Medicaid Benefits Database Notes and Methods

The Kaiser Family Foundation (KFF) contracted with Health Management Associates (HMA) to survey Medicaid directors in all 50 states and the District of Columbia to identify those benefits covered for adult beneficiaries in their programs. The resulting data collection updates previous years of KFF Medicaid benefits data (data from 2012 and previous years remain accessible through drop down menus in most of the indicators). The survey instrument captures information about benefits covered, cost sharing requirements, and notable limits on those benefits as of July 1, 2018. A table summarizing the number of states covering each benefit is included in this document below. The 2018 benefits database tables reflect what the states reported on the survey; responses vary in level of detail and were not verified through another source.

The 2018 survey asked states to report coverage of benefits in their fee-for-service (FFS) programs for categorically needy (CN) traditional Medicaid adults ages 21 and older. Unlike in previous years, the 2018 survey did not ask about benefit coverage for medically needy (MN) coverage groups, which may differ from the state's CN benefit package. Children were excluded from the survey because all children under age 21 enrolled in Medicaid through the categorically needy pathway are entitled to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires states to cover any medically necessary mandatory or optional service (regardless of whether the service is covered for adults). All but four states (Illinois, Iowa, New York, and South Carolina) submitted survey responses, and the territories are not included in the 2018 data.

The survey was designed to cover the range of optional services covered by states as well as any copayment or service limitations imposed on mandatory and optional benefits. States selected from a yes/no dropdown menu to indicate whether optional Medicaid benefits are covered, but responses for mandatory benefits were hard coded as "Yes – Mandatory." For these mandatory benefits that states are required to cover by federal law, all states are counted as "Yes – Mandatory" in the "Benefit Covered" column even if they did not respond to the survey.

Note that while this survey focused on benefit coverage in FFS, managed care organizations contracted in states to serve Medicaid beneficiaries sometimes offer services not available on a FFS basis to their adult enrollees. In addition, managed care contracts are often based on the state plan (FFS) benefit package but some services may be carved out of managed care. States had an opportunity on the survey to note differences in required minimum benefits for Medicaid managed care organizations (MCOs), as well as differences in benefit coverage under Alternative Benefit Plans (benefit plans that Medicaid expansion states are required to design, in line with federal guidelines, for newly eligible ACA expansion adults) or Section 1115 waiver programs. To the extent that they were reported, these notes are included in the tables as state-specific footnotes. However, it is unclear how comprehensive states' responses were related to capturing these differences.

Although a particular service may not be identified on a table as covered, the state is also obligated to pay Medicare coinsurance and/or deductible amounts up to specified limits for certain enrollees who are dually eligible for Medicare and Medicaid (such as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), or Qualified Individual (QI) beneficiaries) and are receiving a service covered by Medicare, even if the Medicaid program does not otherwise cover it or the individual is not otherwise eligible for Medicaid benefits.

Federal rules generally preclude states from charging copayments for emergency services, pregnancy or family planning services, or for services rendered to beneficiaries residing in institutions, such as nursing facilities. American Indians are exempted from any state Medicaid copayment requirement for services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral from one of these entities to a contracted health services provider.

A list of mandatory and optional benefits is available here. For federal definitions of mandatory and optional benefits, see 42 C.F.R. Part 440, Subpart A here.

Medicaid Benefits Database National Summary Counts

Benefit	Benefit Covered in State?			# States Requiring Copayments	# States with Limits on Services
	# Yes	# No	# NR		
INSTITUTIONAL AND CLINIC SERVICES					
Inpatient Hospital Services, other than in an Institution for Mental Diseases	Mandatory			24	21
Outpatient Hospital Services	Mandatory			24	12
Rural Health Clinic Services	Mandatory			25	16
Federally Qualified Health Center Services	Mandatory			24	16
Clinic Services (excluding mandatory FQHC and RHC services)	42	2	7	25	12
Freestanding Birthing Center	33	11	7	0	6
PRACTITIONER SERVICES					
Physician Services	Mandatory			25	17
Medical/Surgical Services Furnished by a Dentist	Mandatory			20	18
Nurse Midwife Services	Mandatory			8	7
Nurse Practitioner Services	Mandatory			21	14
Dentist Services	39	6	6	19	35
Podiatrist Services	40	5	6	19	14
Optometrist Services	43	2	6	23	27
Chiropractor Services	24	21	6	13	18
Psychologist Services	39	4	8	15	17
PRESCRIPTION DRUGS					
Prescription Drugs	51	0	0	36	32
Over-the-Counter Products	42	4	5	27	30
Tobacco Cessation Products (other than as required for pregnant women)	46	0	5	20	25
PHYSICAL THERAPY AND OTHER SERVICES					
Physical Therapy Services	41	5	5	13	25
Occupational Therapy Services	40	6	5	13	24
Services for Speech, Hearing and Language Disorders	38	8	5	12	22
PRODUCTS AND DEVICES					
Dentures	31	15	5	7	27
Prosthetic and Orthotic Devices	45	1	5	13	30
Eyeglasses and other Visual Aids	33	13	5	11	28
Hearing Aids and other Hearing Devices	28	18	5	9	23
Medical Equipment & Supplies (other than through Home Health)	42	3	6	11	29
TRANSPORTATION SERVICES					
Ambulance Services	46	0	5	6	10
Non-Emergency Medical Transportation Services	46	0	5	5	22
OTHER SERVICES					
Laboratory and X-Ray Services, outside Hospital or Clinic	Mandatory			11	15
Family Planning Services	Mandatory			0	8
Diagnostic, Screening and Preventive Services	42	3	6	10	15
Rehabilitation Services - Mental Health and Substance Abuse	42	2	7	7	22
Case Management	19	25	7	2	8
Targeted Case Management	36	8	7	2	17
ACA Health Home	23	19	9	2	6
Other Medical or Remedial Care: Hygienists or Dental Assistants	21	21	9	8	13
Other Medical or Remedial Care: Physician Assistants	36	8	7	17	11

LONG-TERM CARE: HOME AND COMMUNITY-BASED CARE					
Home Health Services: Nursing Services, Home Health Aides, and Medical Supplies/Equipment	46	0	5	10	30
Home Health Services: Physical Therapy, Occupational Therapy, and/or Speech Pathology/Audiology	44	2	5	4	25
Private Duty Nursing Services	25	21	5	3	19
Hospice Care	46	0	5	4	18
Personal Care Services	34	17	0	2	27
Self-Directed Personal Assistance Services	21	24	6	1	17
Program of All-Inclusive Care for the Elderly (PACE)	27	19	5	3	9
LONG-TERM CARE: INSTITUTIONAL CARE					
Nursing Facility Services, Age 21+	Mandatory			12	23
IMD services for adults 65+	42	4	5	1	13
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	44	2	5	6	18

Source: Kaiser Family Foundation Medicaid Benefits Survey conducted by Health Management Associates, data as of July 1, 2018. See the KFF Medicaid Benefits Database for data by state and additional notes.