

**Questions and Answers Regarding  
Medicaid Rule Change  
Allowing Reimbursement for Preventive Services  
Delivered by Non-licensed Providers**

**Questions about How the Rule Change Works and Its Applicability**

Q: Is this rule change only applicable to Medicaid?

A: Yes.

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Q: What does “at state option” mean?

A: This rule provides a new option for states. If they want to take advantage of it, they will need to submit a State Plan Amendment (SPA) requesting permission from the federal CMS office to reimburse for preventive services delivered by non-licensed providers upon referral from a licensed Medicaid provider.

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Q: Is CMS giving states any guidance for State Plan Amendment requests?

A: While CMS does not plan to issue a template for the required State Plan Amendment (SPA), CMCS has issued an information bulletin, [Update on Preventive Services Initiatives](#) and a [State Medicaid Director letter](#). CMCS also presented a webinar on the rule change, available [here](#). Another helpful resource is the [State Medicaid Manual](#), particularly Chapter 4, Services, Section 4385, Preventive Services. CMS encourages states to contact them to discuss their health improvement and prevention priorities, including those that would be applicable to this rule change. States also have the opportunity to join their colleagues who are members of the [Medicaid Prevention Learning Network](#).

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Q: Where can I find examples of evidence-based community prevention initiatives and interventions?

A: Good sources for identifying community-based prevention interventions that have been shown to be effective are the [Guide to Community Preventive Services](#) and [A Compendium of Proven Community-Based Prevention Programs](#).

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Q: Does the requirement for state-wideness apply?

A: Yes. Waiving state-wideness would require a separate process of a 1915(b) waiver.

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Q: Can group counseling be covered?

A: Group preventive counseling is coverable when it allows direct, one-to-one interaction between the counselor and the individual. For more information, see the State Medicaid Manual p.4-381.

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## Questions about Provider Referrals, Qualifications and Billing

Q: How are licensed providers going to be made aware of the preventive services available?

A: It will be up to the state to establish a process for determining which providers are qualified to provide the service, as well as a process for communicating this information to licensed Medicaid providers who might want to refer their patient(s).

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Q: Does the referring licensed Medicaid provider determine who is qualified to provide the preventive service?

A: States will determine who is a qualified practitioner.

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Q: How does the referring provider get feedback when his or her patient receives a preventive service from a non-licensed provider?

A: Existing feedback processes will need to be leveraged, or new feedback mechanisms will need to be developed.

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## Questions about Preventive Services

Q: Does this apply to mental health services?

Q: Can prevention activities include those related to prevention of child abuse and other adverse childhood experiences?

Q: Would Recreation Therapy be covered in community-based environments? Or physical activity, nutrition and wellness programs for those with physical disabilities?

Q: Is it possible to receive reimbursement for those on Medicaid who attend a health fair and receive extremely low cost blood work and other free health screenings?

A: Preventive services are defined in the [State Medicaid Manual \(chapter 4 Section 4385\)](#), or in your individual state's Medicaid Plan. This rule change does not alter the definition or scope of preventive services that a state covers in Medicaid. Therefore, if the mental health service is listed in the state plan and can be provided by a non-licensed provider, it could be eligible for reimbursement under this rule change.

Federal regulations (42 CFR 440.130(c)) define preventive services under the preventive benefit as ". . . services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to--(1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency.

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Q: Is treatment/counseling for tobacco dependence treatment considered preventive?

A: Yes, according to the [federal definition](#) of preventive services. In addition, the Affordable Care Act included new requirements for Medicaid coverage of tobacco cessation, as outlined in a State Medicaid Director letter, [New Medicaid Tobacco Cessation Services](#).

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Q: Could the preventive services delivered be bundled for payment?

A: Yes.

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Q: Is the state required to cover all Level B recommended preventive services?

A: This rule change does not alter the preventive services a state is required to or opts to cover in Medicaid. For more information about the incentive for states to receive a 1% increase in their FMAP by covering a certain set of preventive services and vaccines with no cost-sharing, see the [State Medicaid Director letter](#).

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## Questions about Reimbursement

Q: Who receives the reimbursement for the preventive services, the referring physician or the community partner providing the preventive service(s)?

A: The person/party who provides and bills for the service will be reimbursed. It could be the individual provider or their employer, such as a hospital, medical home or community-based organization.

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Q: What is the federal match rate for preventive services?

A: The match rate is the same as all other Medicaid services within the state.

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Q: Is this a 50/50 (Federal/State) funding formula like traditional Medicaid or 100/0 as in the Medicaid expansions?

A: This funding is based on the traditional Federal/State Medicaid funding formula. The funding, therefore, is consistent with your state's current Federal Medical Assistance Percentage, or FMAP. For Fiscal Year 2015 FMAP rates, see this [chart](#) produced by the Office of the Assistant Secretary for Planning and Evaluation at HHS.

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Q: Is there a set reimbursement for non-clinical providers who provide these preventive services or does that vary by state and Medicaid Managed Care Organization?

A: No, there is no set reimbursement for the services of non-licensed providers. Reimbursements will vary based on the services being provided and the regional costs and will be determined by the state Medicaid agency.

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Q: Do Federally-Qualified Health Centers (FQHCs) qualify for reimbursement?

A: Yes.

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Q: Are private, non-profit organizations that provide Chronic Disease Self-Management Programs (CDSMP) workshops eligible for reimbursement?

A: Yes, if the state submits a SPA and CMS approves it, non-licensed providers (or their employers) might be eligible for Medicaid reimbursement for preventive services they deliver upon referral from a licensed Medicaid provider. Preventive services are defined in the [State Medicaid Manual \(Chapter 4 Section 4385\)](#), or in your individual State's Medicaid Plan. **This rule change does not alter the definition or scope of preventive services that a state covers in Medicaid.**

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Q: Even though we have grant funded programs, can we still bill for what we deliver to a patient?

A: Yes, if the state submits the SPA and CMS approves it.

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## **Questions about Medicaid MCOs, Medicare, and Private Insurance**

Q: Does this rule change apply in Medicaid managed care? How would a Managed Care Organization (MCO) get paid by Medicaid for these services?

A: This rule applies in Medicaid fee-for-Service (FFS). Managed Care Organizations already have the authority to pay non-licensed providers, unless prohibited by the state.

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Q: For Medicaid managed care plans to pay non-licensed providers, is a State Plan Amendment required?

A: No

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Q: Will Medicare also allow payment for preventive services delivered by a non-licensed provider if they are recommended by a licensed provider?

A: No, this rule change applies to Medicaid.

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Q: If a state's Medicaid agency approves certain non-licensed providers, does that mean that private insurers have to reimburse for their services too?

A: No.

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## **For More Information**

Q: Is there a key contact at CMS nationally if we have technical questions about this new rule and state plan amendments?

A: Questions should be emailed to [MedicaidCHIPPrevention@cms.hhs.gov](mailto:MedicaidCHIPPrevention@cms.hhs.gov).