Study 4: Medicaid Benchmark Benefits

Proposed Study Method

b. A detailed description of your proposed study method, including the sources of data to be used in conducting the study and formulating recommendations;

HMA APPROACH

The ACA establishes a new Medicaid eligibility standard. Estimates generated by the Urban Institute's policy simulation model project approximately 76,000 "newly eligible" Medicaid enrollees.[1] Federal financing for these newly eligible Medicaid beneficiaries, along with the new Medicaid "expansion" population (childless adults and some parents up to 138% FPL) will be based on a benchmark benefit package that may not be the same as the current Medicaid benefit package provided in New York. The state therefore has a decision to make regarding benefits to be offered to its newly-eligible and Medicaid expansion populations. This decision has implications for the scope of coverage provided to those individuals, as well as cost implications for the State of New York. HMA will prepare a report that lays out the options available to New York, as well as the pros and cons of those decisions.

New York's Exchange Planning team has developed a comparison chart of benefits for benchmark coverage. HMA will work with Exchange Planning staff to review the assumptions underlying that chart. We will review New York public health and social services law to identify benefits mandates and review the current benefits package offered through New York's Medicaid managed care and Family Health Plus programs. We will then conduct a detailed review of the potential benchmark equivalent packages permitted under the ACA. Recent federal guidance clarifies that New York can

[1] Judith Arnold, Troy Oeschner, Danielle Holahan. Federal Health Care Reform in NYS. Health Insurance Exchange Planning: Status Report and Preliminary Modeling Results. December 2011.

consider its standard Medicaid benefit or its Family Health Plus benefit as potential Medicaid benchmark options. Other benchmark benefit options to be considered are New York's state employee insurance coverage, the best-selling group health product in New York and the federal employee plan. We will also review implications of the recent CMS guidance regarding the 10 ACA required benefit categories in the Essential Health Benefit, which with some additional Medicaid-based services, including EPSDT, non-emergency transportation and family planning, as well as provisions requiring mental health parity, will form the core of the Medicaid benchmark benefit as defined by the ACA.

As part of the review of benefits HMA will look specifically at the 19 and 20-year old age cohort. The state is required to provide this group, which forms part of the expansion population, with the comprehensive set of EPSDT services. We will explore mechanisms that will allow the Medicaid benchmark benefit that provides these mandated services to the young adult population without making them available to the entire benchmark population.

The chart will provide a comparison of benchmark benefits and the benchmark equivalent benefits against New York's current Medicaid benefits, and New York's requirements for mandated insurance benefits. It will also allow the state to identify whether any benefits included in the Essential Health Benefits options proposed by CMS are not currently offered through New York's Medicaid program.

The comparison of benefits chart will provide a framework for evaluating and comparing cost-sharing provisions of the various options. New York's current Medicaid program has very limited cost-sharing; Family Health Plus imposes higher cost-sharing on a wider range of services and benefits. The other benchmark benefit options impose an even greater cost-sharing burden. A full assessment of cost-sharing implications of the Medicaid benchmark options will be finalized when final CMS guidance on the Medicaid benchmark is released.

HMA will conduct an analysis of the cost implications tied to the selection of a benchmark or benchmark equivalent benefit package. Federal funding will only be available for benefits enumerated in the benchmark benefit package or one of its equivalents.

Providing precise cost estimates would require an actuarial analysis, which is outside the scope of this project. HMA will examine current Medicaid cost data to determine the unit cost of various benefits. Current Medicaid utilization data by type of beneficiary will provide estimates of expected utilization by the expansion population. While Urban Institute modeling suggests that 75 percent of newly-eligible Medicaid beneficiaries are likely to enroll, we can test various high-enrollment and low-enrollment scenarios. Given possible differences between the current Medicaid beneficiary population and that of the expansion population, HMA will work with New York State to develop assumptions about expected utilization. We will look at current utilization of each benefit under consideration by type of Medicaid enrollee (e.g. Family Health Plus, Medicaid Managed Care) to establish a range of expected utilization. These assumptions about enrollment and utilization will allow us to establish a range of cost estimates for each mandated benefit under consideration.

HMA will examine mechanisms for financing any costs that would be incurred due to federal requirements being less comprehensive than the current New York Medicaid benefit. This will include an analysis of potential savings to the state program as a result of increased FMAP resulting from the ACA.

This report will provide all necessary information to advise the state's decision regarding what benefits should be provided to newly and expansion Medicaid-eligible individuals through the Exchange. New York has a history of providing comprehensive benefits within its Medicaid package. As New York's fiscal situation remains challenging, the state will have to decide whether to reduce Medicaid costs by enrolling more beneficiaries in benchmark benefits, and whether it might be more cost-

effective/appropriate to offer some populations a more comprehensive benefit package. HMA will review the federal requirements and the state requirements, and where they differ. We will review the implications for enrollment, for comprehensiveness of coverage, and for premium cost. A clear presentation of the benchmark benefits options, the comprehensiveness of each option, and the cost to the state will help inform the state's decision about benchmark benefits.

The ACA establishes a process that allows states to define their own Medicaid benchmark. This option, Secretary-approved coverage, would allow New York to propose a benefit design tailored specifically to its population. Information about what is necessary to include in an application to the Secretary, and what the application process will be, has not yet been finalized by CMS. When that information becomes available HMA will review and summarize the application requirements and process. New York will have the necessary information about what is needed for a submission to the Secretary should the state decide to pursue that option.

A discussion of Medicaid benchmark benefit options for New York State cannot be finalized until CMS releases guidance on this aspect of the ACA. Should guidance be released by June 1, 2012, HMA will incorporate that information into its final report, due July 1, 2012. In the case that federal guidance has not been released, the final report will be submitted in draft form. The report will be finalized no more than four weeks after the CMS guidance has been released.

DATA SOURCES

Information on New York's Medicaid benefits and insurance mandates will come from a review of state law. Discussions with individuals in the Department of Financial Services, the Department of Health, as well as key informants from the insurance industry such as the Health Plan Association of NYS will further clarify how health plans respond to insurance mandates. New York State Department of Health maintains data on Medicaid claims within the fee-for-service program, and encounter data for

those currently enrolled in Medicaid managed care. These will provide both utilization and cost information.

Timeline

e. A detailed timeline showing each step in the study process and the dates for key deliverables;

Project Deliverables and Work Plan	Due Date
Deliverable: Draft Preliminary Analysis and Progress Report • **Overview of research analysis and data sources** • **Description and chart of Benchmark Benefits options** • **Identification of questions or issues requiring guidance from DOH**	May 11, 2012
Deliverable: Draft Cost Analysis for Benchmark Benefit and Benchmark Equivalent Options • **Quantitative and qualitative assessment of the benchmark benefits and benchmark equivalents** • **Cost implications for NYS and alternative financing mechanisms**	June 15, 2012
Deliverable: Draft Report and Recommendations on Benchmark Benefits and Benchmark Equivalent Benefits • **Review of options** • **Review of stakeholder input** • **Discussion and recommendations on benchmark benefits**	July 1, 2012
Deliverable: Final Report and Recommendations on Benchmark Benefits and Benchmark Equivalent Benefits • **Review of options** • **Review of stakeholder input** • **Discussion and recommendations on benchmark benefits**	4 weeks post-release of final CMS regulations regarding the Medicaid benchmark benefit
Deliverable: Presentation of Findings to Stakeholders	TBD

Proposed Report Outline

f. A proposed outline of the report that your organization would produce for the study; and

Study Methodology and Data Sources

Description and Chart of Benchmark Benefits Options

Analysis of New York's Medicaid Benefits Compared with Benchmark Options

Cost of Benchmark Options

Potential Financing Mechanisms

Policy Implications

Recommendations