November 21, 2012

Medicaid Benchmark Benefits for the New Adult Group

On November 20, 2012, through a State Medicaid Director Letter (SMDL), the Center for Medicaid and CHIP Services (CMCS) provided additional guidance to states on Medicaid benchmark benefit coverage options for the new Medicaid adult group (adults under the age of 65 with incomes below 133% of the FPL).

The SMDL starts by noting that Medicaid benchmark benefits will now be referred to as "Alternative Benefit Plans." The balance of the SMDL expands on the information provided in February as part of the Essential Health Benefit (EHB) guidance, but defers significant additional guidance to Medicaid regulations "that will be published shortly." This memorandum reviews the information provided to states in the SMDL.

Background

As laid out in section 1937 of the Social Security Act, amplified in the Affordable Care Act (ACA) and described in the SMDL, states have four reference plans from which to select in crafting their Alternative Benefit Plans for the new adult group:

1. The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit Program
2. State employee coverage that is offered and generally available to state employees
3. The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
4. Secretary-approved coverage, which may include the state's full Medicaid benefit package

Each state's Alternative Benefit Plan must include non-emergency transportation; Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; family planning services; and the 10 Essential Health Benefits (EHBs) described in section 1302(b) of the ACA. The Alternative Benefit Plan must also comply with the requirements of the Mental Health Parity and Addiction Equity Act.

The SMDL states that certain populations, such as blind and disabled and medically frail beneficiaries, are exempt from mandatory enrollment in an Alternative Benefit Plan, clarifying that the so-called benchmark exemptions apply to the new adult group.

The State Medicaid Director Letter

As noted above, the Alternative Benefit Plan must incorporate the 10 EHBs, and the process for doing so in Medicaid will generally follow the EHB regulations for the individual and small group markets.[1] However, recognizing states' traditional role in defining Medicaid benefits and the existing requirements of federal Medicaid law, CMCS indicates that the forthcoming Medicaid regulations will include some modifications to the EHB rules when applied to Medicaid beneficiaries.

[1] The draft EHB rules were also released on November 20, 2012. Patient Protection and Affordable Care Act; *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, CMS-9980-P (https://federalregister.gov/a/2012-28362)

Coverage of EHBs. In designing the Alternative Benefit Plan, a state will choose from one of the four reference plan options described above. If the state selects a reference plan that is also one of the options available for defining EHBs in the individual or small group market (referred to as "base benchmark options" in the proposed EHB regulations),[2] then the Alternative Benefit Plan will be deemed to have met the requirement to cover all EHBs as long as the selected plan includes the 10 EHB categories. If the selected reference plan is missing one of the 10 EHB categories, then the state must follow the supplementation process described in the EHB regulations, as amplified by forthcoming Medicaid regulations. If the state selects a reference plan that is ***not*** one of the options available for defining EHBs in the individual or small group market, then the state must select one of the EHB base benchmark options; compare the benefits in the Medicaid Alternative Benefit Plan to the selected EHB base benchmark option; and to the extent needed, supplement the Alternative Benefit Plan.

While this new information answers one question for state Medicaid agencies — states must have an EHB reference plan — it leaves many others unanswered. For example, if a state selects the Secretary-approved option to define its Alternative Benefit Plan (or selects any other option that is not also a base benchmark option), it must also select one of the ten base benchmark options as its EHB reference plan. States that have done this analysis often find that some of the benefits covered in the base benchmark plan, are not covered in their standard Medicaid package (e.g. chiropractic services). Thus the question remains whether the state must include these additional services in its Medicaid Alternative Benefit Plan for the new adult group. Likewise, the base benchmark plan may include services or providers that federal Medicaid does not cover, such as institutes of mental disease or fertility treatment, raising the question of whether these services or providers may or must be included in the state's Alternative Benefit Plan. Presumably, the forthcoming regulations will provide additional guidance on the relationship between a state's Alternative Benefit Plan and its selected base benchmark/EHB reference plan.

Supplemental Coverage Provisions for EHBs. The SMDL provides for Medicaid-specific definitions for certain EHBs, which will be further detailed in forthcoming guidance:

1. Habilitative Services
2. Pediatrics: EHB supplementation will not be necessary in Medicaid as EPSDT requires coverage of all medically necessary services for children under age 21.
3. Prescription Drugs: The current Medicaid rules apply to Alternative Benefit Plans, including drug rebates; CMCS highlights that states continue to have the flexibility to adopt prior authorization and other utilization control measures as well as policies that promote use of generic drugs.

CMCS concludes this section of the SMDL by confirming that all other provisions of the federal Medicaid law apply unless the state can demonstrate that compliance with a particular provision would be directly contrary to its ability to implement the Alternative Benefit Plan. The SMDL indicates that states may use commercial or Medicaid provider qualifications. CMCS further advises that free choice of providers continues to apply in either case.

Updating EHBs and Alternative Benefit Plans. Medicaid aligns with the EHB regulation in requiring that the selected base benchmark plan will be in effect for two years through December 31, 2015

Medicaid State Plan Amendments (SPAs). The SMDL indicates that SPAs describing the Alternative Benefit Plan for the new Medicaid adult group may be submitted starting in the first quarter of 2013, for implementation effective January 1, 2014. The SPA must include the populations eligible for the Alternative Benefit Plan, the benefits covered and the fee for service reimbursement methodology. If a state intends to implement the Alternative Benefit Plan through a managed care delivery system, managed care contracts must be submitted to CMCS. Finally, if the state intends to apply cost sharing to the new adult group, that

[2] Section 156.100 of the proposed EHB regulations lists the following base benchmark plans: the largest health plan by enrollment in any of the three largest small group insurance products; any of the largest three employee health plan options by enrollment offered to state employees; any of the largest three national Federal Employees Health Benefits Program plan options offered to federal employees; the coverage plan with the largest insured commercial non-Medicaid

information must likewise be included in the SPA. Notably, the SMDL indicates that the forthcoming regulations "may include changes related to cost sharing to similarly modernize them for the new system that starts in 2014."

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