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Overview of HHS' proposed rule on benefits for the Medicaid Expansion population: A Step Guide for Advocates

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The Department of Health and Human Services (HHS) released a proposed rule on January 22nd addressing the benefits the Medicaid Expansion population will receive, and the interaction with the Essential Health Benefits (EHBs). This Step Guide is designed to help state advocates understand the benefit options in the proposed rule and advocacy opportunities available.

Step 1: Recognize Medicaid Benchmarks are now "Alternative Benefit Plans"

HHS has renamed Medicaid Benchmarks "Alternative Benefit Plans." Medicaid benchmarks have existed since the Deficit Reduction Act of 2005 authorized states to develop alternative Medicaid benefit packages for certain Medicaid-eligible individuals. While only a few states have selected this option, the Affordable Care Act (ACA) brings new focus to these benchmarks because the newly eligible Medicaid expansion population will receive Medicaid benchmark or benchmark-equivalent coverage, through "Alternative Benefit Plans."

Step 2: Analyze the Alternative Benefit Plan Options

The state must select an Alternative Benefit Plan (ABP) from the following options:

- ✓ Standard Blue Cross/Blue Shield PPO under the Federal Employee Health Benefit Plan;
- ✓ Any generally-available state employee plan in the state;
- ✓ The HMO plan with the largest commercial, non-Medicaid enrollment in the state;
- ✓ Secretary-approved coverage; or
- ✓ "Benchmark equivalent" plan.

A state's selection will determine the benefit package offered to the Medicaid Expansion population in the state.

Secretary-approved coverage

Of the few states that have offered ABPs to certain Medicaid populations, most have selected Secretary-approved coverage to do so. We expect this trend to continue as states select an ABP for the Medicaid Expansion population. In the proposed rule, HHS clarified what benefits states may include under the Secretary-approved coverage option and provided a list of those benefits. HHS has also clarified that the benefits *added* under this option are eligible for the enhanced (100%) federal match.

According to the proposed rule, Secretary-approved coverage may include:

- benefits of the type available under one or more of the standard ABP coverage packages (e.g., Standard Blue Cross/Blue Shield PPO under the Federal Employee Health Benefit Plan),
- state plan benefits described in section 1905(a),
- any other Medicaid state plan benefits enacted under title XIX,
- state plan home and community based services, self-directed personal assistant services (other than room and board), and home and community based attendant services and supports,
- coordinated care through a health home for individuals with chronic conditions, and
- benefits available under one of the EHB base-benchmark plans.

> **Advocacy Tip:** This means that under the Secretary-approved coverage option, a state can provide the Expansion population with the Medicaid state plan benefits and ***additional services*** (described above) and get an enhanced federal match (100% federal match for the first 3 years.)

Step 3: Ensure the ABP covers the EHBs

Under the ACA, beginning in 2014, ABPs must provide at least the EHBs. HHS' proposed rule outlines a two-step process for ensuring coverage of the EHBs.

If the state selects an ABP that <u>is</u> also an Exchange EHB base-benchmark option, then the ABP is deemed to have met the EHBs as long as all ten EHB benefit categories are covered, including through any necessary supplementing of missing EHB categories (see Figure 2 below).

If the state selects an ABP that <u>is not</u> also an Exchange EHB base-benchmark option, then the state must compare the ABP to an EHB base-benchmark. If the ABP is missing any of the ten EHB statutory categories of benefits, then the state must supplement the

ABP with the coverage of the EHB base-benchmark plan selected for comparison purposes.

> **EHB base-benchmark refresher**: HHS defines EHBs for the individual and small group markets based on a state-specific "base-benchmark plan" selection process. The state can select its EHB base-benchmark from among ten options: the three (3) largest federal employee plans; three (3) largest state employee plans; three (3) largest small group plans in the state; or the largest commercial HMO operating in the state.

Figure 1: Comparison of benchmark plan options for EHBs and ABPs

Type of Plan	EHB Base-Benchmark Plans	Alternative Benefit Plans
Federal Employee Health Benefit Program (FEHBP)	1 of 3 largest	Standard BC/BS PPO
State Employee Coverage	1 of 3 largest	plan that is generally available to state employees
Small Group Plan	1 of 3 largest	n/a
Largest Commercial HMO in the State	✓	✓
Secretary-Approved Coverage	n/a	✓
Benchmark Equivalent Coverage	n/a	✓

Figure 2: EHB ten statutory categories

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services (including chronic disease management); and
- pediatric services, including oral and vision care.

> **Advocacy Tip**: HHS has reserved § 440.347(d) to incorporate an approach in the final rule for states to define habilitative services in ABPs. Take advantage of any opportunity to provide input and help define habilitative services in your state's ABP.

Step 4: Ensure Other ABP requirements are met

States are also required to include the following benefits as part of the ABP:

- Family planning services and supplies, and
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21.

In addition, ABPs must comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, and individuals enrolled in ABP coverage must have access to rural health clinics and federally-qualified health centers.

Step 5: Ensure vulnerable populations are protected

Under federal Medicaid law that existed before the enactment of the ACA, certain groups of individuals cannot be required to enroll in ABPs, although states may offer these individuals the option to do so. The ACA does not change this law, so advocates will have to ensure there is a process for identifying these individuals and notifying them of their benefit options, especially when receiving the traditional Medicaid state plan benefits would be more beneficial to them.

These groups of individuals are:

- Pregnant women;
- Individuals who are blind or have a disability;
- Individuals who are dually eligible for Medicaid and Medicare;
- Terminally ill hospice patients;
- Individuals who are eligible on the basis of hospitalization;
- Individuals who are medically frail or have special medical needs;
- Individuals qualifying for long term care services;
- Children in foster care receiving child welfare services and children receiving foster care or adoption assistance;
- TANF and 1931 parents (i.e., individuals who would have been eligible for Aid to Families with Dependent Children);
- Women in the breast or cervical cancer program;
- Limited services beneficiaries who qualify for Medicaid based on tuberculosis or who qualify for emergency services only; and
- Medically needy or spend-down populations.

Step 6: Analyze the value of aligning benefits in your state

Aligning the benefits provided to the Expansion population with the benefits provided to the traditional Medicaid population can be advantageous for a number of reasons. Evaluate this option for your state.

Some reasons for aligning benefits are:

- **Uniformity of benefits for Medicaid groups:** Households where children are eligible for traditional Medicaid and parents are eligible through the Expansion will receive the same benefits. Also, since churning between the traditional and Expansion populations is likely to occur, having the same benefit package for both groups means the state, providers and beneficiaries do not have to keep track of the different benefit packages available and the benefits an individual is receiving at any given time.

- **Minimize Churning:** The potential for churning between the existing and Expansion Medicaid populations is minimized because individuals will not move from one group to the other due to differences in benefits.

- **Administrative simplicity:** The state will not have to monitor individuals that cannot be mandatorily enrolled in ABPs and will not have to notify applicants and beneficiaries of the differences in benefit packages.

- **Cost-savings:** A simpler eligibility and enrollment process can lead to administrative cost-savings for the state. There may be no need for an additional level of eligibility determinations if the benefits are the same (e.g. disability determination).

Step 7: Look for Advocacy Opportunities in Your State

Determine what your state is doing and get involved in the process.

- ✓ Influence the ABP option your state selects.
- ✓ Ensure your state is complying with the EHB and other ABP requirements outlined above.
- ✓ Provide input and help define habilitative services for your state's ABP.
- ✓ Continue to stay involved. The initial ABP selections are valid for 2 years. States must develop a process for "updating" ABPs in the future.