THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

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KCMU Medicaid Benefits Database: General Benefits and Cost-Sharing Notes

General Benefits Notes

Federal law also specifies services that must be covered by state Medicaid programs. Other services may be offered, at a state's option, if approved by CMS. Mandatory coverages include:

- Inpatient hospital services, excluding services in an institution for mental diseases;
- Outpatient hospital services;
- Federally qualified health center services;
- Rural health clinic services (if permitted under state law);
- Laboratory and x-ray services rendered outside a hospital or clinic;
- Nursing facility services for beneficiaries age 21 and older;
- Physician services;
- Certified pediatric and family nurse practitioner services (when licensed to practice under state law);
- Nurse midwife services;
- Medical and surgical services of a dentist;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children;
- Family planning services and supplies;
- Home health services for beneficiaries entitled to nursing facility services under the state's approved Medicaid plan, including intermittent or part-time nursing services, home health aide services and medical supplies and appliances for use in the home;
- Pregnancy-related services and services for other conditions that might complicate pregnancy, as well as postpartum care for 60 days;
- Tobacco Cessation Services for Pregnant Women, including both counseling and pharmacotherapy (beginning October 1, 2010); and
- Freestanding Birth Center Services (beginning October 1, 2010 if licensed or otherwise recognized by a State

Although a particular service may not be identified on a table as covered, the state is obligated by federal law to provide it for a child if it has been determined medically necessary through an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening (such as a well-child exam) and the state agrees with that determination.

Likewise, although a particular service may not be identified on a table as covered, the state is also obligated to pay Medicare coinsurance and/or deductible amounts up to specified limits for Qualified Medicare Beneficiaries (QMBs) receiving a service covered by Medicare, even if the Medicaid program does not otherwise cover it or the individual is not otherwise eligible for Medicaid benefits.

Special Benefits Notes

There are also benefits covered by most state Medicaid programs for which tables have not been provided. Brief explanations of these special benefits appear below.

Early and Periodic Screening, Diagnosis and Treatment

Federal law and regulations require states to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to Medicaid eligible children under the age of 21, the purpose of which is to ascertain physical and mental defects and to provide treatment to correct or ameliorate any defects or chronic conditions found. With passage of the Deficit Reduction Act of 2005, states are now able to implement alternative benefit packages for certain Medicaid beneficiaries, based on benefits in employer-sponsored plans, which may be more limited than the traditional Medicaid benefit package. The DRA also permits states implementing such packages to reduce the maximum required age for EPSDT benefits to 18 through an amendment to their State Plan. States are to inform children and their families of the availability of EPSDT services, their benefits, and where and how to obtain them. States are also to provide transportation and scheduling assistance if requested, to assure that the children receive necessary services.

"Screening" means a periodic comprehensive child health assessment, which are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children and youth. These screenings are to include a physical examination, vision and hearing testing, age-appropriate immunizations, any necessary diagnostic laboratory tests and a dental examination beginning at least at age three.

"Diagnosis and Treatment" means further investigation of any conditions noted during a screening and the provision of any medically necessary treatment services, irrespective of their inclusion in the State Plan as a routinely covered service.

States provide EPSDT services in various ways. Some rely on health department-operated medical clinics to perform screenings and to make referrals to appropriate health care professionals for diagnosis and treatment. Some states rely on physicians, dentists and other health care practitioners to perform the screenings during well child exams and to diagnose and treat any defects noted. Federal law and regulations are not specific as to the provider(s) that should render EPSDT services, only that the services must be rendered.

States are precluded, by federal law, from requiring a copayment for any EPSDT service for a child under age 18 but may at their option impose a copayment for beneficiaries age 18 and older.

By their nature, EPSDT services may be provided by a number of different providers in many settings. As such, there is no specific coverage policy or reimbursement methodology for this service. Instead, the policy and reimbursement methodology applicable to the provider rendering the service would be used. The reader is referred to the tables for Physicians and Dental Services as the primary source of information about reimbursement.

Extended Services for Pregnant Women

States are required to provide pregnancy-related services and services for other conditions that might complicate pregnancy, both during the pregnancy and for 60 days after the pregnancy ends. Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman being pregnant. They include but are not limited to prenatal care, delivery, postpartum care, and family planning. Services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses, or medical conditions that might threaten the ability of the woman to carry the fetus to full term or its safe delivery. Several states provide targeted case management services as a complement to prenatal care for high-risk pregnant women during and immediately following pregnancy to assist them in accessing needed medical, social, and educational services. Such services are directed toward the alleviation of psychosocial problems and health education deficits so to assure a healthy pregnancy outcome. The 60-day postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

By their nature, these services may be provided by a number of different providers. As such, there is no specific coverage policy or reimbursement methodology for this service. Instead, the policy and reimbursement methodology applicable to the provider rendering the service would be used.

Family Planning Services

Federal law requires states to provide family planning services and supplies to Categorically Needy Medicaid beneficiaries of childbearing age, including minors who can be considered sexually active, if such services and supplies are desired and requested. Family planning services are an optional coverage for a state's Medically Needy population but are universally covered. To encourage coverage of family planning services, the Federal Medical Assistance Percentage (matching rate) is 90 percent.

Family planning services are not precisely defined in federal law or regulations. However, most states have established coverage policies intended to aid beneficiaries who voluntarily choose not to risk an initial pregnancy and to help families with children who desire to control family size. Accordingly, covered services generally include examination and treatment by medical professionals in accordance with applicable state requirements; medically appropriate laboratory examinations and tests; counseling services and patient education; and medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. Several states have, however, established frequency limits for some of these services and/or have limited the types of contraceptive supplies and devices covered. And, while infertility services including sterilization reversals and other treatments for the purpose of enhancing, promoting or restoring fertility are eligible for the enhanced matching rate, such services are rarely covered by states. Abortions may not be claimed as a family planning service.

States are precluded, by federal law, from requiring a copayment for any family planning service.

By their nature, family planning services may be provided by a number of different providers, including Physicians, Nurse Practitioners and Nurse Midwives. Services may be rendered in their offices or in a medical or family planning Clinic, or in an Outpatient Hospital setting. Contraceptive supplies may be provided, through prescription, by pharmacies, or may be dispensed by the medical practitioner. As such, there is no

specific coverage policy or reimbursement methodology for family planning services. Instead, the policy and reimbursement methodology applicable to the provider rendering the particular service would be used. The reader is referred to the tables for the aforementioned providers.

Several states have received approved Section 1115 Waivers from CMS, or more recently State Plan approval as a result of language in the Patient Protection and Affordable Care Act (ACA) of 2010, under which family planning services are made available to women, and in some cases men, who have income above the threshold for coverage through either a mandatory or optional Medicaid eligibility category. Under a Section 1115 Waiver, states may limit coverage to family planning services alone and may also limit the benefit by age and gender. Coverage of beneficiaries with higher income through State Plan approval precludes limiting the benefit by age or gender and also requires states to cover family planning-related services. Family planning-related services are defined as "medical diagnosis and treatment services that are ... provided in a family planning setting as part of or as follow-up to a family planning visit." While family planning services are eligible for the 90 percent federal match rate, family planning-related services receive a state's regular matching rate. Irrespective of whether the state offers these services under Waiver or State Plan authority, the beneficiaries eligible for this benefit are not entitled to any other Medicaid benefits.

Medical and Remedial Care – Other Practitioners

Federal law allows states to include the services of a variety of licensed health care practitioners in their State Plan coverages. The services of the most common practitioners are addressed through tables specific to them, such as podiatrists, chiropractors, optometrists, psychologists and certified registered nurse anesthetists. However, there are other practitioners whose services are covered and directly reimbursed in selected states. Such practitioners include physician assistants, nutritionists, dieticians, dental hygienists, acupuncturists, mechanotherapists, naturopaths, respiratory therapists, pharmacists, medical social workers, behavioral health practitioners and counselors, pastoral counselors, marriage and family therapists, and sign and other language interpreters. States that include these services generally establish copayment and prior approval requirements as well as coverage limitations consistent with other similar services.

Cost Sharing Notes:

Absent Waiver or State Plan approval from CMS, federal regulations preclude states from charging copayments for services rendered to Medicaid-eligible children up to age 18 (although most states with copayment policies extend the exemption up to age 21). Copayments cannot be charged for emergency services, pregnancy or family planning services or for services rendered to beneficiaries residing in institutions, such as nursing facilities. As a result of language in the American Recovery and Reinvestment Act, American Indians are exempted from any state Medicaid copayment requirement for services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral from one of these entities to a contracted health services provider.