Identifying Beneficiaries with Full-Scope, Comprehensive, and Limited Benefits in the TAF

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TAF methodology brief

Summary

- Because of differences in both state programs and beneficiary populations, there is wide variation in Medicaid benefit packages. Beneficiaries might be entitled to "full-scope" benefits, or all services covered under a Medicaid state plan; "comprehensive" but not full-scope benefits, which would cover most medical and pharmacy services but not everything in the state plan; or "limited" benefits, which are narrow packages that cover only a small set of services.
- The restricted benefits code variable in the T-MSIS Analytic Files includes information on the scope of benefits for which each Medicaid and CHIP beneficiary qualifies and can be used to group beneficiaries into these three broad benefits categories.
- This brief explains how to interpret the values of the restricted benefits code variable, how to determine the scope of benefits based on this variable, and what TAF users can do when there is not enough information in the restricted benefits code variable to make this determination.

Background

This brief has two objectives: (1) to help users of the T-MSIS Analytic Files (TAF) understand the distinction between full-scope, comprehensive, and limited (also called restricted or partial) benefit packages in Medicaid and in the Children's Health Insurance Program (CHIP); and (2) to provide guidance on how to use information in the TAF to classify beneficiaries into these three categories. It is important to identify not only the benefit package for which a beneficiary qualifies but also the category into which that package falls because users may want to remove certain beneficiaries (such as those with limited benefits) from their analyses, as not all of their health care utilization is included in the TAF.[1] Alternatively, TAF users may want to study a group of beneficiaries who have a similar benefit package.

The benefit packages available to Medicaid beneficiaries can vary widely within a state, depending on a beneficiary's income and assets, health conditions, and citizenship status, among other factors. CHIP coverage is less variable because most beneficiaries are eligible

[1] Some TAF users may want to identify these beneficiaries in order to link to their Medicare claims or to obtain their claims from other payers.

for comprehensive benefits, and CHIP has fewer limited benefit coverage options.[2] This brief defines full-scope, comprehensive, and limited benefits and describes the restricted benefits code data element (RSTRCTD_BNFTS_CD), which is the recommended method for identifying the three categories of benefit packages in the TAF. These three packages provide the following benefits:

- **Full-scope benefits.** This package provides all services covered under the Medicaid state plan. Beneficiaries who qualify for full-scope benefits will receive both mandatory Medicaid benefits (such as inpatient and outpatient hospital, home health, and physician services, among others) as well as all of the optional benefits (such as dental services, personal care services, and physical therapy) that the state has elected to include in its Medicaid state plan.[3]
- **Comprehensive benefits.** These packages do not provide all services covered in the Medicaid state plan, but for beneficiaries who qualify, they do cover a set of services that meet the minimum essential coverage (MEC) requirements under the Affordable Care Act,[4] which requires 10 essential health benefit categories to be covered.[5] For example, a comprehensive benefits package may provide coverage for all acute-care services, but it can exclude coverage for institutional nursing facility care (a mandatory benefit for full-scope benefit packages) from the coverage offered to certain groups. Beneficiaries in these groups would be considered to have comprehensive benefits even though they do not qualify for full-scope benefits.
- **Limited benefits.** This package covers only a narrow set of services, such as family planning, emergency services, or care limited to a specific condition. For example, beneficiaries with tuberculosis who otherwise do not qualify for Medicaid can get coverage just for tuberculosis-related treatment (Centers for Medicare & Medicaid Services 2011).

[2] Medicaid expansion CHIP (M-CHIP) programs provide a benefit package that is the same as the one for children under each state's Medicaid state plan and/or under its Section 1115 demonstration program. States can also create a program apart from their existing Medicaid programs (referred to as Separate CHIP, or S-CHIP), or they can adopt a combination of the two approaches. While most CHIP beneficiaries are entitled to comprehensive benefits, there are some examples of limited benefits for CHIP beneficiaries, such as supplemental dental-only S-CHIP benefits or individuals eligible only for restricted M-CHIP benefits due to their noncitizen status. More information on CHIP benefits and coverage can be found at https://www.medicaid.gov/chip/benefits/index.html and https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53953.

[3] The mandatory and optional benefits provided to Medicaid beneficiaries are listed on the Medicaid.gov website at https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html.

[4] MEC was initially defined in 5000A(f) of the Internal Revenue Code of 1986 to include all Title XIX Medicaid programs, but final regulations issued by the IRS in 2013 made exceptions for family planning, tuberculosis- and pregnancy-related coverage, as well as coverage for otherwise eligible non-qualified non-citizens. Subsequent rule-making clarified which types of Medicaid coverage for the medically needy could be considered MEC (Centers for Medicare & Medicaid Services 2014). In most cases, S-CHIP coverage meets the MEC criteria and states provide full-scope benefits to S-CHIP beneficiaries. However, there are some exceptions where S-CHIP beneficiaries have limited benefit coverage, such as supplemental dental-only benefits for children who have employer-sponsored health insurance. States may also use CHIP funding (Title XXI of the Social Security Act) to provide coverage to additional low-income children by expanding eligibility for their Medicaid programs through M-CHIP. Additional information on CHIP benefits and limited coverage can be found at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53953.

[5] The 10 essential health benefits that must be covered for a plan to qualify as MEC include ambulatory patient services (outpatient care); emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Determining the Benefits Category

The restricted benefits code data element is how TAF users can distinguish between the three categories of benefit packages. There are 15 valid values for this code.[6] However, in recent years, two of them have rarely been used by states, if at all.[7, 8]

Among the valid values for the restricted benefits code that are reported by states, eight can be easily grouped into one of the three categories of benefit packages. However, it is more challenging to categorize the other five valid values because of the substantial state-to-state variation in benefit packages within these values. Table 1 presents the restricted benefits code values that are associated with each benefit category.

Table 1. Restricted benefits code: Values, description, and details, by benefit category

Coverage category varies by state?	Valid values and descriptions for restricted benefits codes	Details
Full-scope benefits		
No	1: Individual is eligible for Medicaid or CHIP and entitled to the full scope of Medicaid or CHIP benefits.	The beneficiary is entitled to all mandatory and optional benefits covered under the Medicaid state plan.
Full-scope or comprehensive benefits, depending on the state		
Yes	7: Individual is eligible for Medicaid and entitled to Medicaid benefits under an alternative package of benchmark-equivalent coverage, as set forth in the Deficit Reduction Act of 2005.	All beneficiaries with benchmark-equivalent coverage have comprehensive coverage at a minimum. The benchmark-equivalent coverage has been called an "Alternative Benefit Plan" (ABP) since the Affordable Care Act was passed in 2014. Some states have used the flexibility of the ABP design to align their benefit coverage with traditional Medicaid coverage, essentially providing ABP beneficiaries with the full scope of benefits (Congressional Research Service 2018).
Yes	A: Individual is eligible for Medicaid and entitled to benefits under the Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF), as set forth in the Deficit Reduction Act of 2005. PRTF grants help states to provide community alternatives to psychiatric resident treatment facilities for children.	In 2005, Congress authorized a five-year demonstration to test whether children and youth who met the requirements for being served in a PRTF could successfully and cost-effectively be served in the community.[a] Participants in this program are likely to have full-scope benefits.

[6] See TAF Data Dictionary here: https://resdac.org/cms-data/files/taf-de/data-documentation

[7] As of 2024, no states are using the restricted benefits code B (individual is eligible for Medicaid and entitled to Medicaid benefits using a Health Opportunity Account [HOA]). This value refers to a five-year demonstration that began in 2007 (CMS 2007). Under the demonstration, the state Medicaid program placed a pre-defined amount of money per year in the HOA. In South Carolina, the only state that piloted the program, the amount was $1,000 per child and $2,500 per adult. If all this money was spent on health services before the end of the year, the recipient was responsible for paying 10 percent of additional costs up to $250 per adult and $100 per child (Stark 2009).

[8] As of 2024, only one state (Oklahoma) is using the restricted benefits code C (individual is eligible for separate CHIP dental coverage [supplemental dental wraparound benefit to employer-sponsored insurance]). Two states (Iowa and Wisconsin) are using the corresponding eligibility group code 66 (children eligible for dental only supplemental coverage). Iowa includes this restricted benefit package in its state plan at https://www.medicaid.gov/CHIP/Downloads/IA/IA-CSPA-14-FINAL.pdf.

Coverage category varies by state?	Valid values and descriptions for restricted benefits codes	Details
Yes	D: Individual is eligible for Medicaid and entitled to benefits under a "Money Follows the Person" (MFP) rebalancing demonstration, as set forth by Deficit Reduction Act of 2005, to allow states to develop community-based long-term care opportunities.	The MFP demonstration is a federal initiative with two main goals: (1) to give people who need long-term services and supports (LTSS) more choice in where they live and receive care and (2) to increase the capacity of state LTSS systems to serve people in a community setting. To be eligible, individuals must be Medicaid beneficiaries who have resided in an institution for 90 days or more, not counting short-term rehabilitation days (U.S. Department of Health and Human Services 2017). Beneficiaries must have full-scope or comprehensive benefits to qualify for nursing home care.
Comprehensive benefits		
Yes (Coverage category varies by state for years prior to 2025)	4: Individual is eligible for Medicaid or CHIP but only entitled to restricted benefits for pregnancy-related services.	As of January 2025, all states offer individuals in a pregnancy-related Medicaid eligibility group coverage that meets the MEC standard and is therefore comprehensive.[b] Arkansas, Idaho, and South Dakota previously offered some pregnancy-related coverage that did not meet the MEC standard.[c] These states began offering comprehensive pregnancy-related coverage in January 2023, January 2025, and July 2023, respectively.
Yes (Coverage category varies by state for years prior to 2020)	5: Individual is eligible for Medicaid or Medicaid-Expansion CHIP but, for reasons other than alien, dual-eligibility or pregnancy-related status, is only entitled to restricted benefits (e.g., restricted benefits based upon substance abuse, medically needy, or other criteria) that meet the standard for Minimum Essential Coverage.	This code represents a variety of beneficiary groups who are not entitled to full-scope benefits but whose benefits meet the MEC standard and do not fit into other restricted benefits code categories.[d] Prior to May 2020, states were instructed to use this value for any beneficiaries with restricted benefits packages not enumerated in other valid values. As a result, records with this code in 2019 and earlier years may represent a mix of beneficiaries with comprehensive and limited benefits.
Limited benefits		
No	2: Individual is eligible for Medicaid or Medicaid-Expansion CHIP but only entitled to restricted benefits based on alien status.	Non-citizens who are not eligible for anything but limited benefits for some services.
No	3: Individual is eligible for Medicaid but only entitled to restricted benefits based on Medicare dual-eligibility status (e.g., QMB, SLMB, QDWI, QI).	Partial duals are enrolled in a Medicare Savings Program (MSP) or another program under which Medicaid pays for only some of the expenses they incur under Medicare. These expenses include the premiums for Part A and, if applicable, for Part B. Medicaid may also pay for some other cost-sharing amounts owed under Medicare, such as deductibles, coinsurance, and copayments.[e]

Coverage category varies by state?	Valid values and descriptions for restricted benefits codes	Details
No	6: Individual is eligible for Medicaid or Medicaid-Expansion CHIP but is only entitled to restricted benefits for family planning services.	Some beneficiaries who do not qualify for full-scope benefits are only eligible for family planning services.[f]
No	C: Individual is eligible for S-CHIP dental coverage (supplemental dental wraparound benefit to employer-sponsored insurance).	Some children who have employer-sponsored health insurance are also eligible for supplemental S-CHIP dental wraparound benefit in select states. As of 2024, only one state (OK) offers this benefit and reports individuals with this restricted benefits code.
No	E: Individual is eligible for Medicaid or Medicaid-Expansion CHIP, but for reasons other than alien, dual-eligibility, or pregnancy-related status, is only entitled to restricted benefits (e.g., restricted benefits based on substance abuse, medically needy, or other criteria) that do not meet the standard for Minimum Essential Coverage.	This code represents a variety of beneficiary groups who are eligible only for limited benefits that do not meet the MEC standard and do not fit into other restricted benefits code categories.[d] Some examples of what might be included in this code are benefits provided under a medically-needy program, 1115 demonstrations that are not captured under Alternative Benefit Plans, tuberculosis-only coverage, or the inmate coverage exclusion. This code became a valid value in May 2020 but may be present in earlier years of data because some states resubmit historic files.
No	F: Individual is eligible for Medicaid but is only entitled to restricted benefits for medical assistance for COVID-19 diagnostic products and any visit described as a COVID-19 testing-related service for which payment may be made under the State plan during any portion of the public health emergency period, beginning March 18, 2020, as described in Sections 1902(a)(10)(A)(ii)(XXIII), 1902(ss) and clause XVIII in the matter following 1902(a)(10)(G) of the Social Security Act.	During any portion of the COVID-19 public health emergency period beginning March 18, 2020 and ending May 11, 2023, states were permitted to temporarily cover uninsured individuals through an optional Medicaid eligibility group for the limited purpose of COVID-19 testing. This included in vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and any visit for COVID-19 testing-related services for which payment may be made under the State plan.[g]
No	G: Individual is eligible for Medicaid but only entitled to restricted benefits based on Medicare dual-eligibility status Medicare Part B-ID End Stage Renal Disease (ESRD) Benefit.	Section 402 of the Consolidated Appropriations Act, 2021 extended eligibility for immunosuppressive drug (ID) coverage under Medicare Part B for certain individuals whose Medicare entitlement based on ESRD would otherwise end 36 months after a successful kidney transplant, effective January 2023.

Coverage category varies by state?	Valid values and descriptions for restricted benefits codes	Details
		Individuals are only eligible for Medicare Part B-ID benefit coverage if they do not have any other private insurance, Medicaid, or other public coverage of immunosuppressive drugs. As of the time of this publication, all states cover immunosuppressive drugs for beneficiaries with full Medicaid benefits. Therefore, the only Medicaid enrollees who are also have Part B-ID benefit are those with partial Medicaid-Medicare dual eligibility via enrollment in an MSP.[h] These beneficiaries are eligible for Medicaid to pay the Medicare premium and, if applicable, Medicare cost-sharing for the Part B-ID benefit.
Not eligible		
No	0: Individual is not eligible for Medicaid or CHIP during the month.	The beneficiary is not entitled to Medicaid or CHIP benefits during the month.

Source: TAF Data Dictionary.

Note: One value for the restricted benefits code are not included in this table. RSTRCTD_BNFTS_CD = B (Individual is eligible for Medicaid and entitled to Medicaid benefits using a Health Opportunity Account [HOA]) refers to a 5-year demonstration that began in 2007, but no beneficiaries have been in this category in recent years (Centers for Medicare & Medicaid Services [CMS] 2007).

[a] Additional information about the Alternatives to Psychiatric Residential Treatment Facilities Demonstration is available at https://www.medicaid.gov/medicaid/long-term-services-supports/alternatives-psychiatric-residential-treatment-facilities.

[b] Medicaid Secretary-approved Minimum Essential Coverage from February 16, 2016, is available at https://www.medicaid.gov/sites/default/files/2020-01/state-mec-designations.pdf.

[c] The American Rescue Plan Act of 2021 provided states with the option to extend postpartum coverage from 60 days to 12 months, and states that chose to extend postpartum coverage to 12 months were required to provide full-benefit pregnancy-related coverage. CMS guidance on the option to extend postpartum coverage is available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf. Three states that previously only covered limited benefits for individuals eligible based on pregnancy submitted and obtained approval for State Plan Amendments (SPA) to extend coverage for these individuals. Idaho's SPA is available at https://www.medicaid.gov/CHIP/Downloads/ID-25-0002.pdf. Arkansas' SPA is available at http://www.medicaid.gov/medicaid/spa/downloads/AR-22-0027.pdf. South Dakota's SPA is available at https://www.medicaid.gov/medicaid/spa/downloads/SD-23-0008.pdf.

[d] In February 2020, CMS released guidance that the restricted benefits code value of 5 should be used only if the coverage meets the MEC standard and a new valid value of E should be used if the coverage does not meet the MEC standard. Because states vary in their resubmission of historic data, the TAF data for some but not all states may include these updated values in years before 2019. CMS guidance to states for reporting the restricted benefits code is available at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53953.

[e] CMS guidance to states on reporting expectations for dual-eligible beneficiaries is available at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/?entry=51064.

[f] For additional information on family planning services eligibility, see https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-eligible-for-family-planning-services.pdf.

[g] In April 2020, CMS added the new restricted benefits code valid value of F for individuals who are only entitled to restricted benefits that cover COVID-19 diagnostic products and any visit described as a COVID-19 testing-related service. CMS guidance to states on reporting uninsured individuals who receive coverage for COVID-19 testing services is available at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/89306.

[h] Additional information on the Medicare Part B-ID ESRD Benefit is available at https://www.cms.gov/partbid-provider. CMS guidance to states on reporting expectations for dual-eligible beneficiaries with this benefit is available at https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/cms-technical-instructions-reporting-beneficiaries-dually-eligible-for-medicaid-and-medicare-part-b-immunosuppressive-drug-id-benefits-to-t-msis/.

There are five values of the restricted benefits code that may indicate either full-scope or comprehensive benefits (values of 4, 5, 7, A, and D). TAF users who are restricting their analysis to beneficiaries with at least comprehensive coverage can include these values in all states beginning with the 2025 coverage year.[9] TAF users who need to differentiate between beneficiaries with full-scope and comprehensive benefits will need to investigate the benefit packages available to Medicaid beneficiaries in their states of interest to determine state-by-state rules for classifying beneficiaries. For example, restricted benefits code 7 indicates that an individual is eligible for Medicaid and enrolled in an alternative package of benchmark-equivalent coverage, or alternative benefit plan (ABP). All adults who became newly eligible for Medicaid through the Affordable Care Act (also known as expansion adults or the VIII group) are covered by ABPs. Although all beneficiaries with benchmark-equivalent coverage have comprehensive coverage at a minimum, some states have used the flexibility of the ABP to align their benefit package with the traditional Medicaid benefit package, offering these beneficiaries full-scope benefits.[10] As a result, beneficiaries with this restricted benefits code qualify for comprehensive coverage at a minimum, but many states provide coverage that is more generous than what is required by federal law, up to the level of full-scope Medicaid benefits.

The restricted benefits code value of 4 (individual is eligible for Medicaid or CHIP but only entitled to restricted benefits for pregnancy-related services) has changed benefit categories over time for select states. Three states (Arkansas, Idaho, and South Dakota) previously provided only a limited benefit package to certain individuals in a pregnancy-related eligibility group, while all other states provided a comprehensive benefit package that meets the MEC standard to all individuals in a pregnancy-related eligibility group (except those with limited benefits due to noncitizen status) since at least 2016. The American Rescue Plan Act of 2021 provided states with the option to extend postpartum coverage from 60 days to 12 months. States that chose to extend postpartum coverage to 12 months were required to provide full-benefit pregnancy-related coverage.[11] South Dakota implemented a 12-month postpartum coverage extension in July 2023 and Idaho implemented an extension in January 2025.[12] Arkansas did not extend postpartum coverage but amended their state plan in January 2023 to extend full Medicaid benefits to all enrollees in the pregnancy-related eligibility group.[13] Therefore, as of January 2025, CMS considers *all* states as providing comprehensive Medicaid benefits to all individuals in a pregnancy-related eligibility group.

[9] The restricted benefits code value of 4 represents beneficiaries with comprehensive benefits for all states as of January 2025. Records with this value prior to January 2023 in Arkansas, July 2023 in South Dakota, and January 2025 in Idaho represent beneficiaries with limited benefits. The restricted benefits code value of 5 represents beneficiaries with comprehensive benefits starting in May 2020. Records with this code prior to May 2020 may represent a mix of beneficiaries with comprehensive and limited benefits.

[10] More information about alternative benefit plans can be found at https://www.medicaid.gov/medicaid/benefits/alternative-benefit-plan-coverage/index.html.

[11] CMS guidance on the option to extend postpartum coverage is available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

[12] Three states that previously only covered limited benefits for individuals eligible based on pregnancy recently submitted and obtained approval for State Plan Amendments (SPA) to extend coverage for these individuals. Idaho's SPA can be found here: https://www.medicaid.gov/CHIP/Downloads/ID-25-0002.pdf. Arkansas' SPA can be found here: http://www.medicaid.gov/medicaid/spa/downloads/AR-22-0027.pdf. South Dakota's SPA can be found here: https://www.medicaid.gov/medicaid/spa/downloads/SD-23-0008.pdf.

Another restricted benefits codes (value of 5) has changed meaning over time. Prior to May 2020, the restricted benefits code 5 (individual is eligible for Medicaid or M-CHIP but, for reasons other than alien, dual-eligibility, or pregnancy-related status, is only entitled to restricted benefits) included groups with less than full-scope or comprehensive coverage that were not enumerated in other restricted benefit codes. States used this code to report some limited-benefit groups that are covered in every state, such as beneficiaries who qualify for tuberculosis-related services, as well as large programs that only operated in some states, such as medically-needy coverage and Section 1115 waivers. As a result, this restricted benefit code included a heterogeneous group of beneficiaries, some of which qualified for comprehensive benefits and some of which qualified for only limited benefits. Table 2 shows the medically needy and Section 1115 waiver programs that were historically reported into this restricted benefits code value. To improve the usability of the restricted benefits code in identifying beneficiaries with different levels of coverage, CMS released new guidance in February 2020 that changed the definition of the restricted benefits code value of 5 to only include beneficiaries whose coverage qualified as MEC. A new restricted benefits code value of E was then introduced for beneficiaries previously included in this group whose coverage does not meet the MEC standard. Because states vary in how quickly they implemented this change and how much historic eligibility data was resubmitted using the new coding, TAF users should be particularly careful in how they interpret the restricted benefit code of 5 in earlier years of data. Users may want to consider incorporating additional information from the eligibility group code (ELGBLTY_GRP_CD) to identify beneficiaries who qualify for coverage under medically needy or Section 1115 programs and to examine what restricted benefits code was used for these records when using data from 2019 and earlier.[13]

For more information on how states are instructed to populate the restricted benefits code, TAF users are encouraged to refer to the guidance on the T-MSIS Coding Blog.[14]

[13] The eligibility group codes used for medically needy programs are 53, 54, 55, 56, 59, or 60. The eligibility group codes used for Section 1115 coverage expansion waivers are 69, 70, and 71. The information in Table 2 can be used to determine whether beneficiaries in these programs in 2023 qualified for comprehensive or limited benefits in each state.

[14] The T-MSIS Coding Blog is available at https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/.

Table 2. Benefit coverage category for medically needy and Section 1115 programs by state, as of 2023

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Alabama	—	—	—	—	Alabama First Family Planning Demonstration Alabama Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness Alabama Community Waiver Program
Alaska	—	—	—	—	Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP)
Arizona	—	—	—	Arizona Health Care Cost Containment	—
Arkansas	Yes	Yes	—	Arkansas Works, formerly Arkansas Healthcare Independence (expired 2021) AR-TEFRA-like program Arkansas Health and Opportunity for Me (ARHOME)	—
California	Yes	Yes	—	CalAIM (formerly Bridge to Reform)	—
Colorado	—	—	—	Colorado Adult Prenatal Coverage in Child Health Plan Plus (CHP+)	Expanding the Substance Use Disorder Continuum of Care

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Connecticut	Yes	Yes	—	Covered Connecticut	Connecticut Substance Use Disorder Demonstration
Delaware	—	—	—	Delaware Diamond State Health Plan	—
District of Columbia	Yes	Yes	—	Behavioral Health Transformation District of Columbia Childless Adults (expired 2015)	—
Florida	—	—	Yes; provides limited benefits only	MEDS AD (expired 2017) Managed Medical Assistance	Florida Medicaid Family Planning Waiver
Georgia	Yes	Yes	—	Georgia Pathways to Coverage	Georgia Family Planning for Healthy Babies Family Planning Demonstration
Hawaii	Yes	Yes	—	Quest Integration	—
Idaho	—	—	—	—	—
Illinois	Yes	Yes	—	—	Illinois Behavioral Health Transformation Illinois Continuity of Care and Administrative Simplification
Indiana	—	—	—	Healthy Indiana Plan 1.0 and 2.0	—
Iowa	—	—	Yes; provides limited benefits only	Iowa Health and Wellness Plan Marketplace Choice Plan (expired 2016)	Family Planning Network Demonstration (expired 2017)

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Kansas	Yes	Yes	—	KanCare	—
Kentucky	Yes	Yes	—	KY HEALTH	—
Louisiana	—	—	Yes; provides limited benefits only	—	Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Demonstration Greater New Orleans Community Health Connection (terminated 2016)
Maine	Yes	Yes	—	Maine HIV/AIDS Program (Individuals with HIV/AIDS with income at or below 100% of the federal poverty level (FPL) receive full-scope benefits)	Maine HIV/AIDS Program (Individuals with HIV/AIDS with income at or below 250% of the FPL who receive limited services such as durable medical equipment, physical therapy, dental care, home- and community-based services, and optometry) Maine Substance Use Disorder Care Initiative
Maryland	Yes	Yes	—	Maryland Health Choice	—
Massachusetts	Yes	Yes	—	MassHealth Comprehensive Demonstration	—
Michigan	Yes	Yes	—	Healthy Michigan Flint Michigan 1115 Demonstration	Michigan Family Planning Demonstration Michigan 1115 Behavioral Health

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Minnesota	Yes	Yes	—	Prepaid Medical Assistance	MN Reform 2020 Minnesota Family Planning Demonstration Minnesota Substance Use Disorder System Reform
Mississippi	—	—	—	Healthier Mississippi Demonstration	Mississippi Family Planning Demonstration
Missouri	—	—	—	Missouri Former Foster Care Youth	Gateway to Better Health (expired 2022) Missouri Women's Health Services Program (expired 2017) Missouri Targeted Benefits for Postpartum Women
Montana	Yes	Yes	—	—	Montana Additional Services and Populations (formerly Montana Basic Medicaid for Able-Bodied Adults) Montana Plan First Family Planning Demonstration Montana Healing and Ending Addiction through Recovery and Treatment
Nebraska	Yes	Yes	—	—	Nebraska Substance Use Disorder Demonstration Program
Nevada	—	—	—	Comprehensive Care Waiver	—

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
New Hampshire	Yes	Yes	—	Granite Advantage Health Care Program	Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access
New Jersey	—	—	Yes; provides limited benefits only	New Jersey Comprehensive	—
New Mexico	—	—	—	Centennial Care	—
New York	Yes	Yes	—	New York Medicaid Redesign Team (formerly called New York Partnership Plan)	
North Carolina	Yes	Yes	—	North Carolina Medicaid Reform Demonstration	—
North Dakota	Yes	Yes	—	—	—
Ohio	—	—	—	—	Ohio Section 1115 Substance Use Disorder Demonstration
Oklahoma	—	—	—	Oklahoma SoonerCare	Oklahoma Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder
Oregon	—	—	—	Oregon Health Plan	Oregon Health Plan Substance Use Disorder 1115 Demonstration Oregon Contraceptive Care (formerly Oregon Family Planning Demonstration)

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Pennsylvania	Yes	Yes	—	Pennsylvania Medicaid Coverage for Former Foster Care Youth from a Different State and SUD Section 1115 Demonstration (full benefits for former foster care youth) Healthy Pennsylvania (expired 2019)	Pennsylvania's Select Plan for Women (expired 2016) Pennsylvania Medicaid Coverage for Former Foster Care Youth from a Different State and SUD Section 1115 Demonstration (limited benefits for SUD demonstration)
Puerto Rico	—	—	—	—	—
Rhode Island	Yes	Yes	—	Global Consumer Choice (mandatory and optional state plan groups and individuals whose eligibility is derived from the demonstration)	Global Consumer Choice (all others)
South Carolina	—	—	—	—	—
South Dakota	—	—	—	South Dakota Former Foster Care Youth	—
Tennessee	Yes	Yes	—	TennCare III (mandatory and optional state plan groups, medically eligible children, Choices 217 individuals, non-pregnant adults)	—
Texas	Yes	Yes	—	Texas Healthcare Transformation and Quality Improvement	Healthy Texas Women

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Utah	—	—	—	Utah Medicaid Reform 1115 Demonstration (formerly Primary Care Network)	Utah Medicaid Reform 1115 Demonstration, formerly Primary Care Network (adults with income at or below 95% of the FPL who receive a limited primary and preventive care benefit package; high-risk pregnant women who receive pregnancy-related services)
Vermont	Yes	Yes	—	Global Commitment to Health Comprehensive (for mandatory and optional state plan populations)	Global Commitment to Health Comprehensive (for individuals with moderate needs who receive a subset of HCBS)
Virginia	—	—	Yes, provides limited benefits only	Virginia FAMIS MOMS and FAMIS Select for uninsured pregnant women	FAMIS MOMS and FAMIS Select for CHIP with premium assistance
Washington	Yes	Yes	—	Washington Medicaid Transformation Project	Washington Take Charge Family Planning Demonstration
West Virginia	Yes	Yes	—	—	West Virginia Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders Demonstration

State	Medically needy programs			Other programs (including Section 1115 demonstrations)	
	Comprehensive benefit programs for individuals who qualify without needing to deduct medical expenses from income	Limited benefit programs for individuals who qualify only after incurring medical expenses	Other medically needy programs that do not consider expenses in determining eligibility	Comprehensive benefit programs	Limited benefit programs
Wisconsin			—	BadgerCare Reform	Wisconsin SeniorCare
Wyoming	—	—	—	—	Wyoming “Pregnant by Choice” Family Planning Demonstration

Source: State-level information on the Medicaid programs that count as comprehensive coverage (or MEC) is available at https://www.healthcare.gov/medicaid-limited-benefits/.Please note that this information may not be up to date for all states. Additional state-level information on Section 1115 demonstrations and other state waivers is available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html. Additional information on Medically Needy Coverage is available at https://www.medicaid.gov/medicaid/eligibility/minimum-essential-coverage/index.html.

Note: All states provide non-comprehensive coverage for some groups that covers only for family planning, emergency services, tuberculosis-related treatment, or outpatient hospital services. All states also offer full-scope benefits according to the state plan to some groups of beneficiaries.

— = The state does not have any beneficiaries in this group.

Revision History

Revision date	Authors and changes
November 2019	Initial release. Laura Nolan, Allison Barrett, Jamie John, Kimberly Proctor, and Jessie Parker. Initial version of the TAF Methodology Brief #4151: "Identifying Beneficiaries with Full-Scope, Comprehensive, and Limited Benefits in the TAF."
August 2021	Laura Nolan, Allison Barrett, Linda Nguyen, and Jessie Parker. Revisions to the TAF Methodology Brief #4151: "Identifying Beneficiaries with Full-Scope, Comprehensive, and Limited Benefits in the TAF." Changes include the following: • Added new valid values for restricted benefits code 'E' and 'F' under the "limited benefits" category in Table 1. • Clarified the change in definition for restricted benefits code '5' and classified this code under the "comprehensive benefits" category for all states in Table 1.
April 2025	Linda Nguyen, Chandra Couzens, Mary Allison Geibel, Rebecca Winter, Ali Fokar, and Angelica Parker. Revisions to the TAF Methodology Brief #4151: "Identifying Beneficiaries with Full-Scope, Comprehensive, and Limited Benefits in the TAF." Changes include the following: • Added new valid values 'G and 0' for restricted benefits code in the "limited benefits" category in Table 1. • Revised the categorization of restricted benefits code '4' to "comprehensive benefits" for *all* states as of 2025 and provided contextual information for this update. Previously, restricted benefits code '4' was considered "limited benefits" for three states (Arkansas, Idaho, and South Dakota) and "comprehensive benefits" for all other states. • Added contextual information about CHIP limited benefits coverage options. • Updated Table 2: Benefit coverage category for medically needy and Section 1115 programs by state, as of 2023. This table previously included information as of 2019.

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Reviewers: Ali Fokar[2]; Nikki Morelock[2]; Angelica Parker[2]; Josie Musen[2]; Keith Branham[2]; Jeffrey Galecki[2]; Mary Allison Geibel[1]; Amy Lutzky[1]; Rebecca Winter[1]

[1]Mathematica, [2]Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, Data and Systems Group, Division of Business and Data Analysis

Correspondence should be addressed to MACBISData@cms.hhs.gov.