiver, the State provides enriched benefits such as therapies, dental care and private duty nursing to certain Medicaid eligible disabled adults in a program called the Rare and Expensive Case Management (REM) program.

Also part of the 1115 Waiver, the state provides a limited benefit package of primary care services to beneficiaries in the Primary Adult Care (PAC) program for adults with income at or below 116 percent of the FPL. The information provided in the tables does not reflect policies applicable to any limited benefit programs. Pharmacy copayments for PAC are set at higher levels than for beneficiaries receiving full benefits.

All beneficiaries (including those with limited benefit coverage) must comply with applicable HealthChoice copayment requirements.

Massachusetts: The Commonwealth's MassHealth program includes both Medicaid and CHIP and operates in part under an approved Section 1115 Waiver from CMS that includes expansion populations. There are many coverage types under MassHealth including – Standard, CommonHealth, Family Assistance, Basic, Essential, Limited and others – each targeting a different population and with different eligibility requirements. Only policies applicable to all MassHealth enrollees or related to those services reimbursed on a fee for service basis directly by the Commonwealth are reflected on the tables. Some service limitations may apply depending on beneficiary age and coverage type.

Services for members under age 65 are generally provided by managed care organizations (MCOs) or MassHealth's Primary Care Clinician Plan. Those members who choose to enroll in MCOs receive some of their services on a fee for service basis from MassHealth contracted direct service providers.

Copayments for MassHealth members are limited to annual maximums of \$250 for prescription drugs and \$36 for non-pharmacy services per beneficiary.

Michigan: The inpatient hospital copayment requirement does not apply to second hospitals receiving a transfer or to readmissions within 15 days of discharge for the same DRG/diagnosis. The physician copayment requirement is limited to specific office visit codes and does not include mental health services. Services in an Intermediate Care Facility for the Mentally Retarded are indicated as non-covered because the State has now closed all such facilities. This State has an approved Section 1115 waiver from CMS through which it extends Medicaid coverage for a limited package of benefits to non-pregnant childless adults between the ages of 19 and 64 called the Adult Benefits Waiver. Copayments for selected services are required and are higher than for the Traditional Medicaid population. The Adult Benefits Waiver population receives a limited benefit package that is not referenced on the tables.

Minnesota: Minnesota offers different benefit packages to different populations. Differences in these packages are denoted using different letters, described below.

- **Group A:** Included in this benefit group are Minnesota's Traditional Medicaid population of categorically and medically needy beneficiaries, which receive full benefits. Also included is the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA) and childless adults with income at or below 75 percent of the federal poverty level (FPL). Children and pregnant women covered under the MinnesotaCare, an 1115 waiver program, receive the same benefits as the Traditional Medicaid population.
- **Group B:** Included in this benefit group are parents and caretakers with incomes up to 215 of the FPL on MinnesotaCare, an 1115 waiver program. They generally receive a lesser benefit package than those in Group A and face additional copayments.

Minnesota also provides coverage to other groups not reflected in these tables, notably childless adults with incomes between 75 and 200 of the FPL and parents/caretakers with incomes above 215 of the FPL, both served by the MinnesotaCare program. Both groups are eligible for a limited benefit package which includes a \$10,000 annual limit on inpatient hospital care. Childless adults are also responsible for a 10 percent copayment up to \$1,000 for inpatient care.

For all beneficiaries, there is a cap on copayments equal to 5 percent of family income for all individuals with family income at or below 100 percent of the FPL. All MinnesotaCare beneficiaries receive services through managed care organizations.

Mississippi: This State extends Medicaid benefits generally only to populations for which coverage is mandated in federal law. Some optional populations are covered but not the medically needy group.

Missouri: This State's Medicaid program operates as MO HealthNet. Adult coverage for a number of program benefits is limited to pregnant women and those beneficiaries who are blind or are residing in an institutional setting such as a nursing facility. Within federal constraints applicable to specific population groups, services and settings, any identified copayment requirements are applicable to beneficiaries age 19 and older, except for the blind. Dual eligible beneficiaries are exempt from cost sharing if program payment is limited to coinsurance or deductible amounts. The copayment requirement for physician and related services is applicable to and in addition to any amount payable to hospitals or laboratories for services.

Montana: This state offers different benefit packages to different populations. Differences in these packages are denoted using different letters, described below. Cost sharing requirements are the same for both groups.

- **Group A:** Included in this group is Montana's Traditional Medicaid population that receives full benefits as well as the optional Medicaid buy-in group of disabled adults permissible through the Balanced Budget Act of 1997.
- **Group B:** The State has an approved Section 1115 Waiver from CMS – called the Basic Medicaid Waiver for Able-Bodied Adults – under which it extends Medicaid eligibility to individuals between the ages of 21 and 64 who are neither pregnant nor disabled and who are parents and caretaker relatives of dependent children. A group of individuals with schizophrenia and bipolar disease also receive coverage. The Waiver provides mandatory Medicaid benefits as well as a limited package of optional services. Specified services are not covered, including audiology, dental, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, home infusion, personal care services and hearing aids. However the services are available through the Essentials for Employment program if services are essential to obtaining or maintaining employment, consistent with a typical work-related insurance program. The State provides coverage for emergency dental situations, medical conditions of the eye and certain medical supplies such as diabetic supplies and oxygen.

Nebraska: Any identified copayment requirements are applicable to beneficiaries age 19 and older. The State's copayment requirements for physicians are not applicable to primary care services and the copayment requirements for nurse practitioners are not applicable to advance practice nurses with specialties in family practice, general practice, pediatrics or internal medicine. The State contracts with an administrative services organization for behavioral health benefits and copayment requirements for those benefits are limited to specified services. The State requires a \$1 per visit copayment for occupational therapy and physical therapy and a \$2 per visit copayment for speech pathology services rendered in an independent clinic setting but requires a \$3 per visit copayment if the services are rendered in an outpatient hospital setting.

New Hampshire: The prescription copayment requirement applies to beneficiaries age 18 and older.

New Jersey: This State has an approved Section 1115 Waiver called NJ FamilyCare, covers parents and caretaker relatives of Medicaid and CHIP-eligible children with income at or below 200 percent of the federal poverty level (FPL) and also extends coverage to pregnant women with income between 185 percent and 200 percent of the FPL. Under the waiver, pregnant women receive full Medicaid benefits. Parents and caretaker relatives under the waiver receive a reduced benefit package modeled after a standard commercial plan, which

is not reflected on the tables. Also not reflected in the tables are copayments that children in families with income between 200 percent and 350 percent of the FPL as well as parents and caretakers with income above 150 percent of the FPL are required to pay.

The following benefits are not covered for New Jersey's Medically Needy population: services in a nursing facility, inpatient psychiatric hospital for persons under age 21, institution for mental diseases, intermediate care facility for individuals with intellectual disabilities and religious non-medical health care institution, and hospice care. The benefits listed below are also not covered for the state's Medically Needy populations except for those listed:

- Services in an inpatient hospital setting, chiropractor services, targeted case management, and prescription drug coverage are limited to pregnant women
- Podiatrist services are limited to pregnant women and the aged, blind, and disabled.

New Mexico: In addition to providing benefits to the Traditional Medicaid population, this state offers different benefit packages and imposes different cost sharing requirements for two additional populations. Differences in these packages are denoted using different letters, described below.

- **Group A:** The State Coverage Initiative, an 1115 waiver program, covers parents of Medicaid and CHIP-eligible children as well as childless adults between the ages of 19 and 64. These adults receive a benefit package similar to basic commercial coverage, which is more limited than the Traditional Medicaid package, and are required to pay copayments for some services. Copayments with a range are applied based on the individual's income. Services are generally delivered through contracted managed care organizations and there is an annual benefit limit of \$100,000.
- **Group B:** The State has also added the optional Medicaid buy-in group of disabled adults permissible through the Balanced Budget Act of 1997. These beneficiaries receive full Medicaid benefits but are required to pay copayments for some services. Unique copayment information for these disabled adults is identified on the tables as "B."

Any items on the tables without an "A" or a "B" reference are applicable to the Traditional Medicaid population and the disabled group to the extent those individuals are receiving care on a fee for service basis. Traditional Medicaid beneficiaries have no copayment requirements.

With approval of a new Section 1115 Waiver from CMS, the Centennial Care Program will dramatically change health care delivery in New Mexico, but its features are not addressed here or in the tables because the program will not be implemented until 2014.

New York: This State has an approved Section 1115 Waiver from CMS under which it implemented The Partnership Plan. The waiver extends health care coverage to low-income adults covered under the former State-funded cash assistance Safety Net program and moved most Medicaid beneficiaries from a primarily fee for service delivery system to a mandatory managed care environment.

In 2009 the State implemented its Beneficiary-Specific Utilization Threshold (BSUT) policy and now applies the BSUTs to outpatient hospital, physician and clinic services, including dental and mental health clinics, and to prescription drugs and laboratory services. The BSUTs are applied based on a beneficiary's physical health condition using a clinical risk group crosswalk. A subsequent waiver amendment created the Family HealthPlus (FHPlus) program for additional low-income uninsured adults under the age of 65. The benefits package for FHPlus beneficiaries is less comprehensive and requires more and higher copayments for services; the FHPlus benefits and copayments are not reflected on the tables. FHPlus does not include long-term care services for the chronically ill, non-emergency medical transportation, most medical supplies or the majority of non-prescription drugs. Limitations apply to home health, rehabilitation and inpatient and outpatient mental health and substance abuse services as well.

North Carolina: This State's Medicaid program delivers services predominantly through a Primary Care Case Management (PCCM) model of managed care called Community Care of North Carolina. Copayment requirements are applied uniformly within federal constraints and the program is available statewide. Each year the State legislature establishes visit limits applicable to services rendered by specified practitioners; the limits do not apply to certain physician specialties nor are they applicable to pregnant women or beneficiaries enrolled in a community alternatives program providing home and community-based care. Behavioral health services indicated on the tables with capitated reimbursement are managed under a Section 1915(b)/(c) waiver.

North Dakota: Any identified copayment requirements are also applicable to beneficiaries dually eligible for Medicare and Medicaid unless they are institutionalized.

Ohio: All identified copayments apply to the Traditional Medicaid population within federal limitations and to the buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIA). Pregnant women are not exempt from the copayments associated with routine eye exams and the fitting of eyeglasses unless the service is pregnancy-related.

Oklahoma: This State has an approved Section 1115 Waiver under which the SoonerCare program that delivers care through an enhanced primary care case management delivery system, currently through a Patient-Centered Medical Home model. With the exception of dental services, which are more comprehensive for pregnant women and persons residing in an ICF/IID, all SoonerCare members receive the same services and, within federal constraints, are subject to the same cost sharing requirements. Pregnant women are exempt from copayments for pregnancy-related services. The information appearing on the tables represent basic SoonerCare adult benefits. This State imposes a \$1.00 copayment requirement on dually eligible Medicare and Medicaid members for any service for which the State is asked to pay the coinsurance and/or deductible amount.

The State also operates the Insure Oklahoma program under the Section 1115 Waiver, which is authorized to expand coverage to uninsured adults and college students. This program provides premium assistance and direct individual state coverage to select uninsured adults. Also included in the Insure Oklahoma program are working disabled adults with an approved Ticket to Work authorized through the federal Ticket to Work and Work Incentives Improvement Act (TWWIA). Medical benefits under the Insure Oklahoma program are more

limited than under SoonerCare and copayment requirements are higher. Benefits and copayment requirements for the Insure Oklahoma program are not reflected on the tables.

Oregon: This State has an approved Section 1115 Waiver from CMS under which it implemented a prioritized list of covered health services for its Medicaid program, called the Oregon Health Plan (OHP), based on their comparative benefit to the population served. Different populations receive different benefit packages. Differences in these packages are denoted using different letters, described below.

- **Group A:** This group includes the Traditional Medicaid population, covered under OHP Plus. This includes families with income below 100 percent of the federal poverty level (FPL), the elderly, blind and disabled, and pregnant women and children living in families with income at or below 185 percent of the FPL. Also covered under OHP Plus is the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA.) OHP Plus program participants age 19 and older are required to make copayments for specified services if the program makes any payment, even if Medicare or their private insurance covered part of the cost of the service.
- **Group B:** This group includes the waiver's expansion population, covered under OHP Standard, includes adults with income below 100 percent of the FPL not eligible for Traditional Medicaid coverage. The benefit package for the OHP Standard program is more limited than for the OHP Plus program. Imposition of a copayment requirement on the OHP Standard group has been prohibited as the result of a court order.

Pennsylvania: This State's covered services for the Medically Needy (MN) population are more restrictive than for the Categorically Needy (CN) population. Included in the state's CN population is the optional Medicaid buy-in group of disabled and formerly disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA). Major differences are identified on the tables.

Any identified copayment requirements are applicable to beneficiaries age 18 and older in accordance with federal regulations. The copayment amount for x-ray services is also applicable to such services rendered in a clinic, physician office or outpatient hospital setting and may be collected in addition to a copayment required for other services provided.

Rhode Island: This State has an approved Section 1115 Waiver that permitted the State to extend Medicaid eligibility to a number of previously uninsured individuals in its Rhode Island RItE Care and RItE Share programs, each with several components for different groups at different income levels. All Medicaid-funded services on the continuum of care are now organized, financed and delivered under the authority of the waiver. The tables reflect that Home and Community-Based Services (HCBS) Waivers are not covered. This does not mean that such services are not offered by the State, only that they are no longer covered through Section 1915(c) Waivers and are now included under the Section 1115 Waiver. Most services are provided by managed care organizations or a primary care case management model of care, the Rhody Health Partners and Connect Care Choice programs respectively. Medical nutrition therapy (nutrition counseling and group education) is available for adults enrolled in the Waiver's managed care programs as an adjunct to medical treatment for selected chronic conditions. Only policies related to those services available to all adult populations as

medically appropriate or reimbursed directly by the State are reflected on the tables. Services in Rural Health Clinics and Freestanding Birth Centers are indicated as non-covered because the State has no such entities.

South Carolina: Qualifying beneficiaries receive services through contracted managed care organizations, most of which offer additional services and do not charge copayments. Except as specified in federal law, any identified copayment requirements are applicable to beneficiaries age 19 and older.

South Dakota: The Medicaid buy-in group of working adults with disabilities permissible through the Balanced Budget Act of 1997 is subject to the same copayment requirements as other Medicaid beneficiaries.

Tennessee: This State has an approved Section 1115 waiver (“TennCare”) from CMS under which it serves three distinct populations. Differences in these packages are denoted using different letters, described below.

- **Group A:** This group includes TennCare Medicaid, provides a comprehensive package of covered services with some limitations for adults and, recognizing federal copayment exemptions, nominal copayment requirements for prescription drugs.
- **Group B:** This group includes TennCare Standard, provides a similar package of services for certain adults and children who do not meet eligibility criteria for TennCare Medicaid but who meet other eligibility criteria established by the State.
- **Group C:** This group includes TennCare CHOICES, provides both nursing facility and home and community-based services (HCBS) to eligible persons in TennCare Medicaid and TennCare Standard. Persons in group “C” are eligible for long-term services and supports and for most services offered to persons in their respective eligibility category (TennCare Medicaid and TennCare Standard).

Cost sharing requirements in TennCare Standard vary according to income level. TennCare Standard enrollees who are children with income at or above 100 percent of the federal poverty level (FPL) have cost sharing obligations; those with income at or above 100 percent but below 200 percent of the FPL (identified as B1) have lower copayment obligations than enrollees with income at or above 200 percent of the FPL (identified as B2). Within federal constraints, TennCare Standard adults have the same copayment requirements for prescription drugs as TennCare Medicaid adults.

All TennCare services, including long-term services and supports for the elderly and disabled and non-HCBS for persons with intellectual disabilities, are provided through managed care contractors (MCCs): managed care organizations, a dental benefits manager (for children) and a pharmacy benefits manager. MCCs have broad discretion relative to the types of providers they use as long as they can assure appropriate access to care. The MCCs’ providers deliver services within the scope of their licensure and must be appropriately credentialed by the MCC. Within contractual parameters, the MCCs establish their own prior authorization policies, reimbursement methodologies and payment rates. Accordingly, only limitations mandated by the State appear on the tables.

Texas: This State's Medicaid population risk-based managed care program is called STAR – State of Texas Access Reform – and a companion program focused on service coordination and long-term care services for the elderly and disabled is called STAR+PLUS.

Utah: This State has an approved Section 1115 waiver from CMS under which it provides three different packages of services for its Medicaid beneficiaries.

- **Group A:** This group includes Traditional Medicaid, which provides a comprehensive package of covered services for primarily children, pregnant women, and the aged, blind and disabled, with some limitations and nominal copayments where permitted under federal law. Included in this category is the optional Medicaid buy-in group of disabled adults permissible through the Ticket to Work and Work Incentives Improvement Act (TWWIIA).
- **Group B:** This group includes non-traditional Medicaid, which provides a smaller package of covered services for certain adults receiving or previously receiving cash assistance through the State's Temporary Assistance for Needy Families (TANF) program, with some limitations and nominal copayments up to an annual maximum of \$500.
- **Group C:** This group includes the Primary Care Network, which provides a very limited package of covered services for parents of Medicaid-eligible children and other adults with income below 150 percent of the FPL and has higher copayments with an annual maximum of \$1,000.

The State does not require copayments for any preventive services.

Vermont: This State has an approved Section 1115 waiver from CMS called the Global Commitment to Health. The Department of Vermont Health Access, as a managed care entity, administers the waiver and Vermont's public health coverage programs, including Medicaid and Vermont Health Access Plan (VHAP). Medicaid and VHAP services are delivered on a fee for service (FFS) basis or through the State's Primary Care Case Management model of managed care called Primary Care Plus (PC Plus). The State will repeal the VHAP on January 1, 2014, upon implementation of its state-operated health care exchange. Differences in these packages are denoted using different letters, described below.

- **Group A:** This group includes the State's Traditional Medicaid population, including low-income families and caretaker relatives and the aged, blind and disabled, as well as optional and expansion populations of pregnant women with income at or below 200 percent of the federal poverty level (FPL) and the working disabled, permitted through the Balanced Budget Act of 1997, with income at or below 250 percent of the FPL.
- **Group B:** This group includes the VHAP population includes uninsured adults age 18 and older with income at or below 185 percent of the FPL.

The tables reflect that Home and Community-Based Services (HCBS) Waivers are not covered. This does not mean that such services are not offered by the State, only that they are no longer covered through Section 1915(c) waivers. The State covers institutional and community-based long-term care services for the elderly

and physically disabled adults age 18 and older who meet nursing facility level of care criteria under a second Section 1115 waiver called Choices for Care.

Washington: This state has an approved Section 1115 waiver from CMS, called the Transitional Bridge, to sustain coverage for early expansion-eligible individuals age 19 through 64 with countable household income up to 133 percent of the FPL. These individuals are enrolled in the state-only Basic Health, Medical Care Services or Alcohol and Drug Addiction Treatment and Support Act programs and receive a comprehensive package of physical and behavioral health benefits primarily delivered through capitated managed care organizations. This group is not referenced on the tables.

West Virginia: This State has received approval from CMS to implement Medicaid reform permitted by the Deficit Reduction Act (DRA) of 2005 in a program called Mountain Health Choices. The program has a Basic and an Enhanced plan as well as a Traditional Medicaid Plan.

- **Group A:** The Basic plan includes all state and federal mandatory services.
- **Group B:** The Enhanced plan offers additional services to members voluntarily signing a health care responsibility agreement. Some of those additional services include weight management, tobacco cessation programs, diabetes education and nutritional counseling and education.
- **Group C:** West Virginia still offers Traditional Medicaid benefits to some of its beneficiaries.

Wisconsin: This State has an approved Section 1115 waiver under which it extends Medicaid eligibility to families and caretaker relatives with net income up to 200 percent of the federal poverty level (FPL). This population receives full Medicaid benefits either directly or as a wrap-around for services included in an employer's insurance package through the BadgerCare Plus Standard Plan.

A limited benefit package with higher copayment requirements called the BadgerCare Plus Benchmark Plan is available for children and pregnant women with income between 200 percent and 300 percent of the FPL. Under another Section 1115 waiver the BadgerCare Plus Core Plan is available for childless adults with income at or below 200 percent of the FPL. The Core Plan has a much slimmer benefit package of basic health care services and copayments that are similar to the Standard Plan. The tables only reflect characteristics applicable to the State's full benefit package.

Any identified copayments are applicable to pregnant women if the service is unrelated to pregnancy.

American Samoa: The LBJ Tropical Medical Center is the primary provider of medical services in American Samoa. The territory does not provide some of the services generally offered in the states, such as inpatient psychiatric services for children, hospice, family planning and the services of nurse midwives, as well as care in a nursing facility or intermediate care facility for the mentally retarded, and the services of chiropractors are not covered because there are none available. Occupational therapy is limited to services rendered in the inpatient or outpatient hospital setting. Other services, such as home health and private duty nursing are provided off-island if medically necessary.

Northern Mariana Islands: This territory declined to verify the information in the tables for the 2012 point in time so it is unchanged from the 2010 tables. The Commonwealth has a single government-controlled and operated hospital and health system that provides the majority of its citizens' health care services. The hospital and health system is paid on a charge basis using Medicare cost ceilings. This methodology is also used for nursing facility services provided off island. For any other services not available through the hospital and health system, providers are paid negotiated rates or the applicable rates paid by the off island Medicaid program.

Puerto Rico: This territory declined to verify the information in the tables for the 2012 point in time so it is unchanged from the 2010 tables. The Commonwealth of Puerto Rico Department of Health, as the single state agency, manages the Medicaid program. The population in Puerto Rico eligible for Medicaid receives health care services under a program called MiSalud (Spanish for My Health). All health care within the MiSalud program is provided through two contracted physical health managed care organizations (MCOs) and a single behavioral health organization (BHO). Depending on the particular region in which a Medicaid beneficiary resides, the MiSalud program assigns the beneficiary to one of the two physical health MCOs and to the BHO. The MCOs and BHO are required contractually to coordinate services between themselves and two pharmacy benefit managers. The Commonwealth provides but does not claim federal Medicaid matching dollars for some services. Accordingly, although some services are not indicated as a covered benefit on the tables because they are not included in the State Plan, such as Family Planning, Home Health Services, Hospice Care, Medical Equipment and Supplies, Non-emergency Medical Transportation and Nursing Facility Services, the Commonwealth makes the services available to MiSalud beneficiaries on an exception basis.

Virgin Islands: This territory declined to verify the information in the tables for the 2012 point in time so it is unchanged from the 2010 tables.