Chapter 5: Benefit Basics

Mandatory and Optional Benefits

The Social Security Act specifies a set of benefits state Medicaid programs must provide and a set of optional benefits states may choose to provide. **Table 5.1** shows the current set of benefits covered by the Texas Medicaid program.

In This Chapter:

Table 5.1: Mandatory and Optional Services Covered by Texas Medicaid

The state may choose to provide some, all, or no optional services specified under federal law. Some optional services Texas chooses to provide are available only to clients under age 21, and one optional inpatient service is available for clients who are under 21 or are 65 or over in an institution for mental disease. Note: If the client is under age 21, all federally allowable and medically necessary services must be provided as required by federal law.

Mandatory and optional state plan services provided in Texas include:

Mandatory Acute Care Services	Optional* Acute Care Services
• Inpatient Hospital Services • Outpatient Hospital Services • Laboratory and X-Ray Services • Physician Services	• Prescription Drugs • Medical or Remedial Care by Other Licensed Practitioners: ○ Nurse Practitioners/Certified Nurse Specialists

Mandatory Acute Care Services	Optional* Acute Care Services
• Medical and Surgical Services Provided by a Dentist • Early and Periodic Screening, Diagnosis, and Treatment Services for Individuals Under 21 • Family Planning Services and Supplies • Federally Qualified Health Center Services • Rural Health Clinic Services • Nurse-Midwife Services • Certified Pediatric and Family Nurse Practitioner Services • Home Health Services • Freestanding Birth Center Services (when licensed or otherwise recognized by the state) • Transportation to Medically Necessary Services • Tobacco Cessation Counseling for Pregnant Women • Extended Services for Pregnant Women	○ Physician Assistants ○ Licensed Midwife ○ Certified Registered Nurse Anesthetists ○ Anesthesiologist Assistants ○ Psychologists ○ Licensed Clinical Social Workers** ○ Licensed Professional Counselors ○ Licensed Marriage and Family Therapists • Podiatry*** • Limited Chiropractic Services • Optometry (including eyeglasses and contacts) • Telemedicine • Home Telemonitoring • Hearing Instruments and Related Audiology • Home Health Supplies Provided by a Pharmacy • Clinic Services: ○ Maternity Clinic Services ○ Renal Dialysis Facility Services ○ Ambulatory Surgical Center Services • Tuberculosis Clinic Services

Mandatory Acute Care Services	Optional* Acute Care Services
	• Rehabilitation and Other Therapies: ○ Mental Health Rehabilitative Services ○ Rehabilitation and Other Therapy Services ○ Substance Use Disorder Treatment ○ Physical, Occupational, and Speech Therapy • Case Management Services for High-Risk Pregnant Women: ○ Pregnancy-Related and Postpartum Services for 60 days After the Pregnancy Ends ○ Services for Any Other Medical Conditions That May Complicate Pregnancy ○ Respiratory Care Services ○ Ambulance Services ○ Emergency Hospital Services ○ Private Duty Nursing
Mandatory LTSS	**Optional* LTSS**
• Nursing Facility Services for Clients 21 or Over	• Intermediate Care Facility Services for Individuals With an Intellectual Disability or Related Condition • Inpatient Services for Clients Under 21 or 65 and Over in an Institution for Mental Diseases • Services Furnished Under a Program of All-Inclusive Care for the Elderly

Mandatory LTSS	Optional* LTSS

	• Day Activity and Health Services
	• 1915(i) Home and Community Based Services-Adult Mental Health Services
	• 1915(k) Community First Choice Services:
	  ○ Attendant Care (including habilitation)
	  ○ Emergency Response Services
	• Attendant Services:
	  ○ Personal Care/Personal Attendant Services
	  ○ Community Attendant Services
	• Targeted Case Management for:
	  ○ Infants and Toddlers with Intellectual or Developmental Disabilities
	  ○ Adults with Intellectual or Developmental Disabilities
	  ○ Individuals with Chronic Mental Illness
	• Nursing Facility Services for Individuals Under 21 Years of Age
	• Prescribed Pediatric Extended Care Centers
	• Services Provided in Religious Nonmedical Health Care Institutions

Notes:
*Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.
**Except when delivered in an FQHC setting.
***Except when delivered by an M.D. or D.O.

Limits

Federal law allows states to define what constitutes reasonably sufficient amount, duration, and scope of Medicaid benefits. This means state Medicaid programs can, for example, limit the number of visits per year for a certain service or limit a service to outpatient settings. The following limits are not applicable to children under 21 whenever there is a medical necessity for additional services.

Limits on Texas Medicaid services include:

- A 30-day annual limit on inpatient hospital stays per spell of illness for adults served in fee-for-service (FFS) and STAR+PLUS. More than one 30-day hospital visit can be paid for in a year if stays are separated by 60 or more consecutive days. The annual limit does not apply to enrollees for a prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. The exception for prior-approved transplants allows an additional 30 days of inpatient care that begins with the date of the transplant. The limit does not apply to STAR+PLUS members admitted to an inpatient hospital due to a primary diagnosis of a severe and persistent mental illness (bipolar disorder, major depressive disorder, recurrent depressive disorder, schizophrenia, or schizoaffective disorder).
- Three prescriptions per month for adults in FFS for outpatient drugs. Family planning drugs are exempt from the three-drug limit. There are no limits on drugs for:
  - Children under age 21;
  - Adults enrolled in managed care;
  - Clients in nursing facilities; and
  - Clients enrolled in certain 1915(c) waiver programs.

Basic Principles

The Social Security Act establishes the following fundamental principles and requirements for the Medicaid program:

- Statewideness – All Medicaid services must be available statewide and may not be restricted to residents of particular localities.
- Comparability – The same level of services (amount, duration, and scope) must be available to all clients, except where federal law specifically requires a broader range of services, such as for Medicaid-eligible children, or allows a reduced package of services, such as for those who qualify as medically needy.
- Freedom of Choice – Clients must be allowed to go to any Medicaid

health care provider who meets program standards.

- Sufficiency – States must cover each service in an amount, duration, and scope that is "reasonably sufficient." States may impose limits on services only for Medicaid clients who are age 21 and over. A state may not arbitrarily limit services for any specific illness or condition.

State Plans

The Medicaid state plan is a document that serves as the contract between the state and the Centers for Medicare & Medicaid Services (CMS) for the Texas Medicaid program and gives the Health and Human Services Commission the authority to administer the Medicaid program in Texas. It describes the nature and scope of the state's Medicaid program, including Medicaid administration, client eligibility, benefits, and provider reimbursement. CMS must approve the plan and any amendments to the plan. Texas also has a CMS-approved Children's Health Insurance Program (CHIP) state plan.

Waivers

Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. These waivers allow states to waive certain Medicaid basic principles, required array of benefits, mandated eligibility and income groups, or combinations of these. Waivers allow states to develop creative alternatives to the traditional Medicaid program.

States seek waivers to:

- Provide services above and beyond state plan services to selected populations;
- Expand services in certain geographical areas;
- Limit free choice of providers; and
- Implement innovative new service delivery and management models.

Federal law allows three types of waivers: Research and Demonstration 1115 waivers, Freedom of Choice 1915(b) waivers, and Home and Community-Based Services (HCBS) 1915(c) waivers.

Research and Demonstration 1115 Waivers

Purpose

Section 1115 waivers allow flexibility for states to test substantially new ideas for operating their Medicaid programs by waiving a variety of requirements such as comparability or statewideness.

States may use these waivers to structure statewide health system reforms, test the value of providing services not typically covered by Medicaid, or allow innovative service

delivery systems to improve care, increase efficiencies, and reduce costs.

Requirements

Section 1115 waivers must be budget neutral to the federal government for the duration of the waiver.

Timeframe

Generally, Section 1115 waivers are five-year waivers, subject to renewal. CMS analyzes impact on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction.

Freedom of Choice 1915(b) Waivers

Purpose

Section 1915(b) waivers allow states to use a "central broker" (e.g., enrollment broker) to assist people with choosing a managed care organization (MCO), to use cost savings to provide additional services, or to limit clients' choice of Medicaid providers by requiring Medicaid clients join MCOs. Texas has used these waivers to provide an enhanced benefit package (beyond what is available through the state plan) with cost savings from managed care. MCOs selectively contract with hospitals and other types of health care providers to increase cost-effectiveness and to better control quality of services.

Requirements

Section 1915(b) waivers must be cost-effective. Client access, quality of care, and cost must not be negatively impacted by implementation of the waiver.

Timeframe

Section 1915(b) waivers are three-year waivers, except for those that serve individuals dually eligible for Medicare and Medicaid, which are five-year waivers. States may renew 1915(b) waivers, but CMS requires an independent assessment to show cost, quality, and access have not been compromised.

Home and Community-Based Services 1915(c) Waivers

Purpose

Section 1915(c) waivers allow states to provide community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, intermediate care facility for individuals with an intellectual disability or related condition, or hospital).

States may use these waivers to serve people age 65 and older, or those with physical disabilities, an intellectual or other developmental disability, or mental illness. States may also target more specialized populations such as individuals with

traumatic brain injuries or those with sensory impairment. Through 1915(c) waiver programs, states may provide services that are not found in the Medicaid state plan or that extend state plan services. Examples include case management, homemaker/home health aide, personal care, habilitation, respite care, non-medical transportation, in-home support, special communication, minor home modifications, and day activity and health services.

Requirements

Section 1915(c) waivers must be cost neutral for the duration of the waiver. In other words, the aggregated cost of serving individuals in the waiver must be the same or less than the cost to serve them in an institution. Also, the state must assure safeguards are in place to protect individuals' health and welfare.

Timeframe

Section 1915(c) waivers are initially approved for three years and may be renewed for five-year intervals.

Maintenance of Effort Requirements

The Affordable Care Act (ACA) restricts states' ability to make changes to existing Medicaid and CHIP programs by extending maintenance of effort (MOE) requirements. The American Recovery and Reinvestment Act of 2009 prohibits states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Changes to Medicaid benefits, however, can be made. For adults, MOE requirements were in effect until January 1, 2014 (or when a health insurance exchange was established), and for children, including children in CHIP, MOE continues through September 30, 2019. Under the ACA, states must comply with Medicaid and CHIP MOE requirements to receive Medicaid funding.

Federal guidance has clarified how MOE applies to Medicaid waivers. For instance, Section 1115 and HCBS waivers can expire and are not required to be renewed under MOE. In addition, states may renew a waiver – with modifications – at the end of the approved waiver period in effect as of March 23, 2010.