DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

SMDL # 12-003
ACA # 21

RE: Essential Health Benefits in the Medicaid Program

November 20, 2012

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to states on Medicaid benchmark benefit coverage options (hereafter referred to as "Alternative Benefit Plans") under section 1937 of the Social Security Act. Under the Affordable Care Act, states will rely on the benefit options available under section 1937 as they expand eligibility to low-income adults beginning January 1, 2014. This letter provides guidance on the use of Alternative Benefit Plans for the new eligibility group for low-income adults; the relationship between Alternative Benefit Plans and Essential Health Benefits (EHBs); and the relationship of section 1937 with other Title XIX provisions.

General Background

Enacted as part of the Deficit Reduction Act of 2005, section 1937 of the Social Security Act (hereafter referred to as the Act) provides states with significant flexibility to design Medicaid benefit packages under the State plan. There are many options in selecting an Alternative Benefit Plan, including the option to offer the Medicaid state plan adult benefit package, and states may offer different Alternative Benefit Plans to targeted populations to appropriately meet their needs.

Through section 1937 Alternative Benefit Plans, State Medicaid programs have the option to provide certain groups of Medicaid enrollees with "benchmark" or "benchmark-equivalent" coverage based on one of three commercial insurance products, or a fourth, "Secretary-approved" coverage option. "Benchmark" means that the benefits are at least equal to one the statutorily specified benchmark plans, and "benchmark-equivalent" means that the benefits include certain specified services, and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. The four benchmarks are:

(1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program (hereafter referred to as "FEHBP");

(2) State employee coverage that is offered and generally available to state employees (hereafter referred to as "State Employee Coverage");

(3) The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state (hereafter referred to as "Commercial HMO") and

(4) Secretary-approved coverage, which, as noted above, can include the Medicaid state plan -benefit package offered in that state.

These section 1937 benchmark options are minimum standards and states can augment coverage with additional benefits as described below. In addition, for children under age 21, states must ensure Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are included either as part of the benefit package itself or through a combination of the benefit package and additional services. Services provided to individuals age 21 or older will be deemed to meet Medicaid amount, duration and scope requirements when provided in accordance with the parameters of the commercial market product selected by the state, as reflected in items (1)-(3) above.

Certain populations such as people who are blind and disabled are exempt from mandatory enrollment in an Alternative Benefit Plan, as identified at section 1937(a)(2)(B) of the Act and 42 CFR 440.315. States are, however, permitted to offer voluntary enrollment in an Alternative Benefit Plan to those exempt groups. 42 CFR 440.320 outlines the procedures that apply when such voluntary enrollment is offered.

The Affordable Care Act made a number of changes related to section 1937 that are effective on January 1, 2014. These changes include:

- Any Alternative Benefit Plan must cover EHBs as described in section 1302(b) of the Affordable Care Act and applicable regulations;
    - EHBs include the following ten benefit categories, recognizing that some of the benefit categories include more than one type of benefit: (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) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

- The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to Alternative Benefit.

Alternative Benefit Plans and Essential Health Benefits

We intend to propose that the definition and coverage provisions for EHBs in section 1302 of the Affordable Care Act and as described in the Notice of Proposed Rulemaking, CMS-9980-P, generally apply to Medicaid. However, because of the role of the states in defining Medicaid benefits and existing title XIX statutory provisions, we will propose through regulation some modifications that will apply when furnishing these services to Medicaid beneficiaries. Section 1937 coverage options are a starting point for states to establish their Alternative Benefit Plans, and the process for ensuring
coverage of and, as necessary, adding EHBs will mirror steps taken by issuers in the individual and small group markets as described below.

Coverage of EHBs in Alternative Benefit Plans

To develop a benefit plan that meets the statutory provisions discussed above, we propose that states will first choose a coverage option from the choices set forth in section 1937. The next step is to determine whether the 1937 coverage option selected is one of the options available for defining EHBs in the individual and small group market. There is considerable overlap between the 1937 coverage options and the base benchmark plan options identified at 45 CFR 156.100. We intend to propose, in forthcoming regulations, the following:

- If the 1937 coverage option selected is one of the options available for defining EHBs, the state would be deemed to have met the requirement for EHB coverage in an Alternative Benefit Plan to the extent that the selected coverage option includes all EHB categories.
- If the state selects a 1937 coverage option that is not one of the options for defining EHBs in the individual and small group market, states will select any one of the EHB base benchmark options and will then compare the coverage between the 1937 coverage option and the selected EHB base benchmark plan and, if needed, supplement the section 1937 coverage option.

Under either approach, we intend to propose that the supplementation process proposed at 45 CFR 156.110(b) to ensure coverage of the ten statutorily-specified EHBs will apply to Medicaid as well. Further, we intend to propose that states may select more than one benchmark plan to define EHBs for different segments of the Medicaid population, in keeping with states' flexibility to design benefit plans appropriate to meet the needs of targeted populations.

Additional Coverage Provisions for EHBs

Certain EHB definitions or options will be adapted to Medicaid as follows:

Habilitative Services: CMS will propose rules relating to Medicaid to specify that states will define the benefit and will request comment on the parameters for this benefit.

Pediatrics: The EHB proposed regulation provides options for a state to supplement its benchmark plan in the individual and small group market if it is lacking with respect to pediatric services. For children enrolled in Medicaid, all medically necessary services in general, including pediatric oral and vision services, are covered under the Medicaid EPSDT benefit, which applies to every section 1937 Alternative Benefit Plan. As a result, EHB supplementation for pediatric services is not necessary in Medicaid.

Prescription Drugs: Section 1927 of the Act, which describes the conditions for Medicaid coverage of outpatient drugs and the Medicaid drug rebate program, applies to Alternative Benefit Plans. Consistent with this title XIX provision, states have the flexibility to adopt prior authorization and other utilization control measures as well as policies that promote use of generic drugs.

All other provisions under title XIX of the Act apply, unless, as described in section 1937, the state can satisfactorily demonstrate that implementing such other provisions would be directly contrary to their ability to implement Alternative Benefit Plans under section 1937. States can use commercial market and/or Medicaid provider qualifications for each benefit. Free choice of qualified providers continues to apply.

Updating EHBs and Alternative Benefit Plans

The Secretary has proposed through regulation that the EHB benchmark plan options for the individual and small group markets must be identified based on enrollment data available in the first quarter of 2012. These options will remain effective from January 1, 2014 through December 31, 2015, and the process will be evaluated for future years. We will propose that Medicaid adopt this same approach for the initial implementation of the new adult group and all other populations that may be provided benefits under Section 1937. CMS will consult with states and reevaluate the process to determine how often states will update their Alternative Benefit Plans to reflect benefit changes made to 1937 commercial plans and EHBs in individual and small group plans.

Administrative Procedures Pertaining to Alternative Benefit Plans

Medicaid State Plan Amendments (SPAs) describing section 1937 Alternative Benefit Plans may be submitted to CMS beginning in the first calendar quarter of 2013, for individuals in the new adult group effective January 1, 2014. Over the course of 2013, a new automated web-based system for submitting section 1937 SPAs will be implemented.

Three major sections must be submitted together as a package and approved by CMS through the SPA process: Section 2.2/2.6 pertaining to Eligibility for the program; Section 3.1-C pertaining to Benefits/Services covered by the program; and Section 4.19-B pertaining to fee-for-service reimbursement methodology, if applicable. In addition, a Section 4.18 SPA pertaining to cost-sharing must be submitted to CMS and approved if the State plan needs to be modified to reflect cost-sharing for individuals in the Alternative Benefit Plan. States implementing Alternative Benefit Plans in a managed care delivery system will also need to submit for CMS review any contracts with health plans, consistent with current practice.

Regulations at 42 CFR 440.305(d) require that states wishing to establish a new 1937 Alternative Benefit Plan or to substantially modify an existing one, need to publish a public notice with reasonable opportunity for public comment prior to submitting a SPA to CMS.

We intend to work closely with states as you consider the options for designing appropriate benefit packages in the Medicaid program and also will be scheduling webinars to review the information and processes described in this guidance. We expect the proposed regulation will be published shortly, which may also include changes related to cost sharing to similarly modernize them for the new system that starts in 2014. If you have any questions regarding section 1937 Medicaid Alternative Benefit Plan, please contact Ms. Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

/s/

Cindy Mann

Director

cc:

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