BRIEF | MAY 2020

Overview of Medicaid Benefits for Cross-Agency Medicaid-Public Health Teams

State and territorial Medicaid programs provide guaranteed medical benefits at little or no cost to low-income and vulnerable populations, including pregnant women, children, families, individuals with disabilities, and the elderly. Given the diverse needs of Medicaid-enrolled individuals — who often have poorer health status and greater health needs than the general population — Medicaid programs must cover a broad range of services and supports. However, no two states' benefit packages are the same. While all states must cover a minimum set of federally required benefits, they have significant latitude in choosing additional optional benefits to cover and determining the amount, duration, and scope of the services offered.

This brief describes mandatory and optional benefits provided by state Medicaid programs. It is divided into four sections:

- Mandatory and optional Medicaid benefits;
- State flexibility vs. federal protections;
- Options for changing covered benefits; and
- Coverage under managed care.

IN BRIEF

This brief describes mandatory and optional medical benefits offered by state Medicaid programs, with a focus on benefits related to preventive care. This information can help Medicaid and public health agencies that are collaborating to improve preventive services better understand the context for changing or enhancing prevention benefits and removing barriers to services. It was developed to inform states participating in the Centers for Disease Control and Prevention's (CDC) *6|18 Initiative.*

Mandatory and Optional Medicaid Benefits

Federal statute requires Medicaid programs to cover specific "mandatory" services. For most Medicaid-eligible adults (excluding those newly eligible for Medicaid under the Affordable Care Act's (ACA) Medicaid expansion), minimum benefits include services provided by physicians and hospitals, non-emergency transportation to medical care, and laboratory and x-ray services (see Exhibit 1 for a complete list). Mandatory benefits related to the *6|18 Initiative* include family planning services and tobacco cessation counseling for pregnant women. Children under age 21 are also guaranteed a set of comprehensive services through a pediatric benefit package

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called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This benefit includes regular screenings; vision, dental, and hearing services; and any other medically necessary services, regardless of whether that treatment is part of the state's adult Medicaid benefit package.

Many health services not explicitly labeled by the federal government as "mandatory" are considered optional for inclusion in a State Medicaid Plan, which is the agreement between the state and the federal government describing available benefits and many other components related to the Medicaid program's administration.[1] Optional services include prescription drugs, physical therapy, eyeglasses, and dental services, though all states cover prescription drugs, and all but six states cover some adult dental services.[2,3] Most preventive services for adults are considered optional, including most services promoted through the *6|18 Initiative,* such as asthma home visiting programs, the National Diabetes Prevention Program, and home blood pressure devices. Benefits must be deemed "medically necessary" to be covered for a given enrollee, though there is no federally mandated definition for "medically necessary." To cover certain additional benefits not included under federal definitions of "mandatory" and "optional," states can request a waiver from the federal government.

Exhibit 1: Mandatory and Optional Benefits

Mandatory Benefits	Optional Benefits
■ Inpatient hospital services ■ Outpatient hospital services ■ EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services ■ Nursing facility services ■ Home health services ■ Physician services ■ Rural health clinic services ■ Federally qualified health center services ■ Laboratory and X-ray services ■ Family planning services ■ Nurse midwife services ■ Certified pediatric and family nurse practitioner services ■ Freestanding birth center services (when licensed or otherwise recognized by the state) ■ Transportation to medical care ■ Tobacco cessation counseling for pregnant women	■ Prescription drugs ■ Clinic services ■ Physical therapy ■ Occupational therapy ■ Speech, hearing, and language disorder services ■ Respiratory care services ■ Other diagnostic, screening, preventive, and rehabilitative services ■ Podiatry services ■ Optometry services ■ Dental Services ■ Dentures ■ Prosthetics ■ Eyeglasses ■ Chiropractic services ■ Other practitioner services ■ Private duty nursing services ■ Personal care ■ Hospice ■ Case management ■ Services for people age 65+ in an institution for mental disease ■ Services in an intermediate care facility for individuals with intellectual disability ■ State Plan Home and Community Based Services - 1915(i) ■ Self-Directed Personal Assistance Services - 1915(j) ■ Community First Choice Option - 1915(k) ■ Tuberculosis-related services ■ Inpatient psychiatric services for people under age 21 ■ Services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital ■ Health Homes for enrollees with chronic conditions - Section 1945

While most *6|18 Initiative* interventions are considered optional benefits, Medicaid programs tend to reimburse for all or most of the prevention services recommended by the U.S. Preventive Services Task Force (USPSTF) and CDC's Advisory Committee on Immunization Practices (ACIP).[4] States that cover all the USPSTF- and ACIP-recommended preventive services without cost-sharing are eligible to receive a one percentage point increase in the federal government's share of the costs for these specific services. As of 2017, 15 states qualified for this Federal Medical Assistance Percentage increase. Many states, including several participating in the *6|18 Initiative*, have worked to remove co-pays for tobacco cessation services in order to qualify for the reimbursement increase.[5,6]

Childless adults with incomes up to 138 percent federal poverty level (FPL) who gained Medicaid eligibility under the ACA's expansion option are also guaranteed a set of minimum benefits, but in a slightly different form. Instead of receiving services based on a discrete list of mandatory and optional benefits, these enrollees (and a small subset of other Medicaid beneficiaries) are offered a set of services from an "alternative benefit plan" (ABP), which references an overall coverage benchmark (see Exhibit 2 for information on ABPs).

State Flexibility vs. Federal Protections

Medicaid programs vary in each state in part because states have considerable flexibility to design their programs to meet their specific needs and priorities. While all states must cover a minimum set of federally required benefits, they may choose additional optional benefits to cover and additionally have say in the amount, duration, and scope of the services offered. More details about state flexibility versus federal protections are outlined as follows.

State Flexibility

State Medicaid agencies not only have significant discretion in determining which optional benefits to include in their state plans, but also in determining the amount, duration, and scope of the benefit. If a state chooses to cover a benefit, it must decide whether to provide the service in a more limited or comprehensive manner, considering potential impacts on patient access, health outcomes, state costs, and other factors. When covering a benefit, states also have flexibility to include the following programmatic features, which are often used to reduce unnecessary use or to control costs:

- ***Prior authorization***: A requirement placed on services and medications to verify that they are necessary and/or patients meet the medical criteria for use.
- ***Limits on quantity, duration, or annual spending***: A restriction on: (1) the number of services in a given timeframe (e.g., limiting tobacco-using beneficiaries to two quit attempts per year); (2) the length of treatment (e.g., limiting tobacco-using beneficiaries to 12 weeks of nicotine replacement therapy per year); or (3) coverage for services after an annual monetary cap is met (e.g., limiting reimbursement for dental service to $1,000 per beneficiary per year). States cannot impose any amount, duration, or scope limitations on the pediatric EPSDT benefit.
- ***Cost sharing****:* An out-of-pocket payment for a portion of health care costs not covered by Medicaid, such as a nominal copayment for a prescription medication or an office visit. Out-of-pocket costs cannot be charged for certain services (e.g., emergency services) or to certain enrolled populations (e.g., children and pregnant

women), and individuals cannot be denied care for failure to pay. States also have the option to charge "alternative out-of-pocket costs" to certain enrollees with incomes over 100 percent FPL, which are subject to a cap not exceeding five percent of family income.

Federal Protections

While states are granted considerable flexibility in shaping their benefit packages, they do not have absolute discretion. They must adhere to a set of three protections included in federal Medicaid statute, as well as other applicable federal laws, such as the Americans with Disabilities Act and the Mental Health Parity and Addiction Equity Act.[7] Federal Medicaid protections related to covered benefits include:

1. **Amount, Duration, and Scope**: A benefit must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."[8] For example, a state may not limit coverage for inpatient hospital care to one day per year. As there is no definitive definition of the term "sufficient," this protection may be subject to varying interpretations, which could result in legal disputes.

2. **Comparability**: States may not vary the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, types of illness, or condition."[9] For example, states may not exclude Medicaid beneficiaries with hepatitis C from prescription drug coverage. However, states are allowed to provide enhanced benefits for pregnant women.

3. **State-wideness**: States may not vary the amount, duration, or scope of covered services based on a beneficiary's place of residence. For example, a state may not cover home blood pressure devices for residents living in cities but not for residents in rural areas.

Options for Changing Covered Benefits

Each state Medicaid program is unique, reflecting states' use of existing program flexibility and waiver authority to design their programs to meet their specific needs and priorities, including flexibility in changing covered benefits for members. Below are state options to change existing Medicaid benefits:

State Plan Amendments

States/territories use state plans to document and obtain approval from the federal government about specific program approaches, e.g., benefit packages. States seeking to make changes to their Medicaid programs that are allowable within the limitations of federal regulations can submit a State Plan Amendment (SPA) to CMS to modify their existing state plan. SPAs are often used to add or remove optional benefits, change the scope or duration of a current benefit, or change how a benefit is delivered or paid for. Requesting federal approval for a SPA is a relatively simple and straightforward process, and once approved, the authorities granted by the SPA do not need to be renewed. *6|18 Initiative* teams have used SPAs to unbundle reimbursement for postpartum insertion of long-acting reversible contraception from Medicaid's maternity care bundled payment; enable Medicaid-enrolled pharmacists to provide tobacco cessation services; and remove co-pays from tobacco cessation medications.[10]

Waivers

State and territorial Medicaid programs looking to access federal Medicaid financing for a benefit or covered service not outlined within existing federal Medicaid rules can apply to CMS for a waiver. With some limitations, federal statute allows CMS to waive certain federal rules in order to test whether specific innovations may advance the goals of Medicaid. Waivers can provide states with significant flexibility in how they design and administer their Medicaid programs, allowing them to deviate from the federal protections noted above regarding benefits being sufficient, available to all enrollees, and available statewide. Waivers can also be used to allow federal matching funds for services not included as mandatory or optional services. One state participating in the *6|18 Initiative* secured a Section 1115 waiver to establish a new Medicaid payment reform program; it then worked to align the program's tobacco control quality metrics with the state's *6|18 Initiative* priorities.[11]

Coverage under Managed Care

Many states contract with managed care organizations (MCOs) to provide beneficiaries access to their benefits and to coordinate services. MCOs receive a capitated payment for providing some or all benefits to specific Medicaid populations, accepting the financial risk associated with this obligation. While managed care plans must comply with federal and state Medicaid rules and regulations, they are afforded more flexibility than fee-for-service (FFS) arrangements to cover non-traditional services. This flexibility includes the option to cover services that support members' non-medical needs beyond required benefits (known as "value-added" services) and to substitute a non-traditional service for a similar service that is covered under the contract (known as "in lieu of services").

Beneficiaries covered by an MCO may have access to additional benefits that are not required under the state plan. For example, MCOs may cover more preventive and primary care services than a FFS arrangement, with the goal of promoting health and reducing per-member costs. On the other hand, beneficiaries may not be able to access all of their guaranteed benefits through an MCO. In some cases, benefits like behavioral health services or long-term care are not included in an MCO contract because they are carved out (and available under a separate payment scheme). Given the variation across FFS and managed care benefit packages — and between individual MCO contracts — many *6|18 Initiative* teams have sent surveys to all Medicaid MCOs that are contracting with a state to delineate which benefits are available to which beneficiaries.[12] Once teams have a clear understanding of each plan's benefit package, they can develop strategies to standardize or enhance benefits at the state- and/or MCO-level.

Given that a number of *6|18 Initiative* interventions relate to changing or enhancing Medicaid prevention benefits, teams may benefit from understanding how Medicaid benefits are structured, delivered, and altered — and how particular prevention benefits may vary across populations and delivery systems — to develop effective implementation plans. Teams can use a variety of levers and strategies to improve the coverage and delivery of prevention benefits, including applying to CMS for a SPA or Section 1115 waiver, and engaging leadership at Medicaid MCOs about opportunities to promote *6|18 Initiative* priorities and programs through managed care contracts.

Exhibit 2: Alternative Benefit Plans

Since the passage of the 2005 Deficit Reduction Act, states have had the option of covering Medicaid beneficiaries with Alternative Benefit Plans (ABPs) in lieu of the traditional Medicaid benefit.13 Under ABPs, the benefit design is not based on federal Medicaid statute, but rather on: (1) a benchmark plan selected by the state from a list of options (which include three existing insurance plans and a "secretary-approved coverage" option); or (2) a benchmark-equivalent package that has an actuarial value equivalent to the selected benchmark benefit package and meets other requirements. The 37 states (including the District of Columbia) that expanded Medicaid under the ACA are required to cover the Medicaid expansion population using ABPs. States may also choose to cover other Medicaid populations through ABPs, though there are restrictions regarding which populations are eligible.

Unlike traditional Medicaid benefit coverage, ABPs must include the 10 essential health benefits (EHB) that most private insurance plans are required to offer following the ACA's passage, as well as some additional Medicaid services not included in the EHBs. One of the 10 EHBs is preventive services, which must be made available without beneficiary cost-sharing. This benefit includes: (1) screening and counseling services; (2) routine immunizations; and (3) preventive services for women.

ABP Mandatory Benefits:

- 10 Essential Health Benefits
    1. Ambulatory patient services
    2. Emergency services
    3. Hospitalization
    4. Maternity and newborn care
    5. Mental health services and treatment
    6. Prescription drugs
    7. Rehabilitative services and devices
    8. Laboratory services
    9. Preventive services, wellness services, and chronic disease treatment
    10. Pediatric services
- Non-emergency medical transportation
- Family planning services and supplies
- Federally qualified health center and rural health clinic services
- Parity between physical and mental health benefits

ADVANCING IMPLEMENTATION OF THE CDC'S 6|18 INITIATIVE

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, in collaboration with a number of partners, is coordinating technical assistance to facilitate state Medicaid and public health implementation of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative. The CDC's 6|18 Initiative promotes the adoption of evidence-based interventions that can improve health and control costs related to six high-burden, high-cost health conditions — tobacco use, high blood pressure, inappropriate antibiotic use, asthma, unintended pregnancies, and type 2 diabetes. For more information and additional resources, visit www.618resources.chcs.org.

ENDNOTES

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