

SECTION 5

COVERED SERVICES: What Will Medicaid and CHIP Pay For?

Medicaid pays for care delivered in a range of settings, including hospitals, outpatient settings, private-practice settings, clinics, nursing homes, community health centers, schools, mental health clinics, and at home.¹ If a service is covered under a state's Medicaid plan, it must be covered everywhere in the state unless the state obtains a federal waiver that exempts them from the usual "statewideness" requirement.

MANDATORY AND OPTIONAL BENEFITS

Medicaid includes both mandatory benefits that states are required to cover under federal law and optional benefits that states may choose to cover for adults.

Among the many optional Medicaid services are:

- Prescription drugs
- Occupational, speech, and physical therapies
- Optometry
- Targeted case management (see [Case Management/Care Coordination](#));
- Skilled nursing facilities for children and youth under age 21
- Rehabilitative services
- Personal care services
- Dental services
- Hospice services
- Inpatient psychiatric services for children and youth under age 21
- Medical and remedial care from other licensed providers, including psychologists.



MANDATORY MEDICAID BENEFITS

Mandatory Medicaid benefits include:

- Inpatient and outpatient hospital services
- Physician services
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for children (including screening, diagnosis, and any services needed to treat identified conditions, even if those services would otherwise be optional)
- Family planning services and supplies
- Nursing facilities
- Nurse practitioner services
- Laboratory and X-ray services
- Tobacco cessation for pregnant women
- Transportation for non-emergency medical care
- Home health services

1. 42 CFR § 440.1-185.

All 50 states provide some variety of optional services. For example, every state provides prescription drugs, occupational and physical therapies, targeted case management, and optometry. Whether optional or mandatory, each service provided must be adequate in amount, duration, and scope to “reasonably achieve its purpose.”

COPAYMENTS AND DEDUCTIBLES

Medicaid is prohibited from imposing copayments, deductibles, co-insurance, or other fees (“cost sharing”) on services for children and youth whose family income is less than 150% of the federal poverty level (FPL). States and managed care organizations have also been prohibited from imposing anything more than nominal cost sharing on adults receiving Medicaid.²

EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a key benefit for children and youth who receive Medicaid coverage. It requires that states provide screening, diagnosis, and treatment to prevent, ameliorate, or treat conditions and to promote development. Identified needs must be treated even if the service would not normally be covered by the state’s Medicaid plan. Thus, for children covered by the Medicaid program, any medically necessary service must be provided.

This does not mean, however, that Medicaid pays for *everything* a child needs under EPSDT. The service must be a medical service, delivered by a qualified health care provider, and it must be medically necessary. Thus, a child or youth with significant oral health needs identified in an EPSDT screening would be covered for those oral health services even if those services are not listed in the state’s Medicaid plan. On the other hand, a teen with autism spectrum disorder who needs support to learn a new job skill may find that the state Medicaid program denies coverage on the grounds that such support is an educational or vocational service rather than a medical one.

In short, while the EPSDT program provides comprehensive coverage for children, this coverage is limited by the requirements that the services be deemed medically necessary and be delivered by qualified providers.³



EPSDT

The Early Periodic Screening, Diagnosis, and Treatment program requires that states provide children with screening, diagnosis, and treatment to prevent, ameliorate, or treat conditions and to promote development. Identified needs must be treated even if the service would not normally be covered by the state’s Medicaid plan.

2. 42 CFR § 447.56. <https://www.govinfo.gov/app/details/CFR-2021-title42-vol4/CFR-2021-title42-vol4-sec440-1>

3. See 42 CFR §440-441 for descriptions of covered services. <https://www.govinfo.gov/app/details/CFR-2000-title42-vol3/CFR-2000-title42-vol3-part440>, <https://www.govinfo.gov/app/details/CFR-2000-title42-vol3/CFR-2000-title42-vol3-part441>.

CARE COORDINATION/CASE MANAGEMENT

Title V programs often fund care coordination services for children and youth with special health care needs (CYSHCN). Medicaid programs also fund care coordination services through Home and Community-Based Services (HCBS) waivers, managed care plans, primary care case management programs (see Section 7 for more detailed information on managed care and primary care case management), EPSDT, and targeted case management.

Within Medicaid, care coordination is usually called case management. Sometimes case management involves a “gatekeeper” function designed to ensure that services are provided in the most cost-effective manner or in accordance with health-plan utilization management guidelines. In other cases, case management services are similar to Title V-funded care coordination, helping children and youth gain access to needed medical, social, educational, and other services.

HCBS waiver programs are required to include case management as a covered service. This might include information and referral services, coordination across multiple care providers, and service allocation decisions, particularly if there is a concern that the cost of HCBS might exceed the cost of institutional care.

Managed care and primary care case management programs vary widely in both their interpretation and implementation of case management. For example, targeted case management services (TCM) may be provided for specific groups of children and youth with complex needs, such as those in out-of-home placement, with developmental disabilities, or with special health care needs. TCM regulations require that case managers take a client history, perform a comprehensive assessment, prepare a care plan, make referrals, and conduct monitoring and follow-up activities.⁴

EPSDT will cover services such as information and referral, arranging for screenings, and arranging assessment and follow-up care. Sometimes Medicaid programs use EPSDT or TCM funding mechanisms to contract with Title V programs to deliver care coordination services to CYSHCN and receive federal Medicaid matching dollars.

Not all states provide for case management in their CHIP programs. In states that do not, Title V funds can provide critical “wraparound” services to ensure that CYSHCN who are enrolled in CHIP have access to care coordination services.



Medicaid includes mandatory benefits that states are required to cover under federal law and optional benefits that states may choose to cover. Whether optional or mandatory, each service provided must be adequate in amount, duration, and scope to “reasonably achieve its purpose.”

4. The regulatory definition of TCM is found at 42 CFR §440.169(b). <https://www.govinfo.gov/app/details/CFR-2009-title42-vol4/CFR-2009-title42-vol4-sec440-169>

HOME AND COMMUNITY-BASED SERVICES

Some children, youth, and adults with serious disabilities receive Medicaid services through a Home and Community-Based Services (HCBS) waiver or an HCBS option without a waiver. These programs assist children, youth, or adults with severe disabilities to live at home and avoid institutionalization. They are called waiver programs because they waive Medicaid rules regarding covered services and, in some cases, income eligibility. Waiver services may include care coordination, attendant-care services, community support services, home-based behavioral services, visiting nurse services, or other services that are not otherwise available under the state plan.

The waiver restricts the availability of these services to individuals who are enrolled in the program; thus, unlike other Medicaid services, these services are not an entitlement. Historically, these services have been provided only under waivers granted by the federal government. More recently, Congress has permitted states to deliver the same services simply by submitting a state plan amendment (SPA) without going through the waiver process.⁵ Because a state may cap the number of participants under a waiver, but not under a SPA, the choice of a waiver or a SPA will affect the number of people who are able to receive these benefits.

PREMIUM ASSISTANCE PROGRAMS

Finally, many Medicaid and CHIP programs have premium assistance programs. In these programs, if a parent has access to private health insurance for the child or youth through their employer, the state may pay for the parent to purchase this private coverage. The state may do this when it is less expensive to pay the employee's share of the private insurance premium than

to pay directly for the child's or youth's care. The child or youth maintains Medicaid or CHIP coverage to pay for those services not covered by private insurance. In this way, the parent often can obtain coverage as well.⁶

CHILDREN'S HEALTH INSURANCE PROGRAM BENEFITS

States with Children's Health Insurance Program (CHIP) programs that are expansions of the state's Medicaid program and are governed by the same rules must offer the same mandatory services required by federal Medicaid law, including the periodic screenings for physical and mental conditions and vision, hearing, and dental services required by EPSDT.

States that administer their CHIP programs separately from their Medicaid programs have greater flexibility in designing their benefit packages. A state's CHIP benefit package must meet one of the following criteria:

- Benchmark coverage: CHIP coverage is "substantially equal" to that provided through one of three options: the Federal Employee Health Benefit Program, the state employee plan, or coverage offered by the health maintenance organization plan with the largest commercial enrollment in the state.
- Benchmark-equivalent coverage: CHIP coverage that has an "aggregate actuarial value" that is "actuarially equivalent" to the coverage under one of the three benchmark plans.
- Coverage approved by the Secretary of the U.S. Department of Health and Human Services.
- Comprehensive state-based coverage that existed when CHIP was enacted (only in Florida, New York, and Pennsylvania).⁷

5. Social Security Act §1915 [42 USC 1396n] (i). https://www.ssa.gov/OP_Home/ssact/title19/1915.htm

6. Thirty-eight states have premium assistance programs. U.S. Department of Labor, Employee Benefits Security Administration. (2020 July 31). Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP). OMB Control Number 1210-0137 (expires 1/31/2023). Retrieved May 11, 2021, from <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.pdf>

7. Benefits. Medicaid.gov. Accessed at <https://www.medicaid.gov/chip/benefits/index.html>

In addition, all CHIP programs must cover well-baby and well-child care (including immunizations); inpatient and outpatient hospital services; physicians' surgical and medical services; and laboratory, X-ray, dental, and emergency services. As with private insurance, if mental health services are provided, they must not be more restricted than physical health services.

Separately administered CHIP programs are less likely to cover some of the services most needed by CYSHCN that are covered under Medicaid's EPSDT benefit.

Finally, more cost sharing, such as premiums and copayments, may be imposed on CHIP families than on those enrolled in Medicaid; however, total cost sharing may not exceed 5% of the family's income.

THE AFFORDABLE CARE ACT (ACA) AND COVERED SERVICES FOR CYSHCN

In 2014, EPSDT became available to more children and youth in 20 states⁸ because the Affordable Care Act (ACA) required states to raise Medicaid eligibility for children and youth ages 6 to 19 from 100% to 138% of

the FPL, shifting children from CHIP to Medicaid.⁹ Other coverage changes required by the ACA are described in Section 9.

WHERE ARE THE OPPORTUNITIES FOR TITLE V PROGRAMS?

Title V programs have significant opportunities to collaborate with Medicaid agencies regarding Medicaid and CHIP benefits. For example, Title V programs may:

- Advise Medicaid programs on how to help parents of enrollees understand the EPSDT benefits that will be available to their children.
- Work with Medicaid and other state policymakers to develop Medicaid buy-in programs or waiver programs to enhance benefits for CYSHCN whose health and support service needs are above and beyond the services covered by private insurance, CHIP, or standard Medicaid programs.
- Work with the Medicaid agency to improve Medicaid-funded case management.

8. The 20 states are Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming. Farrell, K., Hess, C., and Justice, D. (2011, January). *The Affordable Care Act and Children with Special Health Care Needs: An Analysis and Steps for State Policymakers*, p. 25. National Academy for State Health Policy. Retrieved May 11, 2021, from <https://ciswh.org/resources/the-affordable-care-act-and-children-with-special-health-care-needs-an-analysis-and-steps-for-state-policymakers/>

9. The ACA language sets the eligibility limit at 133% of the federal poverty level in 2014, but then instructs states to disregard an amount of income that brings the household to 138% of the FPL. ACA, Section 2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 Section 1004(e). <https://www.govinfo.gov/content/pkg/PLAW-111publ152/html/PLAW-111publ152.htm>



TEST YOUR KNOWLEDGE

1. EPSDT stands for:

- a. Early Piloting of Special Diagnostic Tests
- b. Early Periodic Sailing is Definitely Treatment
- c. Early Periodic Screening, Diagnosis, and Treatment
- d. Early Partners in Diagnosis and Treatment

2. EPSDT is required by federal law in:

- a. Medicaid, but not CHIP
- b. CHIP, but not Medicaid
- c. All Medicaid and CHIP programs

3. If a vision problem is discovered during an EPSDT screening, treatment for it is covered by:

- a. CHIP in all states
- b. Medicaid in all states
- c. Medicaid in some states

4. Medicaid is prohibited from imposing copayments, deductibles, coinsurance, or other fees (“cost sharing”) on services for children and youth whose family income is less than what percentage of the federal poverty level (FPL)?

- a. 100%
- b. 150%
- c. 200%



FIND OUT IN YOUR STATE

- 1. Does your state have a home health SPA and/or a HCBS waiver?**
- 2. How is care coordination funded for CYSHCN in your state? Is CHIP administered separately from Medicaid?**
- 3. Does Medicaid or CHIP in your state have a premium assistance program?**
- 4. What “optional benefits” are covered by your state Medicaid Plan?**

ANSWER KEY

1. c 2. a 3. b 4. b

This document is part of Medicaid and CHIP: A Tutorial on Coverage for Children and Youth with Special Health Care Needs (CYSHCN). The document is available in its entirety at <https://ciswh.org/resources/Medicaid-CHIP-tutorial>

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