

Medicaid Benchmark Options Analysis

Stakeholder Advisory Committee
November 19, 2012

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MERCER



Human Services
Research Institute

Introductions, Overview and Roles	5 min	DHCS
Review of Federal Requirements & Open Policy Questions	15 min	Manatt
Options Analysis: Approach and Initial Observations	35 min	Manatt, Mercer, TAC/HSRI
Discussion	55 min	
Next Steps	5 min	Manatt

Introductions, Overview & Roles

What “Benchmark” are We Talking About Today?

Medicaid

State-selected benefit package that must be provided to the new adult Medicaid group

Exchange

State-selected benefit package defining “essential health benefits,” which will apply for individual and small group markets, inside and outside of Exchange

State Considerations in Designing Medicaid Benchmark

- **Clinical needs of the individuals covered under new adult eligibility group**
- **Alignment across Medicaid categories**
- **Alignment between Medicaid and QHP**
- **Reduce administrative complexity for consumers, health providers, plans and government**
- **Whether and how to apply cost-sharing**
- **FMAP implications**

Benchmark Options Analysis Project

Consultant Roles

Manatt Health Solutions

Conduct assessment of federal legal requirements and strategic considerations and synthesize analysis into final report

Mercer

Conduct actuarial analysis of current Medi-Cal benefits, which will allow state to model variation benchmark options

TAC/HSRI

Assess behavioral health/substance use services and estimates of services use by the income expansion population

Deliverables/Timeframe

October 2012

November 2012

December 2012

January 2013

Initial Data Collection, Research, & Analysis

- Analyze current full-scope Medi-Cal benefits
- Develop outline of synthesis report
- Develop presentation on project deliverables
- Develop memo on benchmark benefit guidance
- Convene stakeholder meeting (Nov. 19, 2012)

Refinement of Research & Analysis

- Develop cost estimates
- Develop crosswalk of plan options
- Plan stakeholder convening
- Prepare draft of report for DHCS review

Final Report & Special Legislative Session Support

- Finalize cost estimates and assessment
- Convene stakeholders
- Provide final report to DHCS

Review of Federal Requirements & Open Policy Questions

New Adult Eligibility Group Receives Benchmark Coverage

ACA establishes new Medicaid eligibility group of non-pregnant adults between 19-65 with incomes $\leq 133\%$ FPL

- This “new adult eligibility group” consists of childless adults and parents who are above the state’s Aid to Families with Dependent Children (AFDC) eligibility levels in 1996
- States must provide Benchmark or Benchmark-equivalent coverage described under §1937 of the Social Security Act (DRA), as modified by the ACA
- States will receive enhanced FMAP for “newly eligibles” within new adult eligibility group

Benchmark Coverage Under Deficit Reduction Act (DRA)

- Since 2006, DRA has provided state option to tailor Medicaid coverage through
 - Benchmark coverage or
 - Benchmark-equivalent coverage
- May be provided to sub-populations or geographic regions
 - No state-wideness/comparability requirements
 - May be tailored for special populations
- Must be provided in accordance with principles of economy and efficiency

Benchmark and Standard Coverage: Both Subject to Cost-sharing Rules in §§1916 & 1916A

- Certain **groups exempt from cost-sharing**: Pregnant women, children under age 18
- Certain **services exempt from cost-sharing**: Emergency services, family planning
- Only **nominal co-pays** allowed for those with income \leq 100% FPL
- **Premiums prohibited** for individuals with income \leq 150% FPL
- All cost-sharing subject to **aggregate cap of 5%** family income

Maximum allowable Medicaid Premiums and Cost-Sharing			
	\leq 100% FPL	\leq 150% FPL	Above 150% FPL
Aggregate cap	5% family income	5% family income	5% family income
Premiums	Not allowed	Not allowed	Allowed
Deductibles	Nominal	Nominal	Nominal
Maximum service-related co-pays/co-insurance			
Most services	Nominal	10% of cost	20% of cost
Non-emergency ER	Nominal	2x nominal	No limit, but 5% aggregate cap applies
Rx drugs	Nominal	Nominal	Nominal (preferred) 20% of cost (non-preferred)

ACA Changes to Benchmark: Essential Health Benefits (EHBs)

Beginning in 2014, Benchmark must include all EHBs for:

- new adult eligibility group (newly-eligible and currently-eligible)
- all existing Benchmark populations

Ten Categories of EHBs

Ambulatory Patient
Services

Emergency Services

Hospitalization

Maternity and
Newborn Care

Mental Health &
Substance Use
Disorder Services,
Including Behavioral
Health Treatment

Prescription Drugs

Rehabilitative &
Habilitation Services
& Devices

Laboratory Services

Preventive &
Wellness Services &
Chronic Disease
Management

Pediatric Services,
Including Oral &
Vision Care

EHBs and Medicaid Benchmark Coverage

- State must identify an **EHB Reference Plan** for its Medicaid Benchmark
- If EHB reference plan does not cover all required EHBs, state must supplement

Standard BCBS PPO
plan under FEHBP

Largest non-
Medicaid
commercial HMO
in the state

Any generally
available state
employee plan

Any other coverage
that HHS Secretary
determines to be
appropriate for the
targeted population

Benchmark Reference Plan = EHB Reference Plan

If Benchmark reference plan is FEHBP, HMO or
state's employee plan, that plan is the
EHB reference plan

Must include 10 EHBs

EHBs and Medicaid Benchmark Coverage (Ctd)

- EHB Reference Plan for Medicaid **may be different** than EHB Reference Plan for individual and small group market
- State **may select** its **standard Medicaid package** as its Benchmark coverage under “Secretary-approved” option
- State **must specify EHB Reference Plan** as part of 2014-related Medicaid State Plan changes
- States must provide **public notice** and reasonable opportunity to **comment *before*** submitting Benchmark plans to CMS

Unlike in individual and small-group market:

- State may have more than one Benchmark for new adult group
- No default reference plan – State must choose
- No substitution of benefits within or across EHB categories

ACA Changes to Benchmark: Mental Health Parity

- Under current law, **federal mental health parity (FMHP)** requirements only apply to Medicaid managed care, not Medicaid fee-for-service.
- The ACA expands some FMHP requirements to all Benchmark and Benchmark equivalent plans.
 - Mental health and substance abuse benefits must have parity with medical/surgical benefits with respect to:
 - Financial requirements (deductibles, co-pays, and coinsurance)
 - Treatment limitations (frequency/scope/duration)
 - Because Benchmark must cover EPSDT, it meets FMHP requirements for individuals under 21

Open Questions: Awaiting Further Federal Guidance

- How will the requirement that Benchmark include EHB be implemented?
 - *If federal Medicaid law does not cover a type of service/setting/provider that is included in the EHB reference plan, may or must the service be covered in Benchmark?*
 - *If the State selects an EHB reference plan that includes Institutions for Mental Diseases services, may or must the State include such services in its Benchmark? Will the State receive FMAP for covering them?*
- How will the requirement that Benchmark apply mental health parity rules be implemented?
- May states include in their Benchmark services not listed in Section 1905(a) as either a mandatory or optional benefit?
 - *§1915(i) Home and Community-Based Services*
 - *§1915(j) Self-Directed Personal Assistant Services*
 - *§1915(k) Community First Choice*
 - *§1945 Health Home Services*
- Do the Benchmark exemptions in Section 1937(a)(2)(B) apply to the new adult eligibility group?
- Will states receive enhanced FMAP for providing services to individuals in the new adult eligibility group who fall within a Benchmark exempt category?

Options Analysis: Approach and Initial Observations

Approach

FEHBP:
BCBS Standard
PPO

**State
Employee
Plan:**
Anthem
Choice PPO

HMO:
Kaiser
Traditional
HMO

**Secretary
Approved
Option:**
Medi-Cal
Standard

- Compare benefits across potential benchmark options
- Identify meaningful differences in coverage and associated costs
- Identify where Benchmark options may fall short of required EHBs and need to be supplemented
- Project estimates of future costs and translate those costs into State share amounts

Approach

- Step 1: Compare benefits across potential benchmark options and identify meaningful differences in coverage
 - Plan survey template that includes:
 - 10 EHB categories,
 - Long term care (institutional and community-based services)
 - EPSDT, FQHC, Mental Health Parity, Transportation, family planning and “Other”
 - Behavioral Health and Substance Abuse Services (in collaboration with TAC/HSRI)
 - Once completed, identify meaningful differences in coverage and any areas that may fall short of EHB coverage
 - Establish benchmark “bookends”
 - Expect that current Medi-Cal will provide overall the most robust coverage
 - Compare to the benchmark option that provides lowest levels of coverage

Approach

- Step 2: Estimate the total cost of each “bookend” benefit and the costs of key service (or service grouping) differences.
 - Assess commonalities among the benefit plans and focus on the differences
 - Use historical Medi-Cal eligibility, claims and encounter data as the basis for the cost estimation, adjusted to account for demographic frailty differences between the current Medi-Cal adult population and the newly eligible population scheduled for enrollment in 2014.
 - Estimate a per member/per month value for key benefit differences (e.g., benefit group X is worth \$10.00 PMPM)
 - TAC/HSRI will develop the behavioral health analysis

Approach

- Step 3: Trend cost estimates to 2020 and translate into an estimate of state and county share.
 - There will be no state share cost for the “newly eligibles” for the first three years until 2017 due to the 100% FMAP unless California adds a benefit that is not federally-matchable.
 - The projected population will need to reflect any early enrollment (take-up) differences expected (i.e., higher utilizing members may be expected to enroll first).

Behavioral Health Analysis: Service System Plan

- Implemented as part of Special Terms and Conditions in the Medi-Cal Bridge to Reform 1115 Waiver.
- First step was to review the needs and service utilization of current Medicaid recipients and identify opportunities to ready Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform.
- Current step is to use this assessment as a basis for the development of a mental health and substance use service plan for the Medi-Cal expansion population.

Behavioral Health Analysis: Estimated Users

Estimated Users of MH and SU From Needs Assessment Based on:

- The estimated size of the overall Medi-Cal expansion population that will begin enrollment in 2014
- The predicted behavioral health composition of the Medi-Cal expansion population
- The health/behavioral health status of the expansion population
- The proportion of the overall expansion population that is likely to present for mental health and substance use treatment services

Behavioral Health Analysis: Cost Projections

Cost Projections of User Population will be Based on:

- Services included in the benefit
- “Take Up” rate – rate at persons who are eligible actually enroll by year (2014 through 2019)
- Proportion of eligible and enrolled that will actually present for services
- Distribution and intensity of service use – of the services available what proportion will use each service and how much on average
- Medical inflation factors – to account for anticipated increased costs of delivering services

Behavioral Health Analysis: Methodology

- Use claims and encounter data to project utilization patterns for the expansion population based on benefit design
- Adjust costs to 2014 – 2019 dollars
- Use CA experience, published literature and experience of other states expansion efforts to adjust utilization numbers
- Calculate state and county share of projected costs

Initial Observations

Where might we see meaningful coverage differences?

- Long Term Care
- FQHC services
- Bariatric surgery
- Abortion
- Chiropractic
- Non-severe mental illness (Non-SMI)
- Applied Behavioral Analysis (ABA) therapy for autism
- Acupuncture
- Infertility services

Discussion



Next Steps



Next Steps

- Conduct analysis of new federal guidance
- Complete plan template
- Develop benefit cost estimates
- Prepare draft report, including preliminary assessment and cost estimates in December
- Prepare final report, including final assessment and cost estimates in preparation for the January Legislative Special Session

Thank You

