NAMD
National Association of
Medicaid Directors

To: All Medicaid Directors
From: NAMD staff
Date: January 6, 2012
Re: Medicaid crossover issues with Essential Health Benefits

On January 6, 2012, NAMD hosted a call with Cindy Mann and her staff to discuss the Medicaid cross over issues with CMS' Essential Health Benefits bulletin. In addition, NAMD staff attended a meeting for state associations hosted by the Department of Health and Human Services to discuss EHB more generally. The following memo is intended to update Directors and staff about the key points and take-aways from these discussions.

NAMD seeks ongoing state input regarding any of the issues discussed in this memo or others related to Medicaid benchmark benefit and EHB issues. Please direct these to Kathleen Nolan [kathleen.nolan@namd-us.org]

Recap: HHS meeting with state organizations

The HHS Office of Health Reform, Office of the Assistant Secretary for Planning and Evaluation (ASPE), and staff from the Exchange division of CCIIO among others convened a meeting to discuss specific questions and to receive initial feedback from state organizations. The following are some of the key issues for Medicaid Directors.

Insurance will look to Medicaid for guidance. Based on feedback from representatives of the National Association of Insurance Commissioners (NAIC), it is clear there is very little understanding and experience in benchmarking among the insurance regulators. It is likely that in many states Medicaid leadership may be called on – and should be prepared – to work through the nuances of how this works with their state counterparts. Medicaid Directors may want to collect their thoughts and lessons learned from these efforts in CHIP/Medicaid in their own states or in others.

Benchmark approval/certification process. Information was requested on what the process would be at the federal level, and whether state decisions would need to be approved, as well as changes. This may not relate directly to Medicaid, but if the approval process and/or criteria is very different, it could get confusing.

Habilitation coverage. There was a brief discussion of the pending concerns in defining this coverage area, but NAMD's understanding was that the insurance community was unaware of the magnitude of this challenge.

Behavior health. The issue of mental health parity was raised, particularly whether HHS was likely to be further define the services/benefit. Apparently the issue was raised, with a question about who would be responsible for ensure parity (federal enforcement?)

Recap: Medicaid-EHB call with Cindy Mann

Ms. Mann gave a brief overview of the HHS' bulletin on Essential Health Benefits and focused on the implications for and relationship to the Medicaid benchmark benefits. The three Medicaid benchmarks described in Section 1937 are part of the acceptable benchmarks identified in the EHB bulletin.

Ms. Mann made the following key points:

1) States are not tied to picking the same benchmark for all markets. In other words, a state Medicaid program can select a benchmark(s) that is different from the benchmark a state chooses for its individual and small group market. However, the underlying Medicaid statute is the same. The addition is the guarantee that Medicaid benchmark packages must cover at least all 10 categories of EHB.

2) State flexibility under Section 1937 of Title XVIII is essentially unchanged. That is, a state may pick one or more benchmark or benchmark equivalent plan for Medicaid. States can use different benchmarks to provide coverage to different populations as long as each benchmark provides the full array of EHB for the expansion population. CMS noted that this should enable states to pursue innovative approaches to promote continuity of coverage between the Exchange and Medicaid.

3) HHS plans to issue further guidance for the parameters of "Secretary-approved coverage" for EHB. HHS has not yet established a "bottom line" for the minimum or maximum standard for Secretary approved coverage. CMS requested input regarding what states would find useful and what is important for that guidance to contain.

The following are additional clarifications and outstanding issues discussed during the Q&A portion of the call.

- Definition of habilitation. During the discussion portion, states expressed the need for CMS to clearly articulate the intent and a clear definition and/or

reference points for habilitative services. States expressed concern about relationship between the EHB requirement and habilitation for waiver services as well as the operational challenges and potential conflicts with IDEA plan services. CMS acknowledged the need to flesh this out and encouraged state feedback.]

- Previously exempt populations remain exempt. States requested further guidance clarifying and defining the populations exempt from the Medicaid benchmark benefits. CMS staff stated that the exemptions remain and that this would be addressed in the guidance.

- Children retain the full Medicaid package. At a minimum, Medicaid benchmark plans can be "less rich" or "more rich" for some or all enrollees provided it was the same/equivalent to one of the benchmark/Secretary-approved plans and had the 10 essential services. However, children are always entitled to the full Medicaid benefit package and must be provided wrap around services if they are enrolled in a benchmark plan.

- Dental/vision services for children. States requested whether CMS intends to provide additional guidance or recommendation about the scope of the child dental and vision benefits that are *not* included in a benchmark plan. Specifically the issued raised was about medical necessity determination for certain dental services. CMS indicated there was no change in the overarching rules for children in the Medicaid program. States must provide the service through wrap-around coverage if it is not included in a benchmark benefit. CMS indicated that they understood states had some concerns related to coverage of orthodontics services. CMS indicated it would seek to work with states on a better definition outside of EHB/benchmark issues.

- FQHC services in the EHB. CMS stated that FQHC are not defined as a service under EHB benchmark plans. CMS plans to assist states in preparing to address FQHC-related issues.

- State mandates in the EHB vs. Medicaid benchmarks. The EHB bulletin doesn't require state to choose a benchmark plan with state mandates. Medicaid's Section 1937 establishes the benchmarks for the Medicaid program and whether they include the state mandates or not, depends on benchmark a state chooses. In other words, there seem to be scenarios where an EHB benchmark could include state mandates, but the Medicaid benchmark may not.

- IMD exclusion. CMS plans to address the IMD exclusion issues in its forthcoming guidance, but stated during the call that the exclusion remains. Some interpretation will depend on definitions included in the EHB benchmark plan.

- Benchmark benefits. CMS indicated that for targeted benchmark benefits to children, states need to assure only that the benchmark includes the Section 1905 services. CMS indicated states could have a pilot program for less than statewide or use a medical home model, for example for children with autism.

Timelines and processes

CMS intends to issue specific Medicaid guidance "soon", likely in the form of a subregulatory guidance with Q&As. The guidance will review the issues Ms. Mann discussed on the NAMD call and potentially additional questions that are raised.

Regulations. CMS plans to follow-up the EHB bulletin and forthcoming Medicaid guidance with regulations that will have a full notice and comment period.

SPA process. The state's selection of the Medicaid benchmark will become part of the state plan. CMS is moving to automate the entire State Plan Amendment (SPA) process. The benchmark benefit preprint is being revised to accommodate the 2014 requirements. CMS is targeting launch of the automated format for this SPA within the year. CMS is planning technical assistance opportunities to work with states to figure out the nuances of the preprint, the flow of data, and how to operationalize the automated system.

Comments requested

Ms. Mann indicated that CMS seeks additional input and recommendations from states, including on the issues listed below.

- As noted in the EHB bulletin, some of the 10 categories might be missing in the particular benchmark a state selects, for example habilitative services. The bulletin describes various ways that CMS is contemplating how a state would add to the benchmark benefit package to include such a mandatory service category. CMS is actively looking for ideas and comments on this issue.

- As noted above, HHS plans to issue further guidance for the parameters of "Secretary-approved coverage" for EHB. HHS has not yet established a "bottom line" for the minimum or maximum standard for Secretary approved coverage.

CMS requested input regarding what states would find useful and what is important for that guidance to contain.

- A dozen states already have some sort of approved policy or benchmark benefit. CMS seeks input on the specific information states need in order to comply with the EHB requirement. During the NAMD call, CMS suggested that states may wish to talk with the agency on how to accomplish this.

Questions and suggestions may be submitted to CMS's email box: Essentialhealthbenefits@cms.hhs.gov. States are also asked to share your comments with NAMD staff.