Strategy	Benchmark Plans (Tailored Benefits)
Background:	The *Deficit Reduction Act 2005* (DRA) gives states the option, through a state plan amendment process, to provide alternative benefits packages to beneficiaries. These plans, called "benchmark plans," are similar to those allowed under the State Children's Health Insurance Program (SCHIP). "Benchmark" coverage options include the standard Blue Cross Blue Shield plan offered under the Federal Employee Health Benefit Plan, health coverage provided to state employees, or the health coverage offered by the largest commercial HMO in the state. A state could also propose any other plan that would have to be approved by the U.S. Department of Health and Human Services (HHS). Categories of individuals that can be required to enroll in an alternative plan are generally limited to healthy adults and children. Categories of individuals that are exempt and may not be required to enroll in an alternative benefit plan include: mandatory pregnant women, blind or disabled individuals, dual eligibles, terminally ill hospice patients, those eligible on basis of institutionalization, medically frail and special needs populations (to be defined by Secretary of HHS), individuals qualifying for long term care services, children in foster care receiving child welfare services and children receiving foster care or adoption assistance, people receiving emergency Medicaid, medically needy and spend down populations, TANF parents, and women in breast and cervical cancer programs. The alternative benefit options are only applicable to non-exempt eligibility groups covered under a state Medicaid plan before enactment of the DRA and are not applicable to new eligibility groups a state might create. States that cover non-mandatory adults can apply the benchmark plan to those adults already covered in their state plans. For Texas, these plans would be applicable to children and to non-mandatory pregnant women with incomes between 133 percent and 185 percent of the federal poverty level (FPL). Benchmark coverage can be provided to children. However, any medically necessary services covered under Early Periodic Screening, Diagnostic, and Treatment (EPSDT)[1] must continue to be provided for individuals under age 19. According to Centers for Medicare and Medicaid Services (CMS) guidance issued on March 31, 2006, exempt individual can be voluntarily enrolled in an alternative benefit package. States are permitted to offer recipients an alternative benefit package, but may not require them to enroll. The example provided by CMS was that in some states the state employee benchmark coverage may be more generous than the state Medicaid plan. Also, Secretary-approved coverage may offer the opportunity for individuals who have disabilities to receive integrated care for acute care and community-based long-term care. When states offer an individual the option to enroll in an alternative benefit

[1] EPSDT benefits, in particular what are known as Comprehensive Care Program (CCP) benefits, are fairly broad and extensive sets of services provided to Medicaid children. EPSDT benefits are more comprehensive than most private health insurance plans.

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	package, the individual must be informed that enrollment is voluntary and that the individual may opt out of the alternative benefit package at any time and regain immediate eligibility for the state's regular Medicaid program. Note on EPSDT services in DRA benchmark plans Some analysts and advocates have indicated that benchmark plans by themselves are "insufficient to meet all the needs of children with severe or complex physical or developmental conditions." To meet the DRA requirements, states implementing benchmark plans for children under age 19 must ensure that children have access to medically necessary EPSDT benefits in addition to the benchmark plan. States could achieve this by providing EPSDT wraparound benefits sufficient so that, in combination with the benchmark plans, individuals continue to receive the full EPSDT benefit. By ensuring appropriate access to EPSDT services for children needing them, states could potentially combine CHIP enrollees, most Medicaid children, and parents and caretakers (except TANF) in a basic plan to create larger purchasing pools.[2] When delivering "tailored benefits," children with severe or complex or developmental conditions could receive a specific benefits package tailored to their needs, and children without these conditions may be more appropriate to consider for a benchmark plan. *Waivers* — States can utilize Medicaid and SCHIP waivers to implement new benefit designs. The DRA offers flexibility to make some changes via state plan amendments previously only available through waivers. However, waivers may be required for changes not allowable under the DRA provisions. For example, changes available through state plan amendments for new benefit designs via the DRA are only applicable to eligibility groups currently covered by a state, not new groups and many eligibility groups are exempted from the options. Of note is that 1115 waivers have cost neutrality provisions that the DRA does not have. This means that the changes proposed in the waiver must be budget neutral, or cost no more than if they had not been implemented.
Other States:	*DRA* —- Three states have approved benchmark benefits approved through the DRA options. ***Idaho*** – Three different benefit plans: **Basic Benchmark Plan for Low-Income Children and Working-Age Adults** The broad policy goal for this plan is to achieve and maintain wellness by emphasizing prevention and by proactively managing health. All packages are voluntary alternatives to traditional Medicaid. • Consists of healthy low-income children and working-age adults (CHIP

[2] In Texas, there are no non-TANF parents and caretakers in Medicaid.

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	children are also enrolled in this plan). • Provides basic coverage to more than 80 percent of the Idaho Medicaid population. • Covers most of Idaho's current Medicaid State Plan benefits with the exception of long-term care (nursing homes, ICF-MR, and hospice), extended mental health benefits and organ transplants. • Beneficiaries that need the excluded services may transfer to the Enhanced Benefit Plan if the excluded services become medically necessary. • Covers new benefits such as preventive services, nutritional services, and the new Preventive Health Assistance. • Children under 19 will continue to receive benefits under EPSDT. **Enhanced Benchmark Benefit Package for Individuals with Disabilities (and Elders)** The broad policy goal for this plan is to finance and deliver cost-effective individualized care. • Consists of individuals with disabilities and special health needs. • Includes all Medicaid services currently offered in Idaho and new ones including preventive services, nutritional services, and the new Preventive Health Assistance. • It is a voluntary benchmark package in which the beneficiary enrolls only after being informed of the alternatives and his/her right to opt out and go back to regular Medicaid coverage at any time. • Additional benefits will provide incentives for voluntary selection of Enhanced Benchmark by these groups. • This coverage will also be available to Basic Benchmark enrollees who develop the need for long-term services, which are covered only in the Enhanced Benchmark. **Benchmark Package for Dual Eligibles** The broad policy goal for this plan is to finance and deliver cost-effective individualized care, which is integrated to the greatest extent possible with Medicare coverage. • Consists primarily of Medicaid and Medicare dual eligible individuals. • Includes all Medicaid services currently offered in Idaho as well as new services including preventive services and Preventive Health Assistance. • It is a voluntary benchmark package in which the beneficiary enrolls only

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	after being informed of the alternatives and his/her right to opt out and go back to regular Medicaid coverage at any time. • Medicare beneficiaries eligible for Part B and D coverage of Medicare must enroll in it to be eligible for this plan. ***Kentucky*** The goal is to offer the most appropriate benefit plan based on need. New prior authorization requirements and new service limits are in all plans. The new limits on benefits are considered "soft limits." Doctors/providers can request that limits be expanded through prior authorization procedures. The goals for the long-term care redesign (Optimum Choices and Comprehensive Choices) are to provide expanded choices and equal access to institutional and community long-term care options. Four different benefit plans: **Family Choices** • Covers most children covered under Medicaid and the CHIP population • Kentucky covers infants up to 185 percent FPL, and children up to age 19 up to 150 percent FPL in Medicaid, and up to 200 percent FPL through SCHIP. • No prescription drug limits and higher vision care maximum compared with Global Choices. **Global Choices** • Medicaid population including pregnant women and parents, foster children, medically fragile children, SSI-related groups, and women with breast and cervical cancer. • Benefits include basic medical services, not including long-term care services, increased cost sharing, and new benefit limits compared to Kentucky's current Medicaid state plan. • Cost sharing is higher for Global Choices than for Family Choices. **Optimum Choices** • Individuals with mental retardation and long-term care needs. • Includes all benefits in Global Choices and three levels of long-term care services determined by individualized plans of care: high intensity, targeted and basic. The high intensity level includes institutional care. • Requires an 1115 waiver to fully implement that has been submitted to CMS, but has not yet been approved.

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	Comprehensive Choices • People who are elderly and in need of a nursing facility and individuals with acquired brain injuries. • Covers all benefits in Global Choices and services offered through current home and community-based waivers in two levels of care: high intensity and basic. The high intensity includes institutional care. ***West Virginia*** A primary goal for Medicaid program changes is emphasizing personal empowerment and responsibility. Benefit changes affect children and parents including: • Infants with incomes below 150 percent FPL. • Children ages 1 to 6 with incomes below 133 percent FPL. • Children ages 6 to 19 with incomes below 100 percent FPL. • Working parents with incomes below 37 percent FPL. • Non-working parents with incomes below 19 percent FPL. Other eligibility groups in West Virginia, including people who are elderly or have disabilities, will continue with the current Medicaid benefits under the state plan. There are two new plans. According to a news release by HHS, both plans will continue to include EPSDT benefits for children. However, it is not clear based on the following information that children in West Virginia would continue to receive all EPSDT services. There is contradictory language in the plans related to EPSDT provisions. **Basic Plan** • Includes all mandatory state plan Medicaid services and some age-appropriate optional services such as limited vision, dental and hearing for children, and family planning for adults. • Required groups are enrolled in this plan if the member agreement is not signed to enroll in the Enhanced Plan. **Enhanced Plan** • Parents access this plan for themselves and their children by signing a member agreement that allows them to enroll in this plan. • Provides all mandatory Medicaid services with the addition of some optional age appropriate services that focus on wellness. Examples include cardiac rehabilitation, tobacco cessation programs and chiropractic services for adults and nutritional education, chemical dependency and mental health

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	services for children. • Children would receive skilled nursing care and orthotics/prosthetics. • Children are covered for the full range of EPSDT benefits. • Physicians and health plans are to monitor and report to the state regarding compliance with the member agreement including screenings as directed by their provider, adherence to health improvement programs, missed appointments, and medication compliance. ***Waivers*** **Florida's** waiver includes elements of competition and consumer choice. Enrollees choose from several health insurance plans – the plans offer different menus of doctors, covered prescriptions, and co-payments. Plans compete against each other for customers. Florida's plan is based on a defined contribution. Recipients choose a managed care plan with a benefit package they think best suits their needs. Plans must provide all mandatory services as outlined in federal law. Plans can enhance benefit packages to attract more enrollees. Florida's plan has changed somewhat from what was initially envisioned. The benefit package provides a more narrow range of benefit flexibility than planned. The primary differences between the services offered by the health plans are in the areas of dental, vision and over the counter drugs offered. Florida has also had to change their plan related to risk adjustment for enrollees. Because of issues related to encounter data collection, the risk adjustment process will be phased-in over a three-year period. For the first contract year, there will be no more than a 10 percent variation in risk adjusted rates for the total population served. **Maryland** received approval for an amendment of the state's existing 1115 waiver to create a primary care program for an expansion population. **Utah** received approval of an 1115 waiver in 2002 to implement a limited benefit of a Primary Care Network to provide primary and preventive care to adults up to 150 percent of FPL. **Vermont** has a chronic care management system for individuals with chronic conditions for Medicaid and CHIP enrollees.
Application to Texas – **Advantages & Disadvantages:**	Texas has limited applicability for a benchmark plan. **<u>Advantages</u>:** • Advantages cited by states implementing tailored benefits include improved targeting of appropriate services for people enrolled in Medicaid who have different needs, and improved management of care provided based on services needed. • Another advantage ascribed to the benchmark plan is that it would allow

<table>
<tr><td>Strategy</td><td colspan="8">Benchmark Plans (Tailored Benefits)</td></tr>
<tr><td></td><td colspan="8">states to combine CHIP enrollees and the majority of Medicaid recipients for whom a benchmark plan would provide an appropriate level of services into larger purchasing pools, reducing costs, and offering lower cost options to individuals currently uninsured. EPSDT requirements must be satisfied.

<u>Disadvantages</u>:
• Insofar as use of a benchmark package for children would require access to needed EPSDT services, implementation could result in complexity related to coordination of benefits between the benchmark plan and the wrap services; e.g., EPSDT services for children.
• Other disadvantages cited in relationship to a benchmark plan for children, in particular by consumer advocates, include the potential for making access to needed EPSDT or “wrap” services more difficult.</td></tr>
<tr><td>Meets Medicaid Reform Goal(s):</td><td colspan="8"><table>
<tr><td>Cost Reduction or Avoidance</td><td></td><td>Maximizes federal funds</td><td></td><td>Improves Program Sustainability</td><td></td><td>Consumer Choice/ Responsibility</td><td>X</td></tr>
<tr><td>Reduces Number of Uninsured</td><td></td><td>Supports Private Market Coverage</td><td></td><td>Improves Quality</td><td></td><td>Improves Access</td><td></td></tr>
<tr><td>Benefit Options</td><td>X</td><td colspan="6"></td></tr>
</table></td></tr>
<tr><td>Populations Affected:</td><td colspan="8">For DRA provisions, children and non-mandatory pregnant women. For waivers, any population could be affected. EPSDT provisions are required for both DRA and waiver options.</td></tr>
<tr><td>General Revenue Impact:</td><td colspan="8">Unknown at this time.</td></tr>
<tr><td>Other Considerations</td><td colspan="8"><table>
<tr><td>Stand Alone Option</td><td></td><td>This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
</table>
States currently utilizing the DRA benchmark options also include strategies for Enhanced Benefit Accounts to promote healthy behaviors.

Waiver considerations are likely to be considered in conjunction with Medicaid reform financing strategies.</td></tr>
<tr><td>State and Federal Approval(s) Required:</td><td colspan="8"><table>
<tr><td rowspan="3">Federal</td><td>1115 Waiver (if waiver approach pursued)</td><td>X</td><td rowspan="3">State</td><td>Rules</td><td>X</td></tr>
<tr><td>Other Waiver(s), [LIST]</td><td></td><td>Legislation</td><td></td></tr>
<tr><td>State Plan Amendment (if DRA approach pursued)</td><td>X</td><td colspan="2"></td></tr>
</table></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="8">To be determined. If directed to move forward – additional analysis would be required. However, a minimum of 24 months would be expected.

<u>Affected Stakeholders</u>
• Consumers and providers.</td></tr>
</table>

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	Systems and Resource Considerations • Changes would be required, depending on options implemented. **Other Considerations** • Planning and implementation would require data analysis and additional research. • Time must be allowed for public input. **Implementation Timeframes (in months)** • Depending on options implemented a minimum of 24 months is expected.

References:

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- "State of the States: Finding Their Own Way" State Coverage Initiatives, January 2006
- "Uncharted Territory: Current Trends in Section 1115 Demonstrations" State Coverage Initiatives, March 2006
- "Improving and Increasing Access to Care: State Health Coverage Expansions Since 2004" NGA Center for Best Practices, September 28, 2006.
- "The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services" The Commonwealth Fund; George Washington University, October 2006.
- "KYHealth Choices Medicaid Reform: Key Program Changes and Questions" Kaiser Commission on Medicaid Facts, July 2006.
- West Virginia Medicaid State Plan Amendment: Key Program Changes and Questions; Kaiser Commission on Medicaid Facts, July 2006.
- Centers for Medicare and Medicaid Services State Medicaid Directors letter; SMDL #06-008; March 31, 2006.
- Idaho Fact Sheet; May 19, 2006
- KYHealth Choices Update August 2006; State of Kentucky