# Federal Requirements and State Options: Benefits

States have broad flexibility to create a benefit package for their Medicaid enrollees within federal guidelines (Table 1). Certain benefits are mandatory, for example inpatient and outpatient hospital services, and services at rural health clinics and federally qualified health centers (FQHCs). However, many benefits may be provided at state option (§§ 1902(a)(10)(A) and 1905(a) of the Social Security Act (the Act)).

As Medicaid eligibility criteria have evolved, the health needs of Medicaid enrollees have become more diverse. At the same time, the provision of medical care has also advanced, along with new treatment options and delivery methods, such as health homes. As a result, Congress has added services to the Medicaid statute and provided states with the option to cover these services. States consider factors such as their Medicaid populations' health needs and the cost of services in determining their benefit packages. As a result of these considerations, some optional services are covered widely, and others less so. For example, all states cover prescription drugs, and optometry services, but coverage for other services, such as chiropractic services or health homes that coordinate care for enrollees with chronic diseases are less common (Box 1).

**BOX 1.** State Coverage for Selected Optional Medicaid Benefits

| Covered benefit category | Number of states |
|---|---|
| Chiropractic services | 26 |
| Dental services for adults | |
| emergency | 18 |
| preventive | 28 |
| restorative | 26 |
| Dentures | 33 |
| Eyeglasses | 42 |
| Health homes for enrollees with chronic conditions | 10 |
| Home health services (e.g., nursing services, home health aides) | 51 |
| Hospice services | 41 |

| Covered benefit category | Number of states |
|---|---|
| Institutions for mental diseases[1] | |
| under age 21 | 51 |
| age 65 or older | 46 |
| Intermediate care facility services for individuals with intellectual disabilities | 48 |
| Occupational therapy services | 34 |
| Optometry services | 51 |
| Other diagnostic, screening, and preventive services | 45 |
| Personal care services | 31 |
| Physical therapy services | 36 |
| Prescription drugs | 51 |
| Private duty nursing services | 23 |
| Program of All-Inclusive Care for the Elderly (PACE) services | 31 |
| Prosthetic devices | 50 |
| Services furnished in a religious non-medical health care institution | 9 |
| Speech, hearing, and language disorder services | 36 |
| Targeted case management services | 49 |

**Notes:** This table presents the number of states and the District of Columbia with some coverage in the benefit category listed. Covered benefits may not be available to all enrollees. For example, states may opt to cover services for enrollees through categorically needy eligibility pathways, but not medically needy eligibility pathways. Although the benefit category may be covered, the amount or scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits, or coverage may only be available when determined medically necessary.
[1] Services provided in an institution for mental disease are optional services that states can cover for children under 21 or adults who are 65 years of age or older. Services provided to adults between the ages of 21 and 64 are not eligible for federal matching funds.

**Sources:** KFF 2012, MACPAC 2015, and CMS 2016.

In addition, although coverage for some services is considered optional in the statute, in practice, coverage is needed to provide access to appropriate care. For example, prescription drugs are considered an optional covered item in Medicaid but are covered by every state because they are integral to the practice of medical care and are needed to avoid other costs associated with conditions that can be treated pharmaceutically. Although most home- and community-based services (HCBS)—for example, private duty nursing, and personal care services—are optional, states must cover many of these services to meet their legal and strategic goals as they rebalance the delivery of long-term services and supports between institutions and the community.

**Scope of coverage.** In addition to defining which benefits to cover, states have flexibility to define how much of a service an enrollee can receive. States can determine the breadth of coverage (i.e., amount, duration, and scope), and can also employ utilization management strategies, such as requiring prior authorization for certain services to manage enrollees' use of benefits (§1902(a)(10)(B) of the Act). For children, however, the early and periodic screening, diagnostic, and treatment (EPSDT) requirements limit the extent to which states may apply criteria other than medical necessity to covered benefits.

In general, states must offer the same coverage to all enrollees (known as the comparability rule) and offer the same benefits throughout the state (the statewideness rule), but there are exceptions for states that implement managed care or expand HCBS in certain geographic areas (§1902(a)(1) of the Act).[1]

**Alternative benefit plans.** Benchmark coverage, now known as alternative benefit plans (ABPs), emerged as an option to traditional Medicaid benefit design in the late 1990s. Rather than offering traditional Medicaid benefits, states may enroll state-specified groups in benchmark or benchmark-equivalent benefit packages. Using benchmark coverage allows states greater flexibility in benefit design and permits them to bypass requirements such as statewideness, comparability, and freedom of choice.

States can offer ABPs to all enrollees, but some groups are excluded from mandatory enrollment. These include certain parents, pregnant women, individuals dually enrolled in Medicaid and Medicare, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, those who are medically frail or have special medical needs, and children enrolled through child-welfare involved pathways (§1937(b) of the Act). States are required to enroll the new adult eligibility group in alternative benefit plans.

Specifically, states that elect to use this benefit design can provide coverage that is equal to the Blue Cross and Blue Shield standard provider plan under the Federal Employees Health Benefits Program; a plan offered to state employees; the largest commercial (non-Medicaid) health maintenance organization in the state; or other coverage approved by the Secretary of the U.S. Department of Health and Human Services appropriate for the target population. A benchmark-equivalent benefit package must be actuarially equivalent to the benchmark to which it is being compared and must include certain benefits. States must assure access to FQHC services, family planning services, mental health services that comply with parity standards, transportation to and from medically necessary Medicaid-covered services, and EPSDT services for children under age 21 either through these packages or as additional benefits provided by the state (42 CFR 440.335, 42 CFR 440.390, 42 CFR 440.395).

The ACA added a private insurance plan benchmark option, and required that ABPs at least cover the ten essential health benefits, which form the basis of private coverage in health insurance exchanges (42 CFR 440.347).[2] This requirement is significant because states have the option to structure benefits for the new adult group more like the qualified health plans offered in health insurance exchanges than the traditional Medicaid benefits package. Most states expanding coverage to the new adult group offer Secretary-approved benefit packages aligned with their traditional Medicaid benefit package with some

modifications. For example, North Dakota's alternative benefit plan offers traditional state plan benefits except that it does not include adult dental coverage (Lilienfeld 2014, Sheedy 2014).

## Waivers

States can use Section 1915(c) waivers to target HCBS to a subset of residents who need high levels of care and would otherwise be at risk of institutionalization in a nursing home or other facility. 1915(c) waivers can be limited to a certain number of enrollees and to certain areas in a state. States also have the option to provide home- and community-based services statewide through a Section 1915(i) state plan amendment.[3]

States can also waive benefit rules through Section 1115 demonstration waivers, which have been used historically to offer more limited benefit packages to higher income enrollees or to provide additional services that would not otherwise be defined as medical assistance. For example, waivers in Massachusetts and Maryland provide for lead abatement services under Section 1115 waivers. And, prior to passage of the ACA, states needed an 1115 waiver to provide family planning services to individuals who would not otherwise be eligible for Medicaid.

**TABLE 1.** Federal Requirements and State Options: Summary of State Flexibilities Related to Benefits

| Covered benefit category | Federal statutory and regulatory requirements | State plan options |
|---|---|---|
| **Traditional state plan benefits** | States must provide the following services:<br>• inpatient hospital<br>• outpatient hospital<br>• rural health clinic<br>• federally qualified health center (FQHC)<br>• laboratory and x-ray<br>• nursing facility services (age 21 and older)<br>• family planning services and supplies<br>• tobacco cessation counseling and prescription drugs for pregnant women<br>• physician services<br>• nurse midwife services<br>• certified pediatric and family nurse practitioner services<br>• freestanding birth centers<br>• home health<br>• medical transportation[1]<br>• early and periodic screening, diagnostic, and treatment (EPSDT) services<br>(§§ 1902(a)(10)(A), 1905(a), 42 CFR 431.53, 42 CFR 440.210, 42 CFR 440.220, 42 CFR 440.390) | States can choose to provide the following optional services:<br>• prescription drugs<br>• dental services for adults<br>• intermediate care facilities for individuals with intellectual disabilities<br>• services in an institution for mental disease[2]<br>• clinic services<br>• occupational therapy<br>• physical therapy<br>• speech, hearing, and language disorder services<br>• targeted case management<br>• prosthetic devices<br>• hospice services<br>• eyeglasses<br>• dentures<br>• other diagnostic, screening, preventive, and rehabilitative services<br>• respiratory care services<br>• home and community-based services (§1915(i))<br>• community supported living arrangements<br>• personal care services<br>• private duty nursing services |

**TABLE 1.** (continued)

| Covered benefit category | Federal statutory and regulatory requirements | State plan options |
|---|---|---|
| | | • primary care case management<br>• health homes for enrollees with chronic conditions<br>• other licensed practitioners' services (e.g., podiatrist, optometrist)<br>• services for certain diseases (tuberculosis, sickle cell disease)<br>• chiropractic services<br>• Program for All-Inclusive Care for the Elderly (PACE) services<br>• Services furnished in a religious, non-medical health care institution<br>(§1905(a), 42 CFR 440.225) |
| **Alternative benefit plans (ABPs)** | • New adult enrollees must be enrolled in an ABP (42 CFR 440.305(b)).<br>• Groups exempt from mandatory enrollment in these benefit packages include certain parents, pregnant women, people who are dually eligible for Medicaid and Medicare, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, those who are medically frail or have special medical needs, and children enrolled through child-welfare involved pathways (§1937(a)(2)(B), 42 CFR 440.315).<br>• Benchmark-equivalent coverage must be actuarially equivalent to the benchmark to which it is being compared (§1937(b), 42 CFR 440.335, 42 CFR | • States have the option to require certain enrollees to enroll in an ABP (§1937(a)(2)(A), 42 CFR 440.305)<br>• Alternative benefit plans can provide coverage that is equal to BCBS plan in FEHBP, plan offered to state employees, largest commercial HMO in the state, or Secretary-approved coverage (§1937(b), 42 CFR 440.330 42 CFR 440.335, 42 CFR 440.340).<br>• States can waive comparability and statewideness for ABPs (42 CFR 440.375, 42 CFR 440.380), as described below.). |

**TABLE 1.** (continued)

| Covered benefit category | Federal statutory and regulatory requirements | State plan options |
|---|---|---|
| | 440.340).<br>• Must assure access to FQHCs, mental health services that comply with parity, EPSDT services, and family planning services (§1937(b), 42 CFR 440.345, 42 CFR 440.365, 42 CFR 440.395).<br>• Coverage must include the 10 essential health benefits (42 CFR 440.347). | |
| **Comparability** | • A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees (§1902(a)(10)(B), 42 CFR 440.240). | • States can define amount, duration, and scope (§1902(a)(10)(B), 42 CFR 440.240). |
| **Statewideness** | • States cannot exclude enrollees or providers because of where they live or work in the state (§1902(a)(1), 42 CFR 431.50). | • Medicaid managed care plans are not required to be offered statewide, although enrollees must have a choice of more than one managed care plan (§1902(a)(1), 42 CFR 431.50). |

**Notes:** ABP is alternative benefit plan. FEHBP is the Federal Employees Health Benefits Program.
[1] While Medical transportation is not listed as a required benefit, states must ensure necessary transportation for beneficiaries to and from Medicaid-covered services (42 CFR 431.53).
[2] Services provided in an institution for mental disease are optional services that states can cover for children under 21 or adults who are 65 years of age or older. Services provided to adults between the ages of 21 and 64 are not eligible for federal matching funds.

**Sources:** MACPAC analysis of the Social Security Act and the *Code of Federal Regulations*.

## Endnotes

[1] Some consider the freedom of choice requirement to be a component of benefit design.

[2] The 10 essential health benefits (EHB) include: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. A state defines the coverage that meets EHB standards by selecting a base benchmark plan in accordance with the rules set forth under health insurance exchanges. States can choose the same plan to serve as benchmark coverage for their alternative benefit plan, and as the base benchmark for defining EHB. States may have to supplement or substitute benefits in their benchmark plan depending on the extent to which this coverage aligns with the state-selected base benchmark plan.

[3] Section 1915(i) state plan amendments are approved for five-year periods with the option to renew, with CMS approval, for additional five year periods.

## References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. *Medicaid health homes: SPA overview.* Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-overview.pdf.

Kaiser Family Foundation (KFF). 2012. Medicaid Benefits Data Collection. http://kff.org/data-collection/medicaid-benefits/.

Lilienfeld, M. 2014. *Alternative benefit plans for the Medicaid expansion population: Trends in approved benefit plans and tools for advocates.* Washington, DC: National Health Law Program. http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/alternative-benefit-plans-for-the-medicaid-expansion-population#.V5J0vjXO5sB.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Coverage of Medicaid dental benefits for adults. In *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/coverage-of-medicaid-dental-benefits-for-adults-3/.

Sheedy, K. 2014. *Tracking state Medicaid expansion alternative benefit plans.* Washington, DC: State Reforum. https://www.statereforum.org/Tracking-State-Medicaid-Alternative-Benefit-Plans.