Washington State Health Care Authority

Medicaid Benefits under the ACA

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Requirements for Washington's Benchmark Benefit (Alternative Benefit) Plan

New Adult Group Receives Benchmark Coverage

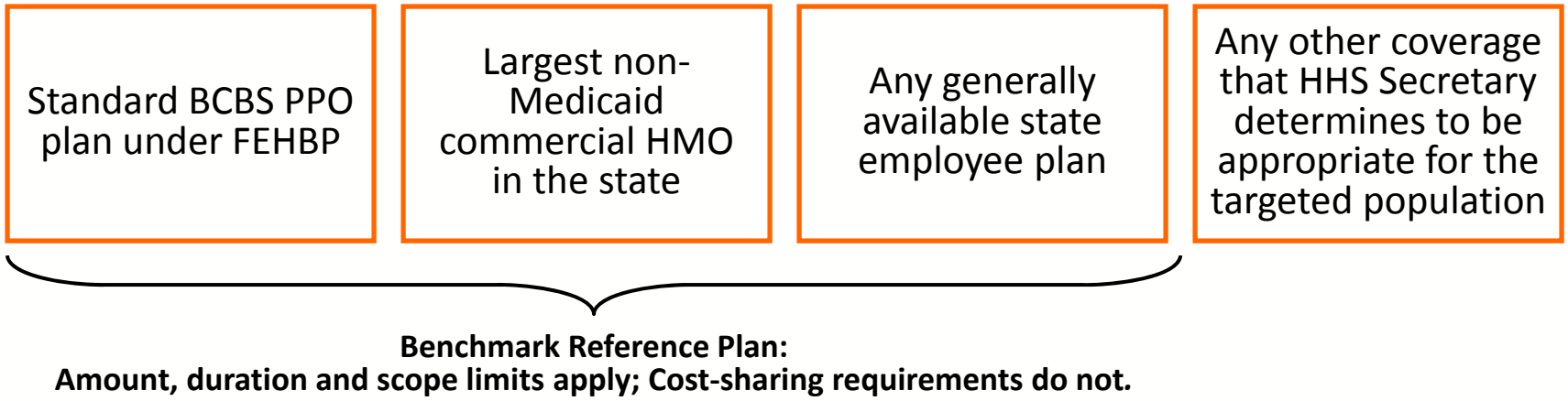
ACA establishes new, mandatory Medicaid eligibility group of non-pregnant adults between 19-65 with incomes ≤138% FPL

- This "new adult eligibility group" consists of childless adults, and parents/caretakers above ~40% FPL
- States must provide Benchmark or Benchmark-equivalent coverage described under §1937 of the Social Security Act (DRA), as modified by the ACA to adults in new adult eligibility group
- States will receive enhanced FMAP for "newly eligibles" within new adult eligibility group

Reminder: 133% = 138% FPL with 5 percent across-the-board disregard.

Benchmark Coverage Under the 2005 Deficit Reduction Act

Benchmark coverage linked to:



- Benchmark must cover:
  - EPSDT for any child under age 21 covered under the state plan
  - FQHC/RHC services
  - Non-emergency transportation
  - Family planning services and supplies
- State may supplement benefits in Benchmark reference plan

Benchmark Coverage Under the Affordable Care Act

Beginning in 2014, Benchmark must include all Essential Health Benefits (EHBs) for:

- new adult eligibility group (newly eligible and currently eligible)
- all existing Benchmark populations

EHB Categories:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

EHBs and Medicaid Benchmark Coverage

- EHB reference plan for Medicaid may be different than EHB reference plan for the Exchange (Regence Innova).
- State must select an EHB reference plan for Medicaid.
  - State may select its full Medicaid package as its Benchmark coverage under "Secretary-approved" option but must also select an EHB reference plan.
  - State must specify EHB reference plan as part of 2014-related Medicaid State Plan changes.
- States must provide public notice and reasonable opportunity to comment before submitting State Plan Amendment with Benchmark plans to CMS.

Unlike in individual and small-group market:

- State may have more than one Benchmark for new adult group
- No default reference plan – state must choose

New Information in Proposed Rules - 1/14/2013

- Medicaid Alternative Benefit Plan must cover full scope of preventive services
  - "A" or "B" services defined by the U.S. Preventive Services Task Force
  - Advisory Committee for Immunization Practices recommended vaccines
  - Preventive care and screening for infants, children and adults recommended by the Bright Futures program
  - Additional preventive services for women recommended by Institute of Medicine (IOM)
- Broadened definition for "Medically Frail"
  - Individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness)
  - Individuals with serious and complex medical conditions
  - Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living
  - Individuals with a disability determination based on Social Security criteria

As of 2014, Mental Health Parity Applies to Benchmark

- Under current law, federal mental health parity (FMHP) requirements only apply to Medicaid managed care, not Medicaid fee-for-service.
- The ACA expands some FMHP requirements to all Benchmark and Benchmark equivalent plans
  - Mental health and substance abuse benefits must have parity with medical/surgical benefits with respect to:
    - Financial requirements (deductibles, co-pays, and coinsurance)
    - Treatment limitations (frequency/scope/duration)
  - Because Benchmark must cover EPSDT, it meets FMHP requirements for individuals under 21

More guidance coming…

In addition to MCOs, which defined in statute, CMS has, by regulation, recognized entities known as Prepaid Inpatient Hospital Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These entities provide a more limited set of State Plan services (in some instances through a carve-out arrangement). CMS urges states with these arrangements to apply the principles of parity across the whole Medicaid managed care delivery system when mental health and substance use disorders services are offered through a carve-out arrangement. ***CMS intends to issue additional guidance that will address this issue and will continue to consider additional regulatory changes that may be necessary to properly implement the Mental Health Parity and Addiction Equity Act (MHPAEA).***

----State Health Official letter (1/16/13*) RE: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans* - http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

Alternative Benefit Plan Open Questions

- Pending further analysis and federal guidance, will Washington be required to include additional benefits from the selected EHB reference plan that are not covered under the current Medicaid State Plan?
- Must the state include in the Alternative Benefit Plan all services or providers in the selected reference plan including those that federal Medicaid does not cover, e.g., institutes of mental disease or fertility treatment?
- How will access to home- and community-based services be addressed in the Alternative Benefit Plan?

Note: See http://www.hca.wa.gov/hcr/me/policies.html for Washington request to CMS

Considerations for Designing Washington's Alternative Benefit Plan

Steps to Design Alternative Benefit Plan

- Select Medicaid EHB Reference Plan.
- Determine if selected EHB reference plan includes required 10 statutory categories for EHBs.
- Compare benefits across selected EHB Reference Plan and Medicaid Standard.
- Identify meaningful differences in coverage.
- Note where state may be required to include EHB-covered service in Alternative Benefit Plan and differences with Medicaid Standard.
- Conduct mental health parity analysis:
  - Cross-walk mental health and substance abuse services from EHB Reference Plan to Alternative Benefit Plan
  - Apply Mental Health Parity

Considerations in ABP Design

- Clinical needs of new adult population
- Alignment across Medicaid categories
- Alignment between Medicaid and QHP
- Administrative ease for beneficiary and State
- Whether and how to apply cost-sharing
- Fiscal Implications:
  - State receives 100% federal financing for ABP benefits provided to newly eligible adults
  - Any additional benefits for currently eligible Medicaid enrollees will be covered at existing FMAP rate

Options for Alternative Benefit Plan(s)

- Align Alternative Benefit Plan to Medicaid Standard, creating one adult benefit package:
  - Add Alternative Benefit Plan benefits to Medicaid Standard
  - Add Medicaid Standard benefits to Alternative Benefit Plan

- Offer different benefit packages to different groups:
  - Alternative Benefit Plan to new adult group
  - Medicaid Standard to children, pregnant women, LIF parents and ABD

See HCA Links for More Information

- Main HCA web-site: http://www.hca.wa.gov/
  - For information about the Medicaid expansion: http://www.hca.wa.gov/hcr/me
  - To contact the HCA concerning the Medicaid expansion: medicaidexpansion2014@hca.wa.gov
- Webinars and presentations around the state
  - See upcoming schedule and past events at: http://www.hca.wa.gov/hcr/me/stakeholdering.html
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