



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Medicaid Learning Lab

A yellow lightbulb icon with a brain inside, symbolizing ideas and learning.

Session 4: Medicaid and CHIP Benefits

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05-20-2021*

Session 4: Medicaid and CHIP Benefits

- Medicaid Benefits
 - Mandatory vs. Optional Benefits
 - Medicaid's Pediatric Benefit: EPSDT
 - Cost-sharing
 - Delivery Systems
- CHIP Benefits
 - CHIP Program Structure
 - Separate CHIP Benefits
 - Cost-sharing
 - Delivery Systems

Poll

- How would you describe your level of knowledge?



MEDICAID BENEFITS

Medicaid Benefit Basics

Federal Requirements

- Beneficiaries have an individual entitlement to have payment made for a defined set of benefits.
- States must cover mandatory benefits.
- Beneficiaries have a right to a fair hearing in the event of a denial of benefits.

State Flexibility

- States have flexibility on:
 - Coverage of optional benefits;
 - Amount, duration, and scope of mandatory and optional benefits;
 - Cost-sharing;
 - Delivery systems (fee-for-service or managed care);
 - Utilization management (e.g., medical necessity, prior authorization);
 - Provider reimbursement rates;
 - And there's more!

Medicaid Benefit Basics, Cont.

Limits on Federal Payments

- Federal matching funds are not available for certain services (e.g., “institution for mental diseases” services)
- Federal matching funds may be available through expenditure authority under a section 1115 demonstration (e.g., substance use disorder demonstrations)

Benefits Topics Not Covered

- Prevention
- Vaccines for Children
- Telehealth
- Pregnancy-related services, including postpartum
- Transportation
- Appeals
- Mental health parity
- And more!

Mandatory

- Inpatient hospital
- Outpatient hospital
- Rural health clinic
- Federally qualified health center (FQHC)
- Nursing facility services (> age 21)
- Freestanding birth centers
- Physician services
- Nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services (< age 21)
- Laboratory and X-ray
- Home health care
- Medical transportation
- Family planning services and supplies
- Tobacco cessation counseling and drugs for pregnant women
- Medication-assisted treatment (to 2025)
- COVID-19 testing, treatment, vaccination

Optional*

- Prescription drugs
- Dental services
- Intermediate care facilities for individuals with intellectual disabilities (ICF/ID)
- Services in an institution for mental disease (IMD) for 65 and older
- Clinic services
- Occupational therapy
- Physical therapy
- Speech, hearing, and language disorder services
- Targeted case management
- Prosthetic devices
- Hospice services
- Eyeglasses
- Dentures
- Other diagnostic, screening, preventive, and rehabilitative services
- Respiratory care services
- Personal care services
- Private duty nursing services
- Primary care case management
- Health homes for enrollees with chronic conditions
- Other licensed practitioner services (e.g., podiatrist, optometrist)
- Services for certain diseases (e.g., tuberculosis, sickle cell disease)
- Chiropractic services
- Program for All-Inclusive Care for the Elderly (PACE) services
- Inpatient psychiatric hospital services for children <21

Limits on the Scope of Benefits

- The state must specify the services it covers in its State Medicaid Plan
- Each service must be “*sufficient in amount, duration, and scope to reasonably achieve its purpose*”
 - AL and OK limit physician services to 4/month
- States may not arbitrarily deny or reduce the amount, duration, or scope of a mandatory benefit “*solely because of the diagnosis, type of illness, or condition*” (e.g., direct-acting anti-viral drugs for hepatitis C virus)

HCBS Waiver Services

- Home and Community-Based Waiver services enable frail elderly beneficiaries and those with intellectual or developmental disabilities to receive needed services in their homes or communities rather than in nursing facilities or other institutional settings.
- Examples:
 - Personal care services
 - In-home nursing
 - Respite care
 - Equipment/technology modifications
- HCBS are neither “mandatory” nor “optional;” states cover them by obtaining a waiver from CMS, not through a State Plan Amendment.
- HCBS waiver services allow states to target particular populations (e.g., medically fragile children) and to limit the number of individuals who obtain HCBS services.
- In 2020, nearly 820,000 people were on waiting lists with an average wait time of 39 months.*

Essential Health Benefits (EHBs)

10 Essential Health Benefits

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services;
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

EHB Rules

- Qualified health plans in the Marketplaces must cover each of these categories of EHB benefits
- States that take up the Medicaid expansion for adults with incomes up to 138% FPL must provide at least EHB benefits, known as Alternative Benefit Plans (ABP) in Medicaid
- EHB benefits do not include nursing facility services and non-emergency medical transportation, among others

Children's Medicaid Benefits: EPSDT

Building Blocks of Medicaid's Early, Periodic, Screening, Diagnostic, and Treatment Benefit

Identify problems **early**, starting at birth

Check children's health and development at **periodic** intervals

Provide development, vision, and hearing **screenings** to detect problems

Perform **diagnostic** tests to identify risks

Provide **treatment** for any problems found

Meet Gavin

When Gavin was born, he received a newborn hearing screening indicating possible hearing loss.

EPSDT Screening

- Children must receive periodic screenings to evaluate their general physical and mental health, development, and nutrition
- States may set their own periodicity schedules in consultation with medical professionals
- The AAP's recommended periodicity schedule is known as Bright Futures

After Gavin's initial hearing screening showed possible hearing loss, he received a comprehensive evaluation from a pediatric audiologist.

EPSDT Diagnosis and Treatment

States must provide diagnostic and treatment services for necessary services (as indicated by the screening process), even if the diagnostic and treatment services are not included in the Medicaid state plan

Gavin was diagnosed with moderate sensorineural hearing loss in both ears. His family chose an auditory-oral approach of treatment, using aided hearing and spoken language for communication and learning. An audiologist fit Gavin with hearing aids in both ears when he was 3 months old.

EPSDT Medical Necessity

- Required coverage includes all health care services found to be *“necessary... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services”*
- Decision must be made on a case-by-case basis
 - States may not impose hard amount, duration, and scope limits on pediatric services
 - States may impose tentative limits pending an individualized determination, a decision shared by the state and the child’s treating provider
 - Children have appeals rights

After 3 years of consistent hearing aid use and periodic habilitative treatment services, Gavin entered preschool with normal receptive and expressive language, on par with his peers.

EPSDT Outreach

- States must inform families about EPSDT within 60 days of determining eligibility and annually thereafter
- It must be clear that services include preventive care plus vision, dental and hearing services, all free of charge
- States must also inform families that transportation services are available

Pop Quiz

- What is the name of Medicaid's pediatric benefit?

Cost-Sharing Basics

- A state Medicaid agency may require beneficiaries to share in the cost of a covered service, although children and pregnant women are largely protected.
- If a copayment is required, the agency reduces the amount of the payment to the provider by the amount of the copayment.
- Participating providers must accept Medicaid payment as payment in full.
- States may allow providers to withhold services for failure to meet the cost-sharing requirement.

Decades of research demonstrate that imposing cost-sharing on low-income populations reduces the use of needed as well as unnecessary services

Cost-Sharing for Children and Adults

- Children
 - No cost-sharing for children under 133% FPL (\$29,207/year for a family of 3) for any service
 - States may charge cost-sharing for children at higher income levels for some services (e.g., non-preventive physician visit, ER visit, non-emergency use of the ER, inpatient hospital visit)
- Adults
 - Nominal cost-sharing for adults is allowed (e.g., \$4 for preferred drugs and \$8 for non-preferred drugs for adults under 150% FPL)
 - No cost-sharing for certain services (e.g., family planning, emergency, pregnancy-related)
- Children and Adults
 - Total premiums and cost-sharing cannot exceed 5% of family income

Freedom of Choice of Provider

- Providers are not required to participate in Medicaid, either FFS or managed care.
- Providers are allowed to participate in Medicaid if they are qualified to furnish the service.
- Beneficiaries may obtain covered services from any participating provider unless the state has restricted freedom of choice.
 - Texas has prohibited Planned Parenthood clinics from participating in its Medicaid program.
- The most common legal restriction is mandatory enrollment in risk-based managed care, which limits a beneficiary to the providers in the network of the managed care organization.

State Options for Delivering Medicaid Benefits

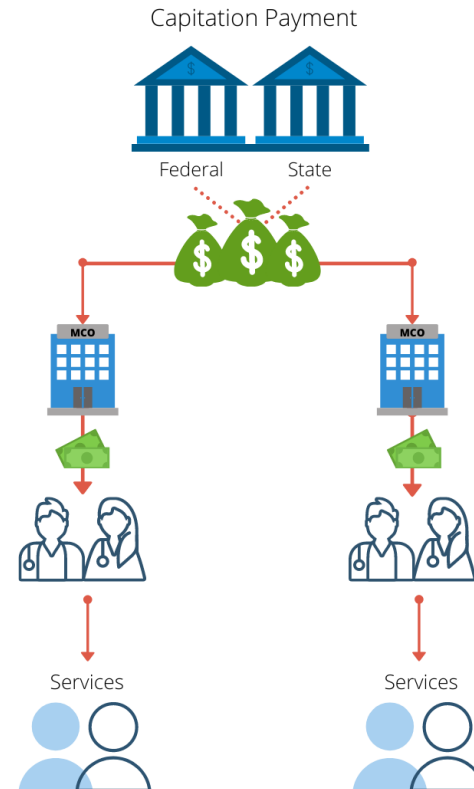
- Fee for Service
- Managed Fee for Service (Primary Care Case Management)
- Risk-Based Managed Care (Managed Care Organizations, or MCOs)

Risk-Based Rules

40 states and the District of Columbia contract with MCOs to arrange for the delivery of covered services to some or all beneficiaries*

Risk-based Managed Care

- States pay an MCO a fixed amount per month (capitation payment) for each enrollee regardless of whether the enrollee uses services in that month.
- In exchange, the MCO agrees to arrange for the provision of the covered services needed by enrollees through a provider network.



Risk-based Managed Care Incentives

- Financial Risk
 - If the MCO pays out less to providers for furnishing covered services to enrollees than it receives in capitation payments, the MCO keeps some or all of the difference.
 - If the MCO pays out more to providers for furnishing covered services to enrollees than it receives in capitation payments, the MCO absorbs some or all of the loss.
- Utilization Management
 - To control the amounts it pays to network providers, an MCO commonly uses techniques to reduce provider claims for services, such as prior authorization requirements.
- Risk Contract
 - The distribution of financial risk, the utilization management techniques, and appeals rights depend on the terms of the risk contract between the state Medicaid agency and the MCO.



CHIP BENEFITS

State Options for CHIP Program Design

Medicaid Expansion	Separate CHIP Program	Combination of Approaches
16 States	2 States	33 States
All Medicaid rules apply except children must be uninsured	Based on one of three benchmark plans or Secretary approved	Medicaid expansion for certain children based on age or income
EPSDT rules apply; Medicaid's cost-sharing rules apply	Greater flexibility in benefits and cost-sharing	Medicaid rules for M-CHIP; Benefits may be more limited and cost-sharing may be higher for separate CHIP

Risk-Based Rules CHIP Too
 40 states use risk-based managed care for all or part of their CHIP programs

Separate CHIP Program Benefits

Mandatory Benefits

- Well-child and preventive care
- Immunizations
- Emergency care
- Inpatient and outpatient hospital services
- Physician services
- Lab and x-ray
- Dental services
- Mental health

Actuarially Equivalent to Benchmark Plan

- HMO with state's largest enrollment
- State Employee Plan
- Federal Employee Plan

13 of 35 Separate
CHIP Programs
Provide EPSDT
Services

CHIP Cost-Sharing

Cost-Sharing Rules

- Cost-sharing may begin at or above 133% FPL
- Cost-sharing can include deductibles and co-insurance, though copayments are the most commonly used
- Total premiums and cost-sharing cannot exceed 5% of family income

Copayments

- Common services with copayment requirements include:
 - Non-preventive physician visits
 - ER visits
 - Non-emergency use of the ER
 - Inpatient hospital visits
 - Prescription drugs

Future Topics

- **June 24, 2021 at 1pm ET**
 - Prescription Drugs
 - NOTE: This is a **new date!**
- July and August 2021:
Summer Break
- See you in September!



For More Information

Center for Children and Families

- ccf.georgetown.edu

Centers for Medicare & Medicaid Services

- <https://www.medicaid.gov/medicaid/benefits/index.html>

MACPAC

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

Kaiser Family Foundation

- <https://www.kff.org/statedata/collection/medicaid-benefits/>