Medicaid Policy in California, 1980–1987 with Special Reference to Pregnant Women and Infants

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Supported by the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services
Preface

This report describes the California Medicaid program between 1980 and 1987 with special reference to prenatal and infant care. It is intended as a reference document for a larger project that examines race and ethnic differences in survival and health costs of very low birthweight infants (< 1,500g). The report should be of interest to persons concerned with public health care financing and issues related to maternal and child health care in the United States.
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Summary

This report describes the California Medicaid program between 1980 and 1987 with special reference to prenatal and infant care. The report is intended as a reference document for a larger project that examines race and ethnic differences in survival and health costs of very low birthweight infants (<1,500g). The project uses linked birth, fetal and infant death certificates that have been matched to the mother’s Medicaid claims during pregnancy and the child’s claims during infancy. The data are for California for the period 1980–1987.

Although we focus on pregnant women and children, they are such an important component of the program that much of the information in this report is germane to the program as a whole. In addition much of the information is also relevant to those eligible for Aid to Families with Dependent Children and Supplemental Security Income because during most of the period of our study, Medicaid eligibility was closely linked to eligibility for these two programs. This linkage was finally broken in 1986.

While compiling detailed information about the California Medicaid program over an eight-year period, with special reference to our study population (mothers and infants), many characteristics of Medicaid policy became evident. First and foremost was the overwhelming complexity of the program. Since Medicaid is jointly controlled and funded by the federal and state governments, both federal and state legislation have to be examined to understand policy changes.

Second was the frequency of changes in policy and reversals of these changes. The federal component is modified annually, usually as part of the budget process. Often, state programs have corresponding changes each year. Because Medicaid policy is so closely tied to an intensely contested portion of the legislative process at the federal level, the year-to-year changes are complex, contradictory and often involve reversals of prior changes. The state level often has many idiosyncratic extensions of eligibility and benefits to particular groups that may modify the federal program in important ways. Like the federal program, these state-specific options change often in complex and contradictory ways.

A third characteristic was the complexity that arises from the structure of the program itself. Simplistically, Medicaid policy involves three components:
eligibility, benefits, and reimbursement. Unfortunately, all three components
often are modified simultaneously and in conflicting ways. As a consequence, it
is often impossible to determine the net effect of a particular year's legislative
changes.

**Federal Program Overview**

Medicaid was created in 1965 through the enactment of Title XIX of the Social
Security Act (O'Sullivan, 1984) to provide "basic and extended health care and
related remedial or preventive services to recipients of public assistance and to
medically needy, aged, and other persons, including such related social services
as are necessary." It is a system of health care for poor people who meet specific
eligibility requirements. Its intent was to provide health care comparable to that
available either purchased out of pocket or through private insurance. It sought
to accomplish these goals by requiring that certain basic services be made
available to all beneficiaries (CDHS, 1990).

During the years 1980–1987, congress first restricted and then expanded the
Medicaid program. The restrictions were a result of the Omnibus Budget
Reconciliation Act of 1981, affecting both eligibility and benefits. The expansions
in subsequent years restored many of the benefits and eligibility criteria
restricted in 1981 and broke the historic linkage between eligibility and federal

**Medicaid Eligibility**

To understand the Medicaid program, first it is essential to understand the
categories of people who are eligible. Medicaid eligibility was strongly linked to
federal cash assistance programs from its inception in 1965 until the passage of
the Omnibus Budget Reconciliation Act of 1986. Only the poor who met specific
federal and state requirements for income and assets were eligible. A person
could be eligible for Medicaid by qualifying for one of the following eligibility
categories:

1. Mandatory Categorically Needy: As its name implies, states were required
   by federal law to provide Medicaid coverage to the mandatory categorically
   needy (MCN). The criteria for eligibility for the MCN were strongly linked
to those for cash assistance programs, i.e., Aid to Families with Dependent
   Children (AFDC) and Supplemental Security Income (SSI).
States had the option of providing Medicaid coverage to two other categories: the optionally categorically needy and the medically needy.

2. Optionally Categorically Needy: People within the optionally categorically needy group met the financial qualifications to be eligible for the state welfare programs. They were not eligible, however, because they did not qualify for the nonfinancial categories that were designated to receive benefits (e.g., families with unemployed parents).

3. Medically Needy: People in the medically needy category met the categorical requirements for state welfare programs but were ineligible for such programs because of their income and assets levels. Unlike the optionally categorically needy, the medically needy can spend down their excess income to qualify for Medicaid.

Comparisons of the California Program to the U.S.

The California Medicaid program has been viewed as one that offers relatively generous benefits. California's need standard for AFDC benefits exceeded the average for all states by about 50 percent on average over the period we are considering. This is a clear indication of the generosity of the program relative to other states. Despite appearances of generosity from the viewpoint of the recipient, however, the California Medicaid program seemed to be lagging behind the nation in their reimbursements to providers as measured by payments per recipient. Although average payments per recipient rose in both California and in the nation as a whole, the level for California was consistently below the national average. The difference increased over our study period.

California Program Status in 1980

As of the beginning of our study period in 1980, California's Medicaid program covered the following groups: the mandatory categorically needy, the optionally categorically needy, and the medically needy. All Medicaid recipients in California received the following basic required services: inpatient hospital services; outpatient hospital services; rural health services; other laboratory and X-ray services; skilled nursing services for individuals age 21 or older; physician services; early and periodic screening, diagnosis, and treatment for individuals under age 21; and family planning services and supplies. California's Medicaid program also covered almost all the optional Medicaid services. In addition, these optional services were offered to the categorically needy.
Changes: 1980–1987

Starting in 1980, a series of congressional budget reconciliation acts was legislated to reduce “Federal spending across government programs” (Medicaid Source Book, 1988). The Omnibus Budget Reconciliation Act of 1981 (OBRA-81) was the most restrictive legislation to affect Medicaid during the period of our study (1980–1987). Its main effects on eligibility were to remove mandatory coverage for first-time pregnancies, to reduce the age limit for coverage from 21 to 18 (19 if the person were in school), and to remove optional coverage for caretakers.

Much of the federal legislation following OBRA-81 sought to restore the restrictions it had imposed. For example, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA-82) restored first time pregnant women as a separate optionally categorically needy group. The Deficit Reduction Act of 1984 (DEFRA-84) continued support for coverage for pregnant women and children by expanding the groups of mandatory categorically needy eligible for federal matching funds and by extending coverage for newborns through the first year of life. These changes did not affect California, which was already providing coverage to these groups. Eligibility expansions for indigent pregnant women and children continued with the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA-85).

The most significant change occurred at the very end of our study period, with the enactment of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86). This legislation broke the historical dependence of Medicaid eligibility on AFDC and SSI eligibility, creating new optionally categorically needy groups: pregnant women, infants, and children under five. This same legislation made assets requirements optional for these groups, allowed states to extend coverage to women 60 days postpartum, and added presumptive eligibility for pregnant women, the homeless, and aliens. California did not adopt the options of dropping the assets test, extending postpartum coverage, or presumptive eligibility.

At the federal level, legislation governing services followed a course similar to that of eligibility, with restrictions following OBRA-81 and expansions thereafter. California followed a course of adding requirements for prior authorization and restricting services.

Throughout our study period, California continued a policy of restricting reimbursement payments and instituting a series of reforms designed to
standardize payments and contain costs. During this same period, the federal
government began allowing states to institute cost-sharing systems for Medicaid.

In 1982, California enacted a major change in contracting policy for hospitals:
acute care hospitals were required to contract with the State, and open and closed
contracting areas were defined. Thus once sufficient contracts had been signed
in an area to assure the projected needs of California’s Medicaid population, then
noncontracting hospitals were not eligible to receive Medicaid reimbursement
except under specified conditions.
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We acknowledge Peter Jacobson’s thoughtful review of an earlier draft that led to substantial revisions and a much improved manuscript. In addition we acknowledge Linde MacLean’s and Jeri Jackson’s assistance with the preparation of the manuscript.
1. Introduction

This report describes the California Medicaid program between 1980 and 1987 with special reference to prenatal and infant care. The report is for a larger project that examines race and ethnic differences in survival and health costs of very low birthweight infants (< 1,500g). The project uses linked birth, fetal and infant death certificates that have been matched to the mother’s Medicaid claims during pregnancy and the child’s claims during infancy. The data are for California for the period 1980–1987.

The present document is intended as a reference for this project. In particular, we are concerned that changes in Medicaid policy over time would affect the mix of Medicaid recipients in our study population (through changes in eligibility), the types of claims submitted (through changes in benefits), and the availability of providers (through changes in reimbursement). The goal of this document is to allow us to identify these policy changes on a year-by-year basis so that we do not make errors in interpreting changes in our data over time.

While compiling detailed information about the California Medicaid program over an eight-year period with special reference to our study population (mothers and infants), a number of characteristics of Medicaid policy became evident. First and foremost was the overwhelming complexity of the program. Since Medicaid is jointly controlled and funded by the federal and state governments, both federal and state legislation must be examined to understand policy changes.

Second was the frequency of changes in policy and reversals of these changes. The federal component is modified annually, usually as part of the budget process. Often, state programs have corresponding changes each year. Because Medicaid policy is so closely tied to an intensely contested portion of the legislative process at the federal level, the year-to-year changes are complex, contradictory, and often involve reversals of prior changes. The state level often has many idiosyncratic extensions of eligibility and benefits to particular groups that may modify the federal program in important ways. Like the federal program, these state-specific options change often in complex and contradictory ways.

A third characteristic was the complexity that arises from the structure of the program itself. Simplistically, Medicaid policy involves three components:
eligibility, benefits, and reimbursement. Unfortunately, all three components often are modified simultaneously and in conflicting ways. As a consequence, it is often impossible to determine the net effect of a particular year’s legislative changes.

Despite the complexity of the program, the frequent changes in policy at both the state and federal level, and simultaneous, conflicting changes in several areas; we were able to discern the following broad changes during our study period (1980–1987). These changes in eligibility, services, and reimbursement detailed in this report can be roughly summarized as follows. Early in our study period eligibility and services were restricted by the Omnibus Budget Reconciliation Act (OBRA) of 1981. This federal legislation was the most restrictive legislation with respect to pregnant women and infants to affect Medicaid during the eight years of our study. Much of the subsequent federal legislation sought to remove the restrictions on eligibility and services that had been imposed by OBRA-81. This program of renewed expansion culminated with OBRA-86, which broke the historical dependence of Medicaid eligibility on eligibility for cash assistance programs. A California fiscal crisis that occurred early in our study period led to restrictions in eligibility for the medically needy as well as restrictions in coverage for certain services. In addition, California continued a policy of restricting reimbursement payments and instituting a series of reforms designed to standardize payments and contain costs. During the same period, the federal government began allowing states to institute cost-sharing systems for Medicaid. Finally, California implemented a selective contracting program for hospital care to further control costs.

The following discussion is an overview of this document.
2. Organization of This Report

To compile this report, we used two types of information. The report, therefore, is divided into two parts, each based on particular information sources. These parts are discussed in turn in Sections 3 and 4. Both parts focus on pregnant women and infants because they are the subjects of our study. The first part (Section 3) concerns legislative changes that describe Medicaid policy at the federal level and for California. The legislative summary was carried out through an extensive review of the literature. The sources are journals, federal and state government documents, and publications by various advocacy groups. Its intent is to describe Medicaid policy as it affected the groups of primary interest for our study. In the discussion that follows, the relevant legislation is discussed in chronological order with the federal legislation first, followed by relevant state of California bills. For this project we chose this ordering for the report because it is important to be able to identify year-by-year changes in the program to interpret changes in the data.

The second part focuses more directly on the program in California. It relies extensively on the *Medicare and Medicaid Data Books* published by the U.S. Health Care Financing Administration (HCFA)—the federal agency in charge of regulating the Medicaid program. This discussion details (1) coverage and eligibility, (2) need and payment standards, (3) services, (4) reimbursement, (5) characteristics of recipients, and (6) limitations on services. Because many of the changes are conflicting, it is difficult to distill the consequences of the changes for any particular year or for the entire study period.
3. Summary of Changes in Medicaid Policy

Introduction

This section is a summary of federal and state Medicaid legislation that affected pregnant women and infants during the time period 1980-1987. It begins with some general background information concerning the Medicaid program and is followed by a description in chronological order of each major federal and state legislative change.

Although we focus on pregnant women and children, they are such an important component of the program that much of the information in this section is germane to the program as a whole. In addition, much of the information is also relevant to those eligible for AFDC and Supplemental Security Income (SSI) because during most of the period of our study, Medicaid eligibility was closely linked to eligibility for these two programs. This linkage was finally broken in 1986.

The discussion that follows first provides a general overview of the program at the federal level and the relation of the federal and state programs. Next it reviews some definitions of eligibility categories that are fundamental to the program structure. Finally, a chronology of changes is given.

Background

Federal Program Overview

Medicaid was created in 1965 through the enactment of Title XIX of the Social Security Act (O’Sullivan, 1984) to provide “basic and extended health care and related remedial or preventive services to recipients of public assistance and to medically needy, aged, and other persons, including such related social services as are necessary.” It is a system of health care for poor people who meet specific eligibility requirements. Its intent was to provide health care comparable to that available either purchased out of pocket or through private insurance. It sought to accomplish these goals by requiring that certain basic services be made available to all beneficiaries (CDHS, 1990).
During the years 1980-1987, congress first restricted then expanded the Medicaid program. The restrictions, a result of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81), affected both eligibility and benefits. The expansions in subsequent years restored many of the benefits and eligibility criteria restricted in 1981 and broke the historic linkage of eligibility to federal cash assistance programs with the Omnibus Budget Reconciliation Act of 1986 (OBRA-86).

**Relation of Federal and State Programs**

The program is jointly funded and jointly controlled by federal and state governments. The California program, commonly known as Medi-Cal, was created pursuant to Chapter 4, Statutes of 1965, by the Second Extraordinary Session of the California Legislature. For simplicity, we refer only to Medicaid rather than using a separate name for the California program.

Federal Medicaid law outlines the basic requirements that states must meet and options that states may adopt in implementing Medicaid programs. Minimum standards regarding eligibility, scope of services, and procedural protections that must be met are also defined by the federal laws. However, states vary substantially in terms of who is covered, the benefits offered, and the methods of payment for services. States must submit plans to the United States Department of Health and Human Services (DHHS) that conform to federal law and operate statewide. If the state plan does not conform to federal law and is not amended, DHHS may withhold federal reimbursement to the state (Perkins, 1991).

The federal government influences state Medicaid law through three mechanisms:

1. Congressional legislation: present Medicaid law and its amendments;
2. Regulations and Guidelines: DHHS is the federal department that sets Medicaid regulations and policy through its HCFA. DHHS issues regulations to implement the legislation. HCFA issues policy guidelines to its regions to implement the regulations. The guidelines are published primarily in the *State Medicaid Manual*. HCFA also uses program statements and transmittals to clarify policy for the states (Perkins, 1991);
3. Reimbursement: Using a mechanism called Federal Financial Participation (FFP), the federal government reimburses the states for participation in the Medicaid program. Reimbursement is based on the state’s per capita income. FFP, therefore, can range from 50 to 83 percent of the total Medicaid costs (Perkins, 1991).
Although these mechanisms help secure federal participation and control, there is considerable variation from state to state, some built into the mechanisms themselves. Some of the reasons for variations include: (1) states electing not to choose an optional federal Medicaid change; (2) HCFA transmittal letters requiring region-specific changes in Medicaid policy (Perkins, 1991); (3) FFP reimbursement calculations based on a state's per capita income (Perkins, 1991); and (4) states choosing to fund their own specific programs.

The optional programs are particularly important sources of state-to-state variations. States may or may not adopt federally specified optional changes to the Medicaid program. The state assembly and/or the state senate decide the options to adopt. Then they enact assembly or senate bills that specify the adopted changes. In addition, the assembly and the senate also can make state-specific changes to Medicaid, which are independent of federally specified options.

**Medicaid Eligibility**

To understand the Medicaid program, first the categories of people who are eligible must be understood. Medicaid eligibility was strongly linked to federal cash assistance programs from its inception in 1965 until the passage of OBRA-86. Only the poor who met specific federal and state requirements for income and assets were eligible. A person could be eligible for Medicaid by qualifying for one of the following eligibility categories:

1. **Mandatory Categorically Needy:** As its name implies, states were *required* by federal law to provide Medicaid coverage to the mandatory categorically needy. The criteria for eligibility for the mandatory categorically needy were strongly linked to those for cash assistance programs, i.e., AFDC and SSI. Families were eligible for AFDC if they met income and assets requirements and had a dependent child. A dependent child was defined as a "child who is deprived of parental support due to a parent's death, incapacity, or continued absence" (Perkins, 1991). SSI eligibility was determined by both income requirements and whether the applicant was aged, blind, or disabled. Other mandatory categorically needy groups included low-income families and children, as well as low-income aged, blind, or disabled individuals (Perkins, 1991).

   States had the *option* of providing Medicaid coverage to two other categories: the optionally categorically needy and the medically needy.

2. **Optionally Categorically Needy:** People within the optionally categorically needy category met the financial qualifications to be eligible for the state
welfare programs. However, they were not eligible because they did not qualify for the nonfinancial categories that were designated to receive benefits (e.g., families with unemployed parents). The optionally categorically needy do not include people who could “spend-down”1 income to meet Medicaid eligibility; rather it included those who met a “fixed income test” to qualify for Medicaid at the outset. Examples of optionally categorically needy categories were (1) Ribicoff children (a specific set of financially needy children; see OBRA-81) and (2) before 1982, pregnant women who financially qualify but are first-time mothers (i.e., have no children) or are married and living with their spouse (see TEFRA-82) (Rosenbaum, 1983).

3. Medically Needy: People in the medically needy category met the categorical requirements for state welfare programs but were ineligible for such programs because of their income and assets levels. Unlike the optionally categorically needy, the medically needy can spend down their excess income to qualify for Medicaid (Perkins, 1991).

The states were required to use the income requirements for the closest eligibility category in the mandatory categorically needy group to determine income eligibility for persons in either the optionally categorically needy or medically needy groups. For example, if a family would have been eligible for Medicaid categorically but did not meet the financial requirements, then AFDC income requirements would have been used to assess whether the family could spend down and be eligible in the medically needy group.

**Comparisons of California Program to U.S.**

The California Medicaid program has been viewed as one that offers relatively generous benefits. Before proceeding to the details of changes over our study period, we provide some graphical comparisons of California to the rest of the nation. Many of these figures refer to the AFDC need standard because it is the primary standard for establishing categorical eligibility for Medicaid during the period of interest. Figure 1 compares the AFDC need standard in California to the average computed over all states (both for an average family of four). It is readily apparent that California’s standard exceeds the average for all states by

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1“Spend down” refers to the process of reducing an individual’s income by subtracting incurred medical care expenses. The goal of the spend-down process is to reduce the individual’s income to a level that is at or below the medically needy level required to qualify for Medicaid (Medicaid Source Book, 1988).
about 50 percent on average over the period we are considering. This finding is a clear indication of the generosity of the program relative to other states.

In Figure 2, we compare the same need standards to the federal poverty level (both for an average family of four). Again the relative generosity of the California program is apparent. Whereas the typical need level was about 60 percent of the poverty level, California’s level was approximately 80 percent. In addition, despite an increase between 1982 and 1983, the overall pattern seems to be one of convergence of the California standard to the average standard toward the end of the period.

Figure 3 examines Medicaid dollars paid out per recipient. Despite appearances of generosity from the viewpoint of the recipient, the California Medicaid program seems to be lagging behind the nation in its reimbursements to providers as measured by payments per recipient. Average payments per recipient have been rising in both California and in the nation as a whole. The level for California, however, is consistently below the national average and the difference increased over our study period. These figures have several possible interpretations: (1) the California program is operating more efficiently, (2) the distribution of recipients in California is concentrated among segments of the population requiring fewer health services, or (3) the California program has lower than average levels of reimbursement. The latter hypothesis is supported
by other studies that have compared payments for specific maternity diagnoses. These studies have found that California is below the national average Medicaid payments per case with a particular diagnosis (AGI, 1987). It is also consistent that a more generous eligibility standard would be associated with a less generous payment policy.

Figure 4 compares time trends in the number of recipients over time and the AFDC need standard for California. Because the need standard typically is set at the start of the year and the number of recipients is the total for the calendar year, we have offset the series by one year. In general, we expect the number of recipients to rise as the need standard increases. In California, both rose through 1982, after which the need standard leveled off and the number of recipients dropped to levels that existed in 1979 and 1980. In interpreting this graph it is important to remember that the population of the state was growing relatively rapidly through the period and that more stringent eligibility requirements (such as a lower need standard) might be partially offset by population growth.

However, we observe no growth in the number of recipients. Instead, the precipitous drop in the number of recipients is more plausibly due to the extensive changes following the enactment of OBRA-81 and the recovery in 1986 because of the reversal of many of the OBRA-81 policies by subsequent legislation.
Figure 3—Payments per Recipient: California Versus the U.S.

Figure 4—California AFDC Need Standard and Number of Recipients
The California Program Before 1980

Unlike the preceding Public Assistance Medical Care program, when initially established in 1966, the California Medicaid program offered an almost unlimited range of medical services to public assistance recipients. These services included inpatient and outpatient hospital services, physician services, laboratory and X-ray, nursing home care, prescription drugs and ambulance services. The program also covered medical care devices (such as hearing aids) and services generally not available through any other insurance program, including chiropractic, podiatry, dentistry, and home health care. It also covered organized outpatient mental health care, birth control devices and drugs, and rehabilitation center services. Some controls were placed on the drug program through a drug formulary and prior authorization for services and supplies (CDHS, 1990).

Following its inception in 1966, the program was modified substantially. The most significant attempt to change the scope and direction of the program came in 1971 with the Medi-Cal Reform Act (for more details, see Appendix B), although its effects were short-lived. In this respect, it is typical of many of the changes and rearrangements that have continually shaped and reshaped the program. Other important changes were restrictions associated with two sets of emergency program cutbacks, the first in 1967 and the second in 1970. Each of these resulted in considerable restrictions of services either by limiting the number of visits and length of stay or by requiring prior authorization. The role of counties in the administration and their financial participation in the program was first reduced and then eliminated. By the end of the period, eligibility requirements were standardized and identification cards were centrally issued. Some expansions of eligibility occurred, mostly for minors. Reimbursement payments also were restricted throughout the period, with substantial cutbacks coinciding with the emergency program cutbacks, and fees were gradually standardized. The main effect of the modifications appears to have added restrictions, specifications and administrative controls needed to keep the program functioning within budgetary constraints.


California Program Status in 1980

As of the beginning of our study period in 1980, California's Medicaid program covered the following groups: mandatory categorically needy, optionally categorically needy, and medically needy. All Medicaid recipients in California
received the following basic required services: inpatient hospital services; outpatient hospital services; rural health services; other laboratory and X-ray services; skilled nursing services for individuals age 21 or older; physician services; early and periodic screening, diagnosis, and treatment for individuals under age 21; and family planning services and supplies. California’s Medicaid program also covered almost all the optional Medicaid services. In addition, these optional services were offered to the categorically needy (both groups: mandatory and optional) and the medically needy (HCFA Data Book, 1981).

Changes: 1980–1987

As the previous discussion and Appendix B illustrate, the program has been revised and amended almost annually since its inception. The remainder of this section summarizes some of the most important legislative changes. Appendix C contains a detailed year-by-year chronology of the federal and state changes from 1980–1987.

Starting in 1980, a series of congressional budget reconciliation acts was legislated to reduce “Federal spending across government programs” (Medicaid Source Book, 1988). Here we describe the changes made to the Medicaid program by these budget reconciliation acts, other Medicaid federal amendments, and corresponding California state legislation.

These changes affected all areas of the Medicaid program during the time period 1980–1987. We have summarized them according to whether they affected the principal aspects of the program of interest to us: eligibility, services, and reimbursement. Each summary describes the most important changes in rough chronological order.

Eligibility

The federal Refugee and the Supplemental Appropriations and Recision Acts of 1980 expanded eligibility for cash aid, medical assistance, and services for refugees. Although many of the people now designated as refugees had been covered previously in California, the state responded by expanding its Refugee Tracking System.

OBRA–81 was the most restrictive piece of legislation to affect Medicaid during the period of our study (1980–1987). Its main effects on eligibility were to remove mandatory coverage for first time pregnancies, to reduce the age limit for
coverage from 21 to 18 (19 if the person were in school), and to remove optional coverage for caretakers.

Much of the federal legislation following OBRA-81 sought to remove the restrictions it had imposed. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA-82) restored first-time pregnant women as a separate optionally categorically needy group. In California, the fiscal crisis of 1980 led to increased spend-down requirements for the medically needy and restricted the categories of medically indigent adults covered by Medicaid to those in skilled nursing and intermediate care facilities and to pregnant women. All other care of the medically indigent was transferred to the counties.

The Deficit Reduction Act of 1984 (DEFRA-84) continued support for coverage for pregnant women and children by expanding the groups of mandatory categorically needy eligible for federal matching funds and by extending coverage for newborns through the first year of life. These changes did not affect California where coverage was already being provided to these groups.

Eligibility expansions for indigent pregnant women and children continued with the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA-85) that extended the coverage granted by DEFRA-84 to children under five. The main change in eligibility requirements was that the unborn child was used to calculate the size of the assistance unit.

The most significant change occurred at the very end of our study period, with the enactment of Omnibus Budget Reconciliation Act of 1986 (OBRA-86). This legislation broke the historical dependence of Medicaid eligibility on AFDC and SSI eligibility, creating new optionally categorically needy groups: pregnant women, infants, and children under five. This same legislation made assets requirements optional for these groups, allowed states to extend coverage for women 60 days post partum, and added presumptive eligibility for pregnant women, the homeless, and aliens. California did not adopt the options of dropping the assets test, extending post partum coverage, or presumptive eligibility.

Eligibility requirements for aliens were specified further by the Immigration Reform and Control Act of 1986 (IRCA-86). In all cases, coverage was ensured for emergency medical services and for labor and delivery. California, however, did extend prenatal care services to eligible aliens regardless of immigration status.
Services

At the federal level, legislation governing services followed a course similar to that of eligibility, with restrictions following OBRA-81 and expansions thereafter. California followed a course of adding requirements for prior authorization and restricting services.

OBRA-81, which restricted eligibility for a number of groups, also restricted services to the medically needy. Previously, states were required to cover all medically needy groups as well as offer a minimum package of services. OBRA-81 made these requirements less stringent, requiring only that states providing care to any medically needy group also provide ambulatory care for children and prenatal and delivery services for women. In addition, if institutional care was provided to any medically needy group, ambulatory services must also be provided to that group.

In California in 1981, prior authorizations were required for emergency hospitalizations for the first time.

Following a severe fiscal crisis in 1980, California restricted coverage in 1982 to services deemed medically necessary to protect life and prevent significant disability. Family planning and early and periodic screening, diagnosis, and testing were specifically exempt. Also in 1982, California began requiring prior authorization for selected outpatient and surgical procedures. Note that before 1982, prior authorization was required only when acute hospitalization was required. Some expansions in services occurred at this time, including the addition of in-home medical care services.

DEFRA-84 continued the expansion of services for pregnant women and children. At the same time, California expanded coverage for comprehensive prenatal care. The state also enacted the Primary Care Case Management Program to contain costs by reducing unnecessary and inappropriate services.

COBRA-85 added postpartum coverage for women who were eligible for Medicaid during their pregnancies and expanded the state’s options for providing prenatal care without offering comparable services to all other groups within the categorically needy program. Services for children under age five were phased in under the same legislation.

OBRA-86, in addition to separating eligibility for Medicaid from that for cash assistance programs, continued the expansion of pregnancy-related services from the time that the pregnancy was verified until 60 days postpartum for women and through age five for their children. Together with IRCA-86, OBRA-86 also
provided for emergency services, including labor and delivery, to certain classes of aliens. California extended all pregnancy-related services to aliens regardless of immigration status.

**Reimbursement**

Throughout our study period, California continued a policy of restricting reimbursement payments and instituting a series of reforms designed to standardize payments and contain costs. During this same period, the federal government began allowing states to institute cost-sharing systems for Medicaid.

In 1981, California required that the combined Medicare/Medicaid payments be restricted to the maximum allowed by Medicaid. Hospital reimbursement increases were limited to 6 percent above the average for the previous fiscal year. In addition, reimbursement rates were reduced when occupancy rates fell below 55 percent.

TEFRA-82 permitted states to impose cost-sharing for some groups for specified services. Specifically services for children and pregnant women were exempt. California adopted some of these cost-sharing options.

In California in 1982, reimbursement rates for physician and outpatient services were reduced by 10 percent, and a major change in contracting policy for hospitals was implemented. At the same time acute care hospitals were required to contract with the state, and open and closed contracting areas were defined. Thus once sufficient contracts had been signed in an area to assure the projected needs of California's Medicaid population, noncontracting hospitals were not eligible to receive Medicaid reimbursement except under specified conditions.

In 1984, California continued to implement cost controls for hospitals with a regulation that supported the use of peer group cost comparisons to determine reimbursement rates. In 1986, the Cost Avoidance System, which required that insurance pay its share of medical expenses before California's Medicaid program was billed, was implemented.
4. Summary of Tabular Information on the Medicaid Program Compiled by the Health Care Financing Administration

This section summarizes the tabular information concerning California’s Medicaid program, as provided by the HCFA. It is intended to complement the description of legislative changes given in Section 3.

The detailed information is contained in a series of approximately biannual publications *Health Care Financing Program Statistics, The Medicare and Medicaid Data Book*. For this report, we used volumes covering the following years (dates of publications are in parentheses).

- 1981 (published April 1982)
- 1983 (published December 1983)
- 1984 (published June 1986)
- 1986 (published September 1987)
- 1988 (published date unknown).

These five books cover most of the information for our study period but have occasional gaps. These books provide data for the years 1980 through 1986. Detailed tabulations are not available for 1981, 1985, and 1987; some information is missing for 1980, 1982, and 1984. Data books are available for 1979 and 1990; however, the 1979 book only covers 1977 (too early to be of interest), and the 1990 book covers either 1986 (already available from the 1988 book) or 1989 (too late to be of interest).

Using the data compiled by HCFA, we have constructed tables covering the following topics:

1. AFDC Coverage and Eligibility
2. AFDC and Medically Needy Annual Need and Payment Standards
3. Medicaid Services
4. Medicaid Reimbursement Methods
5. Distribution of Medicaid Recipients
Each table is preceded by a summary of the principal changes observed. These summaries also include a synopsis of textual information in the HCFA Data Books. For each table, more detailed information was obtained from the text in the HCFA books and is contained in Appendix D.

The tables reveal the following changes in the California Medicaid program. Changes seen in eligibility are broadly parallel to the legislative changes (Table 1). OBRA-81 restricted eligibility for first-time pregnancies; TEFRA-82 and DEFRA-84 restored coverage to first-time pregnant women, first making the coverage optional and then mandatory. Although we might have expected the need and payment standards to increase over time because of inflation, we found no increase in these standards from 1982–1984 (Table 2). This lack of increase corresponded to a period of fiscal crisis for California. Required services are those that must be offered to both the categorically and medically needy, but optional services can be offered independently to either categorically or medically needy individuals. California extended optional services either to both categorically needy and medically needy individuals or not at all (Table 3). Reimbursement methods varied considerably by provider type but did not vary much across the eight years of our study (Table 4). Even though California’s population continued to grow from 1980–1987, the number of Medicaid recipients was relatively stable throughout the same time period (Table 5). Beyond certain federal regulations, each state is relatively free to set whatever limitations it chooses for a given service. The exact nature of the limitations during our study period was not possible to determine. In California, however, limitations were imposed for all the major service categories (Table 6).

**Definitions of the Eligibility Criteria for the Mandatory and Optionally Categorically Needy Under AFDC**

Table 1 summarizes the classes of people and families eligible for AFDC in California. During the period of our study, eligibility for AFDC and for SSI defined the groups that were categorically eligible for Medicaid. We have focused on the AFDC eligibility criteria because they are most relevant for our study population. Table 2 provides information on income-related eligibility criteria.

The changes in eligibility parallel the legislative changes summarized in Section 3. Throughout the period, *mandatory* coverage was provided to families with unemployed parents. The change in wording relating to the coverage of first-time pregnancies and the children subsequently born reflect the impact of
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<td>YES</td>
<td>YES</td>
<td>YES</td>
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<td>YES</td>
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<td>not listed</td>
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<tr>
<td>2b. Pregnant women with no other eligible children</td>
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<td>YES</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
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<tr>
<td>2c. Pregnant women with no eligible children</td>
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<td>not listed</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>3a. Children age 18–21 regularly attending school</td>
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<td>not listed</td>
<td>not listed</td>
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<td>not listed</td>
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<tr>
<td>3b. Children age 18 regularly attending school</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
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<td>YES</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
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<tr>
<td>2b. Financially eligible persons under age 21</td>
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<td>not listed</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
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<td>3. Individuals (persons) eligible for but not receiving aid (cash)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>4a. Individuals eligible but in institutions</td>
<td>YES</td>
<td>YES</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
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<tr>
<td>4b. Persons who would be eligible except for (their) institutional status</td>
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<td>not listed</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
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<td>5a. Individuals who would be eligible if AFDC were as broad as Social Security Act allows</td>
<td>NO</td>
<td>YES</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
<td>not listed</td>
</tr>
<tr>
<td>5b. Individuals who would be eligible if state plan were as broad as Social Security Act allows</td>
<td>not listed</td>
<td>not listed</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>6. Individuals who would be eligible if child care cost (were) paid from earning(s)</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
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</table>
OBRA-81 and TEFRA-82. OBRA-81 restricted AFDC benefits to the last trimester for first-time pregnant women whose unborn children would make them AFDC eligible. It also resulted in unborn children no longer being recognized as a subcategory of Ribicoff children (children under 21, not living with a caretaker relative). TEFRA-82 and DEFRA-84 restored coverage to first-time pregnant women, first making the coverage optional, then mandatory. Other changes in mandatory coverage affect children aged 19–21 who were covered before OBRA-81 but whose coverage became optional thereafter.

Changes also were made in the criteria defining the optionally categorically needy. Following OBRA-81, caretaker relatives were no longer eligible. Children under 21 and persons eligible but not receiving aid were covered in the optional category up to 1986, when this coverage was removed. In addition, the coverage contains a couple of aberrations. In the data referring to 1982 only, optional coverage was extended to persons who would be eligible if AFDC coverage were as broad as the Social Security Act allows. And in the data referring to 1982 through 1984 only, this coverage also was extended to persons who would be eligible if child care costs were paid from earnings.

Note that the comment "not listed" means that data were not available for that category.

**California’s Annual Need and Payment Standards for AFDC and Annual Income Levels for the Medically Needy**

Table 2 documents the changes in the income requirements for various AFDC need and payment standards.

The *need standard* is the amount of money the state determines essential to meet minimal standards of living in that state for a specified family size. The *payment standard* (for most states) is the maximum amount of cash assistance paid to a family with no countable income. The *protected income level for the medically needy* is the highest amount of annual income the state will allow for qualification as medically needy without requiring a spend-down of assets. For the state to receive federal financial participation, this medically needy income level cannot exceed 133-1/3 percent of the maximum AFDC payment standard for a family of the same size. These levels are all set by the individual states. Comparisons of California to national averages and to federal poverty levels are provided in Section 3.
Table 2
California's Annual Need and Payment Standards for AFDC and Annual Income Levels for the Medically Needy

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<td>CATEGORY</td>
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<td>Two-person family—Need</td>
<td>$4,104</td>
<td>$4,896</td>
<td>$6,528</td>
<td>$6,528</td>
<td>$5,688</td>
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<td>Two-person family—Payment</td>
<td>3,972</td>
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<tr>
<td>Four-person family—Need</td>
<td>6,132</td>
<td>7,212</td>
<td>9,612</td>
<td>9,612</td>
<td>8,376</td>
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<tr>
<td>Four-person family—Payment</td>
<td>5,844</td>
<td>7,212</td>
<td>7,212</td>
<td>7,212</td>
<td>8,376</td>
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<tr>
<td>Income Level Protected for Maintenance for Medically Needy</td>
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<tr>
<td>One-person family</td>
<td>3,492</td>
<td>3,972</td>
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<td>Two-person family</td>
<td>5,304</td>
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<tr>
<td>Four-person family</td>
<td>7,800</td>
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<td>11,208</td>
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The figures in Table 2 are given in nominal dollars. Because of inflation, however, it is reasonable to expect all to increase over time. Nevertheless, we do not find a consistent pattern of increase. Instead, we find that the need standard increased from 1979 through 1983, then remained constant through 1984 and decreased thereafter. The payment standard followed a slightly different course, increasing from 1979 through 1982, remaining constant through 1984, then increasing thereafter. The need and payment standards were identical in 1982 and 1986. Similarly, the protected income level for the medically needy increased from 1980 to 1982, was constant through 1984, then increased. The period of no increase in these standards from 1982–1984 corresponds to a period of fiscal crisis for the state.

California’s Medicaid Services

Table 3 summarizes the services offered by California. There are two eligibility categories and two service categories. The eligibility categories are:

1. The *categorically needy* who are aged, blind or disabled individuals, or families and children who meet AFDC, SSI, or optional state supplemental income requirements

2. The *medically needy* who are aged, blind or disabled individuals or families and children whose incomes are above the limits for eligibility as categorically needy but are within limits specified by the state plan and who are otherwise eligible for Medicaid.

The service categories are defined below:

1. *Required services* must be offered to both the categorically and the medically needy (listed in Appendix D).

2. *Optional services* are offered to both the categorically and the medically needy or to neither, at the state’s option.

Changes in eligibility requirements for the categorically and medically needy have been addressed in Tables 1 and 2. The required services remained the same, except for the addition of nurse midwife services in 1986. Optional services changes somewhat more over our study period. Screening and preventive and diagnostic services were added in 1983. Personal care and transportation services were added in 1986.

Note that the comment “not listed” means that data were not available for that category.
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<td>10/1/83</td>
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<td>Optional Services in California Medicaid Program</td>
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<td>Practitioners’ Services</td>
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Table 3—continued

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</table>

KEY:
0 not offered
1 Offered to Categorically Needy (i.e., people receiving federally supported financial assistance) only
2 Offered to both Categorically Needy and Medically Needy (i.e., people who are eligible for medical but not for financial assistance)
Medicaid Reimbursement Methods

Both the amounts and methods for reimbursement can affect provider incentives to care for Medicaid patients. They also affect the costs of the program as a whole. During the period covered by our study, reimbursement methods varied considerably by provider type, although relatively little variation occurred over time. As noted in Section 3, California adopted a series of reforms that address a number of reimbursement issues. These reforms are not reflected in Table 4 that addresses the Medicaid program more generally.

From Table 4 we see that reimbursement for inpatient hospital services followed both Medicaid and Medicare principles from 1980 to 1986. Reimbursement for outpatient hospital services followed a maximum allowable fee schedule in 1980 then changed to an alternate system (i.e., not maximum allowable fee schedule or Medicare principles) from 1982 through 1986. Alternate plans were required to provide payments that did not exceed Medicare reimbursement levels in the aggregate. Reimbursement for long-term care used a prospective class rate from 1982 through 1986 (and is not listed in 1980). Reimbursement of physicians' services changed from a maximum allowable schedule in 1980 to a fee schedule using a relative value scale in 1982. This relative value scale was used for the remainder of the period.

OBRA-81 instituted a number of changes in the reimbursement policy that are detailed in the textual material accompanying the HCFA tables but not shown in the tables themselves. Before OBRA-81, states were required to follow Medicare reasonable cost rules for reimbursement of inpatient hospital services unless the Secretary of the Department of Health and Human Services (DHHS) approved an alternative method. (The requirements for these alternative plans are given in Appendix D.) As of 1982, California was using an approved plan. Following OBRA-81, the reasonable cost requirement was dropped and states were required only to provide assurances that the rates met acceptable standards of efficiency, quality, and access to care. (These standards are given in Appendix D.)

Another cost-saving method implemented by OBRA-81 included allowing states flexibility in limiting the patient’s choice of a provider. (Details are given in Appendix D.) In addition, OBRA-81 expanded the use of prepaid plans for Medicaid. Before OBRA-81 states could enter into prepaid risk contracts only with federally qualified HMOs, and these were required to have an enrollment that consisted of less than 50 percent Medicaid and Medicare patients. After OBRA-81, states were able to enter into contracts with organizations meeting a broader set of guidelines and the enrollment limit was raised from 50 to 75.
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</tr>
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1 Lesser of each hospital's customary charges, allowable costs in accordance with applicable Medicare standards and principles of reimbursement, or all-inclusive rate per discharge.
2 Not listed means that the category/data did not appear in the data book for that year.
3 Medicare and Medicaid principles used.
4 Year of implementation of alternative reimbursement systems.
5 Short-term only; excludes crossover claims. Expenditure data for calendar year 1982. Selected contracting program not fully implemented in 1982.
6 Combination of retrospective system and contracting system.
7 PC = prospective class rate.
percent Medicare or Medicaid patients. Under special circumstances, this limit could be waived. (The detailed guidelines are given in Appendix D.)

**Number of Medicaid Recipients and Distribution According to Eligibility**

Table 5 shows that the number of Medicaid recipients was relatively stable throughout the period, despite substantial population growth in California at the same time. The number of recipients grew slightly between FY1976 and FY1981. The number decreased for the next two years and increased slightly thereafter. This pattern of increases and decreases roughly approximates that of the U.S. as a whole.

In California, the majority of recipients are also eligible for AFDC. This means that the program primarily serves mothers and children—our study population.

**Limitations on Medicaid Services in California**

Federal regulations require that the limitations each state imposes “must be sufficient in amount, duration, and scope to reasonably achieve their purpose” and that, “limits may not be imposed on the basis of ‘diagnosis, type of illness, or condition.’” Beyond these requirements, states are free to set whatever limits they choose, with some exceptions. For instance, TEFRA-82 mandated that no copayments be charged for services related to pregnancy or services provided to individuals under age 18.

In California, limitations exist for all the major service categories: inpatient hospital, outpatient hospital, home health, long-term care, and physician (Table 6). An indication of the categories of services that are limited can be found in the HCFA tables. Unfortunately, the exact nature of the limitation is not typically specified. Specified limitations often refer to required authorizations and to the maximum number of visits per year. In addition, the format of the HCFA tables and the category entries vary substantially from year to year making it difficult to track exact changes.

Note that the comment “not listed” means that the category appeared in the data table; but information about the presence, absence, or type of limitation was not given. If the category did not appear at all in the data table, our table contains a blank cell.
### Table 5

Number of Medicaid Recipients and Percent Distribution by Basis of Eligibility

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<tr>
<td>Number of recipients (thousands): all jurisdictions in the U.S.</td>
<td>21,540.0</td>
<td>21,604.4</td>
<td>21,979.6</td>
<td>21,603.2</td>
<td>21,492.5</td>
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<td>Number of recipients (thousands): California</td>
<td>3,373.7</td>
<td>3,417.7</td>
<td>3,616.9</td>
<td>3,747.9</td>
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<td>Percent distribution for California by basis of eligibility(^1)</td>
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<tr>
<td>Age 65 and over</td>
<td>15.6</td>
<td>16.6</td>
<td>15.7</td>
<td>15.2</td>
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<td>Blindness</td>
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<td>0.7</td>
<td>0.7</td>
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<td>Permanent and total disability</td>
<td>14.8</td>
<td>15.5</td>
<td>14.6</td>
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<td>Other Title XIX(^2) recipients</td>
<td>6.3</td>
<td>7.2</td>
<td>7.1</td>
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<td>5.7</td>
<td>5.8</td>
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\(^1\)The sum of the percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.

\(^2\)Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis, and treatment services for individuals under 21. In addition, states may provide a number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, and dental care.
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<td>24 maximum visits per year; limits or prior authorization required</td>
<td>prior authorization required; 24 services per year</td>
<td>prior authorization required; 24 services per year</td>
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<td>prior authorization required</td>
<td>prior authorization required</td>
<td>not listed</td>
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<td>DATE FOR DATA</td>
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<tr>
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<td>no limits on maximum visits per year, and no procedure-specific limits</td>
<td></td>
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<tr>
<td>Injections</td>
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<td>not listed</td>
<td>limited</td>
<td></td>
<td>no limits</td>
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<tr>
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<td>other limits</td>
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Appendix

A. Glossary

General Medicaid Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Categorically Needy</em></td>
<td>Aged, blind, or disabled people or families and children who meet financial eligibility requirements for Aid to Families with Dependent Children, Supplemental Security Income, or an optional state supplement</td>
</tr>
<tr>
<td><em>Expenditure</em></td>
<td>An amount paid by a state agency for the covered medical expenses of eligible participants</td>
</tr>
<tr>
<td><em>Medically Needy</em></td>
<td>Aged, blind, or disabled people or families and children whose income resources are above the limits for eligibility as categorically needy but are within limits set under the Medicaid State plan and who are otherwise eligible for Medicaid</td>
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<tr>
<td><em>Recipient</em></td>
<td>A person who has been determined to be eligible for Medicaid and who has used medical services covered by Medicaid</td>
</tr>
<tr>
<td><em>Spend-down</em></td>
<td>A method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements</td>
</tr>
<tr>
<td><em>State Plan</em></td>
<td>A comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with federal requirements</td>
</tr>
<tr>
<td><em>Supplemental Security Income (SSI)</em></td>
<td>A program of income support for low-income aged, blind, and disabled persons that was established by Title XVI of the Social Security Act</td>
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</table>
Medicare and Medicaid Acronyms

AAPCC  Adjusted Average Per Capita Cost
ACRG   Annual Compound Rate of Growth
AFDC   Aid to Families with Dependent Children
AHCCCS Arizona Health Care Cost Containment System
CDHS   California Department of Health Services
CFR    Code of Federal Regulations
CMHS   Continuous Medicare History Sample
CN     Categorically Needy
CON    Certificate of Need
DEFRA  Deficit Reduction Act
DHHS   Department of Health and Human Services
DRG    Diagnosis-Related Group
EAC    Estimated Acquisition Cost
EPSDT  Early and Periodic Screening, Diagnosis, and Treatment
ESRD   End Stage Renal Disease
FFP    Federal Financial Participation
FMAP   Federal Medicaid Assistance Percentage
HCFA   Health Care Financing Administration
HCPF   Health Care Prepayment Plan
HHA    Home Health Agency
HI     Hospital Insurance
HMO    Health Maintenance Organization
ICF    Intermediate Care Facility
ICF/MR Intermediate Care Facility for the Mentally Retarded
MAC    Maximum Allowable Cost
MCN    Mandatory Categorically Needy
MI     Medically Indigent
MMIS   Medicaid Management Information System
MN     Medically Needy
OBRA   Omnibus Budget Reconciliation Act
OMB    Office of Management and Budget
OTC    Over-The-Counter (drugs)
PC     Prospective Class
PPS    Prospective Payment System
PRO    Peer Review Organization
SAW    Seasonal and Agricultural Workers
SMI    Supplementary Medical Insurance
SNF    Skilled Nursing Facility
SSI    Supplemental Security Income
SSP    State Supplemental Payment
TEFRA  Tax Equity and Fiscal Responsibility Act
B. Changes in the California Medicaid Program Between 1966 and 1980

This appendix contains a brief description of program changes between its inception in 1966 and the beginning of our study period in 1980. This discussion is taken from The Medi-Cal Program: A Brief Summary of Major Events (CDHS, 1990).

Administration

Initially, the program was administered by the Office of Health Care Services. In 1968, administration moved to the newly created Department of Health Services. In 1973, this department was absorbed into the Department of Health where it was a major division. In 1978, the Department of Health was reorganized into five departments. Since then, the program has been administered as a division of the Department of Health Services within the Department of Health.

Financing

Initially, counties were a major contributor through the Health Care Deposit Fund and billing for indigents. In 1978, county-sharing of funding was eliminated.

Services

Within a year of the inception of the program, a number of services were restricted during a series of emergency program cutbacks. The new limitations eliminated chiropractors, free-standing clinics, special duty nursing, psychiatrists, and audiologists. Also it curtailed dental care and prescription drugs. Physician charges were restricted to “usual and customary charges,” and a number of physician services were eliminated as well. Hospital stays outside of county hospitals and nursing home services were limited.

Additional restrictions were added in subsequent years. In 1969, the extensions of hospital stay for acute, extended, and long term care were limited as well. In 1970 prior authorization was required for all nonemergency hospitalizations, and the length of stay had to be specified. Emergency admissions required certification by the physician.
The medically needy eligibility and benefit standards were also revised in 1970 and generally made more restrictive. At the same time, the full schedule of benefits was extended to all eligibles.

A second set of emergency program cutbacks took place in 1970, additionally restricting physician office and home visits. In addition, prior authorization requirements became more stringent for other providers, and a number of medical procedures were defined as “elective” and required prior authorization.

The 1971 Medi-Cal Reform Act reorganized benefits into a basic and a supplemental schedule. The main change involved limitations on the number of times services could be used without prior authorization. These limitations were removed in 1975, and the two schedules were consolidated. However, at the same time, the length of stay for emergency admissions was reduced from eight to three days.

As a result of an amendment to the Social Security Act in 1972, intermediate care services became a California Medicaid benefit. Federal legislation enacted in 1972 and implemented in 1974 standardized skilled nursing facilities and services for Medicare and Medicaid.

When federal matching funds for family planning services became available in 1973, these services were added to the program. In 1977 federal financial participation was no longer available for elective abortions, and new guidelines for distinguishing between elective and nonelective abortions were established. At the same time, new regulations for sterilization were also established. The latter were revised in 1980.

Eligibility

In 1969 coverage was restricted for certain categories of the medically needy who did not meet public assistance income or asset limitations. These restrictions were dropped in 1970; at the same time more restrictive eligibility standards were put into place for the medically needy. The medically indigent became eligible subsequent to the Medi-Cal Reform Act of 1971. (This act was rescinded in 1982, but medically indigent children, pregnant women, and refugees remained eligible, as did medically indigent adults residing in long-term care facilities.)

Initially, county welfare departments determined eligibility and issued identification. In 1971 a Central Issuance of ID Cards was established, but counties continued to be responsible for determining eligibility. As a result of
federal legislation enacted in 1972 and implemented in 1974, the Social Security Administration became responsible for establishing eligibility of aged, blind, and disabled persons. In addition, a three-month retroactive eligibility was mandated for all new applicants who would have been eligible in the three-month period before their application. A four-month eligibility for Medicaid was added for AFDC families whose increased earnings or hours of employment made them ineligible for cash assistance.

In 1976 eligibility requirements were revised to equalize them across all groups. In the following year, eligibility regulations were completely rewritten and restructured into a comprehensive set of instructions that were distributed to counties and covered eligibility, case management, and administration. This manual was updated regularly.

In 1977 pregnant minors became eligible for medical and financial assistance. In 1978 eligible minors in California were issued "limited services" Medicaid cards that did not require parental consent. The services were expanded in 1982.

In 1978 the Medi-Cal Eligibility Data System replaced the Central Issuance of ID Cards. It was implemented in all counties by 1984.

**Reimbursement**

To meet the 1966 federal implementation date, the program contracted with three fiscal intermediaries: California Physician's Services (Blue Shield), the Hospital Service of California (Blue Cross North), and the Hospital Service of Southern California (Blue Cross South). Until 1972, these three intermediaries had been processing and paying claims independently. At this time, the Medi-Cal Intermediary Operations were established to centrally process claims. In 1978 the three intermediaries were replaced by a single intermediary, Computer Sciences Corporation.

As a result of the emergency program cutbacks of 1967, the level of "usual and customary" physician services was restricted to the level that prevailed in the first quarter of 1967. In 1970 a three-level physician profile for pricing and payment was established. (This system was replaced by a uniform state-wide fee schedule in 1976.) In the same year, a schedule of maximum reimbursement for hospital outpatient services was instituted. It had two options: itemized billing and an all-inclusive per visit rate. The latter was negotiated between county-run facilities and California Department of Health Services (CDHS).
A second set of emergency program cutbacks also reduced reimbursement to providers by 10 percent, although inpatient services were exempt. In 1972 county hospitals and University of California teaching hospitals were granted relief from the individual billing requirement and were allowed to submit quarterly statements. In the same year, federal legislation restricted hospital reimbursement for inpatient services. The changes mandated by the federal legislation were not implemented until 1974.

In 1974 the Relative Value System was adopted for physician billing.

In 1976 a state-wide fee schedule for physician services was adopted. It selectively increased reimbursement rates for maternal and primary care and for anesthesia services.

**Prepaid Plans.** The 1971 Medi-Cal Reform Act encouraged the use of prepaid health plans, and the first contracts were signed in 1972. By December 1972 about 6 percent of Medical enrollees were in prepaid health plans.

**Providers**

All providers who met the qualifications for practicing in the state may provide care for California Medicaid beneficiaries.

Provider audits were instituted in 1971. Professional Standards Review Organizations were established through 1975 federal legislation to perform utilization controls.

In 1978, California’s Medicaid program extended coverage for primary care services provided by paramedical personnel, which included nurse practitioners, physician’s assistants, and nurse midwives. Rural health clinics were added at the same time in accordance with federal legislation.
C. History of Legislative Changes
1980–1987

For each calendar year, we discuss the federal changes followed by California changes.

1980

Federal

The Omnibus Reconciliation Act (ORA, Public Law 96-499) was also known as the Medicare and Medicaid Amendments of 1980. Only Section 331 contained changes relevant to our study population. It required states to cover nurse-midwife services and to include the option of paying the midwife directly. Before this law, states had the option of covering these services through their Medicaid programs; if they did cover these services, they usually reimbursed the clinic, hospital or physician employing or associating with the midwife rather than paying the midwife directly. One stipulation was made: this section was only valid in states legally permitting midwifery. No changes pertained to infants.


California

In 1980, California adopted the Hospital Inpatient Cost Control Plan for inpatient services. These regulations formulated the computation of a hospital-specific all-inclusive rate for each discharge and is an alternative reimbursement rate. Contract hospitals are reimbursed at a negotiated all-inclusive rate (CDHS, 1990).

Pursuant with the provisions of the Refugee and the Supplemental Appropriations and Rescission Acts of 1980, California expanded its Refugee Tracking System. Historically, California had extended benefits to legal aliens with resident status who met standard eligibility requirements. Many of these were refugees under the new guidelines (CDHS, 1990).
To comply with federal sterilization and hysterectomy regulations and to qualify for federal financial participation, a new set of regulations were filed. They raised the age of informed consent from 18 to 21 and added a non-waivable waiting period (CDHS, 1990).

An amendment to Title 22, Section 50657 in California deleted the requirement that only Medicaid-covered benefits could apply toward a beneficiary’s share of cost (CDHS, 1990).

1981

Federal

The Omnibus Budget Reconciliation Act of 1981 (OBRA-81) was the most restrictive legislation to affect Medicaid during the time period of our study (1980–1987). In part, OBRA-81 was a response to efforts to reduce federal spending on Medicaid. OBRA-81 restricted Medicaid eligibility and benefits directly and through changes in AFDC eligibility. For our study population, its main effect was to reduce AFDC benefits to the third trimester and to make prenatal care optional for first-time pregnant women. In addition, eligibility and benefits for children 18 to 21 were reduced as were services for the medically needy.

OBRA-81 changed coverage of 18 to 21-year old AFDC eligibles attending school from mandatory status to optional status. States had the option to cover this group for both AFDC and Medicaid or for Medicaid only (42 C.F.R. § 435.223). States also had the option of offering Medicaid coverage to members of this age group who were not in school. States, however, could limit eligibility within this group either by age or by “any reasonable classification” (Wulsin, 1982; 42 U.S.C. § 1396d(1)(i)).

OBRA-81 contained unclear language about coverage of Ribicoff children. Ribicoff children are “children under age 21 who are ineligible for AFDC because they do not meet the requirement of ‘dependent children living with a caretaker relative’” (Wulsin, 1982; 42 C.F.R. § 435.222; 42 U.S.C. § 1396d(a)(1)). Before OBRA-81, this group was optionally categorically needy. OBRA-81 gave states the option of setting an age cut-off point of 18, 19, 20, or 21, and of covering “reasonable categories” of children (e.g., foster care children and institutionalized children between 18 and 21) (42 U.S.C. § 1396d(a)(i)). In addition, OBRA-81 required states to cover ambulatory services for all medically needy children (42 U.S.C. § 1396a(a)(10)(C)(XII and III)). Combined, these two pieces of the legislation could be interpreted such that coverage of ambulatory services was
offered only to one “reasonable category” of Ribicoff children. A broader interpretation could be that states should cover ambulatory services for all the optionally categorically needy and medically needy Ribicoff children (Wulsin, 1982).

The OBRA-81 restrictions particularly affected first-time pregnant women (Rosenbaum, 1983). OBRA-81 restricted AFDC benefits to the last trimester for first-time pregnant women whose unborn children would make them AFDC eligible (Wulsin, 1982; 42 U.S.C. § 606(b)). In addition, unborn children were no longer recognized as a reasonable subcategory of Ribicoff children eligible for Medicaid (Rosenbaum, 1983). States, however, had the option to provide Medicaid coverage (without AFDC payments) once the pregnancy was verified medically (Medicaid Source Book, 1988). Before OBRA-81, a first-time pregnant woman could receive AFDC payments and Medicaid coverage as the caretaker relative of her unborn child once the pregnancy was medically verified (Rosenbaum, 1983).

OBRA-81 also reduced eligibility for the medically needy. Before OBRA-81, states were required to cover Medicaid for all medically needy groups as well as offer a minimum package of services. OBRA-81 repealed these requirements and placed the following requirements on states with medically needy programs: (1) if the state provided any services for any medically needy group, it had to provide ambulatory services for children and prenatal care and delivery services for women; and (2) if the states provided institutional services to any medically needy group, ambulatory services must also be provided to this group (Wulsin, 1982; Medicaid Source Book, 1988).

California

The state eliminated AFDC coverage for children 18–21 as a result of OBRA-81. The only exception was for children between 18 and 19 years of age attending school full-time who were expected to complete this training before their 19th birthday (Deering’s California Welfare and Institutions Code § 11253, 1985).

AB 251 (Chapter 102, Statutes of 1981) was an urgency bill that effected several changes in eligibility and reimbursement.

The requirement of Proof of Eligibility labels on claims was eliminated. Verification was accomplished by matching the claim to the computerized Recipient Eligibility History File.
Combined Medicare/Medicaid payments were restricted to the maximum allowed by California's Medicaid program. Hospital reimbursement rates were limited to not more than 6 percent above the average rate paid in FY 1980–81. (The federal court reversed this limitation.) In addition, hospital reimbursement rates were reduced when their occupancy rates fell below 55 percent. New, rural, and sole community hospitals were exempt; contract hospitals were reimbursed at a negotiated all-inclusive rate (CDHS, 1990).

Regulations covering emergency hospitalizations were amended to require approval, although these new regulations did not apply to all hospitals or to deliveries and newborns for the first three days of care (CDHS, 1990).

1982

*Federal*

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA-82) and subsequent federal legislation provided relief from OBRA-81's restrictions on Medicaid eligibility and benefits. A common theme throughout the post-OBRA-81 legislation was an increase in both Medicaid eligibility and benefits for pregnant women and children.

Following OBRA-81, a pregnant woman received Medicaid benefits only if: she was AFDC or SSI eligible; the state where she lived provided benefits to the medically needy and, therefore, covered prenatal care and delivery services; the state provided Medicaid coverage to first-time pregnant women; or she was optionally categorically needy (Rosenbaum, 1983).

TEFRA-82 defined pregnant women as a separate *optionally* categorically needy group for Medicaid coverage (42 U.S.C. § 1396d(a)(viii); 42 U.S.C. § 1397a(a)(10)(A)(ii)). Thus, any pregnant woman could qualify for Medicaid if she lived at or below the state poverty level, even if she failed to meet AFDC requirements. Two subcategories of this new eligibility group were first-time pregnant women and pregnant women married to poor workers or to poor unemployed workers in states without AFDC programs for unemployed families (Rosenbaum, 1983).

For the first time, TEFRA-82 permitted states to impose nominal cost-sharing charges or copayments onto some (but not all) groups for some (but not all) services. The list of services excluded from cost sharing included those provided to children under 18, related to pregnancy, and family planning or emergency services (Medicaid Source Book, 1988).
California

Because of the severe fiscal crisis in 1980, California's Medicaid reimbursement rates and covered benefits were reduced (AB 799, Chapter 328, Statutes of 1981). One reason for the budget cut was loss of revenue from Proposition 13 (Dallek, 1982).

Coverage was restricted to services deemed medically necessary to protect life or prevent significant disability. This restricted coverage specifically excluded family planning and early and periodic screening, diagnosis, and treatment.

Other provisions restricted eligibility. These included increased spend-down requirements and transfer of health care for the Medically Indigent (MI) from the state to the counties, resulting in a 30-percent reduction in funding for this group. The MI do not meet either AFDC or SSI categorical requirements but have insufficient income to pay for all their medical care. Federal matching funds are available for specified health care services for MI adults who are pregnant women, refugees, or disabled.

California regulations effective on October 1, 1982, ensured Medicaid coverage to certain groups in the MI category, including those in skilled nursing or intermediate care facilities at the time of application and pregnant women (All County Letter No. 82-54, October 20, 1982; regulation changes required by SE 2012). The combined changes, however, resulted in 270,000 medically indigent adults being dropped from California's Medicaid program. In addition, the responsibility for determining eligibility and services for MIs was transferred to the counties (Dallek, 1982).

Reimbursement rates for physician and outpatient services (not including laboratory or pathology services) were reduced by 10 percent in the 1982-83 budget (A.B. 799 Cal Leg. 1981-82 Reg. Sess.).

In addition, this bill required that acute care hospitals contract with the state. State hospitals and HMOs were exempt from this requirement. A Medicaid negotiator for California, appointed by the Governor, was to have sole authority for one year (ending July 1, 1983) for negotiating contracts with hospitals until the negotiator was replaced by the California Medical Assistance Commission (CDHS, 1990).

This year was the first when open and closed areas were defined. When sufficient contracts had been signed in an area to assure meeting the projected needs of California's Medicaid patients, noncontracting hospitals no longer received Medicaid reimbursement except for (1) emergency services needed to
prevent loss of life or permanent impairment, (2) beneficiaries with concurrent Medicare coverage, and (3) travel time exceeding established travel norms. Negotiations began late in 1982. By the end of 1983 contracts with 241 hospitals were in effect (CDHS, 1990).

Additional utilization controls and restrictions were also put into place. The most important was prior authorization for selected outpatient surgical procedures. Before 1982, prior authorization was required only in cases requiring acute care hospitalization.

In-home medical care services became a benefit in this year but required a written treatment plan and prior authorization (AB 799, Chapter 328, Statutes of 1982).

In addition, a number of administrative changes were made. These included issuing special ID cards to beneficiaries found to be abusing physician services. This procedure placed prior authorization requirements on certain nonemergency visits (CDHS, 1990).

Also in 1982, providers were authorized to collect specified copayments from beneficiaries. The amounts of copayments were modified in 1985 and again in 1986.

1983

No major legislative changes were found.

1984

Federal

Congressional support for Medicaid coverage for pregnant women and children continued with the Deficit Reduction Act of 1984 (DEFRA-84), perhaps as a result of reports that infant mortality was increasing and prenatal care was decreasing (National Health Law Program, 1986).

DEFRA defined two categories of pregnant women and one category of children as mandatory categorically needy, provided they met AFDC income and assets requirements:

1. First-time pregnant women who would become eligible for AFDC once the child was born (or were eligible as AFDC-unemployed parents if the state covered this group)
2. Pregnant women in poor two-parent families where the principal breadwinner was unemployed


In addition, "DEFRA also provided that a child born to a woman eligible for and receiving Medicaid at the time of birth was deemed eligible for one year as long as the woman remained eligible" (Medicaid Source Book, 1988). This amendment applied to children born after October 1, 1984 (42 U.S.C. § 1396a(e); Schwartz, 1984).

DEFRA-84 also prohibited HCFA from penalizing or sanctioning a state that used less restrictive income or assets tests for determining medically needy status than those used for AFDC and SSI. A HCFA transmittal letter, however, limited the application of this rule to those states where less restrictive tests were in effect at the time DEFRA-84 was enacted (National Health Law Program, 1986).

**California**

No legislative changes occurred directly as a result of DEFRA-84. California’s Medicaid program was already covering pregnant women for all nine months, pregnant women in unemployed families, and all poor children under age five (Schwartz, 1984).

Hospital reimbursement methods were supplemented with a regulation supporting peer group cost comparisons (SB 2012, 1982). Hospitals were classified into groups with similar characteristics, then reimbursed at the lesser of the peer group’s 60th percentile rate per discharge or their own rate per discharge as computed using the primary reimbursement methodologies. Hospitals with relatively high proportions of Medicaid and other low income patients and costs above the appropriate 60th percentile received additional reimbursements. New, rural, sole community, children’s, and charitable research hospitals, as well as hospitals in groups of less than five were exempt (CDHS, 1990).

New “lock-in” restrictions were instituted to control the use of benefits by recipients who misuse the program. These limit such recipients to one primary care physician who coordinates the patient’s needs. Providers must obtain prior authorization for nonemergency services (CDHS, 1990).

The Primary Care Case Management program was enacted to contain costs by reducing unnecessary or inappropriate services while improving early detection
and treatment. Under this program a single contractor is responsible for referral, consultation, ordering therapy, hospital admissions, follow-up care and prepayment approval for referred services within its plan.

1985

Federal

The Consolidated Omnibus Budget Reconciliation Act (COBRA-85) was written in 1985 but did not become effective until July 1, 1986. (The House and Senate did not pass a reconciliation bill at the end of 1985; therefore, this bill returned with Congress in 1986.)

COBRA-85 expanded both Medicaid eligibility and services for indigent pregnant women. In addition, COBRA-85 extended the optionally categorically needy status to children under five (Schwartz, 1986). The combination of DEFRA-84 and COBRA-85 (and later legislation, as well) appeared to represent a strong Congressional commitment to prenatal care.

COBRA-85 required states to provide Medicaid coverage to all pregnant women who met the income and assets requirements of the state AFDC program. This requirement resulted in Medicaid eligibility for first-time pregnant women who were in two-parent families where both parents were employed, if the family met the income and assets requirements of the AFDC program. The unborn child was to be used to determine the actual size of the AFDC assistance unit (Schwartz, 1986). Already DEFRA-84 had extended Medicaid coverage both to pregnant women whose unborn child, if born, would make them eligible, and to pregnant women in poor, two-parent families where the principal breadwinner was unemployed (Medicaid Source Book, 1988). The combination of the DEFRA-84 and COBRA-85 amendments resulted in a “statutory mandate that states provide Medicaid coverage to all indigent pregnant women” (Schwartz, 1986).

COBRA-85 also required states to provide 60-day postpartum coverage to women receiving Medicaid during their pregnancies. Coverage continued even if the woman became ineligible for Medicaid during this 60-day period (Schwartz, 1986; 42 U.S.C. §1396b(e)(5)).

COBRA-85 deviated from previous legislation by allowing states to provide pregnant women with pregnancy-related services without requiring them to extend comparable services to all other groups within the categorically needy program. These services now could be covered, provided that they were
comparable in amount, duration, and scope for all pregnant women covered under the state’s Medicaid program (Schwartz, 1986).

The application of these new amendments to medically needy pregnant women is a bit unclear. After OBRA-81, states with a medically needy program were required to provide prenatal care and delivery services to medically indigent but not financially indigent, pregnant women (42 U.S.C. § 1396a(a)(10)(C)(iii)). COBRA-85 allowed Medicaid coverage to be extended to all medically needy pregnant women and for 60 days postpartum. Because the provision regarding prenatal care for medically needy pregnant women was not amended by COBRA-85, states could have refused to extend Medicaid coverage for the postpartum period (Schwartz, 1986).

DEFRA-84 required states to phase in Medicaid coverage for children under age five, born after September 30, 1983, who met AFDC income and assets requirements. COBRA-85 expanded on this requirement by providing states with the option of immediate rather than phase-in coverage of these poor children who did not meet AFDC’s definition of a dependent child. This amendment applied to services provided on or after April 1, 1986 (Schwartz, 1986).

**California**

No changes were found.

**1986**

**Federal**

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86), effective April 1, 1987, provided the first break from the dependence of Medicaid eligibility on AFDC and SSI eligibility. OBRA-86 allowed states to increase the number of Medicaid eligibles by creating three new optionally categorically needy groups: all pregnant women, infants up to one year of age, and a phase-in category for children under age five. All three were eligible if their incomes were below the federal poverty level (42 U.S.C. § 1396a(a)(10)(A)(ix) and 42 U.S.C. § 1396(a)(1); Schwartz, 1987). It also allowed states to waive the assets for these groups, to consider pregnant women presumptively eligible for coverage, and to extend coverage 60 days postpartum.

OBRA-86 also placed some restrictions on these new categories. If the state opted to cover pregnant women and infants, it had to cover all financially eligible
people in these groups. Also, states could choose to cover only children under one year (42 U.S.C. § 1396a(1)(4)(B)), or they could phase-in all children under age five (Schwartz, 1987; 42 U.S.C. § 1396a(1)), but they could not cover one age group of children without covering all younger age groups (Medicaid Source Book, 1988). In addition, the members of these new optionally categorically needy groups could not spend down to become eligible for Medicaid (42 U.S.C. § 1396a(1)(3)(E)). In other words, pregnant women and children less than five years of age could not qualify for Medicaid on the basis of medical expenses if their incomes were above the federal poverty line. However, these same individuals could still qualify for the state’s medically needy program, if the state had one (Schwartz, 1987).

OBRA-86 also gave states the option of eliminating assets standards for these new optionally categorically needy groups, i.e., the states could use income standards alone (42 U.S.C. § 1396(1)(3)). If the state chose to use assets standards; however, the standards for pregnant women could not be more restrictive than those for SSI, and the standards for infants and children could not be more restrictive than those for AFDC (Schwartz, 1987).

OBRA-86 also extended postpartum coverage. Pregnant women eligible for all pregnancy-related services were to be covered up to 60 days postpartum provided the woman’s income remained below poverty (42 U.S.C. § 1396(a)(1)(A)). If the woman’s family income increased above the federal poverty line during this period, states could elect to continue the woman’s eligibility, also 60 days postpartum (Schwartz, 1987; 42 U.S.C. § 1396a(e)(6)). Benefits for infants and children were to be identical to their mandatory categorically needy counterparts. Eligible infants and children who reached their maximum coverage age while they were an inpatient in either a hospital or long-term care facility were to remain eligible until they were no longer an inpatient (Schwartz, 1987; 42 U.S.C. § 1396a(e)(7)).

Three other eligibility issues were addressed by OBRA-86: presumptive eligibility for pregnant women, eligibility of the homeless, and coverage of aliens.

OBRA-86 allowed states to provide ambulatory prenatal care to pregnant women during a presumptive period of eligibility. The period began on the date a “qualified provider” made a preliminary decision that the woman’s income was

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1 A “qualified provider” meets Medicaid provider qualification standards; provides hospital outpatient or clinic services; is determined by the state to be able to make preliminary income eligibility determinations; and receives funds under (1) a Community or Migrant Health Center program, (2) the Title V Maternal and Child Health Block Grant Program, (3) the WIC or commodity supplemental food program, or (4) a state perinatal program (Schwartz, 1987; 42 U.S.C. § 1396r(b)(2)).
at or below the applicable Medicaid standard. The period ended on whichever of the following came first: 45 days after the preliminary determination; the day that the state agency made a positive or negative determination on the woman's application; or 14 days after the preliminary determination, if the woman did not file any application (42 U.S.C. § 1396r(1)). States were guaranteed federal reimbursement for services provided even if the recipient were found to be ineligible (Medicaid Source Book, 1988; Schwartz, 1987).

OBRA-86 contained a provision that stated that residence requirements could not be imposed on an individual who was otherwise eligible for Medicaid (42 U.S.C. § 1396a(b)(2)). In other words, homeless pregnant women and children who resided in a state and were categorically and financially eligible for Medicaid could not be denied Medicaid coverage because they lacked a permanent or fixed address (Schwartz, 1987).

With respect to Medicaid coverage for aliens, OBRA-86 prohibited FFP for any aliens who were not legally permanent residents or were not permanently residing in the U.S. under color of law (PRUCOL, e.g., aliens admitted under discretionary authority of the Attorney General). One critical exception was made to this rule: All aliens, regardless of immigration status, were eligible for Medicaid services for treatment of emergency medical conditions, including emergency labor and delivery, if they met applicable financial and categorical requirements (Schwartz, 1987; Medicaid Source Book, 1988). (IRCA-86, see below, also addressed the issue of Medicaid coverage for aliens.)

The Immigration Reform and Control Act of 1986 (IRCA-86) was the second piece of legislation that affected the Medicaid program. It had two primary objectives:

1. To decrease the number of illegal aliens by creating three new groups of people who could become legalized

2. To minimize the potential drain of the newly legalized aliens on state and federal assistance programs.

Three new groups of aliens were identified by the law: amnesty aliens (individuals who have continuously lived in the United States since January 1, 1982); seasonal and agricultural workers or SAWs (individuals who have performed agricultural field work in the United States for at least 90 days between May 1, 1985, and May 1, 1986); and registry aliens (individuals who have resided in the United States since January 1, 1979) (Mora, 1987).
No new restriction on eligibility for benefit programs were created by IRCA-86 for registry aliens. Amnesty aliens and SAWs, however, were disqualified from AFDC and Medicaid for a five-year period (beginning when the individual was granted temporary resident status) (Mora, 1987). Some exceptions to the five-year disqualification were made in the area of Medicaid. These exceptions can be grouped according to the type of service needed or the type of person (Zacovic, 1987).

Exception groups based on type of service include emergency medical services and services for pregnant women. IRCA-86 provided for all aliens to receive Medicaid coverage of "emergency medical services" including pregnancy, labor, and delivery. Amnesty aliens and SAWs were further entitled to Medicaid coverage of "pregnancy-related services" (Zacovic, 1987).

Exception groups based on type of person include: children under 18; aged, blind, or disabled individuals as defined under SSI; and Cuban and Haitian entrants. All three of these groups were exempted from the five-year disqualification period and were entitled to all Medicaid benefits for which they were otherwise eligible (including AFDC and Medicaid) (Zacovic, 1987; Medicaid Source Book, 1988).

**California**

California did not adopt the following OBRA-86 optional provisions: dropping the assets test and permitting presumptive eligibility for pregnant women.

California did adopt OBRA-86’s provisions pertaining to emergency medical care for all aliens, regardless of immigration status. Also California adopted the provisions specified in IRCA-86 pertaining to Medicaid coverage of new legalized amnesty aliens. California then attempted to equalize the services provided to all aliens by extending IRCA-86’s more extensive provisions for pregnancy related services (not just emergency labor and delivery) to the

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2 "Emergency medical services" are defined by Medicaid regulations as follows. Services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient’s health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious disfunction of any bodily organ or part (42 C.F.R. § 447.53(b)(4)).

3 "Pregnancy-related services" are defined as follows. These services include routine prenatal care, labor and delivery, routine postpartum care, and complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, and urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate postpartum period not to exceed six weeks (42 C.F.R. § 447.53(b)(2)).
undocumented aliens defined by OBRA 86. California covered both emergency labor and delivery (as specified by OBRA-86) and nonemergency pregnancy-related services (as specified by IRC-86) for all eligible aliens regardless of immigration status. California’s Senate noted in 1988 (Senate Bill 175, Chapter 1441) that undocumented aliens might be reluctant to take advantage of OBRA-86’s provision for emergency care for fear that the Immigration and Naturalization Service (INS) would be notified and they would be deported. Therefore, the Senate felt that the law requiring certification of alien status would need to be repealed before undocumented aliens would be comfortable enough to seek emergency care.

In addition, California began implementing the Cost Avoidance System in 1986. Under this plan, insurance companies were required to pay their share of medical expenses before California’s Medicaid program was billed.

1987

Federal

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) is the last piece of Medicaid legislation to be enacted during the time period covered by the data used in our study (1980–1987). OBRA-87’s amendments continued the previous trend of expanding both mandatory and optional coverage of pregnant women and children. The impact of OBRA-87 on the pregnant women and infants in our data set is minimal because OBRA-87 was not signed into law until December 22, 1987. Thus the OBRA-87 amendments did not take effect until mid-1988 (Schwartz, 1988).

California

A new level of “subacute” care was added to the service roster. This form of long-term care is for patients with a “fragile medical condition” (CDHS, 1990).

In response to DEFRA regulations requiring state agencies to develop an income and eligibility verification system, the state began implementing a computer system that cross matches income and benefits data across a range of systems including Social Security, unemployment, and the Internal Revenue Service (CDHS, 1990).

Late in 1987, regulations implementing Comprehensive Perinatal Services (AB 3021, Chapter 1404, Statues 1984) became effective, adding nutrition, health education, and psychosocial services to maternity care.
D. Detailed HCFA Tabulations Regarding the California Medicaid Program

The sections in this appendix correspond to the subsections of Section 4 that describe the information compiled by the Health Care Financing Administration. Whereas Section 4 presented the tabular information in summary form, this appendix contains detailed information compiled in the accompanying text.

Definitions of the Eligibility Criteria for the Mandatory and Optionally Categorically Needy Under Aid to Families with Dependent Children (Table 1)

Sources

1981 State Plans Branch, Bureau of Program Operations, HCFA
1983 State Plans Branch, Bureau of Program Operations, HCFA
1988 Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics

Year-to-Year Notes for Table 1

1981

Medicaid must include:

1. All persons receiving cash assistance under state’s AFDC plan
2. Individuals under age 21 who are eligible if they meet age or school attendance requirements (not specified)
3. Families terminated for cash assistance because of increased earnings or hours of employment.

The state has the option to extend AFDC coverage to the following groups. If the state extends AFDC, it must also extend Medicaid to:

1. Families with unemployed parents
2. Families with unborn children
3. Children age 18–21 regularly attending school.

At state’s discretion, Medicaid can be extended to the following AFDC-related groups (AFDC optionally categorically needy):

1. Individuals who are eligible for but are not receiving cash assistance
2. Certain institutionalized individuals, including those eligible for cash assistance but not receiving it because they are institutionalized
3. Certain relatives who are caring for children under age 21 who would be eligible for AFDC payments except for AFDC age or school attendance requirements
4. All persons under age 21 who meet the AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program, for example, emancipated children. States may limit coverage to reasonable groups such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities
5. Individuals who would be eligible for AFDC payments if they did not receive child care services through the agency but had to pay child care costs out of their earnings
6. Persons who would be eligible for AFDC payments if the state AFDC program were as broad as the Social Security Act allows.

1983

Medicaid must include:

1. All persons receiving cash assistance under state’s AFDC plan
2. Families terminated from cash assistance because of increased earnings or hours of employment.

The state has the option to extend AFDC coverage to the following groups. If the state extends AFDC, it must also extend Medicaid to:
1. Families with unemployed parents
2. Children 18 years of age who regularly attend school
3. In the table, but not listed in text: pregnant women with no other eligible children.

At the state's discretion, Medicaid can be extended to the following AFDC-related groups (AFDC optionally categorically needy):

1. Individuals who are eligible for but are not receiving cash assistance
2. Individuals who are eligible for AFDC cash assistance except for their institutional status
3. Individuals who would be eligible for AFDC payments if child care costs were paid from earnings
4. All persons under 21 years of age (or at state option, under age 20, 19, or 18) who meet the AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program. States may limit coverage to certain groups such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities (ICFs)
5. Persons who would be eligible for AFDC payments if the state AFDC program were as broad as Title IV-A of the Social Security Act allows.

Pertaining to deletion of "caretaker relatives." Before the enactment of OBRA-81, states also could extend coverage to another optionally categorically needy group known as "caretaker relatives." (For further information see the Code of Federal Regulation 42, October 1, 1980, Part 435.)

Pertaining to AFDC and Medicaid coverage of children under 21 years of age and unborn children. Before October 1, 1981, each state had the option of extending AFDC eligibility to children 18 to 20 years of age who were regularly attending school, college or university, or vocational or technical training courses. As of October 1, 1981, OBRA restricted this optional coverage to 18 year-olds who are full-time students in secondary school or in the equivalent level of vocational or technical training and who can reasonably be expected to complete the program before their 19th birthday. Before October 1, 1981, states also had the option under their AFDC program of extending Medicaid coverage to "unborn children." OBRA effectively deleted Medicaid benefits for "unborn children" under the AFDC program and substituted the coverage of pregnant women. In the interest of flexibility, states were allowed to continue covering "unborn children" temporarily under the AFDC dependent child clause described in Section 435.222 of the Code of Federal Regulations (i.e., individuals
under 21 years of age who would be eligible for AFDC if they met the definition of a dependent child). The Tax Equity and Fiscal Responsibility Act (TEFRA-82) subsequently revised Medicaid law to provide coverage directly to pregnant women. TEFRA also extended direct coverage to “unborn children” previously provided on a temporary basis under Section 435.222.

1984

Medicaid must include:

same as 1983.

The state has the option to extend AFDC coverage to the following groups. If the state extends AFDC, it must also extend Medicaid to:

same as 1983.

At the state’s discretion, Medicaid can be extended to the following AFDC-related groups (AFDC optionally categorically needy):

same as 1983.

1986

Medicaid must include:

same as 1983.

The state has the option to extend AFDC coverage to the following groups. If the state extends AFDC, it must also extend Medicaid to:

same as 1983.

At the state’s discretion, Medicaid can be extended to the following AFDC-related groups (AFDC optionally categorically needy):

same as 1983.

1988

States are required to cover all persons receiving cash assistance through its AFDC program. AFDC payments are made to families with children in which one parent is absent or incapacitated.

The state has the option to extend AFDC coverage to the following groups. If the state extends AFDC, it must also extend Medicaid to:
1. Two-parent families in which the principal breadwinner is unemployed
2. Pregnant women without other children in their care
3. Children aged 18 who are regularly attending school.

States are also required to provide Medicaid to the following groups on the same basis as AFDC recipients even though they do not receive AFDC.

1. Children receiving assistance from programs under Title IV-E of the Social Security Act to support foster care and adoptions
2. Families terminated from AFDC because of their income from employment or the receipt of child support from an absent parent
3. Families who do not receive AFDC because the amount they qualify for is less than the minimum amount AFDC will pay
4. All pregnant women and children under the age of seven (eight at state option) born after October 1, 1983, whose family income and resources are at or below AFDC levels but who do not meet other nonfinancial AFDC requirements.

States have the option to cover the following AFDC-related groups:

1. Individuals under 21 (20, 19, or 18 at state option) who meet AFDC income and resource limits but do not qualify for AFDC because they do not meet the AFDC definition of a dependent child. Usually in this case they live with both parents, and the principal breadwinner is employed. States may cover all such children or limit coverage to categories of children who live with neither parent, such as those in foster homes, subsidized options, psychiatric institutions, or intermediate care facilities
2. Individuals who are eligible for but not receiving cash assistance
3. Individuals who would be eligible for AFDC cash assistance if they were not institutionalized
4. Individuals who would be eligible for AFDC payments if the state AFDC program were as broad as Title IV-A of the Social Security Act allows
5. Individuals who would be eligible for AFDC payments if child care costs were paid from earnings.

States also have the option to cover the following additional AFDC-related groups:
1. Pregnant women whose family income is higher than AFDC levels but not higher than 185 percent of federal poverty guidelines

2. Children under one year of age whose family income does not exceed 185 percent of the poverty level

3. Children born on or after October 1, 1983, whose family income is higher than AFDC levels but not higher than 100 percent of the poverty level (covered until age eight)

4. Families that would receive AFDC if their state had elected to cover that type of family in its AFDC program

5. Children with special medical or rehabilitative needs adopted under a state program for facilitating adoptions.

California’s Annual Need and Payment Standards for Aid to Families with Dependent Children (AFDC) and Annual Income Levels for the Medically Needy (Table 2)

Sources

1981 Annual AFDC Need and Payment Standards—Office of Research and Statistics, Social Security Administration, DHHS; Annual Net Income Protected for Maintenance for the Medically Needy—State Plans Branch, Bureau of Program Operations, HCFA

1983 Annual AFDC Need and Payment Standards—Office of Research and Statistics, Social Security Administration, DHHS; Annual Net Income Protected for Maintenance for the Medically Needy—State Plans Branch, Bureau of Program Operations, HCFA

1984 Health Care Financing Administration, Bureau of Data Management and Strategy: Unpublished data


1988 Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics
Year-to-Year Notes for Table 2

1981

In all years, states determine income standards for cash assistance and Medicaid eligibility. In addition, the following definitions of need standard, payments standard and medically needy apply to all years and are not repeated.

The need standard is the amount of money a state (California) determines essential to meet a minimal standard of living in the state for a specified family size.

Note (same for all data books): The standard provides for basic consumption items, such as food, clothing, shelter, fuel and utilities, personal care items, household items, and in certain cases, special or recurrent needs.

The payment standard is established by each state and determines the extent to which the state cash assistance program will meet the need for a minimum standard of living.

AFDC payment standards determine eligibility for Medicaid.

The medically needy are defined as categorically related individuals who are ineligible for cash assistance on the basis of income and financial resources but whose income and resources are considered insufficient to meet their medical needs. The intent of this option is to accommodate individuals who meet all criteria for categorically needy assistance with the exception of income and who are unable to afford medical bills. As of 1969, the medically needy income standards were limited to 133-1/3 percent of the maximum assistance payments for similarly sized families under AFDC in a given state.

Two categories of medically needy individuals have varied over time and are repeated for each year:

1. Families whose monthly incomes are between the AFDC payment standard and 133-1/3 percent of the AFDC payment standard
2. Spend-down provision—persons or families whose income is above the 133-1/3 percent of AFDC payment standard level, but who have high medical expenses that reduce income below the medically needy maximum.
1983

The two categories of medically needy individuals are detailed:

1. For federal matching purposes, a medically needy person is one whose "countable" income does not exceed 133-1/3 percent of the maximum payment standard set by the state.

2. Under the spend-down provision, persons or families with incomes above their group's medically needy income standard can deduct certain incurred medical expenses to determine their countable income. These deductible medical services include:
   a. Medicare and other health insurance premiums, deductibles, and coinsurance charges
   b. Expenses incurred for medical and remedial services included in the Medicaid state plan
   c. Expenses incurred for services not included in the state plan but recognized under state law.

Before OBRA 1981 (October 1981), a single state-wide income standard was used to determine eligibility for medically needy individuals and families. After OBRA 1981, income standards could vary from one group covered to the next.

1984

The two categories of medically needy individuals are detailed:

1. For federal matching purposes, the federal government recognizes as medically needy only those persons whose "countable" income does not exceed 133-1/3 percent of the maximum payment standard set by the state.

   Note: Each state is required to employ a single state-wide income standard when determining eligibility for medically needy individuals and families. (Although this requirement was removed by OBRA-81, which allowed states to vary their medically needy income standard from one covered group to the next, the single state-wide income standard requirement was reinstated by Section 137 of TEFRA.)

2. Under the medically needy spend-down provision (42 CFR 435.831), persons or families with incomes above the medically needy income standard can deduct certain incurred medical expenses to determine their countable income. These deductible medical services include:
a. Medicare and other health insurance premiums, deductibles, and coinsurance charges  
b. Expenses incurred for medical and remedial services included in the Medicaid state plan  
c. Expenses incurred for services not included in the state plan but recognized under state law.  

1986

The two categories of medically needy individuals are detailed:

same as 1984.

1988

Since the enactment of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81), states have been permitted to offer medically needy coverage to some groups but not to others; for example, to the aged and disabled but not to parents of dependent children. However, a state providing any medically needy coverage at all, at a minimum, must cover medically needy pregnant women and children under age 18. Medical benefits may vary by medically needy groups.

The two categories of medically needy individuals are detailed:

1. Since 1969, a state’s medically needy income standard has been limited to 133-1/3 percent of the maximum AFDC assistance payment for a family of the same size. For federal matching, this means that the federal government recognizes as medically needy only those persons whose “countable” income does not exceed 133-1/3 percent of the maximum payment standard set by the state. Each state is required to employ a single state-wide income standard when determining eligibility for medically needy individuals and families.

2. Persons with income above cash assistance levels but below medically needy levels qualify without having to spend down. Under the medically needy spend-down provision (42 CFR 435.831), however, persons or families with incomes above the medically needy income standard can deduct certain incurred medical expenses to determine their countable income. Among the medical services that they are allowed to deduct are Medicare and other health insurance premiums, deductibles, or coinsurance charges; expenses incurred for medical and remedial services included in the state Medicaid plan; and expenses incurred for services not included in the state plan but recognized under state law.
California’s Medicaid Services (Table 3)

General

In California, most optional services are offered to both categorically and medically needy people. Basic required services have stayed relatively constant from 1980 to 1987. Details are contained in the notes for each year.

Sources

1981 not listed
1983 State Plans Branch, Bureau of Program Operations, HCFA
1984 Department of Health and Human Services, Health Care Financing Administration, Office of Intergovernmental Affairs
1986 Department of Health and Human Services, Health Care Financing Administration, Office of Intergovernmental Affairs

All years: The data shown were recorded by individual Regional Offices and compiled by the Office of Intergovernmental Affairs.

Year-to-Year Notes for Table 3

Footnotes to the Tables

The following information is drawn from the footnotes that accompany each year’s tables. Detailed textual information for each year follows.

Basic Required Medicaid Services—Medicaid recipients receiving federally supported financial assistance must receive at least these services:

1. Inpatient hospital services
2. Outpatient hospital services
3. Rural health clinic services
4. Other laboratory and X-ray services
5. Skilled nursing facility services and home health services for individuals 21 and older
6. Early and periodic screening, diagnosis, and treatment for individuals under 21
7a. Family planning
7b. Family planning services and supplies
8. Physician services
9. Nurse midwife services.

Items 1 through 8 (using 7a instead of 7b) are from the 1984 HCFA data book; items 1 through 9 (using 7b instead of 7a) are from the 1986 HCFA data book and remain the same for the 1988 HCFA data book.

The following is taken from the 1984, 1986, and 1988 HCFA data books:

Federal financial participation is also available to states electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, states may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from state to state. Details are available from local welfare offices and state Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

1981

Federal regulations pertaining to Title XIX mandate that certain basic services be offered to all categorically needy persons. States receive federal financial participation (FFP) for these basic services as well as specified services covered at the states’ option. States have the option of limiting the scope of coverage for both required and optional services but must make all covered services available throughout their state.

All states participating in Medicaid must cover the following basic services:

1. Inpatient hospital services, other than services in an institution for tuberculosis or mental disease. This category includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients, provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by an officially designated state standard setting authority and either qualified to participate under Medicare or determined to currently meet the requirements for such participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program.
2. *Outpatient hospital services*, including preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a hospital outpatient. The hospital must meet the same requirements as inpatient services: the hospital must be licensed or formally approved as a hospital, and either must be qualified to participate under Medicare, or must meet the requirements for such participation.

3. *Rural health clinic services* in certified clinics must be provided and furnished by a physician or by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (in states where those professionals are not prohibited by state law from furnishing primary health care).

4. *Other laboratory and X-ray services*, including professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner, within the scope of his practice as defined by state law and provided to a patient by, or under the direction of, a physician or other licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. These services must be provided to a patient by a laboratory that is qualified to participate under Medicare or is determined to meet the requirements for such participation.

5. *Skilled nursing facility (SNF) services* for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases. These services must be ordered by and under the direction of a physician. The facility must be qualified for participation in Medicaid. For all eligible individuals who are entitled to skilled nursing facility services under the state plan, home health services must also be provided.

6. *Physicians' services*, whether provided in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. Physicians' services are defined to include the services provided within the scope of practice of the profession as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

7. *Early and periodic screening, diagnosis, and treatment (EPSDT)* for recipients under age 21. This includes screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

8. *Family planning services and supplies* for individuals of child bearing age who are eligible for Medicaid and desire such services and supplies.
In addition to the services indicated above, each state may, at its option, choose to provide additional services to its categorically needy population. The provision of any service to the categorically needy does not commit the state to the provision of equal (for example, in amount, scope, or duration) services to the medically needy program. These optional services include:

1. *Medical or other remedial care* provided by licensed practitioners within the scope of practice as defined under state law. These practitioners may include among others chiropractors (with limitations), optometrists, and podiatrists.

2. *Home health services* in addition to the home health services that must be available to persons eligible for SNF services under the state’s plan. Home health services, when provided by a licensed agency to a patient in his residence (not including a hospital, an intermediate care facility, or a skilled nursing facility) are defined as:
   a. Intermittent or part-time nursing services furnished by a home health agency
   b. Intermittent or part-time nursing services of a registered professional nurse or a licensed practical nurse under the direction of the patient’s physician, when no home health agency is available to provide the nursing services
   c. Medical supplies, equipment, and appliances recommended by the physician as required in the care of the patient and suitable for use in the home
   d. Services of a home health aide, defined as an individual assigned to give personal care services to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and the home health agency that assigns a registered professional nurse to provide continuing supervision of the aide on his or her assignment.

3. *Private duty nursing services*, defined as nursing services provided by a professional registered nurse or a licensed practical nurse, under the general direction of the patient’s physician, to a patient in his or her own home or in a hospital or skilled nursing facility when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or skilled nursing facility.

4. *Clinic services*, i.e., preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility that is not part of a hospital but that is organized and operated to provide medical care to outpatients.
5. *Dental services*, in addition to those required to be provided to persons under 21 years of age in the state’s Early and Periodic Screening, Diagnosis, and Treatment program.

6. *Physical therapy and related services*, including physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary when rendered by, or under the supervision of, an individual qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession, and under the prescription or referral of a physician.

7. *Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses.* Prescribed drugs that may be provided are simple or compounded substances or mixtures of substances prescribed by a physician or other licensed practitioner of the healing arts.

8. *Other diagnostic, screening, preventive, and rehabilitative services.*

9. *Intermediate care facility services (ICF)*, other than services in an institution for tuberculosis or mental diseases, for the physically ill or mentally retarded.

10. *Inpatient psychiatric hospital services* for persons under 21 years of age.

11. *Other medical or remedial care* recognized under state law. Such additional items and services include transportation, emergency hospital services, personal care services (non-professional) prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoria and nursing services, and skilled nursing facility services for persons under 21 years of age.

State plans that provide for coverage of the medically needy must specify either that all the required services for the categorically needy are also provided for the medically needy or that the seven services listed in the required and/or optional services (numbers 1–10) are provided for the medically needy. If inpatient hospital or skilled nursing facility services are included among the services chosen, physicians' services must also be made available to individuals while they are in the hospital or nursing home, even though physicians’ services might not otherwise be provided for the medically needy. In addition, if skilled nursing facility services are covered, persons entitled to such services also must be entitled to home health coverage.

Once a state has selected a benefit package, federal regulations require that the state plan specify the amount and/or duration of each item of medical and remedial care and services that will be provided. Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose, and limits
may not be imposed on the basis of "diagnosis, type of illness, or condition." States have considerable flexibility to set limits within these requirements.

1983

Regulations regarding uniform service coverage throughout the state may be waived for a limited period to conduct special demonstration studies. OBRA-81 also authorizes waivers of statewidens for federally approved section 2176 home and community-based service programs (as mentioned in less detail in the 1981 data book and will continue to be mentioned in this form in all future data books).

All states participating in Medicaid must cover the following basic services for all categorically needy recipients. (Definitions have been omitted unless they have changed since 1981.)

1. **Inpatient hospital services**
2. **Outpatient hospital services**
3. **Rural health clinic services**
4. **Other laboratory and X-ray services**
5. **Skilled nursing facility (SNF),** except clause about home health services has been omitted
6. **Physicians’ services**
7. **Early and periodic screening, diagnosis, and treatment (EPSDT)**
8. **Family planning services and supplies**
9. **Home health services** when provided in the patient’s residence by a licensed agency. These include nursing services provided on a part-time or intermittent basis by a home health agency (HHA) or registered nurse (when no HHA is in the area); home health aide services provided by an HHA and medical supplies, equipment, and appliances suitable for use in the home.

As of October 1, 1981, states with a *medically needy program* must cover the following services for those individuals:

1. Prenatal care and delivery services for pregnant women
2. Ambulatory services for children under 18 years of age and individuals entitled to institutional services
3. Home health services to any individual entitled to SNF services.
In addition to federally required services, each state may offer coverage for certain “optional” services. (Definitions have been omitted unless they have changed since 1981.)

1. Medical or other remedial care
2. Home health services, in addition to those required under Section 440.70. Specifically physical therapy, occupational therapy, or speech pathology, and audiology services, provided by an HHA or by a facility licensed by the state to provide medical rehabilitation services (Section 440.70(b)(4))
3. Private duty nursing services
4. Clinic services
5. Dental services
6. Physical therapy and related services
7. Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses
8. Other diagnostic, screening, preventive, and rehabilitative services
9. ICF services
10. Inpatient psychiatric hospital services
11. Other medical or remedial care.

Once a state has selected a benefit package, federal regulations require the state plan to specify the amount and/or duration of each item of medical and remedial care and services covered. Such items must be

1. Sufficient in amount, duration, and scope to reasonably achieve their purpose (Section 440.230)
2. Comparable across all categorically needy recipients and within each medically needy group (Section 440.240).

In addition, states may not impose limits on the basis of “diagnosis, type of illness, or condition.” Within these general guidelines, states are free to set whatever service limits they choose.

1984

All states participating in Medicaid must cover the following basic services for all categorically needy recipients:

1. Inpatient hospital services
2. Outpatient hospital services
3. Rural health clinic services
4. Other laboratory and X-ray services
5. Skilled nursing facility services (same as 1983)
6. Physicians' services
7. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
8. Family planning services and supplies
9. Home health services (same as 1983).

Requirements for medically needy program same as 1983.

In addition to federally required services, each state may offer coverage of certain optional services:
1. Medical or other remedial care
2. Home health services (same as 1983)
3. Private-duty nursing services
4. Clinic services
5. Dental services
6. Physical therapy and related services
7. Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses
8. Other diagnostic, screening, preventive, rehabilitative services
9. ICF services
10. Inpatient psychiatric hospital services
11. Nurse-midwife services concerned with managing the care of mothers and newborns furnished by a licensed nurse-midwife within the scope of practice authorized by state law (42 CFR 440.165)
12. Other medical or remedial care
13. Home and community-based services (under waiver agreement) that an individual would need to avoid institutionalization (42 CFR 441, subpart G).

1986

All states participating in Medicaid must cover the following basic services for all categorically needy recipients:
1. Inpatient hospital services
2. Outpatient hospital services
3. Rural health clinic services
4. Other laboratory and X-ray services
5. *Skilled nursing facility (SNF) services* (same as 1983)
6. *Physicians’ services*
7. *Early and periodic screening, diagnosis, and treatment (EPSDT)*
8. *Family planning services and supplies*
9. *Home health services* (same as 1983)
10. *Services that are furnished by a licensed nurse-midwife concerned with managing the care of mothers and newborns* within the scope of practice authorized by state law.

Requirements for *medically needy program* same as 1983.

In addition to federally required services, each state may offer coverage of certain optional services:

1. *Medical or other remedial care*
2. *Home health services* (same as 1983)
3. *Private-duty nursing services*
4. *Clinic services*
5. *Dental services*
6. *Physical therapy and related services*
7. *Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses*
8. *Other diagnostic, screening, preventive, and rehabilitative services*
9. *ICF services*
10. *Inpatient psychiatric hospital services*
11. *Services that are furnished by a licensed nurse-midwife concerned with managing the care of mothers and newborns* within the scope of practice authorized by state law
12. *Other medical or remedial care*

**1988**

All states participating in Medicaid must cover the following basic services for all categorically needy recipients:

1. *Inpatient hospital services*
2. *Outpatient hospital services*
3. *Rural health clinic services*
4. Other laboratory and X-ray services

5. Skilled nursing facility (SNF) services (same as 1983)

6. Physicians’ services

7. Early and periodic screening, diagnosis, and treatment (EPSDT)

8. Family planning services and supplies

9. Home health services (same as 1983)

10. Services that are furnished by a licensed nurse-midwife concerned with the management of the care of mothers and newborns (same as 1986).

Requirements for medically needy program same as 1983.

In addition to federally required services, each state may offer coverage of certain optional services:

1. Medical or other remedial care

2. Home health services (same as 1983)

3. Private-duty nursing services

4. Clinic services

5. Dental services

6. Physical therapy and related services

7. Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses

8. Other diagnostic, screening, preventive, and rehabilitative services

9. ICF services

10. Inpatient psychiatric hospital services

11. Other medical or remedial care


Under section 1915 waiver authority, states may target home and community-based waiver programs to such groups as AIDS, Alzheimer’s, or mentally ill patients without meeting the requirement that comparable services be provided to all categorically and medically needy recipients.

**Medicaid Reimbursement Methods (Table 4)**

**General**

Before 1982, reimbursement was required to follow Medicare reasonable cost rules unless an alternative was approved. OBRA 1981 dropped this requirement,
and it was replaced by a more complex set of rules described in the year-to-year changes.

Sources

1981  State Plans Branch, Bureau of Programs Operations, HCFA
1983  Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982
1988  Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics

Year-to-Year Notes for Table 4

1981

States are required by law to reimburse for inpatient hospital services on the same basis as Medicare—reasonable costs—unless they have approval from the Secretary of the Department of Health and Human Services (DHHS) to use an alternative method of reimbursement. An alternative method will be approved only if the method:

1. Provides incentives for efficiency and economy
2. Provides for payment rates that are no higher than the amounts that would be determined using Medicare principles of cost reimbursement
3. Assures adequate participation of hospitals in the state’s Medicaid program and the availability of hospital services of high quality to recipients
4. Affords individual providers an opportunity to submit evidence and obtain prompt administrative review of payment rates set for them in certain instances
5. Provides for adequate documentation to evaluate experience under the approved methods and standards.
As of December 31, 1980, ten states (including California) and one territory (Northern Marianas) had received approval from DHHS to use an alternative method for reimbursement of inpatient hospital services.

For all other services, states are not required to use the Medicare method of payment; however, Medicaid reimbursement may not exceed the amounts paid under Medicare.

Seventeen states (not including California) have elected to use the Medicare method of payment for outpatient hospital services and ten states (not including California) use the Medicare methods of payment for physicians' services.

For skilled nursing facility services and intermediate care facility services, states have been subject to the requirement that payment systems be reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different states at different times after that date. This cost-related requirement was altered by the Omnibus Reconciliation Act of 1980.

1983

Before FY1982, states were required by law to reimburse for inpatient hospital services on the same basis as Medicare—reasonable costs—unless they received approval from the Secretary of the DHHS to use an alternative method of reimbursement. The criteria for approval are listed under 1981.

As of February 1982, eighteen states (including California) had received approval from DHHS to use an alternative method for reimbursement of inpatient hospital services.

This requirement was dropped by Section 2173 of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81). In its place, states were required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals met acceptable standards of efficiency, quality, and access to care.

Reimbursement for all other services is the same as 1981.

As of February 1982, thirty-three states (not including California) reported using Medicare principles for outpatient hospital services, and 26 states (not including California) reported Medicare principles for physicians' services.

Reimbursement for SNF services and ICF services is the same as 1981.
1984

OBRA-81 required states to provide assurances satisfactory to the Secretary that the rates paid to hospitals:

1. Are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities,” to provide care in accordance with applicable laws, quality, and safety standards
2. Take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, that serve large numbers of low-income patients
3. Provide reasonable access to inpatient hospital services of adequate quality
4. Are routinely documented through uniform cost reports filed by each hospital and through periodic state audits of such reports (42 CFR 447.252).

Reimbursement for all other services is the same as 1981.

As of March 1983, twenty-six states (not including California) reported using Medicare principles for inpatient hospital services, 27 states (not including California) for outpatient hospital services, and 20 states (not including California) for physicians’ services.

Reimbursement for SNF services and ICF services is the same as 1981.

Before October 1, 1981, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a state’s Medicaid program. The Secretary of Health and Human Services, however, was authorized to waive certain federal Medicaid requirements to enable states to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including demonstrations of prospective reimbursement.

To give states more flexibility in implementing various cost-saving measures, Section 2175 of OBRA-81 provides that a state shall not be held out of compliance for failure to meet certain state plan requirements if it limits free choice in any of the following ways:

1. Purchases laboratory services and medical devices through a competitive or other arrangement, and the Secretary finds that adequate services or devices were available to beneficiaries
2. Contracts with organizations that agree to provide services in addition to those offered under the state plan to eligible individuals residing in the area served by the organization and who elect to receive care from the organization
3. Pays for certified rural health clinic services
4. "Locks in" beneficiaries who overutilize services to a particular provider for a reasonable time period
5. "Locks out" providers who abuse the program, subject to prior notice and opportunity for a hearing and provided that eligible individuals have reasonable access to services of adequate quality.

Additionally, the provision authorizes the Secretary to waive certain state plan requirements for a two-year period to assist states in improving cost effectiveness in various areas of program operation (TEFRA Section 137 repeals the Secretary's authority to waive health maintenance organization requirements), such as:

1. Allowing states to create a primary care case-management system or a physician specialty arrangement
2. Allowing a locality to act as a central broker in helping Medicaid enrollees choose among competing health plans
3. Permitting states to share with recipients in the form of more cost-effective care
4. Restricting providers from whom recipients can obtain services (in other than emergency situations) to those who agree to comply with reasonable state standards.

Before October 1, 1981, states could enter into prepaid risk contracts only with federally qualified health maintenance organizations (HMOs). Contracting HMOs were required to have an enrollment consisting of less than 50 percent Medicaid and Medicare patients. Section 2178 of OBRA-81 allows states to enter into prepaid risk contracts not only with qualified HMOs, but also with organizations that:

1. Make covered services accessible to Medicare enrollees to the same extent that these services are accessible to Medicaid recipients not enrolled in the organization
2. Have made adequate provision against the risk of insolvency. (Participating organizations also must assure that Medicaid enrollees will not be held liable for debts if the organization becomes insolvent.)

Additionally, these contracts must provide for:

1. Access by the Secretary of Health and Human Services and the state to certain books and records of HMOs
2. Nondiscrimination on the basis of health status or use of health services in the entity’s enrollment, reenrollment, and disenrollment activities
3. Disenrollment rights for individuals after one full month of membership
4. Reimbursement for medically necessary services received out of plan (under certain circumstances).

Section 2178 also

1. Requires states to continue Medicaid eligibility at the end of an HMO’s minimum enrollment period for Medicaid-covered HMO enrollees who otherwise would lose their Medicaid eligibility
2. Raises the previous enrollment limit from no more than 50 percent to no more than 75 percent Medicare and Medicaid patients
3. Allows the Secretary to modify or waive this last requirement for public HMOs when warranted by special circumstances and when the HMO is making reasonable efforts to enroll individuals from the private sector.

1986

Reimbursement for inpatient hospital services is the same as 1984.

Reimbursement for SNF services and ICF services is the same as 1981.

Reimbursement for all other services is the same as 1981.

As of March 1984, sixteen states (not including California) reported using Medicare principles for inpatient hospital services, 26 (not including California) for outpatient hospital services, and 17 states (not including California) for physician’s services.

The waiver enabling states to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including prospective reimbursement demonstrations, is still in effect.

Measures allowing states flexibility in implementing cost-saving measures are the same as in 1984.

Section 2178 of OBRA-81 allows states to enter into prepaid risk contracts not only with qualified HMOs. The conditions of these contracts are listed under 1984.
1988

Reimbursement for inpatient hospital services is the same as 1984.

Reimbursement for SNF services and ICF services is the same as 1981.

Reimbursement for all other services is the same as 1981.

As of March 1986, sixteen states (not including California) reported using Medicare principles for inpatient hospital services, 24 (not including California) for outpatient hospital services, and 14 states (not including California) for physicians' services.

The waiver enabling states to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including prospective reimbursement demonstrations is still in effect.

Measures allowing states flexibility in implementing cost-saving measures are the same as in 1984.

Section 2178 of OBRA-81 allows states to enter into prepaid risk contracts not only with qualified HMOs. The conditions of these contracts are listed under 1984.

Number of Medicaid Recipients and Distribution According to Eligibility (Table 5)

Sources


1983 Office of Research and Demonstrations, HCFA, Annual Medicaid Statistics, unpublished

1984 Health Care Financing Administration, Office of the Actuary: Annual Medicaid Statistics, unpublished data

1986 Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates

1988 Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics
1990 Health Care Financing Administration, Bureau of Data
Management and Strategy: Data from the Division of Medicaid
Statistics

Limitations on Medicaid Services in California (Table 6)

General

Federal regulations require that the limitations each state imposes “must be
sufficient in amount, duration, and scope to reasonably achieve their purpose.”
Also, “limits may not be imposed on the basis of ‘diagnosis, type of illness, or
condition.’” Beyond these requirements, states are free to set their own limits.
TEFRA-82, however, mandated that no copayments be charged for services
related to pregnancy or services provided to people under age 18.

Sources

1981 State Plans Branch, Bureau of Program Operations, HCFA

1983 Summary Tables, Medicaid Program Characteristics, Office of
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Management and Strategy, Medicaid Statistics Branch: Summary
Tables, Analysis of Medicaid Program Characteristics, December
1983; and Health Care Financing Administration, Bureau of
Management and Strategy and La Jolla Management Corporation:
Analysis of State Medicaid Program Characteristics, Rockville, Md.,
1983

1986 Health Care Financing Administration: Analysis of State Medicaid
Program Characteristics, 1984, HCFA Pub. No. 03204, Office of the
1985

1988 Health Care Financing Administration, Office of the Actuary: Data
from the Office of Medicaid Estimates and Statistics
Year-to-Year Notes for Table 6

1981

Once a state has selected a benefit package, federal regulations require that the state plan specify the amount and/or duration of each item of medical and remedial care and services that will be provided. Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose, and limits may not be imposed on the basis of “diagnosis, type of illness, or condition.” States have considerable flexibility to set limits within these requirements. These requirements hold for all years.

Both inpatient hospital services and physicians’ services have limitations. These limitations range from preauthorization requirements to a ceiling on the number of covered benefit days or visits. SNF benefits and outpatient hospital benefits have limitations. ICF limitations include preauthorization requirements.

1983

The following services are limited: inpatient hospital services, outpatient hospital services, physician services, and services in SNFs. The following home health care services are limited: part-time nursing services, aide services, physical, occupational, speech and hearing therapy, and medical supplies and equipment. Services covered in ICFs and ICFs for the mentally retarded are also limited.

1984

Limitations on services are the same as 1983.

Before October 1, 1982, states were permitted to charge Medicaid recipients copayments except for mandatory services provided to the categorically needy. Section 131 of TEFRA now enables states to charge both categorically and medically needy recipients copayments, except for services provided to individuals under age 18 (or up to age 21 at state option), services related to pregnancy (or any services provided to pregnant women), services furnished to institutionalized individuals who are required to expend all of their income above their personal needs allowance, emergency services, and family planning services and supplies.
1986

Limitations on services are the same as 1983.

The copayment stipulations put in place by TEFRA are still applicable.

1988

Section 1915 waiver authority allows states to target home and community-based waiver programs to such groups as AIDS, Alzheimer’s, or mentally ill patients.

Limitations on services are the same as 1983.

The copayment stipulations put in place by TEFRA are still applicable.
References

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California Department of Health Services (CDHS), California Medi-Cal Reports: Medi-Cal Program Highlights, Register No. 90-03017, Mar 1990

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Health Care Financing Administration, The Medicare and Medicaid Data Book: 75-142, 1983

Health Care Financing Administration, The Medicare and Medicaid Data Book: 57-113, 1984


O'Sullivan, J., Medicaid: Legislative History, Program Description, and Major Issues, Education and Public Welfare Division, Report No. 84-140 EPW, Jul 24, 1984


Schwartz, R., New COBRA Legislation Adopts Many Changes in Medicaid and Other Health Programs, National Health Law Program, *Clearinghouse Review*: 244-251, Jul 1986


