Coverage of Medicaid Preventive Services for Adults – A National Review

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EXECUTIVE SUMMARY

Under the Patient Protection and Affordable Care Act ("ACA"), states are encouraged to increase their role in improving access to evidence-based preventive screenings and strategies. One of these provisions goes into effect on January 1, 2013, when state Medicaid programs will have the opportunity to receive a one percentage point increase in their Federal Medical Assistance Percentage matching rate ("FMAP") if they cover the immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices ("ACIP") and the preventive services rated "A" or "B" by the U.S. Preventive Services Task Force ("USPSTF") without cost-sharing. The USPSTF is an independent panel of experts that reviews scientific evidence on clinical preventive health care services and issues recommendations for primary care providers and health systems. This study evaluates Medicaid coverage across the country for twenty-four of those services that focus on non-pregnant adults. Our main findings are:

It is Difficult to Ascertain Exactly Which Preventive Services are Covered by State Medicaid Agencies*.* A few states provide detailed information about their preventive services coverage. These include Medicaid programs in Kentucky, Indiana, Maine, Massachusetts, Nevada, New Jersey, and Oregon, and Medicaid managed care programs in California, DC, Illinois, New Mexico, and Texas. On the other hand, many Medicaid agencies do not provide a detailed list of specific preventive services that are covered in their program; others elect not to list the

preventive services covered in favor of simply covering "age-appropriate screens," allowing providers to choose the appropriate services based on generally accepted standards of care. Even states indicating that they follow a specific standard of care may only mean they follow that standard for the subset of services they actually cover. In addition to the lack of specificity, confusion relating to the term "medical necessity" made it difficult to determine which services are covered by Medicaid programs.

Coverage of the USPSTF A & B Rated Services Varies Widely Across States*.* There is wide variation in coverage of the twenty-four USPSTF A & B rated services evaluated in this report. It is often difficult to know whether states cover counseling and health education services that are generally not reimbursed separately from an office visit.

Breast and Cervical Cancer: The services most likely to be covered preventively include screening mammograms and pap smears. Only three states explicitly do not cover a screening mammogram: Arkansas, Georgia, and Oklahoma. Three other states are likely to cover screening mammograms, but do not list the service specifically. All other states explicitly cover screening mammograms.

Most states (thirty-six) cover cervical cancer screens (pap smears) explicitly. In addition, nine states are likely to cover this service as part of an age-appropriate exam. Four states (Arkansas, Georgia, Texas, and Wyoming) only cover cervical cancer screening as part of a family planning visit. Only two states, South Carolina and Alaska, do not cover cervical cancer screening using a pap smear at all.

Colorectal Cancer: More than half of the states (thirty-three) cover colorectal screening explicitly, and another ten states are likely to cover this service through an age-appropriate exam. For the states that cover colorectal cancer screening, most cover the basic screening options (fecal occult blood test, flexible sigmoidoscopy, and colonoscopy) and leave it to provider discretion and guidelines to determine which method to utilize.

STDs and HIV: There is significant variation within and among states in terms of STD and HIV screening coverage, and there are often qualifications to coverage. Fee-for-service ("FFS") programs in twelve states and managed care programs in nineteen states cover routine STD screens without qualification. Similarly, FFS programs in nine states and managed care programs in fifteen states cover routine HIV screens without qualification. On the other hand, family planning visits are the only way to obtain routine STD screening in eight states and routine HIV screening in three states. Most states fall under the "AAS" category, meaning they cover age-appropriate screens but do not explicitly cover STD or HIV screens.

Heart Health: A variety of preventive services are related to cardiovascular health. Of these services, more states specify coverage for healthy diet counseling (nineteen yes), obesity screens (seventeen yes), and cholesterol screens (sixteen yes), than many of the other heart related services. Only nine states specified coverage for abdominal aortic aneurysm screens and eight specified coverage for aspirin counseling to prevent cardiovascular disease, although twenty-nine states over over-the-counter ("OTC") aspirin if prescribed by a physician.

Coverage of Well-Adult Exams is Important to Accessing Preventive Services*.* Accessing preventive services is more difficult for beneficiaries in states that do not offer well-adult exams. If beneficiaries do not have an acute issue to be addressed, they will not be able to access a provider for an office visit; if they do have an acute issue to be addressed, the entire visit will likely focus on that issue.

Thirty-three states provide coverage for a well-adult exam in their FFS program, while sixteen states do not. All of the states that cover a well-adult exam in their FFS program also cover one in their managed care program (if they have a managed care program). In addition, four states do not cover a well-adult exam in their FFS program, but require one in their managed care program. Tennessee, which does not have a FFS program, also requires a well-adult exam in their managed care program.

The states that cover well-adult exams are split fairly evenly between those that charge co-pays and those that do not. The decision whether to charge co-pays for well-adult exams applies to other preventive care. In other words, a state that does not charge co-pays for a well-adult exam is also unlikely to charge a co-pay for other preventive services.

Coverage of Treatment Items is Fairly Consistent Across States. Most states cover blood glucose monitors and insulin pumps. It appears common for states not to charge co-pays or seek prior authorization for blood glucose monitors, although there were a number of states where information was not available about these restrictions. While most states do not charge a co-payment for insulin pumps,

it is much more likely that prior authorization is required for insulin pumps than for blood glucose monitors.

About half of the states cover aspirin OTC, increasing beneficiary access to that drug. Relatively few states cover off-label drug use or clinical trials. Most states do not cover the routine costs associated with a beneficiary's participation in clinical trials and the few that do often have restrictions associated with coverage.

Less Variation than Expected Between Fee-For-Service and Managed Care Programs. In general, when there was a difference between FFS and managed care programs, managed care programs provided more coverage and more specificity about coverage, such as identifying which standard of care providers must follow. Coverage differences exist between managed care and FFS more often with STD and HIV screens than in many of the other preventive services; in most cases, these services are more often explicitly covered in managed care programs than in their FFS counterparts. In general, however, there were fewer coverage differences than expected between the two types of programs.

State Medicaid Programs are Not Focusing on Covering the USPSTF A & B Recommendations. Significant confusion or lack of knowledge exists regarding the ACA provision that provides states with an FMAP increase for coverage of USPSTF A & B rated services. Only sixteen states had enough information about the provision to have considered whether the state would change their coverage policies in response to the financial incentives.

Conclusion

There was significant variation among states in which services were covered under Medicaid for non-elderly, non-pregnant adults. While some research has been published examining Medicaid coverage of select preventive services, there has not been a comprehensive look at state-level Medicaid coverage of preventive services for adults. This study is intended to provide a better understanding of Medicaid coverage of preventive services for adults in the current state programs, help guide federal policymakers as they make decisions about the criteria qualifying a state for the FMAP increase, and inform state policy makers as they consider the level of preventive benefits and services to offer should they expand Medicaid in 2014.

INTRODUCTION

On March 23rd 2010, President Obama signed the Patient Protection and Affordable Care Act ("ACA") into law.[1] This law institutes sweeping changes to public and private health insurance coverage, and to the health care delivery system in this country. Major provisions in the ACA include the creation of state-based health insurance exchanges intended to establish a private market for individuals who previously had a difficult time securing affordable health care, new benefits requirements for private insurance companies, and a significant eligibility expansion in the Medicaid program.

A number of sections in the ACA focus on prevention, including mandatory coverage of tobacco cessation services for pregnant women enrolled in Medicaid,[2] and implementation of public awareness campaigns about the availability of prevention and obesity-related services to Medicaid enrollees.[3] One key requirement relating to preventive services affects both private plans and Medicare coverage. Medicare, new private health insurance plans, and existing private plans that are not "grandfathered" (and therefore are not bound by all of the ACA requirements) must cover all preventive services given an "A" or "B" rating by the United States Preventive Services Task Force ("USPSTF") without cost-sharing

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[1] Patient Protection and Affordable Care Act, Pub. Law No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, 30, and 42 U.S.C.), *amended by* the Health Care and Education Reconciliation Act of 2010, Pub. Law No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.) [hereinafter "ACA"].

[2] ACA § 4107 (amending § 1905 of the Social Security Act, codified at 42 U.S.C. § 1396d).

[3] ACA § 4004 (codified at 42 U.S.C. § 300u-12(i)).

requirements.[4] Medicaid programs are not required to cover these services without cost-sharing, but they are given a financial incentive to expand their coverage.[5]

The USPSTF is an independent panel of experts that reviews scientific evidence on clinical preventive health care services and issues recommendations for primary care providers and health systems.[6] The USPSTF assigns one of five grades (A, B, C, D, or I) to each of its recommendations reflecting the degree of net benefit associated with provision of the particular service. The USPSTF recommends that both A & B services should be offered to patients meeting the recommended criteria. An "A" grade indicates *high* certainty that the net benefit of providing the service is *substantial,* and a "B" grade indicates either *high* certainty that the net benefit is *moderate* or *moderate* certainty that the net benefit is *moderate* to *substantial.*[7] Currently, there are forty-four A or B rated services recommended by the USPSTF.[8]

This study evaluates current Medicaid coverage of twenty-four A or B rated services in every state and the District of Columbia ("DC"). Most of the services that were not evaluated in the study are relevant specifically to children or pregnant women and were excluded because services available to these groups tend to be

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[4] ACA § 1001 (amending Part A, Title XXVII of the Public Health Services Act, codified at 42 U.S.C. §§ 300gg et seq.).
[5] ACA § 4106 (amending § 1905(a)(13) of the Social Security Act, codified at 42 U.S.C. § 1396d(a)(13)).
[6] U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/ (last visited Sept. 21, 2012).
[7] *Grade Definitions*, U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm (last updated May 2008).
[8] *USPSTF A & B Recommendations*, U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last updated August 2010).

quite robust compared to other Medicaid populations. Understanding current preventive coverage levels will provide insight into whether beneficiaries have access to critical preventive services and will help quantify the task ahead in encouraging all states to provide full preventive services coverage.

I. PREVENTION

Preventive health services are services designed to promote health and prevent disease.[9] Prevention activities can either reduce the chance that a harmful event will occur or ameliorate the harm of an event that has already occurred. It is common to refer to prevention on one of three levels: primary, secondary or tertiary.

Primary prevention activities are directed toward susceptible individuals or populations for the purpose of preventing diseases or disorders from occurring.[10] Secondary prevention activities are screening and diagnostic services designed to detect diseases before they become symptomatic in order to prevent the disease from recurring or worsening.[11] Screenings detect specific diseases in their early

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[9] National Library of Medicine. *Medical Subject Headings, 2011 MeSH: Preventive Health Services*. Accessed August 28, 2012 from http://www.nlm.nih.gov/cgi/mesh/2011/MB_cgi?mode=&term=Preventive+Health+Services.

[10] National Library of Medicine. *Medical Subject Headings, 2011 MeSH: Primary Prevention*. Accessed August 28, 2012 http://www.nlm.nih.gov/cgi/mesh/2011/MB_cgi?mode=&term=Primary+Prevention&field=entry#TreeN02.421.726.758.

[11] National Library of Medicine. *Medical Subject Headings, 2011 MeSH: Secondary Prevention*. Accessed August 28, 2012 from http://www.nlm.nih.gov/cgi/mesh/2011/MB_cgi?mode=&term=SECONDARY+PREVENTION.

stages so that treatment can be given when it will be most effective and least expensive. Tertiary prevention is the management of chronic diseases to minimize morbidity and maximize quality of life in individuals who have been diagnosed with a long-term disease or injury.[12] Table 1 identifies the target population at each level of prevention and offers examples of associated intervention activities.

Table 1. Levels of Prevention[13]		
Level	**Target Population**	**Examples of Interventions**
Primary	• Entire community • Segments of a community with a particular need	• Widespread immunization • Smoking cessation counseling
Secondary	• Asymptomatic individuals with certain risk factors	• Screening mammograms to detect breast cancer • Blood pressure checks to detect hypertension
Tertiary	• Individuals with an established disease or disability	• Rehabilitation for an individual who has had a stroke • On-going mental health treatment

This study focuses on primary and secondary prevention activities provided by a primary care provider to an individual patient. Primary prevention activities include providing health education and behavioral counseling (e.g., healthy diet

[12] National Library of Medicine. *Medical Subject Headings, 2011 MeSH: Tertiary Prevention*. Accessed August 28, 2012 from http://www.nlm.nih.gov/cgi/mesh/2011/MB_cgi?mode=&term=TERTIARY+PREVENTION.

[13] See National Public Health Partnership, *The Language of Prevention* (2006), *available at* http://www.nphp.gov.au/publications/language_of_prevention.pdf.

counseling and counseling to take aspirin to prevent cardiovascular disease), and secondary prevention activities include testing to detect disease (e.g., screening mammograms and colonoscopies).

The Importance of Prevention

Increasing access to preventive services could make significant headway towards reducing the disease burden on the country, as Americans are suffering from more preventable disease than ever before. The number of individuals with a chronic disease is expected to increase from 133 million in 2005 to 171 million in 2030.[14] In 2009, over 8% of adults in the U.S. had diabetes and over 27% had high blood pressure. In 2010, the rate of obesity reached 35% in adults and 17% in children.[15] If the obesity trend continues unabated over the next 20 years, 44% of all Americans will be obese, while the number of new cases of obesity-related chronic diseases, including type-2 diabetes, coronary heart disease, stroke, and hypertension, could double by 2020 and quadruple by 2030.[16] Obesity-associated medical costs are estimated to be at least $147 billion a year and could increase by as much as $66 billion annually by 2030; indirect costs such as lower productivity could cost $400 billion annually by 2030.[17]

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[14] Steven Woolf, Commentary, *A Closer Look at the Economic Argument for Disease Prevention*, 301 JAMA 536 (2009).
[15] Trust for America's Health, *F as in Fat: How Obesity Threatens America's* Future, at 3-5 (2012), *available at* http://healthyamericans.org/assets/files/TFAH2012FasInFatfinal.pdf.
[16] *Id*., at 3-5.
[17] *Id.*, at 28-32.

Preventive services could play a major role in decreasing the morbidity and mortality rate in the U.S. Four detrimental and preventable health behaviors (smoking, diet, physical inactivity, and alcohol use) account for over a third of all deaths in the United States.[18] Two-thirds of all cancers could be eliminated through change in diet, physical activity, and tobacco use.[19] Providing colorectal cancer screening to asymptomatic patients has been shown to reduce mortality rates by 65% %.[20] An estimated 100,000 lives could be saved just by increasing the use of five USPSTF recommended services: counseling certain adults to take aspirin daily to prevent heart disease, tobacco cessation counseling and medication, providing colorectal cancer screens, immunizing older adults against the flu, and increasing the number of women screened for breast cancer.[21]

Increasing access to preventive services may also help reduce racial and ethnic disparities in our health system. Hispanic-Americans are less likely than non-Hispanic whites and African-Americans to use ten different preventive services, including tobacco cessation counseling and colorectal cancer screening.[22] Asian-Americans have the lowest utilization of any group for screening tests to detect

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[18] Ali H. Mokdad, James S. Marks, Donna F. Stroup, and Julie L. Gerberding, *Actual Causes of Death in the United States, 2000*, 291 JAMA 1328-1245 (2004).
[19] Gail Shearer, American Public Health Association, *Prevention Provisions in the Affordable Care Act (*October 2010), *available at* http://www.apha.org/NR/rdonlyres/763D7507-2CC3-4828-AF84-1010EA1304A4/0/FinalPreventionACAWeb.pdf.
[20] Kahi, et al., *Effect of Screening Colonoscopy on Colorectal Cancer Incidence and Mortality*, 7 Clin Gastroenterol Hepatol 770-775 (2009).
[21] Partnership for Prevention, *Preventive Care: A National Profile on Use, Disparities, and Health Benefits* at 6-7 (2007), *available at* http://www.rwjf.org/content/dam/web-assets/2007/08/preventive-care.
[22] *Id*., at 7.

colorectal cancer, breast cancer, and cervical cancer.[23] While screening rates for colorectal and breast cancer are higher for African-Americans than other minority groups, increased screening would have the greatest impact on African-Americans due to their higher mortality rates for these diseases.[24]

Lack of Focus on Prevention

Although an estimated 75% of health care expenditures are related to chronic disease care,[25] this country spends only 2-3% of its total health care dollars on preventive services.[26] The lack of focus on prevention can be attributed to a number of factors, including:

- Challenges that relate to the provision of preventive services by practitioners during all stages of patient interaction, including contacting patients about receiving preventive services, providing preventive services during patient encounters, and following up with patients about preventive care. In addition, providers usually see patients for acute and chronic conditions, focusing such visits on the treatment necessary to address the acute or chronic issue instead of prevention. A recent study found that as a result of these challenges, providers failed to deliver two-thirds of required

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[23] *Id.*
[24] *Id*.
[25] National Ctr. For Chronic Disease Prevention and Health Promotion, Ctrs. for Disease Control and Prevention, *The Power to Prevent, The Call to Control: At A Glance 2009* at 2, *available at* *http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf*.
[26] David Satcher, *The Prevention Challenge and Opportunity*, 25 Health Affairs 1009 (2006).

immunizations, more than half of recommended counseling services, and a quarter of recommended screening tests. [27]

- A health care system focused on acute care and specialty care, as evidenced by limited medical school training on preventive care, inadequate coverage of preventive services by health insurance plans (or coverage without cost-sharing requirements), and low reimbursement for preventive services.[28]
- A paucity of regular sources of care for those without health insurance. Given financial and access problems, uninsured individuals are less likely than those with insurance to receive preventive services and more likely to receive services when a disease is at a later stage.[29]
- Consumer unfamiliarity with recommended preventive services and limited interest in changing detrimental health behaviors. These factors coupled with the time consuming and occasionally unpleasant nature of some preventive services reduces the likelihood of consumers proactively seeking preventive care.[30]

Although only a small portion of our health care dollars is spent on preventive care, a vigorous debate exists on the cost savings of preventive services. Measuring the cost savings of preventive services is difficult for a variety of reasons: it often

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[27] Shires, et al., *Prioritization of Evidence-Based Preventive Health Services During Periodic Health Examinations*, 42 Am. J. Prev. Med. 164 (2012).
[28] Partnership for Prevention, *supra* note 19, at 14.
[29] Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Found., Pub. No. 7451-07, *The Uninsured: A Primer – Key Facts about Americans without Insurance* (2011), *available at* http://www.kff.org/uninsured/7451.cfm.
[30] Partnership for Prevention, *supra* note 19, at 14.

takes many years before a measurable improvement in health outcomes occurs; changing health behaviors in one area, such as smoking, can have positive effects in relation to several diseases; and societal benefits associated with better health, including increased work productivity and feeling well, can be difficult to measure.[31] In addition, the savings associated with an intervention can often be confused with the savings that result from modifying one's lifestyle in response to an intervention. For example, the savings that result from a clinician advising an overweight individual to increase activity and reduce consumption is questionable, but the health benefit to an individual of actually increasing their activity and improving their diet is not in dispute. Complicating the measurement of cost savings are concerns about the high cost of providing preventive services to many healthy, asymptomatic, low-risk individuals who undergo preventive tests and screens simply to make sure potential diseases are detected early.

In order to account for the complexity inherent in determining the value of preventive services, it is appropriate to use cost-effectiveness, not cost savings, as a key measure. In other words, the concern is not just about the total dollars spent, but how much value is purchased with each dollar spent. Cost-effectiveness can be calculated using the well-established metric of a quality-adjusted-life-year ("QALY"). QALY is a measure that encompasses years of life gained and years of life lived free of disease and injury.[32] Services are considered cost-effective if they cost less than $50,000-$75,000 per QALY, although payers generally cover treatments that cost

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[31] Woolf, *supra* note 12, at 537 - 38.
[32] Partnership for Prevention, *supra* note 19, at 12.

upwards of $100,000 per QALY.[33] Studies that consider the cost-effectiveness of many USPSTF recommendations have found either a net savings or a per-QALY cost well within acceptable ranges. For example, a cost savings is associated with counseling to take aspirin to prevent heart disease, smoking cessation, and alcohol misuse counseling.[34] Chlamydia and colorectal cancer screens have a cost of less than $15,000 per QALY, and screens for breast cancer, cervical cancer, high cholesterol and hypertension cost less than $50,000 per QALY.[35]

Standards of Care

Medical providers should adhere to an accepted standard of care when providing care to patients. Standards of care are developed on a national basis by independent groups of experts such as the USPSTF, provider-specific associations such as the American Congress of Obstetricians and Gynecologists, and non-profit, evidence-based research organizations such as the American Cancer Society, the American Diabetes Association, and the American Heart Association. These standards provide guidance to clinicians regarding appropriate screening, diagnostic and treatment options. Legally, standards of care provide information for assessing provider performance. Practitioners making clinical decisions are held to

[33] Woolf, *supra* note 12, at 536.
[34] Partnership for Prevention, *supra* note 19, at 13.
[35] *Id*.

the standard of a "reasonably prudent and competent practitioner under similar circumstances."[36]

Medicaid programs have the option of choosing a specific standard of care that providers must follow or allowing providers to practice according to unspecified "nationally accepted" or "generally accepted" standards of care. Following a specific standard of care may be required for provision of some services, but not others. The USPSTF A & B recommendations provide a standard of care identifying the patient population that should receive each service and the circumstances under which the service should be provided. Table 2 lists the twenty-four services that are the subject of this report along with the associated standards of care as recommended by the USPSTF.

Table 2. Specified USPSTF A & B Recommendations

Topic	Description	Grade	Date in Effect
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.	B	February 2005
Alcohol misuse counseling	The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.	B	April 2004
Aspirin to prevent CVD: men	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent CVD: women	The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in	A	March 2009

[36] Joel Teitelbaum & Sara Wilensky, *Essentials of Health Policy and Law* at 218-19 (Jones and Bartlett Learning 2d ed. 2013).

Table 2. Specified USPSTF A & B Recommendations			
Topic	**Description**	**Grade**	**Date in Effect**
	gastrointestinal hemorrhage.		
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults aged 18 and older.	A	December 2007
BRCA screening, counseling	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.	B	September 2005
Breast cancer preventive medication	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.	B	July 2002
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.	B	September 2002
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.	A	January 2003
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.	A	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008

Table 2. Specified USPSTF A & B Recommendations			
Topic	**Description**	**Grade**	**Date in Effect**
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005
Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.	A	July 2005
Obesity screening and counseling: adults	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.	B	December 2003
Osteoporosis screening: women	The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.	B	September 2002
STIs counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008

Table 2. Specified USPSTF A & B Recommendations			
Topic	**Description**	**Grade**	**Date in Effect**
Syphilis screening: non-pregnant adults	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004

Standards of care developed by different entities are often very similar to each other, but there are occasionally meaningful distinctions among the standards. Appendix A outlines other commonly used standards of care for many of the services listed in Table 2.

Prevention versus Medical Necessity

"Medical necessity" is a term of art used by public and private insurers. Every insurer will indicate that they only cover and reimburse for services and goods that are "medically necessary" for the patient. The principle underlying medical necessity is that the appropriate care is being given to evaluate and treat a disease, injury, etc. [37]

There is not a uniform definition of medical necessity used by private insurers or in the Medicaid program. Each insurance plan and Medicaid agency crafts its own definition. In general, definitions of medical necessity address five questions relating to care and coverage: 1) does the plan cover a particular good or

[37] Sara Rosenbaum, Brian Kamoie, D. Richard Mauery & Brian Walitt, Substance Abuse and Mental Health Svcs. Admin., U.S. Dept. of Health and Human Svcs. DHHS Pub. No. (SMA) 03-3790, *Medical Necessity in Private Health Plans: Implications for Behavioral Health* (2003), a*vailable at* http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3A45C497-5056-9D20-3DAA24F165B5678A.pdf.

service; 2) is the appropriate standard of care being followed; 3) was the patient cared for in the safest and least intrusive way; 4) does the care qualify as "medical" care; and 5) is the care cost-effective.[38]

Practitioner adherence to the general standard of care is one aspect of determining whether a service is medically necessary, but compliance with clinical guidelines is not sufficient, by itself, to determine the medical necessity of a service. This is because decisions about health care treatment are based on individual circumstances. "The practice of medicine has a core ethical dimension and requires that the physician use his or her knowledge of the particular patient in deciding on the course of treatment along with the patient."[39] If clinical guidelines provided all of the information necessary to make appropriate treatment decisions, individualized knowledge about patients would be irrelevant.[40] In order to properly determine whether a service was medically necessary for a particular patient, insurers must review claims on a "case-by-case" basis.[41]

Unlike medical necessity determinations, decisions about whether preventive services should be provided are grounded in clinical guidelines and are not based on unique individual characteristics of the patient. For example, the USPSTF recommends that all women age forty and older should receive a screening mammogram every one to two years. Whether or not a woman should receive this

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[38] *Id.* at 1.
[39] Sara Rosenbaum, David M. Frankford, Brad Moore, & Phylls Borzi, *Who Should Determine When Health Care is Medically Necessary?*, 340New Eng. J. Med. 229 (1999).
[40] *Id.*
[41] American College of Medical Quality. *Policy 8: Definition and Application of Medical Necessity* (2010), *available at* http://www.acmq.org/policies/policy8.pdf.

screen is based on whether she fits into a category (over age 40), and not on the individual woman's medical history or other factors. This is because the purpose of a screening mammogram is to detect whether an asymptomatic woman has breast cancer. Sometimes a standard of care will identify a specific clinical indication that must be present before a screen is recommended. For example, the USPSTF recommends a diabetes screen for asymptomatic adults with sustained blood pressure greater than 135/80 mm Hg. Even though a specific clinical indicator is required, the screen is still recommended for all individuals who fit that category, regardless of individual factors such as family history or certain health behaviors.

Given the distinction in how to determine whether services are appropriate, a service will be covered either as a case-by-case decision based on medical necessity arising from a patient's individual circumstances or as preventive care based on application of a specific standard of care to the patient; coverage cannot be both. As an illustration of this distinction, we return to the mammogram example. Every Medicaid program covers mammography, but the question is whether the test is covered only when medically necessary or based solely on a recommended guideline. For example, it is a medically necessary diagnostic mammogram if a doctor orders a mammogram after palpating a lump during a clinical breast exam. On the other hand, it is a preventive screening mammogram if a doctor orders a mammogram because the patient is a woman over 40. To be covered preventively as an A & B recommended service, the service has to be available solely based on the USPSTF guidelines.

II. MEDICAID AND HEALTH REFORM

Medicaid is the nation's federal-state public health insurance program for the indigent. Medicaid insures one out of every five people in this country, or approximately 60 million individuals.[42] To be eligible for Medicaid, an individual must meet five requirements: 1) fit into a designated category (e.g., pregnant women, child under one year of age), 2) earn an income no higher than is allowed for that category, 3) have non-wage resources that do not exceed a state mandated threshold, 4) be a resident of the United States and the state where benefits are received, and 5) meet immigration requirements if applicable.[43] As a result of these rules, Medicaid generally covers children, pregnant women, disabled adults and the elderly, and excludes many non-disabled adults.

Almost all (89%) of Medicaid enrollees are either poor (meaning they earn less than 100% of the Federal Poverty Level, FPL) or near-poor (meaning they earn less than 200% FPL).[44] A family of four with a total household income of $23,050 would be at 100% of the FPL in 2012. [45] As shown in Figure 1, almost half of Medicaid enrollees are children, and a quarter of enrollees are non-elderly, non-disabled adults. Eligibility and benefits for children are typically more generous than for adults. In thirty-three states, the maximum income threshold for working

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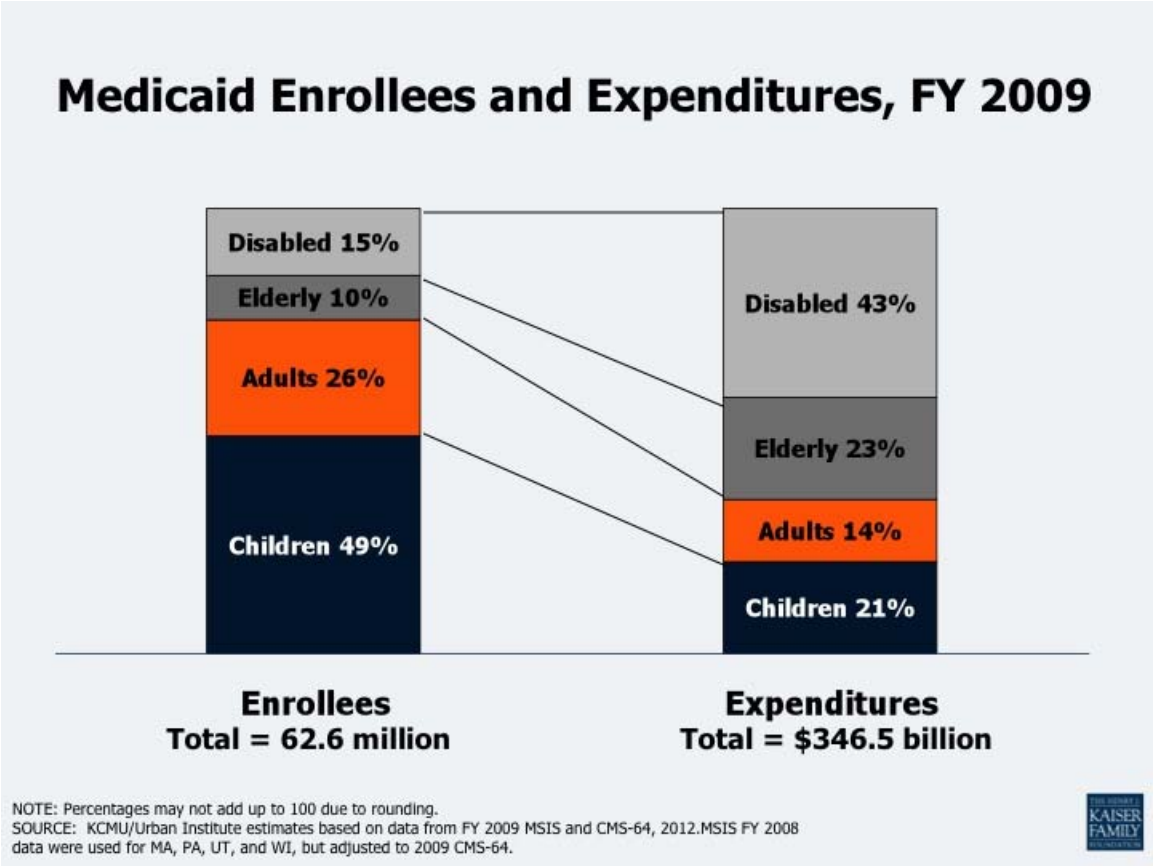
[42] Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Found., Pub. No. 7235-05, *Medicaid Program at a Glance* (2012), *available at* http://www.kff.org/medicaid/upload/7235-05.pdf.
[43] Teitelbaum, *supra* note 34, at 187.
[44] *Id.*
[45] *2012 HHS Poverty Guidelines*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Svcs., http://aspe.hhs.gov/poverty/12poverty.shtml (last visited Sept. 22, 2012).

adults to be eligible for Medicaid is below 100% FPL, and many non-disabled adults without dependent children are not eligible at all. Over half of Medicaid enrollees are part of racial or ethnic minority groups, with African-Americans accounting for 22% and Hispanics accounting for 27% of enrollees in 2009.[46]

Figure 1.



Medicaid programs are jointly designed and administered by the federal and state governments. The Centers for Medicare & Medicaid Services ("CMS") is the federal agency that oversees Medicaid in accordance with applicable federal statutes and regulations. The federal government sets general parameters for all Medicaid

[46] Teitelbaum, *supra* note 34, at 186.

programs, outlining minimum benefit and eligibility requirements as well as additional options states may choose to include in their program. Each state and the DC has its own Medicaid agency responsible for administering the state's program. States file a State Plan with the federal government that outlines the state's Medicaid program, including which optional benefits or populations the state has chosen to cover, if any. Given the flexibility of Medicaid's design, every state program is unique and must be considered individually. As a result, exactly which preventive services are covered, which populations may receive those services, and who is even eligible for the program will vary across all states.

Federal law requires states to cover ten types of services, including physician services, family planning services, laboratory services, and x-ray services.[47] However, these services are defined in general terms and do not mandate inclusion of specific services. For example, physician services are defined as those services that are "within the scope of practice of medicine or osteopathy as defined by State law, and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy."[48]

States may choose to cover certain optional services, including "other diagnostic, screening, preventive, and rehabilitative services."[49] In accordance with

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[47] Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, Ctrs. for Medicare & Medicaid Svcs., *Brief Summaries of Medicare & Medicaid*, at 25-26 (2010), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2010.pdf.
[48] 42 C.F.R. § 440.50(a) (2011).
[49] Social Security Act § 1905(a)(13), 42 U.S.C. § 1396d(a)(13) (2012).

the ACA, this definition has to be expanded to include, "any clinical preventive services that are assigned a grade of A or B by the [USPSTF]" to their definition of these diagnostic, screening, preventive, and rehabilitative services.[50]

Financing, like all other aspects of Medicaid, is a joint venture. States receive federal matching funds for all services covered in their program. The matching level is referred to as the Federal Medical Assistance Percentage ("FMAP"). The state share of the cost of the program is determined by a formula that divides the state's per capita income by the national per capita income, and multiplies that figure by a constant (.45). The federal share is 100% minus the state share.[51] Based on the formula, poorer states receive a higher federal share than wealthier states, but the minimum federal share for most services is 50%. Fiscal Year 2013 FMAP rates range from a low federal share of 50% in states such as California, Illinois, and Massachusetts to a high of 73% in Mississippi, 71% in Idaho, and 70% in Arkansas.[52] Some services receive a higher FMAP rate regardless of the state; these include family planning services, which are reimbursed at a 90% federal match, and services provided to uninsured women with breast or cervical cancer, which are reimbursed at an enhanced FMAP rate. As an incentive for states to cover the

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[50] ACA § 4106 (amending § 1905(a)(13) of the Social Security Act, codified at 42 U.S.C. § 1396d(a)(13)).
[51] *See* Social Security Act § 1101(a)(8)(B), 42 U.S.C. § 1301(a)(8)(B) (2012); Social Security Act § 1905(b), 42 U.S.C. § 1396d(b) (2012).
[52] Kaiser Family Found., *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, State Health Facts, http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4, (last visited Sept. 22, 2012).

USPSTF A & B rated services, the ACA includes a 1% FMAP increase for the preventive services a state chooses to cover.[53]

Medicaid is also financed through beneficiary cost-sharing. This may take the form of deductibles, premiums, or co-payments. Federal law prohibits states from requiring cost-sharing for certain populations and services, such as preventive services for children. When permitted, cost-sharing is generally limited to nominal amounts, with a maximum co-pay of $3.80 for Fiscal Year 2012. Higher cost-sharing amounts may be charged to certain populations with incomes over 100% FPL and in states that have chosen to implement options established through the Deficit Reduction Act.[54]

The ACA included a significant expansion expected to provide coverage to more than seventeen million individuals. The 2012 Supreme Court ruling made the Medicaid expansion optional, allowing states to choose to expand coverage to all non-disabled adults aged 19-65 with incomes at or below 133% FPL.[55] Coverage of this optional group will be different than coverage of those in the traditional Medicaid population. Enrollees in this expansion category will not need to fall into an approved category (e.g., pregnant woman) or pass a resources test. Income eligibility would be calculated based on federal standards relying on Modified

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[53] ACA § 4106 (amending § 1905(a)(13) of the Social Security Act, codified at 42 U.S.C. § 1396d(a)(13)).

[54] Ctrs. for Medicare & Medicaid Servs., *Cost Sharing Out of Pocket Costs*, Medicaid.gov, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html (last visited Sept. 25, 2012).

[55] ACA § 2001 (amending Title 19 of the Social Security Act, codified at 42 U.S.C. §§ 1396a et seq). While the income limit is set at 133%, allowances in how income is calculated make the effective limit 138%.

Adjusted Gross Income (MAGI), instead of state standards. The federal match for the expansion population would be 100% between 2014 and 2016, and will phase down slightly over the next several years so that by 2020 and thereafter, the federal government will pay 90% of the costs. The benefits provided to this expansion population must include the ten broad categories included in the ACA's Essential Health Benefits ("EHB"), but do not have to be the same as those offered to traditional Medicaid beneficiaries. Similar to the private insurers discussed earlier, qualified health plans participating in state insurance exchanges must provide a defined set of benefits that includes the USPSTF A & B recommended services.[56] As a result, the expansion population is likely to have access to preventive services that might not be available to other Medicaid populations in the state.

[56] ACA § 2713 (45 C.F.R. 147.145(c))

III. RESEARCH QUESTIONS AND METHODOLOGY

Research Questions

This research study evaluated coverage of preventive services for adults in Medicaid programs across the country. Specifically, the following five research questions were addressed:

1. **Which of the twenty-four USPSTF A & B rated services shown in Table 2 are covered as preventive care for adults by state Medicaid programs?**

The key question is not whether these services are covered at all, but whether they are covered *as preventive care*. As discussed in Section I, while many of the twenty-four recommendations listed above are covered by Medicaid programs, they may be covered only as medical necessary, not preventively. This research study evaluates when and under what circumstances these A & B rated services are covered preventively for adults.

2. **Which of five select treatment services and goods are covered for adults by state Medicaid programs?**

In addition to having coverage for certain preventive services, access to services and goods related to treatment can improve beneficiaries' health outcomes. The five treatment items evaluated in this study are:

- Blood glucose monitors
- Insulin pumps

- Over-the-counter aspirin
- Off-label drug use
- Clinical trial coverage

3. What restrictions, such as cost-sharing or prior approval requirements, are associated with these preventive services and treatment items?

Even if states provide coverage, restrictions such as cost-sharing or prior approval requirements may create barriers to accessing services. While all states must abide by federal rules relating to cost-sharing exemptions, states otherwise have flexibility relating to imposition of cost-sharing and other requirements.

4. How do coverage requirements differ between Fee-For-Service and managed care programs within a state?

Every state operates a fee-for-service ("FFS") portion to their Medicaid program, but as shown in Table 3, a number of states require almost all of their beneficiaries to enroll in a managed care program. In those states, the FFS program is basically irrelevant to this study because only limited populations such as long term care beneficiaries or those receiving organ transplants are served through the FFS program. There are two general types of managed care programs, Primary Care Case Management ("PCCM") and comprehensive managed care programs provided by Managed Care Organizations ("MCO"), such as Health Maintenance Organizations.

PCCM refers to a system in which a primary care provider acts as a quasi-medical home for a beneficiary. This means that the beneficiary sees that particular provider for primary care services. In some cases, a beneficiary may be required to obtain a referral from their primary care provider if additional services are needed. States vary on whether and when a referral is needed. In most cases, PCCM programs do not offer different services and rules than found in the state's FFS program. Since PCCM coverage is similar to FFS coverage, PCCMs are generally not discussed separately in the findings. Instead, the focus is on the difference between FFS and MCO coverage.

MCO refers to organizations operating in a comprehensive managed care environment. An MCO and the state enter into a contract that specifies the rights and responsibilities of all parties (MCO, beneficiary, state), including covered services and cost-sharing. A beneficiary enrolls in an MCO and is required to obtain all services provided by that MCO through the MCO. Beneficiaries are entitled to all services covered by their state's Medicaid programs. Some services, such as mental health services, may be "carved-out" of the MCO's contract with the state. Beneficiaries may obtain any carved-out services through the state's FFS program. Unlike PCCM programs, MCOs often provide very different coverage and have different rules than FFS programs. Generally, coverage provided by MCOs is more generous and has fewer restrictions than coverage in FFS programs.

Table 3. Type of Managed Care Programs, by State				
STATES	**PCCM**	**PCCM Referrals Required**	**MCO**	**Enrollment**
Alabama	Yes	Required for all services	No	Some enrolled in PCCM
Alaska	No		No	
Arizona	No		Yes	Most in MCO
Arkansas	Yes	Referral required for most relevant services	No	Most enrolled in PCCM
California	No		Yes	Half in MCO; most enrolled in PCCM (overlap)
Colorado	Yes	Referral required for most relevant services	Yes	Voluntary MCO and PCCM; few in either
Connecticut	No		No	
Delaware	No		Yes	Almost all in MCO
District of Columbia	No		Yes	Most in MCO
Florida	Yes	Referral required for most relevant services	Yes	Currently expanding MCO population
Georgia	No		Yes	Mandatory for most
Hawaii	No		Yes	Almost all in MCO
Idaho	Yes	Referral required for most relevant services	No	PCCM required for most
Illinois	Yes	Referrals not needed for most relevant services	Yes	MCO enrollment is voluntary; PCCM enrollment is mandatory unless in MCO
Indiana	Yes	No referrals needed	Yes	Most in MCO
Iowa	Yes	Referral required for most relevant services	No	Most enrolled in PCCM
Kansas	Yes	NR	Yes	Most in MCO
Kentucky	Yes	Referrals not needed for most relevant services	Yes	Currently expanding MCO population; most in PCCM
Louisiana	No		Yes	Currently expanding MCO population
Maine	Yes	Required for all services	No	
Maryland	No		Yes	Most in MCO
Massachusetts	Yes	NR	Yes	PCCM and MCO voluntary for all; most in one or the other
Michigan	No		Yes	Most in MCO
Minnesota	No		Yes	Most in MCO
Mississippi	No		No	
Missouri	No		Yes	Most in MCO
Montana	Yes	Referral required for most relevant services	No	Almost all in PCCM

Table 3. Type of Managed Care Programs, by State				
STATES	**PCCM**	**PCCM Referrals Required**	**MCO**	**Enrollment**
Nebraska	No		Yes	Most in MCO
Nevada	No		Yes	Most in MCO
New Hampshire	No		Yes	Continuing to expand; eventually MCO will be statewide
New Jersey	No		Yes	Most in MCO
New Mexico	No		Yes	Most in MCO
New York	Yes	Referral required for most relevant services	Yes	Most in MCO
North Carolina	Yes	Referral required for most relevant services	No	PCCM mandatory for most
North Dakota	Yes	Referral required for most relevant services	No	PCCM mandatory for most
Ohio	No		Yes	MCO mandatory for most
Oklahoma	Yes	Referral required for most relevant services	No	Almost all in PCCM
Oregon	Yes	NR	Yes	Almost all in MCO; some may choose between PCCM and MCO
Pennsylvania	Yes	Referral required for most relevant services	Yes	Many in MCO; PCCM enrollment mandatory if not in MCO.
Rhode Island	Yes	Referral required for most relevant services	Yes	Choice of PCCM or MCO for small population; MCO enrollment mandatory state-wide for all other populations
South Carolina	Yes	Referral required for most relevant services	Yes	Choice of either PCCM or MCO; entire population is in one or other
South Dakota	Yes	Referral required for most relevant services	No	PCCM mandatory state-wide with usual exemptions
Tennessee	No		Yes	Entire population in MCO
Texas	No		Yes	Mandatory state-wide with usual exemptions
Utah	Yes	No referrals needed	Yes	Mandatory for most with usual exemptions
Vermont	Yes	Referral required for most relevant services	Yes	MCO mandatory for most
Virginia	No		Yes	Mandatory state-wide with usual exemptions
Washington	Yes	N/A	Yes	MCO enrollment mandatory by county with voluntary enrollment

Table 3. Type of Managed Care Programs, by State				
STATES	**PCCM**	**PCCM Referrals Required**	**MCO**	**Enrollment**
				for exempt populations; PCCM enrollment is available only to tribal populations and is voluntary
West Virginia	Yes	Referral required for most relevant services	Yes	Mandatory for most with usual exemptions
Wisconsin	No		Yes	Mandatory for most with usual exemptions
Wyoming	No		No	

NR = No Response

While the contract between an MCO and a state will detail all of the requirements a state places on the organization, MCOs usually have flexibility to provide more generous benefits and coverage beyond what the state requires. Many MCOs choose to provide extra services or lower cost-sharing to entice beneficiaries to choose their organization over another MCO in the same service area. For several reasons, this research project focuses on state *requirements* of MCOs, not whether specific MCOs choose to go beyond those requirements. First, as a policy matter, we are interested in what the state considers necessary for their beneficiaries. Second, an MCO may choose to eliminate extra services at any time, making it impossible to know whether a particular service will continue to be offered by a particular MCO. Third, whether a beneficiary is eligible for a service would depend on the MCO in which that beneficiary is enrolled, making it impossible to draw broad generalizations about coverage across MCOs in a state.

5. **What information do Medicaid programs provide about their benefits to beneficiaries?**

Knowing which services are covered is key to accessing care. Understanding how and what kind of information is provided to beneficiaries is an important factor in assessing whether it is likely beneficiaries will obtain needed services, and whether they can act as their own advocate in the medical system.

Methodology

This study reviewed Medicaid policies in all 50 states and the District of Columbia (DC). The initial review included examination of publicly available documents, including:

- Provider manuals,
- Policy bulletins,
- Managed care contracts (boilerplate and actual),
- State statutes,
- State administrative regulations,
- Information for providers available on state Medicaid websites,
- Information for beneficiaries available on state Medicaid websites, and
- Fee schedules/billing manuals

There was significant variation in which type of documents states relied on most heavily to convey information about their program.

After completing the document review, researchers spoke with individuals in state Medicaid agencies to fill in missing information and clarify program rules. A survey instrument was not used because the information needed was unique to each state.

For most states, we were able to collect a significant amount of information. In a few other states, information was not available for a particular portion of their program, such as FFS programs in California, Pennsylvania's managed care and FFS (but have information relating to PCCM which is usually similar to FFS); and a new managed care program in Louisiana. Answers related to these areas and any other gaps in information collection are recorded as No Response (NR) in the tables.

IV. FINDINGS

Introduction

This section details the results from our document review and discussions with Medicaid personnel. It is difficult to understand exactly which preventive services are covered in each Medicaid program for several reasons. First, many states do not list specific preventive services that are covered, but instead use broad language in their programs indicating that providers should follow a generally accepted standard of care or nationally recognized standard of care. As discussed earlier in this report, there are variations among the standards of care that may be followed, meaning it is not clear exactly which service would be reimbursed in specific cases. In addition, Medicaid personnel were, at times, contradictory in their statements to researchers. For example, researchers were told that a Medicaid program covers age-appropriate screening tests and followed the USPSTF recommendations, but were also told that specific services recommended by the USPSTF were not covered by the state. It is possible they meant that for the services they cover, the state follows the USPSTF guidelines, but that information does not clarify coverage rules. For that reason, program language had to be explicit regarding coverage in order for a particular service to be marked as covered by that state.

Second, confusion with the notion of prevention and medical necessity often made coverage parameters unclear. As discussed earlier, prevention indicates that a service is provided based on a standardized guideline, not on an individualized need, and medical necessity indicates that a service is provided based solely on an

individualized need. Researchers were often told that various preventive services were covered if medically necessary based on a generally accepted standard of care, confusing the two issues and making coverage determinations difficult. In general, if Medicaid personnel referred to coverage based on medical necessity, it was assumed that the state did not cover the service preventively.

Third, some states referred researchers to the billing codes as a way to explain covered services. Most coding sheets, however, do not provide information regarding the specific circumstances under which a service will be covered. Since the question being addressed in this research is when services are covered as preventive care, not just whether a service is covered at all, the coding information was not sufficient to provide a clear answer. As an example, every state covers a lipid panel to test cholesterol levels, but that does not mean every state provides preventive cholesterol screening.

Finally, there are a number of services that are recommended by the USPSTF that are unlikely to be reimbursed separately, but instead are typically folded into an office visit and billed collectively under an Evaluation and Management ("E & M") code. Examples of these kinds of services include: blood pressure checks, counseling and education services, and mental health screening by a primary care provider. Services that are not reimbursed separately are less likely to be listed as specifically covered by a program.

As a result of these complexities, the tables in this section have a variety of entries. "Yes" means that it is clear the state covers that service preventively. This includes when a state indicates that it follows the USPSTF and the language in the

program documents clearly states that all USPSTF services are covered. Conversely, "no" means that it is clear the state does not cover the service preventively. "AAS" stands for "age-appropriate screen" and means that the state uses language such providing coverage for age-appropriate screening tests following generally accepted standards of care. In these cases the state does not list exactly which preventive services are covered. "NR" refers to "no response," meaning we were not able to obtain information on that issue from a state.

Well-Adult Exams

One of the primary ways that many states provide preventive services, and a key way for beneficiaries to access these services, is through a well-adult exam or similar service. A well-adult exam is an office visit when the beneficiary does not have a specific underlying medical issue that is the reason for the visit; it is a check-up. (We designate a state as providing a well-adult exam as long as it meets this definition, even if the state does not refer to that service as a well-adult exam).

Well-adult exams are important for beneficiary access. In states that cover some preventive services but do not have a well-adult exam, beneficiaries would most likely have to obtain those preventive services in the context of a medical visit for an acute need. As discussed earlier, many providers fail to offer patients all the recommended preventive services, and this problem is more likely to occur when the provider's and patient's time and energy are focused on addressing an acute issue.

As shown in Table 4, thirty-three states provide coverage for a well-adult exam in their FFS program, while sixteen states do not. All of the states that cover a well-adult exam in their FFS program also cover one in their managed care program, if they have one. In addition, four states do not cover a well-adult exam in their FFS program, but require one in their managed care program. Tennessee, which does not have a FFS program, also requires a well-adult exam in their managed care program. It is encouraging that more states than expected cover a well-adult exam, although a significant number of states lack coverage of this important service.

Table 4. Well Adult Exams

STATES	Well-Adult Exam (FFS)	Well-Adult Exam (MCO)	Preventive Services Specified	Age-Appropriate Services	Specify Standard of Care	Co-pay for Well-Adult Exam	Preventive Services Co-Pays
AL	No						Yes
AK	No						Yes
AZ	No	No					No (FFS); Yes (MCO)
AR	No						Yes
CA	No	Yes	x		USPSTF (MCO)	NR	Yes, except health ed (MCO; NR (FFS)
CO	Yes	Yes		x	No	Yes	Yes
CT	Yes			x	No	No	No
DE	Yes	Yes		x	No	No	No
DC	Yes	Yes	x		USPSTF (MCO)	No	No
FL	Yes	Yes	Yes		No	Yes (FFS); No, non-pilot Medicaid HMO, Yes other managed care options	Yes (FFS); No, non-pilot Medicaid HMO, Yes other managed care options
GA	No	No					N/A
HI	Yes	Yes		x	No	No	No

Table 4. Well Adult Exams							
STATES	**Well-Adult Exam (FFS)**	**Well-Adult Exam (MCO)**	**Preventive Services Specified**	**Age-Appropriate Services**	**Specify Standard of Care**	**Co-pay for Well-Adult Exam**	**Preventive Services Co-Pays**
ID	Yes			x	No	No	No
IL	No	Yes	x		No	No	No
IN	No	No					No
IA	Yes			x	No	Yes	Yes
KS	Yes	Yes		NR	NR	Yes (FFS); No MCO)	Yes (FFS); No MCO)
KY	Yes	Yes	x	x	Varies	Yes	Yes
LA	Yes	Yes		x	No	Yes (FFS); NR (MCO)	Yes (FFS); NR (MCO)
ME	Yes			x	USPSTF	Yes	Yes
MD	Yes	Yes		x	No	No	No
MA	Yes	Yes		x	No	Yes	Yes
MI	Yes	Yes		x	Varies	Yes	Yes (FFS); Yes, except health ed (MCO)
MN	Yes	Yes		x	No	Yes	Yes
MS	Yes		x	x	No	No	Yes
MO	Yes	Yes		x	ACS*	Yes (FFS; No (MCO)	Yes (FFS; No (MCO)
MT	Yes			x	No	Yes	Yes
NE	No	No					No
NV	Yes	Yes	x		USPSTF	No	No
NH	Yes	Yes		x	USPSTF (MCO)	No	No
NJ	Yes	Yes	x (MCO)	x	No	Yes	No
NM	No	Yes	x	x	USPSTF	No	No
NY	Yes	Yes	NR	NR	NR	NR	NR
NC	Yes			x	No	Yes	Yes
ND	No						Yes
OH	No	Yes		x	No	No	NR
OK	No						Yes
OR	Yes	Yes	x	x	USPSTF	No	No
PA	NR	Yes	NR	NR	NR	Yes	Yes
RI	Yes	Yes		x	No	No	No
SC	Yes	Yes	x		No	Yes	Yes
SD	Yes			x	No	Yes	Yes

Table 4. Well Adult Exams							
STATES	Well-Adult Exam (FFS)	Well-Adult Exam (MCO)	Preventive Services Specified	Age-Appropriate Services	Specify Standard of Care	Co-pay for Well-Adult Exam	Preventive Services Co-Pays
TN		Yes		x	USPSTF	No	No
TX	Yes	Yes	x	x	USPSTF	No	No
UT	No	No					No
VT	Yes	Yes		x	No	No	No
VA	No	No					No
WA	Yes	Yes	x (FFS)*	x (MCO)	No	No	No
WV	Yes	Yes		x	NR	No	No
WI	Yes	Yes		x	No	Varies	Yes
WY	No						NR

WA: specify pap and mammogram as services provided in their routine physical and one new patient visit in a three year period (FFS)

N/A: not cover preventive services

Of the states with a well-adult exam in either FFS, managed care, or both, twenty-three do not specify a particular standard of care for providers to follow and most of those twenty-three states also do not list specific services that should be provided during the exam. These are the states where it is particularly difficult to know whether a specific service is covered or under what circumstances it is or is not covered. There are twelve states that specify a standard of care, most often following the USPSTF. As seen in Table 4, a few states have variations between their managed care and FFS programs regarding specificity of services and standards of care, but for the most part they are the same across programs.

In both states that cover well-adult exams and those that do not, the states are split fairly evenly about whether they charge co-pays. The decision whether to charge co-pays for well-adult exams applies to other preventive care as well. In other words, most states that do not charge co-pays for well-adult exams also do not

charge co-pays for other preventive services. The three exceptions are Mississippi, New Jersey, and Wisconsin, which have different co-pay rules for well-adult exams and other preventive services.

Breast Cancer

The USPSTF A & B rated services include services related to breast cancer. These include: screening mammograms, BRCA testing, and counseling to take medication to prevent breast cancer. Of these three services, a screening mammogram is most likely to specified and covered by Medicaid programs, even in those states that generally do not cover preventive services. As shown in Table 5, only three states explicitly do not cover a screening mammogram: Arkansas, Georgia, and Oklahoma. Three other states are likely to cover screening mammograms, but do not list the service specifically. All other states explicitly cover screening mammograms.

Most states provide specific guidelines to providers regarding when screening mammograms should take place. The most common standard either refers to ACS guidelines or details that annual screening mammograms should start annually at age forty. The USPSTF is the next most common guideline specified. A handful of states allow a screening mammogram between ages thirty-five and thirty-nine to establish a baseline. A few states use different guidelines for FFS or managed care, but most states use the same guidelines across their programs. In addition, six states (IN, KS, KY, MA, MN, and PA) specify that they cover breast MRI

for high-risk women. Breast MRIs are only used for diagnostic purposes and are not covered as a screening tool.

Table 5. Screening Mammograms			
STATES	**Screening Mamm. (FFS)**	**Screening Mamm. (MCO)**	**Screening Mammogram Guidelines**
AL	Yes		Annually, age 50-64.
AK	Yes		ACS.
AZ	Yes	Yes	No guideline specified.
AR	No		No guideline specified.
CA	Yes	Yes	Baseline, age 35-59; Annually, age 40+ (FFS). USPSTF (Geographic and COHS MCO). Breast exam, age 40; mammogram, age 50 (2plan MCO).
CO	Yes	Yes	Baseline, age 35-39; Biannually, age 40-49 (Annually age 40-49 if at high-risk); Annually, age 50-65.
CT	Yes		No guideline specified.
DE	AAS	AAS	No guideline specified.
DC	Yes	Yes	USPSTF (MCO).
FL	Yes	Yes	Baseline age 35-39, annually 40+, based on ACS.
GA	No	NR	No guideline specified.
HI	Yes	Yes	Annually, age 40-69; Biannually, age 69+.
ID	Yes		Annually, age 40+.
IL	Yes	Yes	Baseline, age 35; Annually, age 40+.
IN	Yes	Yes	Biannually, age 40+.
IA	Yes		Annually, age 35+.
KS	NR	NR	No guideline specified.
KY	Yes	Yes	Annually, age 40+.

Table 5. Screening Mammograms			
STATES	**Screening Mamm. (FFS)**	**Screening Mamm. (MCO)**	**Screening Mammogram Guidelines**
LA	Yes	NR	Annually, age 40+.
ME	Yes		USPSTF.
MD	AAS	AAS	No guideline specified.
MA	AAS	Yes	Biannually, age 40-74 (more frequently ages 50-74 at provider's discretion).
MI	Yes	Yes	ACS, Annually, age 40+.
MN	Yes	Yes	No guideline specified.
MS	Yes		Annually, age 40+.
MO	Yes	Yes	ACS.
MT	Yes		Baseline age 35-39; Biannually 40-49; Annually 50+.
NE	Yes	Yes	ACS.
NV	Yes	Yes	USPSTF.
NH	AAS	Yes	USPSTF (MCO).
NJ	Yes	Yes	Baseline, age 35-39; Biannually, age 40-49; Annually, age 50+ (FFS). ACS; high-risk and under 40 at provider's discretion (MCO).
NM	Yes	Yes	USPSTF (MCO).
NY	Yes	Yes	No guideline specified.
NC	Yes		ACS.
ND	Yes		ACS.
OH	Yes	Yes	ACS.
OK	No		No guideline specified.
OR	Yes	Yes	Biannually, age 40-74.
PA	NR	Yes	Annually, age 40-69; high-risk, under 40 and over 70 at provider's discretion (PCCM).
RI	AAS	AAS	No guideline

Table 5. Screening Mammograms			
STATES	**Screening Mamm. (FFS)**	**Screening Mamm. (MCO)**	**Screening Mammogram Guidelines**
			specified.
SC	Yes	Yes	Baseline, age 35-39; Annually, age 50+.
SD	Yes		No guideline specified.
TN		Yes	USPSTF.
TX	Yes	Yes	ACS/USPSTF.
UT	Yes	Yes	No guideline specified.
VT	Yes	Yes	USPSTF.
VA	Yes	Yes	ACS, age 35+.
WA	Yes	Yes	NCI, Annually, age 40+ (FFS); no guideline specified (MCO)
WV	Yes	Yes	ACS, any age.
WI	Yes	Yes	No guideline specified.
WY	Yes		ACS.

AAS = age-appropriate screen

As shown in Table 6, it is much less likely that states cover BRCA testing. Only eleven states specify coverage for BRCA testing. It is unclear whether the states that cover age-appropriate screening tests would include BRCA testing as a covered service. For example, researchers were told by one state official that their state does not cover BRCA testing even though it generally covers age-appropriate screening tests based on USPSTF guidelines. Again, there is little difference in coverage between FFS and managed care programs, with New Mexico being the only state that clearly does not cover BRCA testing in FFS while clearly covering it in managed care.

While it is likely that many providers counsel about breast cancer medication as appropriate, only three states specify this as a covered service. It is expected that the states covering age-appropriate screens and relying on the USPSTF standard of care would also provide this service, but this cannot be confirmed.

Table 6. BRCA Screens and Chemoprevention Counseling				
STATES	BRCA Screen (FFS)	BRCA Screen (MCO)	Chemoprev. Counseling for Breast Cancer (FFS)	Chemoprev. Counseling for Breast Cancer (MCO)
AL	No		No	
AK	No		No	
AZ	No	No	No	No
AR	No		No	
CA	Yes	NR	No	No
CO	No	No	No	No
CT	AAS		AAS	
DE	AAS	AAS	AAS	AAS
DC	AAS	AAS	AAS	AAS
FL	No	NR	NR	NR
GA	No	NR	No	No
HI	AAS	AAS	AAS	AAS
ID	AAS		AAS	
IL	No	No	No	No
IN	Yes	Yes	No	No
IA	AAS		AAS	
KS	NR	NR	NR	NR
KY	No	No	No	No
LA	No	NR	No	NR
ME	Yes		Yes	
MD	AAS	AAS	AAS	AAS
MA	AAS	No	AAS	No
MI	AAS	AAS	AAS	AAS
MN	AAS	AAS	AAS	AAS
MS	AAS		AAS	
MO	AAS	AAS	AAS	AAS
MT	AAS		AAS	

Table 6. BRCA Screens and Chemoprevention Counseling				
STATES	BRCA Screen (FFS)	BRCA Screen (MCO)	Chemoprev. Counseling for Breast Cancer (FFS)	Chemoprev. Counseling for Breast Cancer (MCO)
NE	No	No	No	No
NV	Yes	Yes	Yes	Yes
NH	AAS	Yes	AAS	Yes
NJ	Yes	Yes	AAS	AAS
NM	No	AAS	No	AAS
NY	AAS	AAS	AAS	AAS
NC	No		AAS	
ND	No		No	
OH	No	No	No	AAS
OK	No		No	
OR	Yes	Yes	Yes	Yes
PA	NR	AAS	NR	AAS
RI	AAS	AAS	AAS	AAS
SC	No	No	AAS	AAS
SD	No		AAS	
TN		AAS		AAS
TX	Yes	Yes	No	No
UT	Yes	Yes	No	No
VT	Yes	Yes	AAS	AAS
VA	No	No	No	No
WA	Yes	Yes	AAS	AAS
WV	Yes	Yes	AAS	AAS
WI	AAS	AAS	AAS	AAS
WY	No		No	

AAS = age-appropriate screen

Colorectal Cancer

More than half of the states (thirty-three) cover colorectal screening explicitly, and another ten states are likely to cover this service through an age-appropriate exam. As shown in Tables 7 and 8, only five states explicitly do not cover colorectal cancer screening tests in either their FFS or managed care program.

In addition, for the states that cover colorectal cancer screening, most cover the basic screening options (fecal occult blood test, flexible sigmoidoscopy, and colonoscopy) and permit providers to determine which method to utilize, on the basis of either a specified guideline or a generally accepted standard of care. Ohio is the exception, covering colorectal screens only through use of colonoscopies.

Table 7. Colorectal Cancer Screen and Guidelines		
STATES	**Colorectal Cancer Screen**	**Guidelines**
AL	Yes	No guideline specified
AK	Yes	No guideline specified
AZ	Yes	No guideline specified
AR	No	
CA	NR (FFS); Yes (MCO)	USPSTF (MCO).
CO	AAS	No guideline specified
CT	AAS	No guideline specified
DE	AAS	No guideline specified
DC	Yes	USPSTF (MCO).
FL	Yes	No guideline specified
GA	Yes	Flexi. Sig every 48 months, age 50+; Colonoscopy every 24 months for high risk; FOBT annually, age 50+ (FFS).
HI	Yes	Digital rectal annually, age 50+; FOBT annually age 50+; Flexi. Sig. every 10 years, age 50+.
ID	AAS	No guideline specified
IL	Yes (MCO)	FOBT annually, age 50+; May consider Flexi. Sig. or Colonoscopy every 5-10 years.
IN	Yes	Age 50-75.
IA	AAS	No guideline specified
KS	NR	NR

Table 7. Colorectal Cancer Screen and Guidelines		
STATES	**Colorectal Cancer Screen**	**Guidelines**
KY	Yes (FFS)	FOBT during preventive exam and annually if only screening method used, age 50+; Flexi. Sig. every 5 years with annual FOBT, age 50+; OR Colonoscopy every 10 years at Yes discretion. Refers to ACS and USPSTF guidelines.
LA	AAS	No guideline specified
ME	Yes	USPSTF.
MD	AAS	No guideline specified
MA	Yes	Flexi. Sig. every 5 years with FOBT annually, age 50+; OR Colonoscopy every 10 years, age 50+; OR FOBT annually, age 50+. Screening under age 50 for high-risk. Discuss screening options with patient.
MI	AAS	No guideline specified
MN	Yes	No guideline specified
MS	Yes	FOBT annually, age 50+; Flexi. Sig. and Barium Enema every 5 years, age 50+; OR Colonoscopy every 10 years, age 50+. Screening under age 50 for high-risk.
MO	Yes	ACS.
MT	Yes	No guideline specified
NE	No	
NV	Yes	USPSTF (MCO).
NH	Yes	USPSTF (MCO).
NJ	Yes	ACS (MCO).
NM	Yes	USPSTF (MCO).
NY	Yes	USPSTF.
NC	AAS	NR.

Table 7. Colorectal Cancer Screen and Guidelines		
STATES	**Colorectal Cancer Screen**	**Guidelines**
ND	Yes	FOBT annually, age 50+; Flexi. Sig. (if no colonoscopy within ten years) OR barium enema every 48 months, age 50+; Colonoscopy (if no Flexi. Sig. within four years) every 10 years, age 50+. Colonoscopy every 24 months for high-risk, any age.
OH	Yes	Age 50+.
OK	No	
OR	Yes	ACS.
PA	NR	ACS (PCCM).
RI	AAS	USPSTF (FFS); No guideline specified (MCO)
SC	Yes	ACS.
SD	No	
TN	Yes	USPSTF.
TX	Yes	ACS, USPSTF.
UT	No	No guideline specified
VT	AAS	No guideline specified
VA	Yes	ACS (MCO).
WA	Yes	FOBT any frequency, any age; Flexi. Sig. every 48 months, age 50+; Barium enema every 5 years, age 50+; Colonoscopy every 10 years, age 50+. Colonoscopy every 24 months for high-risk, any age (FFS); no guideline specified (MCO).
WV	Yes	FOBT annually, age 50+; Flexi. Sig. OR barium enema every 48 months, age 50+; Colonoscopy OR barium enema every 24 months for high-risk, any age.
WI	Yes	Colonography every 5 years for certain patients.
WY	NR	NR.

AAS = age-appropriate screen

Most states provide a specific standard of care, while fifteen states rely on generally accepted standards of care. Since the recommendations are similar across guidelines and most states cover all screening options, it appears that most Medicaid programs offer comparable coverage for colorectal screening exams.

Table 8. Colorectal Cancer Screening Tests

STATES	FOBT (FFS)	FOBT (MCO)	Flexible Sig. (FFS)	Flexible Sig. (MCO)	Colonoscopy (FFS)	Colonoscopy (MCO)
AL	Yes		Yes		Yes	
AK	Yes		Yes		Yes	
AZ	Yes	Yes	Yes	Yes	Yes	Yes
AR						
CA	NR	Yes	NR	Yes	NR	Yes
CO	Yes	Yes	Yes	Yes	Yes	Yes
CT	Yes		Yes		Yes	
DE	Yes	Yes	Yes	Yes	Yes	Yes
DC	Yes	AAS	Yes	Yes	Yes	Yes
FL	Yes	Yes	Yes	Yes	Yes	Yes
GA	Yes	Yes	Yes	Yes	Yes	Yes
HI	Yes	Yes	Yes	Yes	No	No
ID	Yes		Yes		Yes	
IL		Yes		Yes		Yes
IN	Yes	Yes	Yes	Yes	Yes	Yes
IA	Yes		Yes		Yes	
KS	NR	NR	NR	NR	NR	NR
KY	Yes (FFS)	NR	Yes	NR	Yes	NR

Table 8. Colorectal Cancer Screening Tests						
STATES	**FOBT (FFS)**	**FOBT (MCO)**	**Flexible Sig. (FFS)**	**Flexible Sig. (MCO)**	**Colonoscopy (FFS)**	**Colonoscopy (MCO)**
LA	Yes	NR	Yes	NR	Yes	NR
ME	Yes		Yes		Yes	
MD	Yes	Yes	Yes	Yes	Yes	Yes
MA	Yes	Yes	Yes	Yes	Yes	Yes
MI	Yes	Yes	Yes	Yes	Yes	Yes
MN	Yes	Yes	Yes	Yes	Yes	Yes
MS	Yes		Yes		Yes	
MO	Yes	Yes	Yes	Yes	Yes	Yes
MT	Yes		Yes		Yes	
NE						
NV	Yes	Yes	Yes	Yes	Yes	Yes
NH	AAS	Yes	AAS	Yes	AAS	Yes
NJ	Yes	Yes	Yes	Yes	Yes	Yes
NM	Yes	Yes	Yes	Yes	Yes	Yes
NY	Yes	Yes	Yes	Yes	Yes	Yes
NC	NR		NR		NR	
ND	Yes		Yes		Yes	
OH	No	NR	No	NR	Yes	Yes
OK						
OR	Yes	Yes	Yes	Yes	Yes	Yes

Table 8. Colorectal Cancer Screening Tests						
STATES	FOBT (FFS)	FOBT (MCO)	Flexible Sig. (FFS)	Flexible Sig. (MCO)	Colonoscopy (FFS)	Colonoscopy (MCO)
PA	NR	Yes	NR	Yes	NR	Yes
RI	Yes	AAS	Yes	AAS	Yes	AAS
SC	Yes	Yes	Yes	Yes	Yes	Yes
SD						
TN		Yes		Yes		Yes
TX	Yes	Yes	Yes	Yes	Yes	Yes
UT						
VT	Yes	Yes	Yes	Yes	Yes	Yes
VA	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	AAS	Yes	AAS	Yes	AAS
WV	Yes	Yes	Yes	Yes	Yes	Yes
WI	Yes	Yes	Yes	Yes	Yes	Yes
WY	NR		NR		NR	

AAS = age-appropriate screen

Cervical Cancer and Sexually Transmitted Diseases

Most states (thirty-six) cover cervical cancer screens (pap smears) explicitly. In addition, nine states are likely to cover this service as part of an age-appropriate exam. Four states (Arkansas, Georgia, Texas, and Wyoming) only cover cervical cancer screening as part of a family planning visit. While it is better to cover services through family planning visits than not at all, offering a service only as part

of a family planning visit has significant limitations. Family planning services are intended for individuals who are concerned with controlling the size of their family, not simply those who are sexually active. As a result, Medicaid patients who could benefit from a pap test may not be eligible for this type of visit. Only two states, South Carolina and Alaska, do not cover cervical cancer screening using a pap smear at all.

As shown in Table 9, most states that cover cervical cancer screening provide a guideline for providers. The guidelines are generally permissive, allowing screening without restriction, starting at age twenty-one or at the onset of sexual activity, or following guidelines established by ACS or USPSTF. In general, the guidelines are the same for FFS and managed care, although a few FFS programs rely on generally accepted standards of care while the managed care programs in those states follow more specific guidelines.

Table 9. STD and Cervical Cancer Screens

STATES	STD (FFS)	STD (MCO)	HIV (FFS)	HIV (MCO)	Pap Smear	Pap Smear Guidelines
AL	Yes		Yes		Yes	No guideline specified.
AK	No		No		No	
AZ	No	No	No	No	Yes	No guideline specified.
AR	FP		FP		FP	No guideline specified.
CA	NR	Yes	NR	AAS	Yes (MCO)	USPSTF.
CO	Yes	Yes	Yes	Yes	Yes	Annually, under age 40. Can do more frequently, age 40+ or based on diagnosis.
CT	AAS		AAS		AAS	No guideline specified.
DE	AAS	AAS	Yes	Yes	AAS	No guideline specified.

Table 9. STD and Cervical Cancer Screens						
STATES	**STD (FFS)**	**STD (MCO)**	**HIV (FFS)**	**HIV (MCO)**	**Pap Smear**	**Pap Smear Guidelines**
DC	FP/AAS	Yes	FP/AAS	Yes	Yes	Annually. USPSTF (MCO).
FL	Yes	Yes	Yes	Yes	Yes	Normal paps limited to 1 every 200 days, cover all sexually active women 18+ (FFS)
GA	yes	FP	No	No	FP	ACS.
HI	No*	No	AAS	AAS	Yes	Annually, sexually active women age 18-65. Every 3 years after 3 consecutive normal results.
ID	Yes		AAS		AAS	No guideline specified.
IL	FP	AAS	FP	AAS	Yes	Annually. Every 3 yrs after 3 consecutive normal results.
IN	No*	No	High-risk	High-risk	Yes	USPSTF
IA	AAS		AAS		Yes	Annually, age 21+.
KS	AAS	Yes	AAS	Yes	AAS	No guideline specified.
KY	AAS	AAS	AAS	AAS	Yes	Annually, age 21+.
LA	FP/AAS	NR	FP/AAS	NR	Yes	No guideline specified.
ME	FP/AAS		FP/AAS		FP/AAS	USPSTF
MD	FP/AAS	FP/AAS	FP/AAS	FP/AAS	FP/AAS	No guideline specified.
MA	AAS	Yes	AAS	Yes	Yes	ACS, ACOG, or USPSTF annually, age 21+ or younger if necessary; Biannually, age 21-29; Every 3 years after three negative test results, age 30+. Age 30-65 depending on risk factors.
MI	FP/AAS	FP/AAS	AAS	AAS	Yes	No guideline specified.

Table 9. STD and Cervical Cancer Screens						
STATES	**STD (FFS)**	**STD (MCO)**	**HIV (FFS)**	**HIV (MCO)**	**Pap Smear**	**Pap Smear Guidelines**
MN	AAS	FP/AAS	AAS	FP/AAS	AAS	No guideline specified.
MS	FP/AAS		FP/AAS		Yes	No guideline specified.
MO	AAS	Yes	AAS	Yes	Yes	ACS.
MT	Yes		AAS		Yes	No guideline specified.
NE	NR	NR	High-risk	High-risk	AAS	ACS.
NV	Yes	Yes	Yes	Yes	Yes	USPSTF.
NH	FP	Yes	AAS	Yes	AAS (FFS); Yes (MCO)	USPSTF (MCO).
NJ	Yes	Yes	AAS	AAS	Yes	Annually, age 20+ (MCO).
NM	No	Yes	No	Yes	Yes	Age 21+ (FFS). Annually if high-risk; Every 3 years, beginning at onset of sexual activity or age 18, whichever is earlier, until age 65 (MCO).
NY	Yes	Yes	Yes	Yes	AAS	NR
NC	No		No		Yes	No guideline specified.
ND	No		No		Yes	No guideline specified.
OH	FP	FP	FP/AAS	FP/AAS	Yes	Annually, adults.
OK	FP		AAS		Yes	Annually, child-bearing age.
OR	Yes	Yes	Yes	Yes	Yes	Every 3 years, sexually active with a cervix

Table 9. STD and Cervical Cancer Screens						
STATES	**STD (FFS)**	**STD (MCO)**	**HIV (FFS)**	**HIV (MCO)**	**Pap Smear**	**Pap Smear Guidelines**
PA	NR	Yes	NR	AAS	Yes	ACOG (FFS); Annually, within 3 years of onset of sexual activity or age 21, whichever is earlier until age 30; Every 2-3 years after 3 negative test results within the last 10 years, age 30-70; Higher frequency depending on risk factors (PCCM).
RI	AAS	Yes	AAS	AAS	Yes (FFS); Yes (MCO)	No guideline specified (FFS); Annually (MCO).
SC	FP	FP	AAS	AAS	No	
SD	No		No		Yes	No guideline specified.
TN		Yes		Yes	Yes	No guideline specified.
TX	Yes	Yes	Yes	Yes	FP	USPSTF
UT	Yes	Yes	Yes	Yes	Yes	No guideline specified.
VT	Yes	Yes	AAS	AAS	Yes	USPSTF
VA	FP	FP	AAS	AAS	Yes	ACS, Annually.
WA	FP	FP	AAS	FP/AAS	Yes	Annually (FFS); no guideline specified (MCO)
WV	No	No	No	High-risk	Yes	Annually (FFS). USPSTF (PCCM).
WI	FP	FP	AAS	AAS	Yes	Age 12-65.
WY	FP		FP		FP	NR

AAS = age-appropriate screen

FP = covered in family planning only

FP/AAS = covered in family planning visits and have overed for age-appropriate screen

Hawaii: STD screenings covered once during pregnancy and based on history for non-pregnant adults.

Indiana: STD screenings covered only if medically necessary and for pregnant women.

In terms of sexually transmitted disease ("STD") screening coverage, some states limit screening to specific STDs while other states indicate they cover STD screening without further details. In the latter case, it is not clear whether HIV tests are included in the STD coverage. While HIV is a sexually transmitted disease, most states that list their STD coverage refer specifically to chlamydia, gonorrhea, and/or syphilis, while HIV is indicated separately, if at all. In many states, the only place that coverage for STD or HIV is mentioned specifically is in family planning visits.

There is significant variation within and among states in terms of STD and HIV screening coverage, and there are often qualifications to coverage. For example, Hawaii only covers routine STD and HIV screens for pregnant women, and New Mexico's managed care program only provides screening specifics relating to chlamydia, but covers other STD and HIV screens. Table 9 shows that FFS programs in twelve states and managed care programs in nineteen states cover routine STD screens without such qualifications. Similarly, FFS programs in nine states and managed care programs in fifteen states cover routine HIV screens without qualification. On the other hand, family planning visits are the only way to obtain routine STD screening in eight states and routine HIV screening in three states. Most states fall under the "screen" category, meaning they cover age-appropriate screens but do not explicitly cover STD or HIV screens. Coverage differences exist between managed care and FFS more often with STD and HIV screens than in many of the other preventive services; in most cases, these services are more often explicitly covered in managed care programs than in their FFS counterparts. Such wide variation exists in the standard of care guidelines that it is hard to make

generalizations, although five states refer to ACS guidelines and ten states refer to USPSTF guidelines.

Heart and Cardiovascular Health

A number of preventive services are related to the early identification and prevention of heart disease, stroke, and other forms of cardiovascular disease, directly or indirectly. These include: abdominal aortic aneurysm screening tests, counseling to take aspirin to prevent cardiovascular disease, blood pressure checks, cholesterol screening, obesity and healthy diet counseling, and tobacco cessation programs. In addition, the ability of the beneficiary to follow counseling and take aspirin is enhanced if Medicaid programs cover aspirin over-the-counter ("OTC") because it will be more affordable for beneficiaries to obtain the drugs. The states are split fairly evenly over coverage of aspirin OTC, with twenty-nine providing coverage (see Table 10). In general, beneficiaries need a prescription from their provider to receive coverage for any OTC pharmaceutical.

Unfortunately, several of these preventive services are frequently not listed by states as being covered. This does not mean the services are not covered, but simply that they are not specified as being covered. As mentioned earlier, counseling services are usually considered to be part of an office visit and therefore not listed or reimbursed separately. While more states specify coverage for healthy diet counseling (nineteen yes), obesity screens (seventeen yes), and cholesterol screens (sixteen yes), than many of the other heart related services, it would not be surprising if many other states included these services as part of a well-adult exam.

Only nine states specified coverage for abdominal aortic aneurysm screens and eight specified coverage for aspirin counseling to prevent cardiovascular disease. For this reason, many of the results in Table 10 are entered as "AAS" meaning the service is not specified as covered but the state provides age-appropriate screening that may include these services. Overall, there appears to be little difference between FFS and managed care coverage for these services, although in a few states coverage is limited to managed care plans.

Table 10. Preventive Services for Heart Health

States	AAA Screen	Aspirin Counsel	Aspirin OTC	Blood Pressure Screen	Choles. Screen	Obesity Screen and Counsel	Healthy Diet Counsel
AL	No	No	Yes	No	No	No	Yes
AK	No	No	No	No	No	No	No
AZ	No	No	MCO	No	Once	No	No
AR	No	No	Yes	No	No	No	No
CA	AAS (MCO)	Yes (MCO)	Yes	AAS (MCO)	Yes (MCO)	AAS (MCO)	Yes (MCO)
CO	AAS	AAS	NR	AAS	Yes	No	No
CT	AAS	AAS	Yes	AAS	AAS	AAS	AAS
DE	AAS	AAS	Yes	AAS	AAS	AAS	AAS
DC	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)	Yes	Yes	Yes	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)
FL	No	No	Yes	Yes	No	Yes	Yes
GA	No	No	No	Yes	No	No	No
HI	AAS	AAS	No	Yes	Yes	AAS	Yes
ID	AAS	AAS	No	AAS	AAS	Yes	Limited
IL	AAS (MCO)	AAS (MCO)	No	Yes (MCO)	Yes (MCO)	AAS (MCO)	Yes (MCO)
IN	Yes	Yes	Yes	Yes	Yes	Yes	Yes
IA	AAS	AAS	Yes	AAS	AAS	AAS	No
KS	NR	NR	No	NR	NR	NR	NR
KY	AAS	Yes	No	Once	Yes	Yes	Yes
LA	AAS	AAS	No	AAS	AAS	AAS	AAS
ME	Yes	Yes	No	Yes	Yes	Yes	Yes
MD	AAS	AAS	No	AAS	AAS	AAS	AAS

Table 10. Preventive Services for Heart Health							
States	**AAA Screen**	**Aspirin Counsel**	**Aspirin OTC**	**Blood Pressure Screen**	**Choles. Screen**	**Obesity Screen and Counsel**	**Healthy Diet Counsel**
MA	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MI	AAS	AAS	No	AAS	AAS	Yes (MCO)	AAS
MN	AAS	AAS	Yes	AAS	AAS	AAS	AAS
MS	AAS	AAS	Yes	AAS	Yes	AAS	AAS
MO	AAS	AAS	Yes	AAS	AAS	No	No
MT	No	AAS	Yes	AAS	No	AAS	Limited
NE	No	No	Yes	No	No	No	No
NV	Yes	Yes	Yes	Yes	Yes	Yes	Yes
NH	Yes	AAS (FFS); Yes (MCO)	Yes	AAS (FFS); Yes (MCO)	AAS (FFS);Yes (MCO)	No (FFS); Yes (MCO)	No (FFS); Yes (MCO)
NJ	Yes	AAS	No	AAS	AAS (FFS); Yes (MCO)	AAS	AAS (FFS); Yes (MCO)
NM	No (FFS); AAS (MCO)	No (FFS); Yes (MCO)	No	No (FFS); Yes (MCO)	No (FFS); Yes (MCO)	No (FFS); Yes (MCO)	Limited (FFS); Yes (MCO)
NY	AAS	AAS	Yes	AAS	AAS	AAS (FFS); Yes (MCO)	AAS
NC	AAS	AAS	No	AAS	AAS	AAS	AAS
ND	NR	NR	No	No	No	Yes	Yes
OH	No	No (FFS); AAS (MCO)	Yes	No (FFS); AAS (MCO)	No (FFS); AAS (MCO)	Yes	Yes
OK	No	No	No	No	No	No	No
OR	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PA	NR (FFS); AAS (MCO)	NR (FFS); AAS (MCO)	Yes	NR (FFS); Yes (MCO)	NR (FFS); Yes (MCO)	NR (FFS); Yes (MCO)	NR (FFS); Yes (MCO)
RI	AAS	AAS	No	AAS	AAS	Limited*	Limited*
SC	No	AAS	Yes	AAS	No	No	Limited
SD	No	AAS	No	AAS	Yes	No	No
TN	AAS	AAS	No	AAS	AAS	AAS	AAS

Table 10. Preventive Services for Heart Health							
States	**AAA Screen**	**Aspirin Counsel**	**Aspirin OTC**	**Blood Pressure Screen**	**Choles. Screen**	**Obesity Screen and Counsel**	**Healthy Diet Counsel**
TX	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UT	No	No	Yes	No	No	No	No
VT	Yes	AAS	Yes	AAS	Yes	Yes	AAS
VA	No	No	No	No	No	No	No
WA	Yes	AAS	Yes	AAS	No	Limited	Limited
WV	AAS	AAS	No	AAS	AAS	No	No
WI	AAS	AAS	Yes	AAS	AAS	Yes	AAS
WY	No	No	Yes	No	No	No	No

AAS = age-appropriate screen
Limited: only covered for limited populations or number of visits
RI: Weight management/nutritional classes will be covered for all populations upon approval of a recently submitted state plan amendment

Although not one of the twenty-four services evaluated in this report, smoking is another risk factor contributing to heart disease and stroke, as well as cancer and COPD. The USPSTF recommends smoking cessation counseling as an A rated service. The American Lung Association ("ALA") recognizes the effectiveness of counseling provided face-to-face on both an individual and a group level, as well as counseling provided over the telephone. In addition, the ALA recommends coverage for medication as well as counseling to maximize effectiveness of cessation efforts. [57] Seven different medications may be used in conjunction with cessation efforts, including prescription and OTC options as well as nicotine-replacement and nicotine-free products. The most recent comprehensive study of state Medicaid

[57] American Lung Association, *Helping Smokers Quit: Tobacco Cessation Coverage 2011*, at 5, *available at* http://www.lung.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2011.pdf.

coverage of tobacco cessation programs may be found at: http://www.lung.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2011.pdf.

Under the ACA, all Medicaid programs must now provide smoking cessation counseling and medication coverage for pregnant women. Each state must provide a comprehensive tobacco cessation benefit to pregnant enrollees, to include both counseling and pharmacotherapy options.[58] In developing this benefit, states must follow the recommendations of the Public Health Service Guideline on treating tobacco use.

Additional Preventive Services

The USPSTF A & B rated services include a few additional preventive services that have not been discussed previously. These include screening for: alcohol misuse, depression, diabetes, and osteoporosis. States generally have comprehensive substance abuse and behavioral health programs that include initial outpatient assessments. The USPSTF assessment, however, refers to screens performed by a primary care provider, not a mental health provider. A key access issue regarding behavioral health is getting in to the behavioral health system in the first place and screens by primary care providers are an important part of improving access.

[58] ACA, § 4107 (amending § 1905 of the Social Security Act, codified at 42 U.S.C. § 1396d).

Medicaid programs treat coverage for alcohol misuse and depression screening similarly. In other words, they typically specify coverage for both or neither. As shown in Table 11, states are most likely to offer explicit coverage or possibly include these services in an age-appropriate screen. Only nine states do not offer either screening test in their Medicaid programs. Fewer states explicitly provide for diabetes screening and very few states clearly cover osteoporosis checks. There is little differentiation between FFS and managed care coverage for these services, but where difference exists, more managed care programs provide explicit coverage.

Table 11. Additional Preventive Services

STATES	Alcohol Misuse Screening & Counseling	Depression Screening & Counseling	Osteoporosis Screening	Diabetes Screening
AL	No	No	No	No
AK	No	No	No	No
AZ	No	No	No	Yes
AR	No	No	No	No
CA	Yes (MCO)	Yes (MCO)	No	Yes (MCO)
CO	AAS	AAS	AAS	AAS
CT	AAS	AAS	AAS	AAS
DE	AAS	AAS	AAS	AAS
DC	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)
FL	Yes	No	No	Yes
GA	No	No	No	No
HI	Yes	Yes	No	Once
ID	AAS	AAS	AAS	AAS
IL	Yes (MCO)	AAS (MCO)	AAS (MCO)	AAS (MCO)
IN	Yes	No	No	No
IA	AAS	AAS	AAS	AAS
KS	NR	NR	NR	NR
KY	Yes	Yes	Yes	Yes

Table 11. Additional Preventive Services				
STATES	**Alcohol Misuse Screening & Counseling**	**Depression Screening & Counseling**	**Osteoporosis Screening**	**Diabetes Screening**
LA	Yes	Yes	AAS	AAS
ME	Yes	Yes	Yes	Yes
MD	AAS	AAS	AAS	AAS
MA	Yes	Yes	Yes	Yes
MI	AAS	AAS	AAS	AAS
MN	Yes	Yes	AAS	AAS
MS	AAS	AAS	AAS	Yes
MO	AAS	AAS	AAS	AAS
MT	Yes	AAS	AAS	AAS
NE	No	No	No	No
NV	Yes	Yes	Yes	Yes
NH	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)	Yes (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)
NJ	AAS (FFS); Yes (MCO)	AAS (FFS); Yes (MCO)	Yes	AAS (FFS); Yes (MCO)
NM	No (FFS); Yes (MCO)	No (FFS); Yes (MCO)	No (FFS); Yes (MCO)	No (FFS); Yes (MCO)
NY	Yes	AAS	AAS	AAS
NC	AAS	AAS	No	AAS
ND	Yes	Yes	No	Yes
OH	No (FFS); AAS (MCO)	No (FFS); AAS (MCO)	No (FFS); AAS (MCO)	No (FFS); AAS (MCO)
OK	No	Yes	No	No
OR	Yes	Yes	Limited	Yes
PA	NR (FFS); AAS (MCO)	NR (FFS); AAS (MCO)	NR (FFS); AAS (MCO)	NR (FFS); AAS (MCO)
RI	Limited	Limited	AAS	AAS
SC	Yes	AAS	No	Yes
SD	AAS	AAS	No	No
TN	Yes	Yes	AAS	AAS
TX	Yes	Yes	Yes	Yes
UT	No	No	No	No
VT	Yes	Yes	Yes	Yes
VA	No	No	No	No
WA	AAS	AAS	No	No

Table 11. Additional Preventive Services				
STATES	Alcohol Misuse Screening & Counseling	Depression Screening & Counseling	Osteoporosis Screening	Diabetes Screening
WV	AAS	AAS	Limited	AAS
WI	AAS	AAS	AAS	AAS
WY	No	No	No	No

AAS = age-appropriate screen
Limited: only covered for limited populations or number of visits

Treatment Items

In addition to the USPSTF A & B rated recommendations, researchers also evaluated whether and how Medicaid programs covered a variety of items related to treatment. These include: coverage of blood glucose monitors and insulin pumps, coverage of aspirin OTC, routine costs of clinical trials, and coverage of drugs for off-label use beyond the minimum required by Medicaid. In general, programs are much more likely to cover blood glucose monitors, insulin pumps, and aspirin OTC than clinical trials and off-label drug use (see Table 10 in the discussion of heart health for details on aspirin OTC coverage).

Coverage of outpatient drugs in the Medicaid program is an optional benefit that every state has chosen to provide to varying degrees.[59] The Medicaid rebate statute requires states offering this benefit in their FFS programs to cover all outpatient drugs offered by manufacturers that have rebate agreements with the

[59] Ctrs. for Medicare & Medicaid Servs., *Prescription Drugs*, Medicaid.gov, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Prescription-Drugs.html (last visited Sept. 18, 2012).

Secretary of HHS.[60] A state's ability to restrict coverage of drugs offered by such manufacturers is limited,[61] but states may choose to exclude or restrict coverage of an outpatient drug if the prescribed use [of that drug] is not for a "medically accepted indication."[62] Use of a drug to treat a particular condition is a medically accepted indication if the FDA has approved the drug for purposes of treating that condition ("on-label" use), or if the use of the drug to treat that condition is supported by a citation in one of three medical compendia ("off-label" use).[63] The negative inference drawn from this is that states *should* cover outpatient drugs prescribed for a medically accepted indication, including off-label use cited in one of the referenced compendia. Whether states may cover drugs for indications that are not medically indicated in accordance with the regulatory definition remains an unsettled question.[64] States may place limitations on their coverage of drugs by requiring prior authorization,[65] implementing prescribing and/or dispensing limits,[66] and/or imposing cost-sharing requirements.[67] Note also that managed care plans are subject to different drug coverage regulations, but federal administrative

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[60] Jean Herne, Cong. Research Serv., RL 30726, Prescription Drug Coverage Under Medicaid, at CRS-5 (2008), *available at* http://aging.senate.gov/crs/medicaid16.pdf.
[61] States may also choose to exclude or limit coverage of drugs that fall into one of eleven categories, including non-prescription drugs and smoking cessation drugs (Social Security Act § 1927(d)(2), 42 U.S.C. 1396r-8(d)(2) (2012)).
[62] Social Security Act § 1927(d)(1)(B)(i), 42 U.S.C. § 1396r-8(d)(1)(B)(i) (2012).
[63] Social Security Act § 1927(k)(6), 42 U.S.C. § 1396r-8(k)(6) (2012).
[64] *See*, *e.g.*, United States *ex rel.* Franklin v. Parke-Davis, 147 F. Supp. 2d (D.Mass. 2001).
[65] Social Security Act § 1927(d)(1)(A), 42 U.S.C. § 1396r-8(d)(1)(A) (2012).
[66] Social Security Act § 1927(d)(6), 42 U.S.C. § 1396r-8(d)(6) (2012).
[67] Social Security Act § 1916A(a)(1), 42 U.S.C. § 1396o-1(a)(1) (2012).

policy requires that any drugs covered under a state's plan must also be available to the state's Medicaid managed care enrollees.[68]

As shown in Table 12, almost every state that provided information covers blood glucose monitors. The exceptions are Oklahoma, Texas, and Utah. In addition, Arkansas only covers monitors for pregnant women and New Jersey does not cover monitors for individuals enrolled in their Plan D. It appears more common for states not to charge co-pays or seek prior authorization for blood glucose monitors, although there were a number of states where information was not available about these restrictions. Similarly, most states cover insulin pumps; of those states that provided information, Pennsylvania and Washington are the only states that do not cover pumps at all and Arizona only covers them in their FFS program. Since almost all beneficiaries in Arizona are in the managed care program, this means there is no coverage from insulin pumps for most enrollees. While most states do not charge a co-payment for insulin pumps, it is much more likely that prior authorization is required for insulin pumps than for blood glucose monitors.

Most states do not cover the routine costs associated with a beneficiary's participation in clinical trials and the few that do often have restrictions associated with coverage (see Table 13). Nine states cover all types of clinical trials in both their FFS and managed care programs, while Nevada covers clinical trials only in its managed care program. Montana only covers clinical trials if the beneficiary is treated inpatient at a hospital. New Mexico, North Dakota, and Vermont only cover clinical trials relating to cancer treatment. South Carolina will cover medically

[68] Herne, *supra* note 59.

necessary services that are not covered by the clinical trial. DC covers Medicare-approved clinical trials. All of the other states that provided information do not cover clinical trials.

It is also rare that states cover off-label drug use. Only seven states cover off-label use beyond the medically accepted definition and most of those states have strict criteria for allowing coverage.

Table 12. Coverage of Treatment Items

STATES	Blood Glucose Monitors	Blood Glucose Monitors Co-Pay	Blood Glucose Monitors Prior Auth.	Insulin Pump	Insulin Pump Co-Pay	Insulin Pump Prior Auth.
AL	Yes	Yes	No	Yes	Yes	Yes
AK	Yes	No	No	Yes	No	Yes
AZ	Yes	No	Varies	Yes (FFS)	No	Varies
AR	Limited	No	No	Yes	Varies	Yes
CA	Yes	Yes	No	Yes	NR	Yes
CO	Yes	Yes	Varies	Yes	Yes	Yes
CT	Yes	No	NR	Yes	No	NR
DE	Yes	No	High cost	Yes	No	High cost
DC	Yes	No	No	Yes	No	No
FL	Yes	No	No	Yes	No	Yes
GA	Yes	NR	High cost	Yes	NR	High cost
HI	Yes	NR	High cost	Yes	NR	High cost
ID	Yes	No	No	Yes	No	Yes
IL	NR	NR	NR	NR	Yes	NR
IN	Yes	No	No	Yes	No	No
IA	Yes	Yes (FFS)	No	Yes	Yes (FFS)	No
KS	Yes	Yes (FFS)	No	Yes	Yes (FFS)	Yes

Table 12. Coverage of Treatment Items						
STATES	Blood Glucose Monitors	Blood Glucose Monitors Co-Pay	Blood Glucose Monitors Prior Auth.	Insulin Pump	Insulin Pump Co-Pay	Insulin Pump Prior Auth.
KY	Yes	No	Yes	Yes	NR	Yes
LA	Yes	NR	Yes	Yes	NR	Yes
ME	Yes	Yes	Yes	Yes	Yes	Yes
MD	Yes	No	Varies	Yes	No	Varies
MA	Yes	Yes	No	Yes	Yes	Yes
MI	Yes	No	Varies	Yes	No	Varies
MN	Yes	No	No	Yes	No	Yes
MS	Yes	Yes	Yes	Yes	Yes	Yes
MO	Yes	No	No	Yes	No	Yes
MT	Yes	Yes	High cost	Yes	Varies	High cost
NE	Yes	Yes	No	Yes	Yes	Some
NV	Yes	No	Yes	Yes	No	Yes
NH	Yes	No	Varies	Yes	No	Yes
NJ	Limited	No	Yes	Yes	No	Yes
NM	Yes	No	Yes	Yes	No	No
NY	Yes	No	No	Yes	No	Yes
NC	Yes	No	Yes	Yes	No	Yes
ND	Yes	NR	No	Yes	NR	Yes
OH	Yes	No	No	Yes	No	Yes
OK	No			Yes	Yes	Yes
OR	Yes	No	No	Yes	No	No
PA	Yes	NR	No	No		
RI	Yes	No	No	Yes	No	NR
SC	Yes	Yes	No	Yes	Yes	No
SD	Yes	Yes	No	Yes	Yes	No
TN	Yes	No		Yes	No	
TX	No			Yes	No	Yes
UT	No			Yes	No	Yes
VT	Yes	No	No	Yes	No	No
VA	Yes	No	No	Yes	No	Yes
WA	Yes	No	No	No		
WV	Yes	No	No	Yes	No	Yes
WI	Yes	Varies	No	Yes	Varies	Yes

Table 12. Coverage of Treatment Items						
STATES	Blood Glucose Monitors	Blood Glucose Monitors Co-Pay	Blood Glucose Monitors Prior Auth.	Insulin Pump	Insulin Pump Co-Pay	Insulin Pump Prior Auth.
WY	Yes	No	No	Yes	No	No

AK: monitors for pregnant women only
Limited: coverage for limited populations only

Table 13. Clinical Trials and Off-Label Drug Use Coverage		
STATES	Clinical Trials	Off-Label Drugs
AL	No	No
AK	No	No
AZ	No	No
AR	No	No
CA	Yes	No
CO	No	No
CT	No	No
DE	No	No
DC	Yes* (FFS); NR (MCO)	No
FL	No	No
GA	No	No
HI	No	No
ID	No	No
IL	No	No
IN	Yes	No
IA	No	No
KS	No	No
KY	No	No

Table 13. Clinical Trials and Off-Label Drug Use Coverage		
STATES	**Clinical Trials**	**Off-Label Drugs**
LA	No	No
ME	NR	No
MD	Yes	No
MA	No	No
MI	No	No
MN	Yes	Yes
MS	No	No
MO	No	No
MT	Yes*	No
NE	No	No
NV	Yes (MCO)	No
NH	No	No
NJ	Yes	Yes (MCO)
NM	Cancer trials	No
NY	Yes	NR
NC	No	No
ND	Cancer drug trials	No
OH	No	No
OK	No	No
OR	No	Yes
PA	No	No
RI	No	No
SC	Yes	No
SD	No	No
TN	Yes	Yes
TX	No	No
UT	No	Yes
VT	Cancer trials	Yes*
VA	No	No
WA	Yes	No
WV	Yes	Yes
WI	No	No

Table 13. Clinical Trials and Off-Label Drug Use Coverage		
STATES	Clinical Trials	Off-Label Drugs
WY	No	No

DC -Medicare approved trials only
MT - inpatient clinical trials only
VT - off label drug coverage for cancer drugs only

Beneficiary Information

Another key question is what type of information Medicaid programs provided to their beneficiaries. Unfortunately, beneficiaries do not receive very specific information about covered benefits. While MCOs generally have lengthy requirements about developing beneficiary handbooks and contacting beneficiaries, even their handbooks and website information are fairly general. It will indicate that physician services are covered, for example, but not specify which services. An example of preventive services may be given, but a detailed list is not generally available. Beneficiaries in FFS programs are likely to have even less information, and often are not given a handbook at all. They may receive more limited information or have to access information on the Medicaid agency's website. Beneficiaries are often referred to help lines or their provider's office for further details.

V. DISCUSSION

Based on these findings, it becomes apparent why it has been difficult for researchers, providers, beneficiaries, and policy makers to understand the extent of coverage for adult preventive services in Medicaid programs across the country. The combination of lack of information published by many Medicaid agencies and confusion relating to the notions of medical necessity and prevention have resulted in a dearth of information about preventive services coverage.

It is difficult to ascertain exactly which preventive services are covered by State Medicaid agencies.

As noted throughout this report, it is difficult to ascertain exactly which preventive services are covered in many state programs. This occurs for a variety of reasons. Many programs simply do not list the preventive services covered and prefer to cover "age-appropriate screens," allowing providers to choose the appropriate services based on generally accepted standards of care. While agencies may take this approach to limit the need to revise provider manuals and other materials on a regular basis, it makes it difficult to know which services are covered. Even if states indicated that they followed a specific standard of care (such as the USPSTF), this may only mean they follow that standard for the subset of services they actually cover. If they choose not to cover services such as BRCA screening, then even though they otherwise follow the USPSTF recommendations, coverage will be denied for that test. Parsing out which of the recommended services are covered proved to be difficult.

In addition to the lack of specificity, confusion relating to the term "medical necessity" made it difficult to determine which services are covered by Medicaid programs. Medical necessity is based on individualized patient needs while the USPSTF A & B services being evaluated here are based on general standards. It is incongruous to state that a Medicaid program covers services for prevention as long as they are medical necessary. Given the frequency that such phrasing was used, it is clear this is a widespread issue in Medicaid programs.

Finally, the quality and detail of information about state programs varied as much as the programs themselves. States rely on a variety of sources to capture their program information, some emphasizing provider manuals, others using their website with more depth, and others relying on regulations. Regardless of the source of the material, states vary in the details that are made available, either through public documents or discussions with Medicaid personnel. There was also widespread variation in the information that Medicaid officials were willing or able to provide to researchers.

Coverage of well-adult exams is important to accessing preventive services.

Well-adult exams are office visits for beneficiaries that do not have an acute medical issue to be treated. These exams evaluate the overall health status of beneficiaries, and are an ideal setting for providing preventive services because the provider and patient are not focused on addressing an acute health issue. Thirty-two states provide coverage for a well-adult exam. About half the states with well-adult

exams charge co-pays for that services. States that charge co-pays for well-adult exams generally will charge co-pays for other preventive services and vice versa.

While more states than anticipated cover this type of routine exams, just under half the states do not have such coverage. It is likely that accessing preventive services is more difficult for beneficiaries in those states. If they do not have an acute issue to be addressed, they will not be able to access a provider for an office visit; if they do have an acute issue to be addressed, that issue will be the focus of the visit. Even in the states with well-adult exams, many do not specify a list of services to be covered or a particular standard of care to be followed.

Coverage of the USPSTF A & B Rated Services Varies Widely

There is wide variation in coverage of the twenty-four USPSTF A & B rated services evaluated in this report. The services most likely to be covered preventively include screening mammograms, colorectal cancer screens, and pap smears. Coverage of STDs and HIV screening is more commonly found in family planning visits, which restricts beneficiary access in many states. It is often difficult to know whether states cover counseling and health education services that are generally not reimbursed separately from an office visit. A few services, such as BRCA testing and osteoporosis screens, were rarely covered by states.

Coverage of Treatment Items is Fairly Consistent across States

Coverage of five treatment items was evaluated. Most states covered blood glucose monitors and insulin pumps. It was much more likely that states required

prior authorization for insulin pumps than for monitors. More than half of the states cover aspirin OTC, increasing access for beneficiaries to that drug. Relatively few states covered off-label drug use or clinical trials.

Less Variation than Expected Between Fee-For-Service and Managed Care Programs

In general, when there was a difference between FFS and managed care programs, managed care programs provided more coverage and more specificity about coverage, such as identifying which standard of care providers must follow. In general, however, there were fewer coverage differences than expected between the two types of programs. A number of states have many or most of their beneficiaries in managed care, further diminishing the importance of the differences in programs in regard to access for preventive services. While managed care programs have more extensive requirements regarding beneficiary outreach and information, beneficiaries in both types of programs do not have access to detailed coverage information without calling a helpline or their provider.

State Medicaid Programs are Not Focusing on Covering the USPSTF A & B Recommendations

Significant confusion or lack of knowledge exists regarding the ACA provision that provides states with an FMAP increase for each USPSTF A & B rated service that is covered. Only sixteen states had enough information about the provision to have considered whether the state would change their coverage policies in response to the financial incentives. Of those states, four reported that they have decided against adding services – Utah, Vermont, Virginia, and Montana – and eleven are currently

looking into the effect of adding the services – Alabama, Colorado, Delaware, Idaho, Kentucky, Missouri, New Mexico, Oregon, New York, Nevada and South Dakota. Most other Medicaid agencies were unaware of or had little information about this provision.

CONCLUSION

It is not surprising that there is state variation in the coverage of preventive services as variation is the hallmark of the Medicaid program. Even so, it would be beneficial for policymakers and patients alike to have a better understanding of exactly which services are covered and under what circumstances. It would be possible to obtain more detailed information by discussing very specific patient scenarios with Medicaid programs and examining which preventive and treatment services would be covered or rejected. The findings from such a study would provide more detailed information than is available at this point, yet would still be limited to the scenarios reviewed. Alternatively, policymakers and administrators could work together to provide more detailed information about state coverage choices as a platform to discuss whether any changes need to be made to improve beneficiary access to services or health outcomes.

APPENDIX A – STANDARDS OF CARE

American Cancer Society	
Service	**Clinical Recommendation**
Breast Cancer Screening	Yearly mammograms starting at 40 and continuing as long as the woman in good health; clinical breast exams every three years for women 20-39 and annually for women 40 and older; breast MRIs for high-risk women.
Colorectal Cancer Screening	Starting at age 50, flexible sigmoidoscopy every 5 years OR colonoscopy every 10 years OR double contrast barium enema every 5 years OR CT colonography every 5 years AND fecal occult blood test annually OR fecal immunochemical test annually.
Cervical Cancer Screening	Age 21-29 pap test every 3 years and HPV test only if pap test is abnormal, 30-65 pap tests and HPV test every five years OR pap test alone every 3 years, over 65 no testing if have history of regular results, with history should test for 20 years after diagnosis, regardless of age.

National Cancer Institute	
Service	**Clinical Recommendation**
Breast cancer screening	Mammograms for women in their 40s every 1-2 years; women at higher-than-average risk of breast cancer should talk to provider about whether to have mammograms before age 40, and how to often to have them.
Cervical cancer screening	Pap test at least once every 3 years for women within 3 years of after they begin having sexual intercourse, or when they reach age 21, whichever comes first.
Colorectal cancer screening	People over age 50 should be screened; people at higher-than-average risk of colon cancer should talk to provider about whether to have screening tests before age 50, and often to have them. NCI lists the following screening tests: fecal occult blood test, sigmoidoscopy, colonoscopy, double-contrast barium enema, digital rectal exam.

American Heart Association	
Service	**Clinical Recommendation**
Cholesterol screen	Fasting lipoprotein profile to measure HDL and LDL cholesterol and triglycerides every five years for normal risk people, starting at age 20. More often for people with cholesterol higher than 200 mg/dl, for men over 45, for women over 50, for men with HDL cholesterol less than 40 mg/dl, for women with HDL cholesterol less than 50 mg/dl, for people with other risk factors for coronary heart disease and stroke.
Blood pressure screen	Each regular healthcare visit, or at least once every 2 years if blood pressure is less than 120/80 mm HG, starting at age 20.
Blood glucose test	Every 3 years starting at age 45
Weight/Body Mass Index (BMI)	Each regular healthcare visit, starting at age 20
Waist circumference	As needed to help evaluate cardiovascular risk, starting at age 20
Discuss smoking, physical activity and diet	Each regular healthcare visit, starting at age 20

American Diabetes Association	
Service	**Clinical Recommendation**
Diabetes Screening	Screening for any adult with a BMI of 25 or greater with at least one additional risk factor for diabetes; screening for adults without risk factors starting at age 45. If results are normal, repeat testing every 3 years.
Healthy diet counseling	Individuals with pre-diabetes or diabetes should receive individualized medical nutrition therapy as needed
Weight loss support program	Individuals with pre-diabetes or at high-risk for type 2 diabetes should be referred to a weight loss program targeting 7% loss of body weight and increase of physical activity to at least 150 minutes per week of moderate activity.
Blood glucose monitor	For patients using multiple insulin injections or insulin pump therapy, self-monitoring of blood glucose at least three times daily

Medicare	
Service	**Clinical Recommendation**
Abdominal aortic aneurysm screening	Covers screening one time for people who have a family history of abdominal aortic aneurysms and for men age 65-75 who have smoked at least 100 cigarettes in lifetime.
Alcohol misuse screening and counseling	Covers once a year for adults who use alcohol but do not meet medical criteria for alcohol dependency.
Breast cancer screening	Screening mammogram covered once every 12 months for women over 40; one baseline for women 35-39
Cardiovascular disease behavioral therapy	Covers one visit per year with primary care doctor for all enrollees
Cardiovascular disease screening	Covers screening for cholesterol, lipid and triglyceride levels every five years for all enrollees

Medicare	
Service	**Clinical Recommendation**
Cervical cancer screening	Pap test/pelvic exam covered once every 24 months for all women; once every 12 months for women at high risk for cervical or vaginal cancer; once every 12 months for women who have had an abnormal pap in the past 36 months
Colorectal cancer screening	Starting at age 50, covers different types of tests:Starting at age 50, covers different types of tests: • Fecal Occult Blood Test (FOBT) every 12 months AND • Barium enema* every 48 months OR • Colonoscopy every 120 months OR • Colonoscopy 48 months after a screening flexible sigmoidoscopy OR • Flexible sigmoidoscopy every 48 months for most; if not at high risk, covers every 120 months after a screening colonoscopy For individuals at high risk, covers tests according to this periodicity: • Barium enema* every 24 months OR • Colonoscopy every 24 months *Barium enemas covered only if used in lieu of a flexible sigmoidoscopy or colonoscopy
Depression screening	Covers once a year for all enrollees.
Diabetes screenings	Up to 2 fasting blood glucose tests per year for individuals with at least one of four risk factors (hypertension, dyslipidemia, obesity and/or history of high blood sugar), or for individuals who meet at least two of four criteria (age 65+, overweight, family history of diabetes, and/or history of gestational diabetes)
Healthy diet counseling	For individuals who have kidney disease, have had a kidney transplant and/or have diabetes, covers nutritional assessment, one-on-one counseling and therapy provided by a registered dietitian or approved nutrition professional.
HIV screening	Covers screening tests for all enrollees.
Obesity screening & counseling	May cover when provided by at a primary care doctor's office or at a primary care clinic for individuals with a BMI of 30 or higher.

Medicare	
Service	**Clinical Recommendation**
Osteoporosis screening	Covers bone density measurement once every 24 months for all people at risk of osteoporosis meeting at least one of five risk factors
STI screening (chlamydia, gonorrhea, syphilis and/or Hepatitis B)	Once every 12 months for pregnant women and people at increased risk for an STI.
STI behavioral counseling	Up to 2 sessions each year for sexually active adults who are at increased risk for STIs.
Tobacco use cessation	For any tobacco user, up to 8 face-to-face visits every 12 months.
Wellness visit	Covers one initial preventive visit within first 12 months of program enrollment; covers wellness exam once every 12 months for people who have been enrolled longer than 12 months.