



STATE OF WASHINGTON  
**HEALTH CARE AUTHORITY**

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July 24, 2012

Cindy Mann, Director  
Centers for Medicare and Medicaid Services (CMS)  
7500 Security Boulevard  
Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

**SUBJECT: Medicaid Benchmark Design**

As Washington State considers implementation requirements for the expansion of our Medicaid program, immediate guidance for designing the Benchmark benefit package for the new Section VIII adult group is requested. To support continuity of care and clarity of coverage for beneficiaries, as well as administrative efficiencies for state and federal governments, HCA is assessing the implications of offering the *same* benefit package to all Medicaid beneficiaries. This includes the alignment of our Medicaid Standard and Benchmark packages, which may require us to add benefits to benchmark to align with standard and also add benefits to standard to align with benchmark.

To understand the potential differences in Benchmark and Standard benefits that would need to be reconciled, the applicable provisions of the Affordable Care Act (ACA), the Deficit Reduction Act (DRA), as well as the Essential Health Benefits (EHB) and Medicaid Benchmark guidance must be reviewed. The standard benefit was then cross-walked to the potential EHB Benchmark reference plans. HCA has also had the benefit of participating in the CMCS Coverage Learning Collaborative.

Several issues were identified that require CMS' technical assistance:

1. Scope of EHBs when individual services are not included in Medicaid Standard.
2. Scope of EHBs with respect to utilization management for select Medicaid Standard services.
3. Alignment of mental health and substance use disorder services with the Mental Health Parity and Addiction Equity Act.
4. Access to 1915 Home and Community Based Services (HCBS) waiver services.

### **Scope of EHBs when individual services are not included in Medicaid Standard**

At issue is the degree of flexibility a state has to adjust benefits included in the EHB reference plan. For Washington State, the issue arises specifically with respect to the following services and providers that are included in potential EHB reference plans, such as the state employees' benefits package, but not in the Medicaid Standard benefit package.

- Chiropractic
- Acupuncture
- Naturopath
- Lactation consultation
- Massage therapy
- Biofeedback for head-aches
- Eyeglasses for adults
- Hearing aids for adults
- Osteoporosis screening
- Infertility diagnosis

Some of these services, such as chiropractic, are included as a result of state law – mandating that commercial plans, but not Medicaid, include chiropractors. Medicaid does not allow coverage of services provided to patients of institutions for mental disease (IMDs) or room and board for alcohol and substance abuse detoxification, but these services are covered in EHB reference plan offerings. The question that arises is whether Washington State *must* include all EHB reference plan covered services in its Medicaid Benchmark benefit.

Guidance to date from CCIIO, with respect to EHBs in the individual and small group market, does not require plans (insurers or issuers) to include each and every service covered in the EHB reference plan. Instead, it provides flexibility to modify particular services within an EHB category. Specifically, the CMS Frequently Asked Questions on Essential Health Benefits Bulletin (Question 7) provides that a plan could substitute coverage of services within each of the ten statutory EHB categories, so long as substitutions were actuarially equivalent – based on standards set forth in the CHIP regulations, which mirror the actuarial equivalent rules applicable to Medicaid Benchmark in the DRA.

The FAQs note that the EHB reference plan “*provide[s] States and issuers with a frame of reference for the EHB categories.*” At a minimum, HCA hopes that this same level of flexibility applies to the design of Medicaid Benchmark. Alternatively, we would propose that states be permitted to use their Medicaid Standard benefit package as their EHB reference plan, providing a particularly appropriate frame of reference for designing benefits for low-income populations. The agency understands that, were a state’s standard benefit package to be missing any of the ten EHB statutory categories, the state would be required to supplement the standard benefits with the missing category of service in its benchmark design.

If Washington State's Medicaid Benchmark must include all services described above, it will cover services not offered in standard, including state mandated services and provider types that the Washington State Legislature specifically did not extend to Medicaid. The fiscal implications to the state and federal governments would require considerable review.

If CMS regulatory flexibility in this area is limited, it would be helpful to know whether CMS would consider a waiver proposal designed to create a uniform, comprehensive Medicaid benefit package that avoids the unintended consequences and inequity that would result from the adoption of a misaligned EHB reference plan.

### **Scope of EHBs with respect to utilization management for select Medicaid Standard services**

Washington's Medicaid standard benefit includes physical therapy, occupational therapy, and speech therapy as do all the potential EHB reference plans. However, Medicaid standard requires that, after six visits, the Medicaid beneficiary secure prior authorization for further visits. By contrast, reference plans provide as many as 75 visits with apparently no utilization management. In practice, a Medicaid beneficiary who needs 75 visits (or more) may receive them, so long as the additional visits are pre-determined to be medically necessary.

We do not believe that state Medicaid agencies should be required to abandon reasonable medical necessity reviews to demonstrate that the benefits they offer are substantially equal to those included in the EHB reference plan. To conclude otherwise would effectively require Washington State to offer a broader benefit to Section VIII adults than offered to its lowest income parents, pregnant women, children, and disabled adults.

### **Alignment of mental health and substance use disorder services with the Mental Health Parity and Addiction Equity Act**

HCA understands that the Medicaid Benchmark package must:

- Cover all ten EHBs, including “mental health and substance use disorder services, including behavioral health treatment.”
- Meet the requirements of the Mental Health Parity and Addiction Equity Act.

To comply with these requirements, HCA has just begun to examine its current approach to providing both mental health and substance abuse services in Medicaid Standard. As you know, Washington's Medicaid standard package provides limited outpatient mental health services with an expanded benefit available to children; additional services are provided through a 1915(b) waiver, the Washington State Integrated Community Mental Health Program, which is currently in the renewal process.

To access inpatient psychiatric services and/or more comprehensive community mental health services, Medicaid beneficiaries must go through a clinical screen that determines the clinical need for further mental health services, commonly referred to in Washington as the "access to care" standard. These services are delivered through a county-based Regional Support Network (RSN), which contracts for and administers all mental health services for qualifying Medicaid beneficiaries who meet the “access to care” standard.

HCA understands that Medicaid Benchmark for Section VIII adults must include comprehensive mental health services; however, we need to confirm that the limitations on delivering mental health services with “access to care” standards through RSN contracted providers are permitted and consistent with parity – given that the delivery of physical health services is not likewise limited.

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CMS' early guidance is essential. Changes to Washington State's mental health benefit package and/or delivery system would require an enormous coordinated effort among county-based delivery systems and a wide range of consumer and provider representatives. HCA staff is also evaluating the magnitude of statutory changes that would also be necessary.

Washington State's substance abuse delivery system is similarly unique and is not fully integrated in the Medicaid benefit package for currently eligible populations. The state provides substance abuse treatment through fixed appropriations to counties, tribes and residential treatment programs. As mentioned earlier, Medicaid does not allow coverage for patients in IMDs, nor does it allow payment for room and board in detoxification facilities. Similar to the agency's question about mental health, we need to confirm that these limitations on substance use services are not an issue.

### **Access to 1915 HCBS Waiver Services**

From the work with the Learning Collaborative, HCA knows that CMS is considering whether states may include in their Benchmark benefits services that are not listed as mandatory or optional in Section 1905(a) of the Social Security Act. Of particular importance are home and community-based services covered under 1915 HCBS waivers, through which Washington State has made enormous strides in rebalancing its long-term care system – a key goal of the ACA. It is understood that Benchmark benefits are linked in the DRA to Section 1905 services. However, since Section 1905 covers institutional care and Section 1915 services are intended as a lower cost, more appropriate alternative to institutional care – where a state chooses to include institutional long-term care in its Benchmark benefit, it might appropriately offer Section VIII adults eligible for such institutional care 1915 home and community based services instead. Furthermore, in the past Washington has been court-directed to offer community services to individuals otherwise eligible for institutional long-term care. If access to these services may not be provided for Section VIII adults, what other remedies might a state seek short of providing an institutional benefit without any alternatives?

In conclusion, I want to reiterate that we see inherent value to beneficiaries and to the state, in offering the *same* benefit package to all Medicaid beneficiaries – building on the Medicaid Standard baseline. This is the best way of ensuring that beneficiaries have access to needed services without confusion when their circumstances change; it also dramatically simplifies the administration of the Medicaid program – a key goal of the ACA. Furthermore, we believe that offering two benefit packages for similarly situated individuals could create significant parity issues, with some higher income Medicaid enrollees potentially receiving a more comprehensive benefit package than those with the lowest incomes. Clearly, this was not the intent of the ACA.

Like many states, Washington State is also weighing long-term budgetary elements of these decisions and there is a concern that inflexible implementation of Benchmark guidance could result in state fiscal exposure, which could undermine the policy goals underlying the ACA. Overarching concerns are both practical and fiscal; whether Medicaid Benchmark must include services and provider types not currently allowed in Medicaid Standard and/or eliminate evidence-based utilization controls in rehabilitation services.

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Thank you for your urgent attention to these issues. We hop this will allow Washington State to quickly proceed towards a successful implementation of the ACA, while providing clarity for other states engaged in designing a Benchmark package.

Sincerely,



Doug Porter  
Director

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