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State Benefit Design Choices under SCHIP - Implications for Pediatric Health Care

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Issue Brief

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Executive Summary

This policy brief[1] is the second in a series of reports focusing on the design of state SCHIP programs as they near full implementation. It examines the extent to which state agencies adopt conventional insurance norms or adhere to special principles of Medicaid coverage design for children in designing separately administered (or freestanding) SCHIP programs. The issue of coverage design is particularly relevant for children with low prevalence conditions and special health care needs. Increasingly, conventional insurance uses standardized coverage norms to limit coverage and treatment. These standardized norms take the form of across-the-board treatments and exclusions, limited definitions of medical necessity, and the use of irrebuttable, standardized treatment guidelines in determining when covered treatments will be available. All of these practices are impermissible under

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Medicaid, which uses exceptionally broad preventive standards to determine coverage of children; such standards favor coverage of children with low prevalence problems.

The issue of coverage design takes on particular significance in the context of the current health system, since the use of managed care (which dominates separately administered SCHIP programs, as it does Medicaid) effectively merges issues of coverage, treatment, and ultimately, the quality of health care.

A detailed, nationwide analysis of coverage design choices by separately administered SCHIP plans, as well as managed care contracts maintained by separate programs, indicates that in terms of exclusions, coverage limitations and the definition of medical necessity itself, virtually all states with freestanding programs "tip" their programs to parallel conventional insurance and depart from special Medicaid coverage rules. Specific findings include:

- Among the 34 states with separately administered SCHIP programs in effect in 2000, 32 states use coverage exclusions that would not be permissible in Medicaid. All states use coverage limitations in addition to those permitted under Medicaid.

- Of the 19 states that provide a definition of medical necessity as a stated part of their program design, 13 states use a definition that parallels the preventive standard of medical necessity used by the Medicaid program. This standard ensures that coverage is available when needed to promote growth and development.

- None of the 26 standard contracts used by separate SCHIP programs in their purchase of managed care products prohibits the use of standardized treatment guidelines in determining when covered treatment will be available, a practice that would not be permitted under Medicaid.

These findings suggest that, when given the option to do so, states will adopt conventional insurance norms in lieu of Medicaid's special coverage rules for children, at least with respect to children who are near-poor. Whether this distinction on states' part between near-poor children and the poorest children is justified is debatable, since only a nominal amount of family income separates the two groups, and health status data show virtually no distinction in health status measures for the poorest children and their near-poor counterparts.

How state choices affect the accessibility and quality of health care for children with chronic illness and disability is unclear. In states that supplement SCHIP benefits with other sources of health care funding for disabled children, the effects may be minimal. In states without complementary programs that are closely coordinated with basic SCHIP benefits to

overcome the limits of SCHIP, the impact of exclusions, limitations, a narrowed definition of medical necessity, and the use of standardized (and irrebuttable) treatment guidelines may be more significant for children with serious and chronic physical and mental disabilities.

Introduction

This Policy Brief examines coverage design in separately administered State Children's Health Insurance (SCHIP) programs and assesses the implications of those coverage design choices for children with special health care needs.[2] The Brief opens with a background and overview of the concept of coverage design, reviews the basic differences in design between conventional private health insurance and Medicaid, and describes state options under separately administered SCHIP programs. Following a brief description of the methods used to carry out this study, this analysis presents findings regarding the coverage design choices in SCHIP and discusses the implications of these findings for children with special health care needs.

Background

The concept of coverage design: key issues. Coverage design is a basic concept in health insurance law and policy.[3] Health insurance coverage design is actually an amalgam of several distinct factors that together determine the conditions under which third party financing will be available to pay for health care furnished to eligible individuals by participating providers.

A discussion of health insurance coverage design can be divided into two basic categories: "macro" design issues and "micro" design issues.[4] Macro design issues are those that involve the *face* of the coverage document itself (e.g., a private health insurance contract, a state Medicaid plan, a SCHIP plan). In essence, the macro aspect of coverage focuses on the coverage that is available to *any* member of a health plan regardless of the individual's particular condition. Examples of macro design choices are service exclusions (e.g., no coverage of cosmetic or experimental procedures or "custodial" care); fixed, across-the-board limits on certain services (such as 20 mental health visits per year); cost-sharing rules;

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[2] For purposes of this Brief, the term "children with special health care needs" denotes "children under 21 who have a chronic physical, developmental or behavioral condition, and require health and related services of a type or amount beyond that which is required by children generally." See M. McPherson *et al.*, "A New Definition of Children with Special Health Care Needs." 102 *Pediatrics* 1137-40 (1998). This definition is used under the Title V Maternal and Child Health Services Block Grant program, 42 U.S.C. §701 *et seq.* It is particularly useful in insurance design analyses because it directly addresses the issue of individuals whose health needs require a level of resource consumption that exceeds actuarial norms.

[3] Rand Rosenblatt, Sara Rosenbaum and David Frankford, *Law and the American Health Care System* (Foundation Press, 1997, 2001-02 Supplement) (Ch. 2D and 2E).

[4] *Id.* Ch. 2(B), 2(D) and 2(E).

and annual or lifetime dollar caps on benefits. Terms and definitions of coverage also are macro issues. Thus, the definition of "medically necessary" care, or "emergency" care both represent macro aspects of coverage design because they drive the interpretation of the entire document.

The micro dimension of coverage occurs at the point at which the actual terms of a contract of coverage are applied to a specific, individual enrollee's case. Thus, individual medical necessity decisions (i.e., the act of determining when an individual's health condition merits access to a particular service that falls within the "four corners of the plan") are the best known example of micro design. Medical necessity micro design focuses on the act of applying the terms of a contract or health plan to a particular case. Not only is the standard of medical necessity important, but also critical are the procedures used to make the determination. In the context of children with special health care needs, perhaps the most critical aspect of the treatment determination process is whether the determination can be based entirely on standardized practice guidelines or must involve a weighing of the facts of an individual's case, as well as other relevant and reliable evidence.[5]

Individual micro determinations most typically arise in the context of medical necessity decisions. In fact, however, the micro review process arises every time a decision must be made as to whether the facts of a particular patient's case place the patient "outside" or "inside" the terms of a contract. For example, a health insurer might determine that private duty nursing is excluded as "custodial" in a specific case. In order to make this decision regarding how to apply an insurance exclusion to the child, the insurer, in theory, would need to consider the facts of the child's case against the contract's definition of "custodial."

Coverage design in private insurance. Private insurers (whether organized to sell conventional indemnity insurance or managed care-style products) operate in accordance with principles of risk.[6] As a result, insurers build a range of risk limiting approaches into their coverage agreements and seek to avoid situations in which they must depart from actuarially-based, standardized, population-wide norms with respect to coverage.[7] In employment-based insurance products, standardized limitations are calibrated to extend members a level of coverage that typically is needed by working persons and by young and healthy family members. These risk-avoidance limitations can have a significant impact on the standard of

[5] See also Henry Ireys *et al., Defining Medical Necessity: Strategies for Promoting Access to Quality Care for Persons with Developmental Disabilities, Mental Retardation, and Other Special Health Care Needs* (National Center on Education for Maternal and Child Health, Arlington, VA: 1999).
[6] Deborah Stone, "The Struggle for the Soul of Health Insurance," 18 *Journal of Health Politics Policy and Law* 347-69 (1993).
[7] David Eddy, "Rationing Resources While Improving Quality: How to Get More for Less," 272 *JAMA* 817-24 (1994).

care that is available through the health plan in the case of members whose health care needs exceed standardized norms (i.e., persons who require a greater level of care and a more customized approach to treatment decision-making).

Private insurers use a variety of techniques for calibrating the macro elements of coverage to a healthy population. Certain classes of services typically used by individuals with special health care needs (e.g., speech and physical therapy) may be excluded altogether.

Other treatments may be subject to fixed facial limits (e.g., 20 mental health visits per year) or express limits based on the condition presented (e.g., a lifetime limit of $2 million for treatment, but a $5,000 limit on treatment for HIV/AIDS and AIDS-related conditions).[8]

Insurers also use certain distinct approaches to definitional drafting, including the drafting of medical necessity terms. An examination of cases involving medical necessity denials by private health insurers suggests that insurers typically use a definition of "medically necessary" that permits coverage only where a service is necessary to diagnose and treat an illness or injury or restore a patient to normal functioning.[9] The effect of such a definition would be to deny coverage for care and services otherwise included in a contract in those cases in which a patient has a "condition" rather than an illness or injury or where the patient's condition means that treatment will not "restore normal" functioning or "cure" a condition. The use of such a standard has obvious effects on children with special health care needs whose need for a covered treatment is based on the avoidance of further deterioration, the attainment of some level of functioning, or the maintenance of functional abilities.

Beyond using limiting medical necessity definitions, in recent years insurers have adopted a new coverage design practice that entails building standardized treatment guidelines directly into the face of the contract. This practice permits an insurer to exclude, on an irrebuttable basis and without any consideration of the individual facts of a patient's case, all but certain expressly enumerated treatments for certain conditions. In effect the incorporation of fixed and irrebuttable treatment guidelines into the contract of coverage itself eliminates all

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[8] Condition specific treatment limits and exclusions have been ruled lawful under private insurance under both ERISA and the Americans with Disabilities Act. *McGann v H. and H. Music Co.* 946 F. 2d 401 (5th Cir., 1991); *cert. den.* 506 U.S. 981(1992) (exclusion of treatment for AIDS does not violate ERISA anti-discrimination provisions); *Doe v Mutual of Omaha* 179 F. 3d 557 (7th Cir., 1999).

[9] See, e.g. *Bedrick v Travelers Insurance Co.* 93 F. 3d 149 (4th Cir., 1996) (denial of physical therapy for a child with cerebral palsy because the child could not achieve normal functioning); *McGraw v Prudential Insurance Co. of America* 137 F. 3d 1253 (10th Cir., 1998) (denial of physical therapy for a patient with multiple sclerosis on the ground that the treatment could not be "effective" and "required for the diagnosis or treatment of the particular sickness or injury" because therapy would not result in "improvement" and the condition was not "curable").

customized treatment decisions in which medical judgement is exercised in light of the individual facts of a patient's case.[10]

Coverage design in Medicaid. In terms of coverage design, Medicaid does not operate according to conventional insurance norms. It is well understood that Medicaid covers classes of benefits and services not typically found in commercial insurance products, such as in-home therapies, and long term institutional and home and community-based services. However, the distinctions between Medicaid and conventional insurance extend far beyond classes of benefits and reach into the inner workings of coverage design. This is particularly true in the case of children, where Medicaid coverage design principles are exceptionally broad.

Unlike private insurance, federal Medicaid law prohibits the use of arbitrary limitations and exclusions on required treatment.[11] Furthermore, because Medicaid's purpose in the case of children is preventive, federal amount, duration and scope standards prohibit the use of across-the-board limits, and exclusions based on standards other than medical necessity.[12] They also prohibit the use of irrebuttable, condition-specific treatment guidelines that eliminate individualized decision-making and measure treatment coverage in accordance with pre-fixed standardized norms.[13]

Most importantly, perhaps, the medical necessity standard that governs coverage design and coverage decision-making in the case of Medicaid-enrolled children is preventive and does not distinguish between treatment needed to restore normal functioning following illness or injury and treatment needed to address the consequences of a chronic health condition. In other words, the concept of medical necessity for children in the case of Medicaid reaches all treatments, whether needed to treat in the conventional insurance sense (i.e., to restore normal functioning following illness or injury), or to lessen or ameliorate the effects of a chronic physical or mental health condition, or to promote growth and development and maintain functioning. This special standard of medical necessity, which emanates from the

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[10] The clearest example of this is *Jones v Kodak Medical Assistance Plan* 169 F. 3d 1287 (10th Cir., 1999), in which a patient with alcoholism was precluded from appealing a coverage denial because the health plan documents prescribed fixed treatment guidelines that were the exclusive form of treatment available to her under her health plan. The incorporation of treatment into the face of the contract essentially eliminated her access to an individualized determination of what treatment was most appropriate to her condition.

[11] 42 C.F.R. §440.230(c).

[12] 42 C.F.R. §440.230(b). For a discussion of the special Medicaid principles that govern coverage of children see Sara Rosenbaum *et al., Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3d ed., Vol. 1) (Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, Washington, D.C., 1999), www.gwu.edu/~chsrp (click on "contract studies").

[13] *Massachusetts Eye and Ear Infirmary v Commissioner of the Division of Medical Assistance* 705 N.E. 2d 592 (Mass, 1999).

very purpose of Medicaid in the case of children, can be thought of as a "preventive" standard of medical necessity. Since the enactment of this special standard of coverage for children in 1967, courts have consistently struck down limitations that deviate from this deep purpose of health promotion and the mitigation of disability.[14] In short, in the case of children, Medicaid's special coverage rules and its preventive standard of medical necessity prohibit the use of fixed limits on services that are covered under state Medicaid plans. These special coverage design conventions require that, in the case of children, the need for treatment be considered in accordance with a preventive standard of coverage and on an individualized basis. Irrebuttable, standardized treatment guidelines would be prohibited, as would be the use of condition-related exclusions and across-the-board limitations on services.[15]

Finally, it is important to note that regardless of whether children receive Medicaid coverage directly from the state or through enrollment in some form of managed care, these terms of coverage do not change. While states can condition the receipt of coverage on managed care enrollment, their obligations to furnish coverage up to federal levels – either directly or through their contractors – remain unaffected.[16]

Coverage design and separately administered SCHIP plans. Under federal law, states have two basic choices in designing their SCHIP programs from a coverage point of view. A state may elect to use its federal SCHIP allocation to expand Medicaid coverage, in which case all federal Medicaid rules apply, including the special rules on coverage for children. Alternatively, a state may elect to design and operate a separately administered plan for some or all targeted low income children. States that elect to develop separate plans operate directly under the legal authority of the federal SCHIP statute,[17] which, at least in comparison to Medicaid, contains almost no federal standards related to coverage design.

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[14] These cases are reviewed in Sara Rosenbaum *et al.*, "An Overview of Medicaid Managed Care Litigation," *Issue Brief #2, Managed Behavioral Health Care Issue Brief Series* (Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, Washington, D.C., 1998), www.samhsa.gov.

[15] While Medicaid coverage rules for adults are broader than those used in conventional insurance, they are significantly narrower than those used for children.

[16] Sara Rosenbaum and Colleen Sonosky, "Federal EPSDT Coverage Policy," *Final Report to HCFA* (Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, Washington, D.C., December 2000), forthcoming at www.gwu.edu/~chsrp. §1932(b) of the Social Security Act, 42 U.S.C. §1396u-2(b). See also *J.K. v Dillenberg* 836 F. Supp. 694 (D. Ariz., 1993). The Balanced Budget Act of 1997 requires states to specifically disclose to managed care enrollees and their contractors which state plan services are part of their insurance contracts and which remain a direct obligation of the state. §1932(a)(5) and (b)(1) of the Social Security Act, 42 U.S.C. §§1396u-2(a)(5) and 1396u-2(b)(1).

[17] Title XXI of the Social Security Act, 42 U.S.C. §1397aa *et seq.*

An examination of federal SCHIP law underscores that SCHIP gives states the option to design their programs as a system of premium support rather than a legal entitlement to defined benefits.[18] Because premium support is designed to support the purchase of conventional insurance, separately administered SCHIP program must comply with relatively minimal federal standards. Under SCHIP, benefits are not "defined" as they are in the case of the federal Medicaid entitlement (although the definition of what *may* constitute "child health assistance" for purposes of federal financial participation is as broad as the one used in Medicaid).[19] Instead, state plans must achieve a certain level of "actuarial value" for "basic" services as well as any "additional" services included in the state's actuarial benchmark plan.[20]

The SCHIP statute does not contain federal amount, duration and scope coverage standards, nor does it contain minimum federal statutory principles of pediatric medical necessity. Furthermore, because separately administered SCHIP plans have the option of running in accordance with conventional insurance norms, federal legal principles of coverage under separately administered SCHIP programs would not prohibit the use of standardized treatment guidelines in coverage agreements with insurers or in programs directly administered by state SCHIP agencies.

In sum, states that elect to administer separate SCHIP plans have the legal discretion to make certain basic choices in coverage design that are not available under federal Medicaid law. However, a separate SCHIP plan can elect an approach to coverage design that adheres to Medicaid coverage principles. A state might make this choice because it desires to offer the broadest possible coverage for the children who receive assistance under its plan, even though it has opted for a separate program to avoid creating a legal entitlement.

Alternatively, a state could design its separate SCHIP program to parallel the principles of conventional insurance. With the exception of pre-existing condition exclusions and cost-sharing rules (which are permitted in most instances in conventional insurance but limited in SCHIP), a separately administered SCHIP plan could adopt coverage design rules that are designed to replicate conventional insurance. Table 1 summarizes certain key distinctions in coverage design between conventional insurance and Medicaid and summarizes the design options available to separate SCHIP plans.

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[18] For a discussion of state entitlement choices under SCHIP, see Sara Rosenbaum and Barbara Smith, *State SCHIP Design and the Right to Coverage* (Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, Washington, D.C., 2001), www.gwhealthpolicy.org.

[19] §2110 of the Social Security Act, 42 U.S.C. §1397jj.

[20] Basic services are inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Additional services are prescribed drugs, mental health services, vision services, and hearing services. §2103(b)(3) of the Social Security Act, 42 U.S.C. §1397cc(b)(3).

Table 1. Coverage Design Elements by Source of Coverage

Coverage Design Element	Type of Coverage: Conventional Insurance	Medicaid	Separate SCHIP Programs
Pre-existing condition exclusions and waiting periods	Permitted within HIPAA limits	Prohibited	Exclusions prohibited; waiting periods permissible within HIPAA limits
Classes of benefits	Limited to "major medical" care with certain preventive benefit additions in order to limit risk exposure	Broad classes of benefits, including care and services required by persons with special health care needs; all federal classes of services that fall within federal medical assistance definition are mandatory for children	States can elect to design in accordance with Medicaid or conventional insurance principles
Benefit definitions	Left to the discretion of the insurer	Typically defined in federal law	States can elect to design in accordance with Medicaid or conventional insurance principles
Limitations and exclusions	Typically included	No limitations where care is medically necessary and the service falls within the definition of medical assistance	States can elect to design in accordance with Medicaid or conventional insurance principles
Patient cost-sharing	Left to the discretion of the insurer and purchaser	Prohibited in the case of children under 18	Permissible within federal limits set forth in SCHIP law
Medical necessity	Left to the discretion of the insurer	Preventive pediatric standard	States can elect to design in accordance with Medicaid or conventional insurance principles

The implications of SCHIP coverage design choices. In the current health system, in which treatment and coverage decision-making become merged under principles of managed care,[21] studies of coverage design inevitably become an exploration of the standard of care that health plans furnish to patients. In the current health care framework, coverage is embedded in treatment; as a result, most coverage decisions inevitably become judgments regarding the "when and how" of treatment itself[22] and thus relate directly to the standard of care that may be available to patients.[23]

[21] *Pegram v Herdrich* 120 S. Ct. 2143 (2000) (eliminating the distinction between coverage decisions and health care quality in the case of most managed care treatment distinctions).
[22] *Id.* at 2157.
[23] This merger of macro and micro issues in coverage design and the standard of care can be seen in a growing number of managed care liability cases. See, e.g., *In re U.S. Health Care* 193 F. 3d 151 (3d Cir., 1999); *cert. den.*

This discussion of the relationship between coverage design and quality is relevant to SCHIP, just as it is central to modern Medicaid coverage design analyses. As Table 2 shows, most states with separately administered SCHIP programs use some form of managed care for children, and the majority maintain contracts for use with comprehensive service managed care organizations. Table 2 also shows that among the 26 states that maintain agreements with managed care organizations, 14 use contracts that are wholly separate from those used by the state Medicaid program, 11 states draft their SCHIP purchasing specifications as an addendum to their Medicaid agreements or incorporate them in their Medicaid agreements, and one state maintains both a separate contract for one component of its SCHIP program and a contract integrated with the Medicaid contract for another component of its SCHIP program

Table 2. Health Care Purchasing Arrangements under Separate SCHIP Programs

State (*)	Direct payment by state (no managed care contract)	Primary Care Case Management	Comprehensive Managed Care Arrangement (I/S)**
AK*			
AL	✔		
AZ			✔ (I)
AR*			
CA			✔ (S)
CO			✔ (S)
CT			✔ (S)
DE			✔ (I)
D.C.*			
FL***			✔ (MK: I; HK: S)
GA	✔		
HI*			
ID*			
IL			✔ (I)
IN			✔ (I)
IA			✔ (S)
KS			✔ (S)
KY			✔ (I)
LA*			
ME			✔ (I)
MD****			

120 S. Ct. 2182 (2000) (ERISA does not preempt vicarious and corporate liability claims against managed care company for the use of substandard treatment guidelines in the case of covered services to determine treatment of newborns); *Lazorko v Pennsylvania Hospital* 237 F. 3d 242 (3d Cir., 2000) (ERISA does not preempt claims for corporate and vicarious liability against managed care plan for the use of substandard treatment guidelines for covered services that allegedly incentivized a network physician to provide negligent treatment); *Pappas v Asbel* 2001 WL 327888 (ERISA does not preempt corporate and vicarious liability claims against a managed care company and its network physicians for failing to order covered treatment in accordance with an appropriate standard of care).

State (*)	Direct payment by state (no managed care contract)	Primary Care Case Management	Comprehensive Managed Care Arrangement (I/S)**
MA			✔ (I)
MI			✔ (S)
MN*			
MS			✔ (S)
MO*			
MT			✔ (S)
NE*			
NV			✔ (I)
NH			✔ (S)
NJ			✔ (I)
NM*			
NY			✔ (S)
NC	✔		
ND	✔		
OH*			
OK*			
OR			✔ (I)
PA			✔ (S)
RI*			
SC*			
SD		✔	
TN*			
TX			✔ (S)
UT			✔ (S)
VT		✔	
VA		✔	✔ (S)
WA			✔ (I)
WV	✔		
WI*			
WY	✔		
TOTALS	6	3	26

(*) A "*" after a state indicates that the state does not maintain a separate SCHIP program. **An "I" indicates that the SCHIP contract is integrated with the state's Medicaid contract. An "S" indicates that the SCHIP contract is separate from the Medicaid agreement.
*** Under the umbrella of "Florida KidCare," children are separated into 4 programs: Medicaid, MediKids (MK) (aged birth-4 years/not Medicaid eligible), HealthKids (HK) (aged 5-18 years/not Medicaid eligible) and Children's Medical Services (CMS) (children with special health care needs). **** Maryland's separate SCHIP program will be effective in July 2001.

Source: The George Washington University School of Public Health and Health Services (CHSRP).

Methods

This study was designed to analyze coverage design in separately administered SCHIP programs and the extent to which SCHIP coverage design is "tipped" toward conventional health insurance versus Medicaid. In order to conduct this study, researchers collected and analyzed state SCHIP plans in effect during 2000, using a research methodology that captures several of the key elements of coverage design discussed above. Specifically, we examined two issues. The first was the presence of benefit limitations and exclusions. The

second was the program's medical necessity definition. We also examined a data base of standard contracts for use by separately administered SCHIP programs in their business dealings with managed care organizations in order to assess the extent to which these contracts prohibit the use of standardized treatment guidelines in making treatment decisions.

Analysts examined 34 separately administered SCHIP plans, along with 15 managed care contracts that were separate from the state's Medicaid agreement with managed care organizations, three primary care case management contracts, and 12 Medicaid managed care contracts. The review of these state SCHIP plans and contract documents was structured to analyze and typologize state plan and contract design in accordance with a methodology that reflects certain critical distinctions between Medicaid and conventional health insurance. Specifically, the review was structured to identify the following issues:

- *Treatment classes*: whether the state SCHIP plans captured all classes of benefits covered under federal Medicaid law, and whether the documents specified amount, duration and scope limitations that would not be applicable in Medicaid;

- *Vision, dental and hearing services*: whether the state SCHIP plans covered these services, and if covered, whether the documents imposed amount, duration and scope limitations;

- *Medical necessity*: whether the state SCHIP plans and/or contracts defined the standard used in separately administered programs to calibrate benefit limitations and to make individual decisions regarding whether covered services would be furnished to an enrolled child; and

- *The use of standardized and irrebuttable treatment guidelines:* whether standard contracts with managed care organizations prohibited contractors, in their treatment decisions for covered services, from using irrebuttable, standardized treatment guidelines.

Where a state adopts the full Medicaid benefit package and the Medicaid medical necessity definition, and prohibits the use of irrebuttable guidelines, the state would be considered in this typology to be "tipped" toward Medicaid despite the absence of Medicaid's open-ended entitlement feature.[24] This is because, from a structural point of view, its benefit design virtually replicates the pediatric component of Medicaid.

Where a state introduces amount, duration and scope limits, excludes benefit classes, or fails to expressly adopt Medicaid's preventive medical necessity standard (either through its own

[24] For further information, see *State SCHIP Design and the Right to Coverage*, *supra*, note 17.

choice or by delegating the power to define the term to its contractor), its program could be considered to be "tipped" toward conventional health insurance. The degree of "tipping" depends on whether a state uses one, two, three, or all four devices (exclusions, limitations, more restrictive medical necessity definitions, and prohibitions on irrebuttable guidelines) to "tip" its plan.

Results

Results are summarized on Tables 3 through 5.

Coverage exclusions and limitations. The results of the SCHIP state plan reviews are summarized on Table 3. As Table 3 shows, every state that administers a separate SCHIP program tips its plan toward insurance principles and away from Medicaid. All states tip their programs through the use of limitations with respect to treatment services and with respect to vision, dental and hearing services; all but two states tip their programs through the use of exclusions; and six states use a more restrictive definition of medical necessity under their state SCHIP programs and 15 states fail to specify the more expansive definition as a matter of basic program design. The same six states that use a more restrictive definition of medical necessity—Colorado, Delaware, Iowa, Mississippi, Montana, and South Dakota—use all three devices (i.e., exclusions, limitations, and more restrictive definition of medical necessity).

Certain distinct patterns emerge from the analysis of state SCHIP plans regarding the types of benefits exclusions and limitations that are most likely to be present. In the case of treatment for medical conditions, all but two states exclude one or more categories of services (or sub-classes of services) that fall within the statutory definition of "child health assistance." Services that tend to be excluded entirely are hospice services, case management services, enabling services, care coordination, home and community based services, long term inpatient rehabilitation services, private duty nursing services, and physical and speech therapy. While only certain medical treatment services that fall within the definition of "child health assistance" are excluded entirely, Table 3 also shows that virtually all states place limits on amount, duration and scope of treatment as part of their coverage design. Non-emergency transportation, a mandatory service under Medicaid, also tends to be entirely excluded from separate SCHIP plans.

Certain services commonly used by children with developmental and mental disabilities appear to be more likely to contain exclusions and limitations than others. This is particularly true in the case of outpatient mental health services, physical and occupational therapy, and speech therapy.

In the case of vision, dental and hearing care, Table 3 also shows that far fewer states entirely exclude any one of these classes of services. Dental care and audiology services are two classes of service that are equally excluded. While total exclusions are less common, coverage limitations are extremely common. All states limit these services to some degree. Typical examples of service limitations related to vision, dental and hearing include coverage of dental services for the treatment of injury only or up to a certain dollar amount (e.g., $600 or $1,000 per year).

Medical necessity. States' approaches to medical necessity are particularly striking. Table 4 shows whether the 34 SCHIP plans explicitly indicate which standard of medical necessity applies and/or provide a definition of the standard, with a special focus on whether the standard follows the Medicaid preventive standard. Of the 34 states with separately administered SCHIP programs, 15 states do not build any definition into their state program coverage design. Of those, eight contract with managed care organizations, six pay directly for services, and one uses primary care case management (Table 2). Since the majority of these states contract with managed care organizations, this finding suggests that these states elect instead to delegate the authority to define medical necessity to contractors, which would be consistent with a state's desire to use its SCHIP flexibility to foster conventional insurance design principles rather than the unique standards employed by Medicaid.

As Table 4 shows, however, 19 states do specify a medical necessity definition either in their state SCHIP plan documents, their contracts (whether separate from or integrated with Medicaid), or both. Although most states do not provide a medical necessity definition in their state SCHIP plans, they do so in their managed care contracts. In addition, while the standard should be defined in both the state plan and the managed care contract, this is the case in only four states (Connecticut, Iowa, Kansas, and Pennsylvania).

Table 5 sets forth the medical necessity definitions found in the state SCHIP plans, the contracts, or both types of documents. Among the 19 states that specify a medical necessity definition, 13 states appear to have expressly adopted a definition that could be construed as satisfying the preventive standard of the Medicaid program. The remaining definitions take a more conventional insurance approach, limiting coverage to treatment for illnesses and injuries and eschewing any notion of treatment to attain functioning, maintain functional status, or avert the deterioration of functioning. Of note, among the 18 contracts with a definition, the preventive definition was present more often in contracts integrated with Medicaid (eight states) than in separate contracts (five states), and the more limited definition was present more often in separate contracts (four states) than in contracts integrated with Medicaid (one state).

Irrebuttable standardized treatment guidelines. We were unable to find any managed care organization contracts that specify the authority of the contractor to apply irrebuttable standardized treatment guidelines to individualized treatment decisions with respect to covered services under the contract. A state's silence on this practice, which is an emerging custom and practice under conventional insurance, would likely be construed as sanctioning the practice, particularly in those states in which the basic design of the state SCHIP program is premium support: that is, where the state appears to intend to use its SCHIP allocations to replicate conventional insurance for low income uninsured children rather than to extend the special coverage afforded by Medicaid.

Conclusion

The findings from this study suggest that when states are given flexibility to exercise coverage design discretion in the case of near-poor and low income children, they will tip their choices in the direction of conventional insurance and away from the unique principles of the Medicaid program. This choice of design shows up in four distinct respects, three of which relate to macro design questions and one of which relates to micro design questions. The findings in this study also suggest that the tipping tends to occur in relatively subtle ways that are comprehensible only through a detailed study that examines the inner workings of insurance design from the viewpoints of both Medicaid and conventional insurance.

In the area of macro design, the tendency to tip toward conventional insurance shows up in several ways. Certain services and benefits that would qualify for federal financial participation nonetheless are entirely excluded. The use of total exclusions tends to be focused on services used by children with special health care needs, including those with severely disabling conditions: private duty nursing, hospice care, long term institutional placements, and medical case management. Several states do, in fact, however also exclude one or more classes of far more basic vision, dental, and hearing care.

Second, the use of coverage limitations is extremely common in SCHIP benefit design. Virtually all states include in their SCHIP designs coverage limitations that would not apply to children enrolled in Medicaid. Coverage limits are especially prevalent in the case of services used by children with mental and developmental disabilities, but also are common in the areas of durable medical equipment, and prescribed drugs. These areas all are typically subject to coverage limitations in the case of conventional insurance.

In theory, coverage limits are a less stringent form of design choice than a total exclusion. However, depending on the point at which it is calibrated, an across-the-board coverage limitation may affect children with special health care needs who have mild, or moderate or severe disabilities. Even where a coverage limit is nominally high and thus calibrated to curb

only the heaviest utilization, it may be that the presence of *any* across-the-board limit results in a curb on resource consumption, as providers pursue certain treatments less aggressively to avoid exhaustion of a benefit lest it should be unavailable at some future point when it is "really" needed.

The findings from this study suggest that SCHIP separate programs also depart from the hallmark of Medicaid for children, i.e., the preventive standard of medical necessity. By avoiding the overt use of a preventive standard of medical necessity, the sponsor signals that coverage is to be limited to the rules of conventional insurance and that limits are to be interpreted in accordance with insurance conventions – i.e., that treatment is to occur when there is an illness or injury and when the intervention can be "effective" in the conventional sense by restoring normal health and functioning. The protocol in these cases is to avoid extensions of coverage that would flip the plan from one modeled on conventional insurance to one that reflects the unique standards of Medicaid.

The findings from this study underscore that states do not follow Medicaid coverage principles when designing programs for near-poor children. The Medicaid preventive standard is singular in its extension of coverage to cases in which care is necessary to attain or maintain growth and development or prevent deterioration in long term functioning. Were a state to want to retain this standard for children in separately administered SCHIP plans, legal conventions would necessitate that the state make this issue clear in its design documents, particularly in a case in which the state contracts with private insurers. Clear adoption of this unique coverage standard would be essential to signal health plans and providers that the state's intention is to sustain this unique level of coverage. Where a state is silent on this matter, it is doubtful that, were a child who needed care for growth and functional purposes to appeal a coverage denial,[25] a court or other independent reviewing entity care would hold the coverage to Medicaid levels. Indeed, the very separation of SCHIP from Medicaid, accompanied by the state's express failure to include the Medicaid medical necessity standard in its SCHIP plan, probably would be interpreted as a signal that these conventions are not to be applied under separate SCHIP programs.

In addition, these findings indicate that states do not explicitly prohibit the use of irrebuttable standardized norms in treatment decision-making involving covered services.

[25] It is not clear that children have legal rights to appeal denials under separate SCHIP plans. There is no individual federal right to enforce SCHIP. See *State SCHIP Design and the Right to Coverage, op. cit., supra*, note 17. Furthermore, it is not known how many states extend to SCHIP enrolled children an individual right of action to enforce their eligibility for coverage under state administrative or insurance law. For example, while more than 40 states maintain systems of external review for health plan treatment decisions, it is not known whether these external review systems cover beneficiaries whose enrollment is funded by SCHIP. A forthcoming Policy Brief in this series will examine grievance and appeals rights under SCHIP managed care organization contracts.

This is a growing insurer practice and one that effectively removes the need to conduct individualized treatment decisions. The impact of this evolving practice would be most significantly felt on children with low prevalence, significant physical and mental health conditions that merit customized treatment approaches because of the severity or complexity of their conditions or the co-existence of two or more conditions.

The findings from this study suggest that, consistent with the discussions that accompanied SCHIP's initial enactment and its federal legal structure, states that adopt separate SCHIP programs do so because they fundamentally view SCHIP as a means of extending conventional insurance to children who otherwise would have none. This view of the program explains the omission of certain low prevalence services for children with special health care needs as well as the elimination of non-emergency transportation and the adoption of a conventional definition of medical necessity. These particular services and coverage rules are almost non-existent in standard insurance policies.

Using a conventional insurance approach in SCHIP eliminates certain problems that plague Medicaid. Because Medicaid's coverage rules are unique, state agencies that contract for conventional insurance coverage from managed care organizations effectively retain extensive residual liability for services that are part of the plan but external to the contract.[26] By adopting conventional insurance norms and practices, separately administered SCHIP programs can avoid much of this problem (although not all, since SCHIP cost-sharing rules are more stringent than those used in conventional insurance).

An important question for future policy decisions is whether, were they given the choice to do so, states would adopt conventional insurance norms in lieu of the special rules that govern Medicaid coverage of children. Indeed, in its recent policy statements the National Governors' Association (NGA) has called for greater flexibility in coverage design under Medicaid.[27]

States might retain Medicaid's structure in the case of poor children; both the NGA documents and informal discussions with state officials suggest that states view the poorest children in significantly worse health and in far greater need of comprehensive coverage. However, studies that examine the health status of children do not find dramatic differences between low income children and poor children in the prevalence of disabling conditions. While low income has been found to be associated with reduced health status among children, the variables used to measure low income have not been precise enough to

[26] Sara Rosenbaum *et al.*, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (1st ed., Vol. 1) (Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, Washington, D.C., 1997).
[27] See NGA Policy Statement (February 26, 2001) (Washington, D.C., Winter Meeting), pp. 35-38.

distinguish between low income and poverty levels. Put another way, there is no reason to believe that a child with family income equaling 140% of the federal poverty level is in significantly better health and at significantly reduced risk for disability than a child whose monthly income is 100% of the federal poverty level. For a family of three, the difference in monthly income in these two cases would be $5,660, using the 2000 federal poverty guidelines, not enough to eliminate coverage of treatments for chronic and disabling conditions.

Which children would be most affected by this move away from Medicaid rules and toward insurance conventions? We believe that the implications would be greatest for two types of children with special health care needs. The first are children with profound and potentially life threatening disabilities who need customized care of great intensity, such as ongoing therapies, private duty nursing, institutionalization, and hospice care. A considerable body of literature suggests that this group of children is exceedingly small.

The second group of children is significantly larger and potentially harder to spot. These are children with physical, cognitive, and mental disabilities and delays that are perhaps not profound but that nonetheless are sufficient to cause limitations in daily activities and thwart normal growth and development. It is these children for whom Medicaid's preventive medical necessity standard may be the most important. The elimination of this standard, therefore, can be expected to have its most important impact on these children.

The question is who will pay for this cluster of services for children with special health needs if Medicaid and SCHIP do not. In some states, the Title V Maternal and Child Health Services Block Grant Program may be a logical source of funding for children with extremely serious physical disabilities and conditions. But most Title V programs do not fund services for children with mental and developmental disabilities and delays. For these services one would have to look to special education programs, state block grants for mental illness and mental retardation, and other grant-style programs.

Because this analysis was designed as an in-depth study of coverage design, it does not shed light on the actual impact of these facial choices on coverage, access and quality of health care for children with special health care needs. However, these findings do suggest important areas for health services research. Of particular importance is research that examines the actual process of coverage and treatment decision-making under separate SCHIP programs in the case of children with serious conditions. It could be that state plans and managed care organizations routinely provide extra-contractual services by overriding otherwise applicable limits in the case of higher needs children. This is probably unlikely, particularly where it is a managed care organization that makes the decision, since the premium it receives would not have been calibrated to tolerate this type of practice. Studies

of state Medicaid treatment decision-making in the case of children suggest that when state agencies make their own decisions regarding treatment for children with serious conditions, they are more likely to approve covered treatments than are insurers.[28] Whether separately administered SCHIP programs act similarly cannot be known from this study.

These issues and research questions can only be expected to increase in importance as interest in reforming public insurance programs for lower income children and families intensifies.

[28] B. S. Finkelstein *et al*., "Insurance Coverage, Physician Recommendations, and Access to Emerging Treatments," 279 *JAMA* 663-68 (1998).

Table 3. Coverage Design under Separately Administered SCHIP Plans (as of 2000)

State	Medical Treatment		Vision, Dental and Hearing	
	Exclusions	A, D and S Limits	Exclusions	A, D and S Limits
AL	Y	Y	N	Y
AZ	Y	Y	N	Y
CA	Y	Y	N	Y
CO	Y	Y	N	Y
CT	Y	Y	N	Y
DE	Y	Y	Y[1]	Y
FL	Y	Y	N	Y[2]
GA	Y	Y	N	Y
IA	Y	Y	N	Y
IL	Y	Y	N	Y
IN	Y[3]	Y	N[4]	Y
KS	Y	Y	N	Y
KY	Y	Y	N	Y
MA	Y	Y	N	Y
ME	Y[6]	Y	N	Y
MI	Y	Y	N	Y
MS	Y	Y	N	Y
MT	Y	Y	N	Y
NC	Y	Y	N	Y
ND	Y	Y	N	Y
NH	Y	Y	N	Y
NJ	Y[7]	Y	Y[8]	Y
NY	Y	Y	N	Y
NV	Y	Y	N	Y
OR	Y[9]	Y	N	Y
PA	Y	Y	N	Y
SD	Y[10]	Y	N	Y
TX	Y	Y	N	Y
UT	Y	Y	N	Y
VT	N[11]	Y[12]	N[13]	Y[14]
VA	Y[15]	Y[16]	N	Y[17]
WA	N[18]	Y[19]	N	Y[20]
WV	Y	Y	N	Y
WY	Y[21]	Y	N	Y
34	32 (94%)	34 (100%)	2 (6%)	34 (100%)

▢ = States with combination plans

Source: The George Washington University School of Public Health and Health Services (CHSRP).

NOTES

[1] Dental excluded; vision and hearing covered.
[2] Limits on dental only.
[3] EPSDT covered.
[4] Not clear if hearing is covered.

[5] The plan does not specify whether it uses the Medicaid standard but it includes a preventive standard similar to Medicaid (see Tables 4 and 5).
[6] EPSDT covered.
[7] EPSDT covered, but limited to vision, hearing, and dental.
[8] Hearing aids and audiology services are not covered under NJ KidCare Plan D, which covers children whose family income is between 200 and 350 percent of the federal poverty level, but vision and dental are. All three types of services are covered under NJ KidCare Plan B and Plan C, which cover children whose family income is between 133 and 200 percent of the federal poverty level.
[9] Oregon provides the Medicaid benefit package based on the Oregon Health Plan Prioritized List of Health Services as funded by the State of Oregon Legislature.
[10] EPSDT covered.
[11] All SCHIP eligible children have access to the full range of services covered by Medicaid. The majority of services are provided through one of the contracted managed care organization; the remainder is covered through the fee-for-service delivery system.
[12] Covered services are subject to the same limits as Medicaid.
[13] Not clear if hearing is covered.
[14] Covered services are subject to the same limits as Medicaid.
[15] EPSDT covered.
[16] The state's EPSDT standard applies.
[17] The state's EPSDT standard applies.
[18] The Washington SCHIP plan provides the same scope of coverage available under its Medicaid program, i.e., medically necessary services available to children eligible for Categorically Needy Medicaid, which includes EPSDT.
[19] Covered services may require prior approval or have other requirements.
[20] Covered services may require prior approval or have other requirements.
[21] EPSDT covered.

Table 4. Medical Necessity Standards in Separately Administered SCHIP Programs (as of 2000)

State	Plan explicitly indicates which standard applies	Plan provides definition	Contract provides definition	Plan or contract provides definition	Plan or contract uses a preventive definition
AL			(*)		
AZ	✔(Medicaid)		✔(Preventive)[3]	✔	✔
CA					
CO			✔(Other)	✔	
CT	✔(Medicaid)	✔(Preventive)	✔(Preventive)	✔	✔
DE			✔(Other)	✔	
FL			✔(Preventive) [4]	✔	✔
GA	✔(Medicaid)		(*)		
IA	✔(Other)	✔(Other)	✔(Other)	✔	
IL					
IN	✔(Medicaid)				
KS	[1]	✔(Preventive)	✔(Preventive)	✔	✔
KY			✔(Preventive)	✔	✔
MA			✔(Preventive)	✔	✔
ME			✔(Preventive)	✔	✔
MI					
MS			✔(Other)	✔	
MT			✔(Other)	✔	
NC	✔(Other)		(*)		
ND			(*)		
NH	✔(Medicaid)		✔(Preventive)	✔	✔
NJ					
NY					
NV			✔(Preventive)	✔	✔
OR	✔(Medicaid)		✔(Preventive)[3]	✔	✔
PA	✔(Other)	✔(Other)[2]	✔(Preventive)	✔	✔
SD	✔(Medicaid)	✔(Other)	(**)	✔	
TX			✔(Preventive)	✔	✔
UT					
VT	✔(Medicaid)		(**)		
VA	✔(Medicaid)		[5]		
WA			✔(Preventive)	✔	✔
WV	✔(Other)		(*)		
WY	✔(Medicaid)		(*)		
34	14 (41%)	5 (15%)	18 (53%)	19 (56%)	13 (38%)

□ = States with combination plans

Source: The George Washington University School of Public Health and Health Services (CHSRP).

NOTES

(*) State does not maintain a managed care contract under its separate SCHIP program (i.e., state pays directly for services).
(**) State uses Primary Care Case Management (PCCM) under its separate SCHIP program.

(1) The Kansas plan does not specify whether it uses the Medicaid standard but it includes a preventive standard similar to Medicaid (see Table 5).
(2) Definition found in the BlueCHIP Handbook submitted by the participating insurer to the state and provided by the state as an attachment to the Pennsylvania plan. This study's assumption is that the preventive definition in the separate managed care contract overrides this one.
(3) Arizona and Oregon only provide a definition of medical necessity in their Medicaid behavioral contract and Medicaid mental health contract, respectively.
(4) Florida uses a contract integrated with the Medicaid contract for MediKids (aged birth-4 years/not Medicaid eligible) and a separate contract for Healthy Kids (aged 5-18 years/not Medicaid eligible).
(5) Virginia's separate contract refers to the Medicaid medical necessity definition without providing it. A definition was found in the state's Medicaid contract, but is too vague to determine whether it is preventive.

Table 5. Medical Necessity Definitions in Separately Administered SCHIP Programs (as of 2000)

State	Definition
AL	---
AZ	Definition in Medicaid managed care contract: "MEDICALLY NECESSARY SERVICES Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life." Arizona Behavioral Health Contract, page 6.
CA	---
CO	Definition in separate managed care contract: "Z. 'Medically Necessary,' or 'Medical Necessity:' A Covered Service shall be deemed Medically Necessary if, in a manner consistent with accepted standards of medical practice, it is: 1. consistent with the symptom, diagnosis and treatment of a Member's medical condition; 2. widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence; 3. not Experimental or Investigational; 4. not solely for cosmetic purposes; 5. not solely for the convenience of the Member, Subscriber, physician or other provider; 6. the most appropriate level of care that can be safely provided to the Member; and, 7. failure to provide the Covered Service would adversely affect the Member's health. When applied to inpatient care, Medically Necessary further means that Covered Services cannot be safely provided in an ambulatory setting." Colorado CHIP Contract, pages 7-8.
CT	Definition in state SCHIP plan: "Section 3. General Contents of State Child Health Plan… 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children:… For both Parts A and B, the Medicaid definition of medical necessity will prevail. "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring. Medically necessary behavioral health services for children in Medicaid Managed Care shall include: • The coordination of and linkage to those social and medical services which ensure the health and safety of the child; • Preventive health care services that are designed to avoid the need for future medically necessary services; • Services for chronic, long-term disorders which, if left untreated, will affect the physical or mental health of the child; and • The duration of treatment provided by a managed care health plan for these children shall be based on the individual needs of the child." Connecticut SCHIP plan, p. 4-5. Definition in separate managed care contract: "When responding to this proposal, MCP's are advised that the Medicaid definition of 'Medical Necessity' will prevail: 'Medical Necessity or Medically Necessary' means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring. Medically necessary behavioral health services for children shall include: • The coordination of and linkage to those social and medical services which ensure the health and safety of the child; • Preventive health care services that are designed to avoid the need for future medically necessary services; • Services for chronic, long-term disorders which, if left untreated, will affect the physical or mental health of the child; and • The duration of treatment provided by a managed care health plan for these children shall be based on the individual needs of the child." Connecticut Husky B RFP, Section I, page 3.
DE	Definition in Medicaid managed care contract: "Appendix R MEDICAL NECESSITY DEFINITION MEDICAL NECESSITY is defined as: the essential need for medical care or services (all covered State Medicaid Plan services, subject to age and eligibility restrictions and/or

State	Definition
	EPSDT requirements) which, when prescribed by the beneficiary's primary physician care manager and delivered by or through authorized and qualified providers, will: - be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition) and be provided to the beneficiary only; - be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities and environment) of the beneficiary and the beneficiary's family; - be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary's family, or the beneficiary's provider (this means that services which are primarily used for educational, vocational, social, recreational, or other non-medical purposes are not covered under the Medicaid program); - be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time; - be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds; - be the most appropriate, available health service alternative, and will represent an effective and appropriate use of program funds; - be sufficient in amount, scope, and duration to reasonably achieve its purpose; - be recognized as either the treatment of choice (i.e. prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; - be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay; and will be reasonably determined to: - diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or - restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition or - provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition, in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safely, and integration into all natural family, community and facility environments and activities." Delaware RFP, Appendix R, pages R.1-R.2.
FL	Definition in Medicaid managed care contract: "47. Medically Necessary or Medical Necessity - services provided in accordance with 42 CFR Section 440.230 to include that medical or allied care, good, or services furnished or ordered must: (a) Meet the following conditions: 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain; 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, as not in excess of the patient's needs; 3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. (b) 'Medically necessary' or 'medical necessity' for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. (c) The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in itself, makes such care, goods or services medically necessary or a medical necessity or a covered service." Florida Contract, pages 156-157. "27. Medically Necessary - … medically necessary is the requirement that the goods and services provided or ordered must be: a. Calculated to prevent, diagnose, correct, cure, alleviate or preclude deterioration or a condition that threatens life, causes pain or suffering, or results in illness or infirmity; b. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; c. Necessary and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; d. Reflective of the level of service that can be safely provided, and for that no equally effective and more conservative or less costly treatment is available; and e. Provided in a manner not primarily intended for convenience of the recipient, the recipient's caretaker, or the provider." Florida Contract, page 166. “YY. Medically Necessary - The requirement that the goods and services provided or ordered must be: 1. Calculated to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity;

State	Definition
	2. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; 3. Necessary and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; 4. Reflective of the level of service that can be safely provided, and for which no equally effective and more conservative or less costly treatment is available; and 5. Provided in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." Florida Mental Health RFP, pages 16-17.
GA	---
IA	Definition in state SCHIP plan: **"HAWK-I Evidence of Coverage** **Iowa Health Solutions** **Part I. Definitions** **Medically Necessary –** The use of services and/or supplies, as described in this Evidence of Coverage, which are required to identify or treat Your illness or injury and which are: a. Consistent with the symptoms or diagnosis and treatment of Your condition, disease, ailment or injury; b. Appropriate, safe, and effective with regard to standards of good medical practice; c. Not solely for Your convenience, Your physician, Hospital, or other health care provider; d. Consistent with the most appropriate supply or level of service which can be safely provided to You. When applied to an inpatient, it further means that Your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to You as an outpatient; and e. Consistent with medical policy and procedure as defined by the Iowa Health Solutions Quality Management Program." Iowa SCHIP plan, Attachment AA, p. 3,5. "**BENEFITS POLICY** **CLASSIC BLUE** **HAWK-I** **IMPORTANT INFORMATION** **QUESTIONS WE ASK WHEN YOU RECEIVE HEALTH CARE** Even though a service may appear in SECTION 1: BENEFITS, you should know that, before you are eligible to receive benefits, we first answer all of the following questions: **Is The Service Medically Necessary?** All services must be medically necessary. We decide what is medically necessary and our decision is final and conclusive. Medically necessary means those covered services that are determined to be: • *Appropriate and necessary* for the symptoms, diagnosis, or treatment of your condition. • *Provided for the diagnosis* or direct care and treatment of the condition and enabling you to make reasonable progress in treatment. • *Within standards of professional practice* and given at the appropriate time and in the appropriate setting. • *Not primarily for your convenience* or the convenience of your physician or other provider. • *The most appropriate level of covered services* which can safely be provided." Iowa SCHIP plan, Attachment CC, p. 5, 6-7. **GLOSSARY** **Medically Necessary** means a covered procedure, service, or supply that we consider eligible for benefits under this policy. All covered services must be *medically necessary*. We decide what is medically necessary and our decision is final and conclusive. Even though your provider may recommend a procedure, service, or supply, the recommendation doesn't always mean the care is medically necessary. *Medically necessary* means those covered services that are all of the following: • *Appropriate and necessary* for the symptoms, diagnosis, or treatment of your condition. • *Provided for the diagnosis* or direct care and treatment of the condition and enabling you to make reasonable progress in treatment. • *Within standards of professional practice* and given at the appropriate time and in the appropriate setting. • *Not primarily for your convenience* or the convenience of your physician or other provider. • *The most appropriate level of covered services* which can safely be provided." Iowa SCHIP plan, Attachment CC, p. 43. [#] "…**JOHN DEERE HEALTH PLAN, INC**. … …**EVIDENCE OF COVERAGE**… **ARTICLE III-SCHEDULE OF MEDICAL BENEFITS**… 3.2 Benefits will be paid only for a service or a treatment, hospital, medical or otherwise, which is medically necessary. To be medically necessary, the service or the treatment must meet the following criteria as determined by the Attending Physician and be authorized in advance and on a timely basis by the medical director of JDHP:

[#] Unity Choice, added in 1999 to the choice of health plans available under the separate SCHIP plan, uses the same definition as Classic Blue. Wellmark Health Plan of Iowa owns both plans.

State	Definition
	3.2.1 The service or the treatment must be consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Member's medical condition; and 3.2.2 The service or the treatment must be performed in the most cost effective way in terms of the treatment, the method, the setting, the frequency and the intensity, taking into consideration the Member's medical condition." Iowa SCHIP plan, Third Amendment, March 8, 2000 letter attachment, Contract between HAWK-I Program Administrator and John Deere Health Plan, Inc., p. 3, 4. **DEFINITION USED UNDER THE BENCHMARK PLAN** "PRINCIPAL HEALTH CARE OF IOWA, INC.SM CERTIFICATE OF COVERAGE **SECTION 1** **DEFINITIONS OF TERMS USED IN THIS CERTIFICATE** **'Medically Necessary' –** those Health Services which are determined by Health Plan to be necessary to meet the basic health needs of an individual. Determination of Medical Necessity is done on a case-by-case basis and considers several factors including, but not limited to, the standards of the medical community. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular Injury, Sickness or Mental Illness does not mean that it is Medically Necessary. In addition, the service must: (1) be consistent with the diagnosis of and prescribed course of treatment for the patient's condition or be generally accepted by the medical community as a preventive Health Service; (2) be required for reasons other than the convenience of the patient or his or her Physician or not be required solely for custodial, comfort or maintenance reasons; (3) be performed in the most cost-efficient type of setting appropriate for the condition, and (4) be rendered at a frequency which is accepted by the medical community as medically appropriate." Iowa SCHIP plan, June 7, 1999 letter attachment, p.1, 4. Definition in separate managed care contract: "p. Medically Necessary Services - means those Covered Services that are, under the terms and conditions of this Contract, determined through Plan utilization management to be: (1) Appropriate and necessary for the symptoms, diagnosis, and treatment of the condition of the Enrollee. (2) Provided for the diagnosis or direct care and treatment of the condition of the Enrollee enabling the Enrollee to make reasonable progress in treatment. (3) Within standards of professional practice and given at the appropriate time and in the appropriate setting. (4) Not primarily for the convenience of the Enrollee, the Enrollee's physician or other Provider, and (5) The most appropriate level of Covered Services, which can safely be provided." Iowa CHIP Contract, page 2.
IL	---
IN	---
KS	Definition in state SCHIP plan: "**OVERVIEW OF THE BENEFITS SCHEDULE** **Medical Necessity:** In addition to the basic benefits package below, contractors must provide all medically necessary services to children insured by this program. Determination of medical necessity may be made on a prior authorization, concurrent or post-utilization basis, must be in writing and must be based upon the following standards, the satisfaction of which will result in authorization of the service: i) the service or benefit is necessary to prevent the onset of an illness, condition or disability; ii) the service or benefit is necessary to reduce or ameliorate the effects of an illness, injury, disability, disorder or condition; iii) the service or benefit will aid in the individual's overall physical and mental growth and development; iv) the service will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age. Determinations of medical necessity shall be based on information provided by the individual's primary care provider, as well as any other providers, programs and agencies that have evaluated the child." Kansas SCHIP plan, Attachment A, p. 23. Definition in separate managed care contract: "SECTION X BENEFITS PACKAGE 10.1. This plan proposes a standard benefits package. Indicate your ability and willingness to provide the services detailed in Attachment 3. 10.2. Medical Necessity. In addition to the basic benefits package in Attachment 3, contractors must provide all medically necessary

State	Definition
	services to children insured by this program. Determinations of medical necessity may be made on a prior authorization, concurrent or post-utilization basis, must be in writing and must be based upon the following standards, the satisfaction of any one of which will result in authorization of the service: i) the service or benefit is necessary to prevent the onset of an illness, condition or disability; ii) ii) the service or benefit is necessary to reduce or ameliorate the effects of an illness, injury, disability, disorder or condition; iii) the service or benefit will aid in the individual's overall physical and mental growth and development; iv) the service will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age. Determinations of medical necessity shall be based on information provided by the individual's primary care provider, as well as any other providers, programs and agencies that have evaluated the child. 10.2.1 Appeal Procedure. Describe the procedure you will utilize to resolve disputes regarding 'medical necessity.' This process must also be a part of the grievance process outlined in RFP Section 3.5.3." Kansas CHIP RFP, page 43.
KY	Definition in Medicaid managed care contract: "Medically Necessary Health Services means age appropriate services reasonable and necessary to diagnose and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care generally accepted at the time services are provided, and in accordance with 42 C.F.R. §440.230, including services for children authorized under 42 U.S.C. 1396d(r)." Kentucky Contract, page 14. "Kentucky Medicaid covers only medically necessary services." Kentucky RFA, Attachment VIII, page 62.
MA	Definition in Medicaid managed care contract: "SECTION 1. DEFINITION OF TERMS... Medically Necessary - those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no comparable medical service or site of service available or suitable for the Enrollee requesting the service that is more conservative or less costly; and (3) are of a quality that meets generally accepted standards of health care…" Massachusetts Contract, pages 6-13. "SECTION 2: DEFINITIONS The following terms shall have the meaning stated, as they appear hereunder, unless the context clearly indicates otherwise…" Massachusetts MH/SAP Contract, Appendix A, page 6. "Medical Necessity Criteria - shall mean minimal criteria used to determine the most clinically appropriate and necessary level of care and intensity of services as set forth in Appendix E to this Contract to ensure the provision of Medically Necessary Services. Medically Necessary Service - shall mean those mental health and/or substance abuse services which are: 1) reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity, and 2) there is no other equally effective course of treatment available or suitable for the Enrollee requesting the service that is more conservative or substantially less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality…" Massachusetts MH/SAP Contract, Appendix A, page 12.
ME	Definition in Medicaid managed care contract: "II. DEFINITIONS. A. The following terms used in this Contract shall be interpreted as defined herein, except to the extent that the context may clearly require otherwise: ... 40. Medical Necessity is defined as health care services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury." Maine Contract, pages 2, 7.
MI	---
MS	Definition in separate managed care contract: "Medically Necessary - Prescription Drugs, Health Care Services or Supplies required to identify or treat the illness or injury, which a Physician or Allied Health Professional has diagnosed or reasonably suspects. The Prescription Drugs, Health Care Services or Supplies must be (1) consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (2) in accordance with the standards of good medical practice found in established managed care environments; (3) required for reasons other than the convenience of the patient or his Provider; (4) the most appropriate Prescription Drug, Supply or level of service which can be safely and efficiently provided to the patient. When applied to the care of an inpatient, it further means that the patient's medical symptoms or condition require that the services cannot safely be provided to the patient as an outpatient. The fact that a Physician or Allied Health Professional has prescribed, ordered, recommended, or approved a Prescription Drug, Health Care Service or Supply does not in itself, make it Medically Necessary.

State	Definition
	The Company makes no payment for services, treatments, procedures, equipment, drugs, devices, items or supplies which are not documented to be Medically Necessary. The fact that a Physician or other Provider has prescribed, ordered, recommended, or approved a service or supply does not in itself, make it Medically Necessary." Mississippi CHIP Benefit Plan, page 28.
MT	Definition in separate managed care contract: "Medically Necessary Service - means services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to accepted standards of medical practice and that are not provided only as a convenience as defined at MCA 33-36-103(16). Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Children's Health Insurance Plan." Montana CHIP Contract, Attachment 12, page 12-4.
NC	---
ND	---
NH	Definition in separate managed care contract: "Medically Necessary means a service which: • Provides for the diagnosis, prevention, or treatment of a covered medical condition; • Is appropriate for the diagnosis, prevention, or treatment of a covered medical condition; • Is within standards of good and generally accepted medical practice, as reflected by scientific and peer medical literature, and recognized within the organized medical community in the State of New Hampshire; • Is not primarily for the convenience of the Member, his or her family, his or her physician, or another provider, • Is care or treatment which could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and • Is the most appropriate level of service or supply which can be provided safely and effectively." New Hampshire CHIP Contract, Exhibit 1, pages 46-47.
NJ	---
NY	---
NV	Definition in Medicaid managed care contract: "Medically Necessary Service: To be considered medically necessary, items and services must have been established as safe and effective. The items and services must be: consistent with the symptoms or diagnosis of the illness or injury under treatment; necessary and consistent with generally accepted professional medical standards (in other words, not still experimental or investigational); not furnished primarily for the convenience of the patient the attending physician, or to his/her physician or supplier; furnished at the most appropriate level which can be provided safely and effectively to the patient. Medicaid will only cover items and services which are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Any service covered under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by an EPSDT screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in the Medicaid State Plan." Nevada Contact, page 18.
OR	Definition in Medicaid managed care contract: "DEFINITIONS With the following exceptions and additions, the terms in this agreement have the same definitions as those terms appearing in Oregon Administrative Rules (OARs)... Appropriate: The extent to which a particular procedure, treatment, test, or service is documented to be effective, clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to the needs of the OMAP Member... Medically Appropriate: Services and Supplies which are required for prevention (including preventing a relapse), Diagnosis and treatment of mental disorders and which are Appropriate and consistent with the Diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental disorder; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the OMAP Member or provider of the service or supply; and the most cost effective of the alternative levels of Covered Services or supplies which can be safely and effectively provided to the OMAP Member in the Contractor's judgement." Oregon Mental Health Contract, Appendix K, pages K1, K12.
PA	Definition in state SCHIP plan: "**BlueCHIP HANDBOOK** **FREE AND LOW-COST HEALTH CARE BENEFITS FOR CHILDREN…** **MEDICALLY NECESSARY (OR MEDICAL NECESSITY) –** services or supplies provided by a Professional Provider that the Plan and your Primary Care Physician determines are: a) appropriate for the symptoms and diagnosis or treatment of the Eligible Child's condition, illness, disease or injury; and b) provided for the diagnosis, or the direct care and treatment of the Eligible Child's condition, illness, disease or injury; and c) in accordance with current standards of good medical practice; and

State	Definition
	d) not primarily for the convenience of the Eligible Child, or the Eligible Child's Professional Provider; and e) the most appropriate supply or level of services that can safely be provided to the Eligible Child." Pennsylvania SCHIP plan, Appendix K, p. 35-36. Definition in separate managed care contract: "Medical Necessity - Determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review or post-utilization basis, shall be in writing and be compensable under CHIP. The insurer shall base its determination on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other providers, programs and agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained providers and be appropriate and consistent with the diagnosis and in accordance with acceptable medical standards. Satisfaction of any one of the following standards will result in authorization of the service: * The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability. * The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability. * The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age." Pennsylvania CHIP RFP, page XI.
SD	Definition in state SCHIP plan: "Generally, all services provided under the Medicaid program must be "medically necessary". CHIP-NM services must also meet the requirements of the definition of medically necessary used by Medicaid. Medically necessary services are those that: • *are consistent with the recipient's symptoms, diagnosis, condition, or injury* • *are recognized as the prevailing standard and consistent with generally accepted professional medical standards of the provider's peer group* • *are provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition* • *are not furnished primarily for the convenience of the recipient or the provider* • *there is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly."* South Dakota SCHIP plan, Amendment #2, p. 20.
TX	Definition in separate managed care contract: "CHIP Scope of Benefits Covered CHIP services must meet the CHIP definition of 'medically necessary'. 'Medically necessary' health services are: ... A. Physical: - Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life; - provided at appropriate facilities and at the appropriate levels of care for the treatment of Members' medical conditions; - consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies; - consistent with the diagnosis of the conditions; and - no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency." Texas CHIP RFP, Appendix C, page 1.
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VT	---
VA	---
WA	Definition in Medicaid managed care contract: "1.7 Medically Necessary Services means services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this contract, course of treatment may include mere observation or, where appropriate, no treatment at all. Medically necessary services shall include, but not be limited to, diagnostic, therapeutic, and preventive services which are generally and customarily provided in the service area (WAC 388-500-0005.)" Washington Contract, pages 2-3.

State	Definition
	"4.2 Medical Necessity Determination: The Contractor shall determine which services are medically necessary, as defined in section 1.7, according to utilization management requirements included in the Quality Improvement program standards. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in sections 5.2 and 5.3." Washington Contract, page 15.
WV	---
WY	---

■ = States with combination plans

Source: The George Washington University School of Public Health and Health Services (CHSRP).