

# Medicaid Highlights of the Final Rule Alternative Benefit Plans and Essential Health Benefits 7/9/13

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# Overview

- Section 1937 Medicaid Benchmark or Benchmark Equivalent Plans are now called Alternative Benefit Plans (ABPs)
- ABPs must cover the 10 Essential Health Benefits (EHB) as described in section 1302(b) of the Affordable Care Act, whether the state uses an ABP for Medicaid expansion or coverage of any other groups of individuals
- Individuals in the new adult eligibility group will receive benefits through an ABP

# Steps for Designing a Medicaid ABP

Step 1: States must select a coverage option from the choices found in section 1937 of the Act

- Four benchmark options
  - (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) commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
  - 4) Secretary-approved coverage, a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population

# Steps for Designing a Medicaid ABP (continued)

Step 2: States must determine if that coverage option is also one of the base-benchmark plan options identified by the Secretary as an option for defining EHBs

- If so, the standards for the provision of coverage, including EHBs, would be met, as long as all EHB categories are covered
- If not, states must select one of the base-benchmark plan options identified as defining EHBs.

# Steps for Designing a Medicaid ABP (continued)

- Step 3: Select a base benchmark plan to define the EHBs
  - Any of the three largest small group market health plans by enrollment
  - Any of the three largest state employee health benefit plans by enrollment
  - Any of the three largest federal employee health benefit plans by aggregate enrollment
  - The largest insured commercial non-Medicaid health maintenance organization operating in the state

# Substitution Policy

- Aligns with the individual and small group market
- Allows flexibility for states to align benefit packages with their Medicaid state plan
- Requires actuarial equivalence and placement in the same essential health benefit category

# Medicaid and Essential Health Benefits

- Primarily Medicaid will align with EHB provisions in the individual and small group market.
- States may use more than one EHB base benchmark to determine EHB coverage for Medicaid purposes
- There are a few exceptions to address the specific needs of the Medicaid population



# Prescription Drugs

- The amount, duration, and scope of prescription drugs for an ABP is governed by the requirements of section 1937.
- EHB prescription coverage standard:
  - Provide at least the greater of:
    - 1 drug in every USP category and class; or,
    - Same # drugs in each category and class as EHB benchmark plan.
- States must include sufficient prescription drug coverage to reflect the EHB benchmark plan standards at 45 CFR 156.122, including procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the plan.
- To the extent that a prescription drug is within the scope of the ABP benefit as a covered outpatient drug, section 1927 and Federal rebates apply.



# Habilitative Services and Devices

- Coverage based on the habilitative services and devices that are in the applicable base benchmark plan
- If habilitative services and devices are not in the applicable base benchmark plan, the state will define habilitative services and devices either in parity with rehabilitative services and devices or as determined by the state and reported to CMS in the ABP template

# Preventive Services

- EHB requirements for coverage of preventive services, including the prohibition on cost sharing, will apply to section 1937 ABPs

# Medical Frailty

- Definition of “medically frail” is modified and includes the addition of people with substance use disorders
- Individuals in the new adult group, if determined to be medically frail, will receive the choice of ABP defined using EHBs or ABP defined as state’s approved Medicaid state plan

# Additional Items

- States may include other benefits outside of 1905(a) described in sections 1915(i), 1915(j), 1915(k) and 1945 of the Social Security Act
- All children under 21 enrolled in an ABP must receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT), including pediatric oral and vision services
- ABPs must also comply with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA)
- ABPs must include family planning services and supplies, FQHC/RHC services, and an assurance of NEMT

# Additional Information

- We strongly encourage states to contact CMS through the SOTA process to request Technical Assistance with designing ABPs, as early as possible
- We also encourage states that wish to have early 2014 implementation to submit draft ABP SPAs as soon as possible

# Transition

- CMS is permitting transition time, if needed, as long as states are working toward, but have not completed a transition to the new ABPs on January 1, 2014.

# 1905(a) Preventive Services

- CMS has codified changes to the definition of preventive services to be provided to the general Medicaid population
  - These changes do not relate to the provision of preventive services as an EHB
  - They relate to aligning the general 1905(a) definition of preventive services with the statutory construct at 1905(a)(13) of the Social Security Act
- Services can be ordered by a physician or OLP