Mandatory and optional benefits

Benefits <https://www.macpac.gov/topics/benefits>

Under Medicaid, states are required to cover mandatory benefits and may choose to cover optional benefits. In general, benefits must be equivalent in amount, duration, and scope for all enrollees (known as the comparability rule); benefits must be the same throughout the state (the statewideness rule); and enrollees must have freedom of choice among health care providers or managed care plans participating in Medicaid.

The breadth of coverage (i.e., amount, duration, and scope) varies by state. For example, one state may elect to cap the number of inpatient hospital days an enrollee might receive each year, while another state may allow an unlimited number of inpatient hospital days. For adults, states may limit the extent to which a covered benefit is available by defining both medical necessity criteria and the amount, duration, and scope of services (e.g., a limit on the number of inpatient hospital days). For children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) <https://www.macpac.gov/subtopic/epsdt-in-medicaid/>requirements limit the extent to which states may apply criteria other than medical necessity to covered benefits.

Mandatory and Optional Medicaid Benefits

Mandatory	
Certified pediatric or family nurse practitioner services (to the extent authorized to practice under state law or regulation)	Non-emergency transportation to medical care <https://www.macpac.gov/?post_type=subtopic&p=7019&preview=true> [1]
Early and Periodic Screening, Diagnostic, and Treatment services for individuals under age 21 (screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state	Nurse midwife services (to the extent authorized to practice under state law or regulation)
Family planning services and supplies	Nursing facility services (for ages 21 and over)
Federally qualified health centers	Outpatient hospital services

Freestanding birth centers	Physician services
Home health services	Rural health clinic services
Inpatient hospital services	Tobacco cessation counseling and pharmacotherapy for pregnant women
Laboratory and X-ray services	

Sources: CMS <https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html>and Social Security Act.
[1]Federal regulations require states to provide transportation services; they may do so as an administrative function or as part of the Medicaid benefit package.

Optional	
Community supported living arrangements	Optometry services
Chiropractic services	Other diagnostic, screening, preventive, and rehabilitative services
Clinic services	Other licensed practitioners' services
Critical access hospital services	Personal care services
Dental services	Physical therapy services
Dentures	Prescribed drugs
Emergency hospital services in a hospital not meeting certain Medicare or Medicaid requirements[1]	Primary care case management services
Eyeglasses	Private duty nursing services
Health homes for enrollees with chronic conditions	Program of All-Inclusive Care for the Elderly (PACE) services
Home and community based services	Prosthetic devices

Hospice services	Respiratory care for ventilator dependent individuals
Inpatient hospital and nursing facility services for individuals age 65 or older in institutions for mental diseases	Services furnished in a religious non-medical health care institution
Inpatient psychiatric services for individuals under age 21	Speech, hearing, and language disorder services
Intermediate care facility services for individuals with intellectual disabilities	Targeted case management services
Occupational therapy services	Tuberculosis-related services

Sources: CMS <https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html> and Social Security Act.

[1]Federal regulations define these services as being those that are necessary to prevent death or serious impairment of the health of the recipient and, because of the threat to life, necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet Medicare's participation requirements or the definition of inpatient or outpatient hospital services under Medicaid rules.

EPSDT

Children under age 21 are covered under the Early, Periodic, Screening, Diagnostic, and Treatment benefit, which requires states to provide all services described in the Medicaid statute necessary to correct or ameliorate physical or mental conditions found by a screening, regardless of whether that treatment is part of the state's traditional Medicaid benefit package. This includes treatment for any vision and hearing problems, as well as eyeglasses and hearing aids. In addition, regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health, as well as some orthodontia, is covered. States must establish schedules for screening, vision, dental, and hearing services.

Learn more about EPSDT in Medicaid <https://www.macpac.gov/subtopic/epsdt-in-medicaid/>.

Preventive services

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) mandates that many preventive services be provided with no cost sharing to individuals enrolled in exchange plans, Medicare, and Medicaid expansions to childless adults, who are often referred to as the new adult group (HHS 2014 <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html#coveredpreventiveservicesforadults>). These include:

- routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children, women, and adolescents, as recommended in evidence-based guidelines supported by the federal Health Resources and Services Administration (HRSA);
- preventive care and screening for women, as recommended in evidence-based guidelines supported by HRSA;
- evidence-based items or services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved;
- contraceptive methods, sterilization procedures, and patient education and counseling on reproductive health (not including abortifacient drugs), except in health plans sponsored by certain exempt religious employers (HRSA 2016 <https://www.hrsa.gov/womens-guidelines-2016/index.html>); and
- tobacco cessation services for pregnant women including both pharmacotherapy and counseling (CMS 2011b <http://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd11-007.pdf>).

States are eligible for a one percentage point increase in their federal matching rate effective January 1, 2013, applied to expenditures for adult vaccines and USPSTF-recommended preventive services if they cover the full list of these services without cost sharing. The increase applies to such expenditures whether or not the services are provided on a fee-for-service or managed care basis, or under a benchmark or benchmark-equivalent benefit package, also referred to as an alternative benefit plan.

Benefits for pregnant women

Almost all state Medicaid programs have some enhanced benefits for pregnant women. Currently, a state may provide a greater amount, duration, or scope of services to certain pregnant women than it provides under its plan to other individuals who are eligible for Medicaid (42 CFR 440.210(a)(2), 42 CFR 440.250(p)). For example, several states have extended dental coverage only to pregnant women due to an emerging link between periodontal disease and an increased risk for preterm birth and low birth weight infants. Others provide targeted case management, medical home programs, and nutrition counseling not available to other Medicaid enrollees. At the federal level, the Strong Start for Mothers and Newborns initiative is a joint effort between CMS, HRSA, and the Administration for Children and Families (ACF). Strong Start goals are to reduce preterm births and improve outcomes for newborns and pregnant women enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) through a variety of programs. (See MACPAC's June 2013 report chapter <https://www.macpac.gov/publication/ch-1-maternity-services-examining-eligibility-and-coverage-in-medicaid-and-chip/> for more information on these initiatives.)

Long-term services and supports

Medicaid beneficiaries who use long-term services and supports (LTSS) are a diverse group that includes working adults with physical disabilities, children who are medically fragile, individuals age 65 and older, people with intellectual and physical disabilities, and individuals who are severely mentally ill. The only two mandatory LTSS benefits provided to these beneficiaries are nursing facility and home health services. All other LTSS benefits are optional. Optional LTSS benefits include home and community-based services, such as personal care attendants and adult day care, and institutional LTSS, such as intermediate care facilities for individuals with intellectual disabilities. Optional LTSS benefits <https://www.macpac.gov/medicaid-optional-long-term-services-and-supports-2/> can be provided under the state plan or through waiver programs. Once a state includes an optional service as part of its state plan, that service must be provided

to all individuals eligible under all eligibility pathways that grant access to the traditional benefit package. Waivers offer more flexibility as they permit states to provide optional benefits only to specific groups and to cap enrollment. (For more information on optional LTSS benefits, read the chapter from MACPAC's June 2014 report, Medicaid's Role in Providing Long-Term Services and Supports <https://www.macpac.gov/publication/ch-2-medicaids-role-in-providing-assistance-with-long-term-services-and-supports/>.)

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About MACPAC

The Medicaid and CHIP Payment and Access Commission is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).