Medicaid and CHIP MAC Learning Collaboratives

Coverage Expansion Learning Collaborative

Virtual Meeting #18
Medicaid Alternative Benefit Plan

Date: October 29, 2013

Time: 4:00 – 5:30 pm (EST)

URL: https://manatt.webex.com/manatt/onstage/g.php?t=a&d=572050121
Event Password: Coverage1
Dial: 1.866.922.3257
Passcode: 793656#

Agenda

Introduction and Roll Call	5 mins.
Updated Guidance: ABP Final Rule, SPA Template	10 mins.
ABP Requirements & State FAQs	50 mins.
Questions & Answers	20 mins.
Next Steps and Wrap-Up	5 mins.

Updated Guidance

- Final Medicaid ABP Rule released July 15

  http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf

- ABP SPA Template released

  http://157.199.113.99/MMDLDOC/abp.html

- This presentation will update states on most recent guidance and review state questions.

Updates on ABP Requirements + State FAQs

- ABP Benefits and Alignment with State Plan
- Exempt Individuals and Asset Tests
- Notices and Choice Counseling
- SPA Template

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ABP Benefit Requirements

ABPs must:

- **Include all 10 essential health benefits (EHBs)**
  - For new adult group (newly-eligible and currently-eligible)
  - For all existing Section 1937 "Benchmark" benefit packages
  - As defined by designated EHB-benchmark plan
- **Meet the Mental Health Parity and Addiction Equity Act (MHPAEA)**
- **Provide early and periodic screening, diagnostic and treatment (EPSDT) services for individuals below age 21**
- **Assure non-emergency transportation**
- **Include FQHC/RHC services**
- **Provide family planning services and supplies**
- **Comply with all other Medicaid rules, including:**
  - Fee-for-service
  - Managed care
  - Cost sharing

10 EHBs:

- 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
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

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Habilitative Services

- ABP must include all habilitative services in the base benchmark reference plan
- States must supplement if no habilitative services in the base benchmark plan:
  - States may offer habilitative services in parity with rehabilitative services; or
  - States may define the category
- States may use substitution to replace habilitative benefits from ABP with State Plan habilitative benefits
- States who wish to align State Plan benefits with the ABP may add 1905(a)(11) therapies (physical, occupational, speech, audiology) to the habilitative service category of ABP. States could also implement 1915(i) habilitative services in the State Plan and the ABP.

Prescription Drugs

- ABPs must cover at least the greater of:
  - (i) One drug in every United States Pharmacopeia (USP) category and class; or
  - (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan
- States must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered

Questions or issues from states regarding prescription drug benefits?

Mental Health Parity

- ABPs must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA)
- Treatment limitations and financial requirements for mental health/substance use disorder (SUD) benefits cannot be more restrictive than those for medical/surgical benefits
- Technical Guidance tool available to help states compare ABP MH/SUD benefits with medical/surgical benefits across three categories:
  - Quantitative treatment limitations (limits on duration and scope of treatment)
  - Non-quantitative treatment limitations (utilization management procedures)
  - Financial requirements (deductibles, copayments, coinsurance, etc.)

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Secretary-Approved Coverage Options

States may add services to the ABP under the Secretary-approved option:

- State Plan benefits (SSA § 1905(a)), such as:
  - Adult Dental
  - Adult Vision
- Home and Community Based Services
  - Home and Community Based Services (HCBS) (SSA § 1915(i))
  - Consumer Directed Personal Assistance Services (SSA § 1915(j))
  - Home Attendant Services(SSA § 1915(k))
- Health Homes Services (SSA § 1945)

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Supplementation & Substitution

- **Supplementation:**
  - If the base benchmark plan is missing a required EHB category, states must supplement the ABP by adding the entire missing benefit category from any other benchmark plan option
- **Substitution:**
  - States may use substitution to replace one or more of the benefits from the base benchmark plan in the ABP
    - Substitution may only occur within an EHB category
    - Substituted service(s) must be actuarially equivalent to the service(s) being replaced.

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Alignment of ABP & State Plan Benefits

- **Aligning ABP with State Plan Benefits:**
  - States may add benefits to the ABP from the State Plan
    - *For example: add HCBS and LTC services, vision, dental to ABP*
  - States may use duplication where the State Plan offers the same benefits as the ABP in amount, duration, and scope equal to or greater than the ABP
  - States may use substitution to replace ABP benefits not included in the State Plan on benefits where duplication does not apply
    - *For example: replace fertility, chiropractic services in ABP with state plan services*
- **Aligning State Plan Benefits with ABP:**
  - States may add ABP (EHB) benefits to the State Plan benefit package
    - *For example: add habilitative services or preventive services to the state plan*
- **Alignment rules apply over long term, not just at initial ABP approval**

Sufficiency Standards

- Definition of sufficiency: a service must be sufficient to meet the needs of 90% of Medicaid beneficiaries in need of the service.
- Application to § 1905(a) benefits
  - More flexibility to define the purpose of optional benefits
- Application to ABP:
  - Sufficiency standards do not apply to ABPs:
    - Where the ABP tracks to the base benchmark plan
    - Where the ABP tracks to approved State Plan services
  - Sufficiency standards do apply to ABPs where a state is adding a benefit to the ABP that is not in the base benchmark plan, another commercial benchmark plan option, or the State Plan.

Exempt Individuals & Asset Tests

ABP Exempt Individuals

- **All new adults must receive ABP coverage, except those who are exempt:**
  - Blind or disabled – 42 CFR 440.315(b)
  - Terminally ill and receiving hospice – 42 CFR 440.315(d)
  - Lives in a long term care facility, group home, or nursing home – 42 CFR 440.315(e)
  - Medically frail – 42 CFR 440.315(f)
  - Emergency services – 42 CFR 440.315(l)

Coverage for ABP Exempt Individuals

- Exempt individuals must have the option to enroll in ABP or in the ABP that is the State Plan benefit package
- States may receive enhanced FMAP for newly eligible adults, regardless of whether they are exempt or not.

> *"Individuals in the new adult group meeting the exemption criterion found in section 1937 of the Act have the ability to choose between ABP benchmark coverage designed by the state using the rules of section 1937 of the Act including EHBs as a minimum level of coverage, or ABP benchmark coverage defined as the state's approved regular state plan benefit package, which is not subject to the requirements of section 1937 of the Act."*

Medically Frail Exemption

- Regulations at 42 CFR 440.315 define "medically frail" to include individuals with:
  - Disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness)
  - Chronic substance use disorders
  - Serious and complex medical conditions
  - Physical, intellectual or developmental disability that significantly impairs ability to perform 1 or more activities of daily living
  - Disability determination based on Social Security criteria or in states that apply more restrictive criteria than SSI, the State Plan criteria
  - Or are described in § 438.50(d)(3) (SSI, disabled and foster care children)
- States may add other categories of individuals to the definition of "medically frail"

Identifying Medically Frail Individuals

- If the ABP is equal to or more generous than the State Plan, a state is not required to identify medically frail individuals
- States that do need to identify medically frail individuals have flexibility:
  - For individuals enrolled in Medicaid: states could identify based on eligibility category or use historic medical encounter data
  - For newly enrolled individuals: states could allow beneficiaries to self-identify during the enrollment process

How are states considering identifying medically frail individuals?

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Asset Tests

States may not apply asset or resource tests to the eligibility of any MAGI group, including new adults regardless of if they are exempt from ABP.

States may not apply asset or resource tests to new adults, even if the asset test was a condition of eligibility for enrollment in a waiver.

CMS expects to issue guidance soon on whether the transfer-of-asset rules and other § 1917 rules will apply to new adults who need institutional services or other long-term services and supports.

Asset Tests & HCBS/LTC Services

- New adults may access HCBS and LTC services through:
  - The State Plan benefit package (to the extent HCBS and LTC services are included), which new adults who meet the definition of "medically frail" may choose over the standard ABP
  - A waiver that covers new adults
  - An ABP that includes HCBS and LTC services
- New adults may access these services without asset tests
- New adults must meet applicable level of care/functional needs standards to access HCBS and LTC services

Notices & Choice Counseling

Notices & Choice Counseling

- If the ABP is equal to or more generous than the State Plan, a state is not required to notify individuals of benefit options or provide choice counseling.
  - Adding State Plan benefits to ABP may simplify process
- If the State Plan includes benefits not included in the ABP, the state must provide notice and choice counseling to new adults:

Initial Notices:

  - At eligibility determination beneficiaries must be notified that they may qualify for different health care services if they have special health care needs.

Choice Counseling:

  - More detailed notices and choice counseling are required for:
    - Medically frail individuals
    - Pregnant women
    - Other new adults who also qualify under other Medicaid categories and are benchmark exempt

Choice Counseling Requirements

CONTENT

- Choice of enrollment in either the ABP that includes EHBs, or the ABP that is the state's approved Medicaid plan
- Ability and process for disenrollment and regaining immediate access to standard full Medicaid coverage
- ABP benefits and costs
- Comparison of how ABP benefits and costs differ from standard Medicaid

PROCESS & TIMING

- Exempt individuals in the new adult group may be enrolled in the ABP during the choice counseling period
- If an individual is identified as exempt after they are enrolled, state must provide choice counseling within 30 days of exemption determination

42 CFR § 440.315
78 FR 42233

SPA Template

SPA Template

- ABP SPA Template: http://157.199.113.99/MMDLDOC/abp.html
- CMS encourages states to submit SPAs as soon as possible so as to implement on January 1, 2014. All ABP SPAs must be submitted by March 31, 2014 in order to protect the January 1 effective date.
  - However, as stated in the Final Rule, CMS does not intend to pursue compliance actions to the extent that states are working toward but have not completed a transition to the new ABPs on January 1, 2014.
- Appendix walks through each section of template and highlights considerations for states.

FAQs on SPA Template

If my state's State Plan benefit package and ABP are aligned, do we need to fill out the sections related to exemption communications?

No. Because the two packages are aligned, exemption notice and choice counseling requirements are not applicable and no further information is needed.

If my state's notices for exempted individuals are not final, do we still need to include them?

Yes. States should include draft notices if final notices are not available.

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FAQs on SPA Template

Do all covered ABP benefits need to be included in the benefits description section?

- Even those from the EHB base benchmark plan?
- Does the description need to include details on amount, duration and scope?

Yes, all covered ABP benefits need to be described, including amount, duration and scope, regardless of if the benefit is in the EHB base benchmark plan or in the State Plan.

If my state is using a Secretary-approved ABP, do we need to provide assurances on actuarial review?

No. However, if your state is substituting benefits, you will need to attest that those substituted benefits are actuarially equivalent. The actuarial equivalence information used in the substitution process must be available to CMS upon request.

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Questions & Answers

Next Steps & Wrap Up

Next meeting: November 19; 3:00 pm – 5:00 pm EST

Topic: Coverage Options for Pregnant Women

Feedback/Comments: Alice Lam; alam@manatt.com

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Appendix

SPA Template: Considerations

ABP SPA Category	ABD PDF Templates	Required Fields	Considerations

Covered Population	ABP1, ABP2a, ABP2b, ABP2c	• Identification of eligible Medicaid populations
		• Exemption process assurances:
		  ○ identification of exempt populations:
		  ○ notice that enrollment in ABP is voluntary
		  ○ process for transferring out of ABP; and,
		  ○ choice counseling on different benefits and costs.
		• Exemption communication to consumer including how, when, and content of notice.
		• Disenrollment process and documentation of exemption
		• Eligibility criteria for exemption identification process (e.g., self-identification, medically frail screening)
		• Frequency in reviewing for exempt population
			• If state fully aligns ABP with state's Medicaid Standard package, state meets requirements for providing voluntary choice counseling and no exemption communication to consumers required
			• Exemption communication and notices to be attached to SPA

Benefit Packages	ABP3	• Name of benefit package • Benchmark or Benchmark equivalent • Overview of benefit package and any limits • Base Benchmark reference plan	
Cost Sharing	ABP4	• Description of cost-sharing with attachment	
Benefits Description	ABP5	• Detailed description of covered benefits categorized by 10 EHBs • Source, authorization, provider qualifications, and any amount, duration or scope limits	• Must include all covered ABP benefits including benefits from EHB base benchmark reference plan and additional required benefits included that are not covered under EHB base benchmark (e.g., long-term care services)

SPA Template: Considerations

ABP SPA Category	ABD PDF Templates	Required Fields	Considerations
Benchmark Equivalent Benefit Package	ABP6	• Description of benefits including aggregate actuarial value • Cross-walk of benefits against EHB categories to be attached • Copy of actuarial report to be attached • Assurances of actuarial review • EHB assurances	• Required only for states offering Benchmark equivalent benefit package
Benefits Assurances	ABP7	• EPSDT for individuals under the age of 21 • Prescription drug coverage • Substituted benefits are actuarially equivalent • Access to FQHCs and RHCs • EHB benefits • Mental health and substance abuse parity • Family planning services • Emergency and non-emergency transportation • Preventive services	
Service Delivery	ABP8	• Managed care, fee-for-service or other delivery service model • Narrative description	
Employer Sponsored Insurance (ESI) Premium Payment	ABP9	• ESI premium payment • Other premium payment assistance	
General Assurances, Payment Methodology	ABP10, ABP11	• Economy and efficiency of plans • Compliance with the law • For each benefit not provided through managed care, state will use SPA payment methodology	

Federal Guidance

- Benchmark Benefit Plans Under DRA, Social Security Act Section 1937, 42 CFR Part 440
  - http://www.ssa.gov/OP_Home/ssact/title19/1937.htm
  - http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=3e1319645cbb49c63028027131e00ee6&rgn=div5&view=text&node=42:4.0.1.1.9&idno=42#42:4.0.1.1.9.3
- Benchmark for Section VIII, Social Security Act Section 1902(k)
  - http://www.ssa.gov/OP_Home/ssact/title19/1902.htm
- "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule," CMS-9980-P, *77 Fed Reg 227*
  - http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf
- "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing," CMS-2334-P, *78 Fed Reg 4594*
  - https://federalregister.gov/a/2013-00659
- "Essential Health Benefits in the Medicaid Program," SMDL-12-003
  - http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf
- "Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans," SHO-13-001
  - http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf
- "Essential Health Benefits Bulletin." Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. December 16, 2011
  - http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf