Traditional Versus Benchmark Benefits Under Medicaid

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Summary

The Medicaid program, which served 69 million people in FY2011, finances the delivery of a wide variety of preventive, primary and acute care services as well as long-term services and supports for certain low-income populations. Benefits are available to beneficiaries through two avenues. First, the traditional Medicaid program covers a wide variety of mandatory services (e.g., inpatient hospital services, lab/x-ray services, physician care, nursing facility care for persons aged 21 and over) and other services at state option (e.g., prescribed drugs, physician-directed clinic services, physical therapy, prosthetic devices) to the majority of Medicaid beneficiaries across the United States. Within broad federal guidelines, states define the amount, duration, and scope of these benefits. Thus, even mandatory services are not identical from state-to-state.

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) created an alternative benefit structure for Medicaid. Under this authority, states may enroll certain Medicaid subpopulations into benchmark benefit plans that include four choices: (1) the standard Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program, (2) a plan offered to state employees, (3) the largest commercial health maintenance organization in the state, and (4) other coverage appropriate for the targeted population, subject to approval by the Secretary of Health and Human Services (HHS).

Since the enactment of the Patient Protection and Affordable Care Act in 2010 (ACA; P.L. 111-148, as amended), benchmark benefits have taken on a new importance in the Medicaid program. As per the ACA, a new mandatory group of non-elderly, non-pregnant adults with income up to 133% of the federal poverty level will be eligible for Medicaid beginning in 2014, or sooner at state option. (For more information about a recent Supreme Court ruling regarding this group, see CRS Report RL33202, *Medicaid: A Primer*.) These individuals will be required to enroll in benchmark plans rather than traditional Medicaid (with some exceptions for subgroups with special medical needs). However, to date, only a handful of states have experience administering these plans, nearly all of which have been tailored to specific subpopulations.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated that coverage expansion provisions in the ACA would increase enrollment by about 7 million in FY2014, rising to 11 million by FY2022 in both the Medicaid and the State Children's Health Insurance Programs (Congressional Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, July 2012). Many of these new enrollees will get benchmark benefits. To assist Congress in evaluating the current scope of benefits available under Medicaid, this report outlines the major rules that govern and define both traditional Medicaid and benchmark benefits. It also compares the similarities and differences between these two benefit package designs.

Contents

Tables

Contacts

Medicaid was established in 1965 to provide basic medical services to certain low-income populations. It is a means-tested entitlement program that financed the delivery of primary and acute medical services, as well as long-term services and supports, to more than an estimated 69 million people in FY2011.[1] The estimated annual cost to the federal and state governments for Medicaid was nearly $404 billion in FY2010.[2]

Each state designs and administers its own version of Medicaid under broad federal rules. State variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are delivered and reimbursed.

Not everyone enrolled in Medicaid has access to the same set of services. Different eligibility classifications determine available benefits, as described below. This report begins with a summary of major Medicaid eligibility pathways. Then traditional Medicaid benefits and benchmark coverage are described. The final section provides an analysis of state experiences with benchmark benefit packages as of early 2011. Additional CRS resources on the Medicaid and Children's Health Insurance Program are provided at the end of this report.

Medicaid Eligibility

Historically, eligibility for Medicaid was subject to "categorical restrictions" that generally limited coverage to the elderly, persons with disabilities, members of families with dependent children, certain other pregnant women and children, among others. Recent changes in federal law established Medicaid eligibility for poor non-elderly, childless adults who do not fit into these traditional categories; states may cover such individuals now, but coverage of this new group will become mandatory beginning in 2014.

In addition, to qualify for Medicaid, applicants must have income (and sometimes assets) that meet financial requirements. These financial criteria are typically tied to certain federal cash assistance program rules or to specific percentages of the federal poverty level (FPL).[3]

Below is a description of services available for Medicaid beneficiaries by eligibility classification. First, "categorical needy" individuals represent the vast majority of people enrolled in Medicaid, most of whom receive traditional Medicaid benefits (described in more detail below). The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) requires that a newly established categorically needy group consisting of poor nonelderly, non-pregnant adults with income below 133% FPL receive Medicaid benchmark benefits, an alternative to traditional Medicaid benefits. However, on June 28, 2012, the United States Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include non-elderly, non-pregnant adults

[1] Beneficiary statistics for FY2011 were taken from Table 1.16, *2011 CMS Statistics*, U.S. Department of Health and Human Services.

[2] Expenditure statistics for FY2010 were taken from Table III.2, *2011 CMS Statistics*, U.S. Department of Health and Human Services.

[3] For example, pregnant women and children under age 6 with family income below 133% of FPL are mandatory eligibility groups under Medicaid. In 2012, the FPL for a family of four is $23,050—133% of FPL for a family of four would equal $30,656.50. See http://aspe.hhs.gov/poverty/12poverty.shtml.

under 133% of the federal poverty level. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but based on the Court's opinion, it appears that a state can refuse to participate in the expansion without losing any of its current Medicaid matching funds.[4]

Other benefit rules apply to individuals classified as "medically needy," including people who meet the main categorical restrictions described above but may have higher income. States electing the medically needy option must provide coverage to certain pregnant women and children under age 18. For the medically needy, states may offer a more restrictive benefit package than is available to most categorically needy individuals.

Finally, states also use the authority in Section 1115 of the Social Security Act to tailor benefits to state-specified subpopulations that can include both currently authorized groups and/or new groups not specified in federal statute. Each such waiver delineates the unique terms and conditions that are negotiated between a given state and the federal Centers for Medicare & Medicaid Services (CMS).[5]

Table 1 provides examples of Medicaid benefits available by selected eligibility classifications. As illustrated, different Medicaid subpopulations may have access to benefit packages that can be quite varied. Additional details are described further below.

Table 1. Examples of Medicaid Benefits by Eligibility Classification

Type of Benefit and Benefit Package	Eligibility Classification			
Type of Benefit	Categorically Needy (excluding Non-Elderly, Non-Pregnant Adults)	Medically Needy	Section 1115 Waivers	Non-Elderly, Non-Pregnant Adults
Mandatory	-Inpatient hospital -Nursing facility care (age 21+) -EPSDT (< age 21) -Physicians -Federally-qualified health centers -Family planning -Pregnancy-related services	-Prenatal and delivery services -Ambulatory services (< age 18; persons entitled to institutional care) -Home health for those entitled to nursing facility care	-Negotiated between the states and the Secretary of Health and Human Services (HHS)	-Benchmark plans
Optional	-Clinic services -Prescribed drugs	-Nursing facility care -Clinic services	-Negotiated between the states and	-For special needs subgroups, option to

[4] For a more detailed discussion, see the CRS Congressional Distribution Memo, Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirement in Section 2001 of the Affordable Care Act, by Kathleen S. Swendiman and Evelyne P. Baumrucker. Also see http://www.crs.gov/analysis/legalsidebar/pages/details.aspx?ProdId=117 and http://www.crs.gov/analysis/legalsidebar/pages/details.aspx?ProdId=121.

[5] For additional information about Section 1115 waivers, see CRS Report RL33202, *Medicaid: A Primer*.

Type of Benefit and Benefit Package	Eligibility Classification			
	-Physical, occupational, and speech therapy -Other practitioners -Dental	-Physical, occupational, and speech therapy -Other practitioners -Dental	Secretary of HHS	have same benefits as categorically needy or enroll in benchmark plan
Traditional Benefits Versus Benchmark Package	Traditional Benefits	Traditional Benefits	Not applicable	Benchmark plans with exceptions; see **Table 3** for details

Sources: Title XIX of the Social Security Act and related federal guidance.

Note: With respect to medically needy groups, broader requirements apply if a state has chosen to provide coverage for medically needy individuals in intermediate care facilities for the mentally retarded or in institutions for mental diseases. In these cases, states are required to cover either the same services as those which are mandatory for the categorically needy, or alternatively, the care and services described in seven of the first twenty-four paragraphs in the federal Medicaid statute defining covered mandatory and optional services. EPSDT means "early and periodic screening, diagnostic and treatment." This benefit includes well-child visits, immunizations, lab tests, as well as vision, dental and hearing screening services at regular intervals.

Traditional Medicaid Benefits

Like eligibility, under traditional Medicaid, states must cover certain benefits, while other services may be offered at state option. Examples of benefits that are mandatory for most Medicaid groups (i.e., categorically needy populations) include inpatient hospital services, physician services, laboratory and x-ray services, early and periodic screening, diagnostic and treatment services (EPSDT) for individuals under 21,[6] nursing facility services for individuals aged 21 and over, and home health care for those entitled to nursing facility care. Examples of optional benefits for such Medicaid groups include prescribed drugs, physician-directed clinic services, services of other licensed practitioners (e.g., chiropractors, podiatrists, psychologists) services, nursing facility services for individuals under age 21, physical therapy, and prosthetic devices.

Table 2 provides additional information for selected optional benefits covered by most states under the traditional Medicaid program.

[6] With respect to EPSDT, states also must provide medical care that is necessary to address health problems identified through screenings, including optional services that states may not otherwise cover in their Medicaid programs.

Table 2. Examples of Frequently Covered Optional Benefits Under Traditional Medicaid as of August 13, 2010

Selected Optional Benefits	Number of States Offering Benefit	Description of Benefit
Examples of Preventive, Primary and Acute Care Services		
Clinic Services	50	A wide range of health care services including services for prevention or treatment of health conditions or illnesses, surgery, and other care provided in a centralized facility
Hospice Services	48	Care for persons with illnesses that cannot be cured or fully treated. Hospice care involves a team of medical professionals who take care of the medical, physical, social, emotional and spiritual needs of the patient, and also support to the patient's family or caregiver
Occupational Therapy	50	Services to enhance an individual's participation in, or performance of, common activities such as eating, dressing, moving about, working, and going to school
Optometric Services	50	Services from an individual with training to diagnose and prescribe treatment for diseases of the eye and problems with vision, and may include eye glasses, lenses, exercises or referrals for specialized treatment
Physical Therapy	50	Services to restore physical function to a person with a disability caused by illness, trauma, or birth defects
Prescribed Drugs	50	Drugs that an individual can get only if a doctor (or another authorized health care provider) gives permission through a prescription
Speech and Language Therapy	49	Services to diagnose and treat speech and language problems
Targeted Case Management	50	Services to help individuals be independent and learn to manage their health care, including linking such people with health care providers, social services, educational services, etc., based on that person's needs
Examples of Long-Term Services and Supports		
Inpatient Psychiatric Services for Individuals < Age 21	48	Services that a person < age 21 might receive at a hospital or psychiatric residential treatment facility while staying overnight for treatment of mental illness, and may include services provided by a physician or nurse, lab work, surgery, and drugs
Intermediate Care Facilities for the Mentally Retarded	51	Services at a facility that provides 24-hour rehabilitative as well as health care and services for persons with developmental disabilities
Nursing Facility Services for Individuals < Age 21	50	Skilled nursing, rehabilitation, and other services provided in a facility to assist individuals with illness, injuries, or other disabilities to recover or improve, and to provide long-term care to those who need support with daily activities such as bathing, dressing and eating
Prosthetic Devices	49	Devices to replace, correct or support missing or impaired portions of the body
Targeted Case Management for Mental Health	51	Services to help individuals with mental health needs learn how to manage their health care

Source: Centers for Medicare & Medicaid Services, derived from www.healthcare.gov and individual state Medicaid websites as of August 13, 2010, personal communication, fall of 2010.

Note: The definition of state includes the District of Columbia.

The breadth of coverage for a given benefit can and does vary from state to state, even for mandatory benefits. In general, in defining a covered benefit, federal guidelines require that (1) services be sufficient in amount, duration and scope to reasonably achieve their purpose; (2) the amount, duration, and scope of services must be the same statewide; and (3) with some exceptions, beneficiaries must have freedom of choice of providers among health care practitioners or managed care entities participating in Medicaid. States can modify these rules via existing waiver authority provided in Section 1115 of the Social Security Act.

Medicaid Benchmark Benefit Packages

As an alternative to providing all the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to enroll state-specified groups in benchmark and benchmark-equivalent benefit packages.[7] These plans can exist in sub-state areas and can be limited to specific subpopulations.

States can require "full benefit eligibles" (or specific subgroups of these individuals) to enroll in Medicaid benchmark benefits. A full benefit eligible is someone who is eligible for all the mandatory and optional services that a state covers under its traditional Medicaid program. Medically needy and certain spend-down populations (e.g., individuals whose Medicaid eligibility is based on a reduction of countable income for costs incurred for medical or remedial care) are excluded from the definition of a full benefit eligible. Specific groups are exempt from mandatory enrollment in benchmark benefit packages (e.g., those with special health care needs such as disabling mental disorders or serious and complex medical conditions). **Table 3** provides a description of each of these exempted populations.

Table 3. Statutory and Regulatory Exceptions to Mandatory Enrollment in Medicaid Benchmark Benefit Plans

(i) mandatory pregnant women with income below 133% of the federal poverty level (FPL)
(ii) blind or disabled individuals without regard to whether the individual is eligible for Supplemental Security Income (SSI) benefits and certain children under age 19 who meet the SSI disability definition, require an institutional level of care and the expected cost of care outside an appropriate institution is less than the expected cost that would be incurred within an appropriate institution; this latter group is sometimes referred to as the Katie Beckett group
(iii) Medicaid beneficiaries entitled to benefits under Medicare
(iv) terminally ill individuals receiving Medicaid hospice benefits
(v) inpatients in an institution who are required to pay for the costs of such care, excluding a minimal amount required for personal needs (e.g., hair care, clothing, telephone services)
(vi) certain persons who are medically frail or have special needs such as children under age 19 eligible for SSI, or foster care or other out-of-home placement, or those receiving foster care or adoption assistance, or receiving community-based services through certain Title V Maternal and Child Health grants
(vii) beneficiaries qualifying for long-term care services (e.g., nursing facility services or similar level of care in any institution, certain home and community-based waiver services (under Section 1915(c) and (d), and other optional state plan long-term care services)

[7] These benchmark plans were later modified by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) and the Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

(i) mandatory pregnant women with income below 133% of the federal poverty level (FPL)
(viii) certain children in foster care receiving child welfare services (under Title IV-B) or certain children for whom adoption or foster care assistance is made available (under Title IV-E), without regard to age
(ix) Temporary Assistance for Needy Families (TANF) and Section 1931(i) parents
(x) optional breast and cervical cancer women (under age 65, with income below 250% FPL who are identified through the Centers for Disease Control screening program who need treatment for either of these cancers and are not eligible for other creditable coverage)
(xi) limited services beneficiaries, including optional tuberculosis-infected individuals with income up to the level applicable to mandatory SSI populations, or individuals who are not a qualified alien (e.g., certain aliens lawfully admitted for permanent residence in the U.S.) and for whom only treatment of emergency medical conditions is covered (as per Section 1903(v))

Source: Section 1937(a)(2)(B) of the Social Security Act and 42 CFR 440.315.

These exempted groups may get traditional Medicaid benefits or may be offered voluntary enrollment in benchmark benefit plans. In such cases, states must describe the differences between traditional Medicaid and benchmark plans to these beneficiaries in order to facilitate an informed choice.

In general, benchmark benefit packages may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT and transportation to and from medical providers (as per a recent regulation[8]), that might make them more generous than private health care insurance. The benchmark options include

- the Blue Cross/Blue Shield standard provider plan under the Federal Employees Health Benefits Program (FEHBP),
- a plan offered to state employees,
- the largest commercial health maintenance organization (HMO) in the state, and
- other Secretary-approved coverage appropriate for the targeted population.

Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans identified above. Such coverage must include (1) inpatient and outpatient hospital services; (2) physician services; (3) lab and x-ray services; (4) emergency care; (5) well-child care, including immunizations; (6) prescribed drugs; (7) mental health services; and (8) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the applicable benchmark plan for vision care and hearing services (if any).

For children under age 21 in one of the major mandatory and optional Medicaid eligibility groups, benchmark and benchmark-equivalent coverage must include EPSDT. Also, Medicaid beneficiaries enrolled in such coverage must have access to services provided by rural health clinics and federally qualified health centers.

Starting in 2014, both benchmark and benchmark-equivalent packages must cover at least the essential health benefits that will also apply to plans in the private individual and small group

[8] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Program: States Flexibility for Medicaid Benefit Packages, Final Rule, 75 *Federal Register*, 23068 (April 30, 2010).

health insurance markets. The 10 essential health benefits include (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) lab services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.[9] Many of these essential health benefits are currently coverable under benchmark packages. All benchmark plans must also cover family planning services and supplies.

Mental Health Parity Requirements Under Both Traditional Medicaid and Benchmark Plans

The federal mental health parity requirements, as established in the Public Health Service Act (Section 2726), generally require that, under a given insurance plan, coverage of mental health services (if offered) should be on par with coverage of medical and surgical services in terms of the treatment limitations (e.g., amount, duration and scope of benefits), financial requirements (e.g., beneficiary co-payments), in- and out-of-network covered benefits, and annual and lifetime dollar limits. Managed care plans under both traditional Medicaid and benchmark packages must comply with all federal mental health parity requirements. Benchmark packages that are not managed care plans are only required to comply with federal requirements for parity in treatment limitations and financial requirements. However, these plans are deemed to comply with federal mental health parity requirements if they offer EPSDT, which they are statutorily required to cover.[10]

State Experience with Medicaid Benchmark Packages

As noted above, states have had the authority to implement benchmark benefit packages in their Medicaid programs since the Deficit Reduction Act of 2005. A summary of state and territory experiences with benchmark benefits as of July 2012 is provided in **Table 4**. Of the 12 states and one territory (Guam) with approved benchmark plans, 11 had only one such plan and 2 (Idaho and Kentucky) had more than one benchmark plan. The type of benchmark used in 10 states and Guam was classified as secretary-approved, which generally means the benefit plan was tailored to the targeted population(s) to be enrolled. Missouri had a plan classified as benchmark-equivalent to the FEHBP Blue Cross/Blue Shield standard option preferred provider organization (PPO). One of Kentucky's plans was identified as benchmark-equivalent to a state employee health plan, while Wisconsin provided coverage offered through the state's largest health maintenance organization (HMO), the United Health Care Choice Plus Plan. In eight states (Connecticut, District of Columbia, Kansas, Minnesota, Missouri, Virginia, West Virginia, and Wisconsin) and Guam, benchmark plans were available statewide. In other states (Idaho, Kentucky, New York, and Washington), benchmark plans were limited to sub-state areas, such as specific counties or cities.

[9] See the "Essential Health Benefits Bulletin" at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. This document notes that CMS plans to issue further guidance on essential health benefits implementation in the Medicaid program.

[10] For more detailed information on mental health parity under Medicaid including substance use disorder services, see CRS Report R41768, *Mental Health Parity and Mandated Coverage of Mental Health and Substance Use Disorder Services After the ACA*, by Amanda K. Sarata.

The state-level details with respect to the covered services offered through Medicaid benchmark plans were quite varied, at least in part reflecting the populations to be enrolled in these plans and the unique objectives of each state. Preventive and primary care services (e.g., nutrition counseling, smoking cessation services, weight management counseling, dental care for adults) were covered in several states. Support services designed to facilitate independent living in community-based settings for individuals with disabilities and/or the elderly were components of benchmark plans in a few states.

There was also considerable state-level variation in other benchmark plan characteristics. Across the 17 state/plan combinations shown in **Table 4**,[11] there was almost an even split between benchmark programs for which enrollment was mandatory versus voluntary. There was also quite a bit of variation in terms of the type of service delivery systems utilized. Fee-for-service alone (8 of 17 state/plan combinations) or in conjunction with some type of managed care arrangement (5 of 17 state/plan combinations) were the two most common service delivery system designs.

It is unclear how these state experiences to date with Medicaid benchmark plans will influence the design of such service packages roughly two years from now in 2014 when all states will be required to provide benchmark benefits to the new group of non-elderly, non-pregnant adults with income up to 133% of the federal poverty level. It is likely that states with no such experience will look to those states that have implemented benchmark packages for lessons learned in order to make choices tailored to their given circumstances and resources.

[11] For additional details about Guam's Medicaid benchmark plan, see **Table 4**.

Table 4. Selected Characteristics of Medicaid Benchmark Plans

State and Eligibility Group(s)	Type of Benchmark	Examples of Covered Benefits	Enrollment Mandatory or Voluntary	Geographic Area	Delivery System
Connecticut; non-elderly, non-pregnant adults with income < 133% FPL	Secretary approved	Full state plan benefits under CT's traditional Medicaid program	Mandatory	Statewide	Fee-for-Service (FFS)
District of Columbia; non-elderly, non-pregnant adults with income < 133% FPL	Secretary approved	Standard Medicaid benefit package for adults (e.g., hospital care, MD services, Rx drugs, mental health care)	Mandatory	Statewide	Combination FFS and managed care
Guam; non-elderly, non-pregnant adults with income < 133% FPL	Secretary approved	Full state plan benefits as per Section 1905(a) of the Social Security Act	Mandatory	Statewide	FFS
Idaho-1; children and working age adults	Secretary approved	Standard Medicaid benefit package plus preventive care and nutrition services	Mandatory, with exceptions for changes in medical need	Statewide	Primary care case management (PCCM)
Idaho-2; individuals with disabilities or special health care needs and the elderly	Secretary approved	Preventive care, nutritional services and preventive health assistance plus all other Medicaid covered services	Voluntary (i.e., right to opt out and receive traditional Medicaid mandatory services)	Statewide	PCCM
Idaho-3; elderly and persons dually eligible for Medicaid and Medicare	Secretary approved	All Medicaid covered services	Voluntary (i.e., right to opt out and receive traditional Medicaid mandatory services)	Select counties	Managed care (through Medicare Advantage Plans)
Kansas; certain working disabled populations	Secretary approved	State plan benefits plus independent living counseling to direct and manage needed services and budgets for that care; participants choose to self direct care or have an agency do so	Voluntary	Statewide	FFS with option to self direct care and use the cash and counseling model (e.g., purchase services of certain caregivers, such as a family member, that are provided in a home setting)

State and Eligibility Group(s)	Type of Benchmark	Examples of Covered Benefits	Enrollment Mandatory or Voluntary	Geographic Area	Delivery System
Kentucky-1; general Medicaid population; foster care and medically fragile children; elderly and disabled not opting into KY-3 and KY-4 (described below)	Secretary approved (Global Choices)	All mandatory benefits plus dental care; physical, occupational, speech therapy; non-emergency transportation, Rx drugs, prosthetic devices	Mandatory	Statewide (excluding 16 counties near Louisville operating under an 1115 waiver)	FFS
Kentucky-2; families	Benchmark-equivalent to state employee health plan (Family Choices)	All mandatory benefits plus chiropractic services; speech, physical and occupational therapy; home health and skilled nursing	Mandatory	Statewide (excluding 16 counties near Louisville operating under an 1115 waiver)	FFS
Kentucky-3; individuals needing a nursing home level of care; includes such persons receiving care in the community	Secretary approved (Comprehensive Choices)	All mandatory benefits plus vision care, chiropractic services, dental care, hearing and audiometric services	Voluntary	Statewide (excluding 16 counties near Louisville operating under an 1115 waiver)	FFS
Kentucky-4; individuals with mental retardation and developmental disabilities who meet an ICF/MR level of care	Secretary approved (Optimum Choices)	All mandatory benefits plus dental care, vision care, chiropractic services, hearing and audiometric services	Voluntary	Statewide (excluding 16 counties near Louisville operating under an 1115 waiver)	FFS
Minnesota; non-elderly, non-disabled, non-pregnant adults otherwise ineligible for the state's traditional Medicaid and "prepaid medical assistance plus" programs with gross income < 75% FPL (no resource test)	Secretary approved	Alcohol/drug treatment, chiropractic care, dental care, eyeglasses, family planning services, hospital services, interpreter services, home health care, nursing home and ICF-MR facility care, prescriptions	Mandatory	Statewide	Combination FFS and managed care
Missouri; parents and specified caretaker relatives up to 100% FPL—NOT IMPLEMENTED	Benchmark equivalent to federal Blue Cross/Blue Shield Standard option preferred provider organization (PPO)	Selected traditional mandatory and optional benefits plus transplant related services	Mandatory	Statewide	Combination FFS and managed care

State and Eligibility Group(s)	Type of Benchmark	Examples of Covered Benefits	Enrollment Mandatory or Voluntary	Geographic Area	Delivery System
New York; categorically eligible adults ages 21 - 63	Secretary approved	Traditional state plan benefits plus medication therapy management	Voluntary	Bronx	FFS
Virginia; certain working individuals with disabilities	Secretary approved	Traditional state plan benefits plus personal assistance services in various settings	Voluntary	Statewide	FFS
Washington; Aged, blind or disabled adults age 21+ with certain chronic, complex medical conditions (categorically needy only)	Secretary approved	Traditional state plan benefits plus chronic care management, coordination between behavioral health systems and other services (e.g., housing, transportation)	Voluntary	King County	Pre-paid ambulatory health plan and Regional Support Networks for mental health services
West Virginia; TANF and TANF-related individuals	Secretary approved	Basic package—all mandatory services plus home health, DME, prescribed drugs, tobacco cessation; Enhanced package—basic package plus weight management, podiatry, skilled nursing care, mental health care	Mandatory	Statewide	Combination managed care and FFS
Wisconsin; pregnant women and infants with income between 200-250% FPL, and newborns of women with income between 200-250% FPL	State's largest HMO (United Health Care Choice Plus Plan)	Family planning, child health screenings, inpatient hospital services, mental health and substance abuse services, nursing home care, prescribed drugs, smoking cessation services, transportation	Mandatory	Statewide	Combination managed care, FFS, and PCCM

Source: Centers for Medicare & Medicaid Services, Office of Legislation, personal communication, July 26, 2012, based on information that was current as of July, 2012.

Notes: DME means durable medical equipment. ICF/MR means intermediate care facility for the mentally retarded that provides 24-hour rehabilitative and health care services for people with developmental disabilities. TANF refers to the Temporary Assistance for Needy Families program, which provides cash assistance to certain low-income families. PPO means preferred provider organization. Under the FFS delivery system, payments are made for each unit of service delivered. Under managed care delivery systems, payments are made on a predetermined, per-person-per-month basis. Under PCCM delivery systems, primary care physicians are paid a small, pre-set monthly fee per enrolled beneficiary to provide basic medical care, and serve as case managers or gate-keepers (via referrals) to specialty care (e.g., mental health care,

dental services). A pre-paid ambulatory health plan provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. Washington State had another Secretary-approved statewide benchmark plan similar to the plan outlined in this table in a single county. The King county-specific plan supersedes the statewide plan. Finally, New York state withdrew its program on June 7, 2012.

Additional CRS Medicaid and CHIP Resources

CRS Report RL33202, *Medicaid: A Primer*

CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*

CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*

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