HMA

HEALTH MANAGEMENT ASSOCIATES

Medicaid Benchmark Benefits under the Affordable Care Act: Options for New York

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PREPARED BY:
DENISE SOFFEL, PH.D.
ROBERT BUCHANAN
TOM DEHNER
DAVID FOSDICK
LISA MAIURO, PH.D.

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

Affordable Care Act

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act (ACA). The ACA established a new mandatory Medicaid eligibility category that provides coverage to non-elderly, non-pregnant individuals with family income below 133 percent FPL who not entitled to or enrolled in Medicare Part A, not enrolled in Medicare Part B, and not eligible under any other mandatory Medicaid eligibility category. Prior to the ACA, eligibility standards varied widely across the nation, depending on state-specific coverage of certain optional and waiver populations. The effect of the ACA is to create consistency across states by filling in gaps in Medicaid coverage.

Current New York Public Health Insurance Coverage and the ACA Expansion

The new mandatory Medicaid eligibility category, as well as other provisions in the ACA regarding benefit coverage, will impact certain non-disabled, non-pregnant adults, ages 19-64, for whom New York already provides public health insurance coverage. Section 1 of the report describes the current eligibility landscape and how the ACA Medicaid expansion impacts on enrollment estimates.

Medicaid Benefit Changes under the ACA

The ACA required that most individuals covered under the new mandatory eligibility group be enrolled in Medicaid benchmark plans. The concept of a Medicaid benchmark benefit was established under the Deficit Reduction Act (DRA) of 2005 as a way of allowing states to modify and narrow Medicaid coverage for certain populations. As a result, these plans have traditionally been less comprehensive than standard Medicaid benefits. The DRA gave states the authority to limit coverage to one of several named benchmarks, which can be drawn from four approved comparison private plans:

1. The standard Blue Cross/Blue Shield preferred provider option for federal employees in the state;
2. A health plan that is offered and generally available to state employees in the state;
3. Coverage offered by the largest commercial, non-Medicaid HMO in the state; or
4. Coverage approved by the Secretary of Health and Human Services.

Medicaid benchmark plans must include basic benefits, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and non-emergency transportation, as well as access to services provided by rural health clinics and federally qualified health centers. The ACA required that all Medicaid benchmark plans provide family planning services and supplies. The ACA also expanded the reach of federal mental health parity laws to include Medicaid benchmark plans.

The Benchmark-Eligible Population and Federal Financing

Newly Eligible Adults – Enhanced FMAP - For the purposes of federal financing, “newly eligible” individuals are limited to those who were not eligible for coverage under a state’s eligibility rules. For

these “newly eligible” individuals, the federal government will pay an enhanced FMAP percentage that starts at 100 percent of costs and phases down to 90 percent in 2020 and thereafter. In New York, this newly eligible group is limited to childless adults with incomes between 100 percent and 133 percent of FPL, including 77,000 individuals.

Expansion Population – Expansion FMAP - A number of states, including New York, had expanded Medicaid eligibility prior to the enactment of the ACA to include groups that were historically outside of federal Medicaid categorical eligibility. States that had opted to cover parents and non-pregnant childless adults with incomes of at least 100 percent of FPL are defined as “expansion states.” These states will receive a phased-in increase in their federal matching rate for the childless adults in their expansion population, bringing them in line with newly eligible FMAP rates after 2019. In New York, this expansion population includes childless adults ages 21 to 64 who are currently eligible for coverage, either through Medicaid or through FHP. This group includes 681,700 individuals currently enrolled in or eligible for Medicaid and 117,800 individuals currently enrolled in or eligible for FHP.

Previously Eligible Adults – Base FMAP - States will continue to receive their base FMAP rates for non-disabled populations, ages 19 to 64, who were previously eligible for Medicaid. In New York, the base FMAP rate is 50 percent. For the purpose of the benchmark benefit, this group includes parents covered through FHP (with incomes between 85 percent and 133 percent of FPL), including 337,500 individuals currently enrolled in or eligible for FHP.

Medicaid Benchmark Options in New York

The choice of a Medicaid benchmark plan will affect the services that are available to the benchmark population and the cost of that population to New York. In most states, the population that will be covered by a Medicaid benchmark plan is made up of individuals previously not eligible for Medicaid or other public health insurance. In New York, by contrast, a substantial portion of the Medicaid benchmark-eligible population is already covered. As a result, benchmark options must be evaluated with regard to current benefits that qualifying individuals in New York receive today. The different FMAP levels for the currently covered populations will influence state costs of any particular Medicaid benchmark plan option.

This report using four specific options for New York’s Medicaid benchmark selection:

1. Multiple benchmark selections by population;
2. Medicaid as the benchmark option;
3. FHP as the benchmark option;
4. A commercial insurance benchmark option.

Policy Considerations for Benchmark Options

Medicaid as a Benchmark Option in New York

Choosing to provide its current Medicaid benefit package as the benchmark is the most comprehensive option from a benefits perspective and would allow for continuity of coverage for those individuals currently enrolled. Individuals currently eligible for FHP would gain access to long-term care benefits,

the most significant difference between Medicaid and FHP. Individuals currently eligible for FHP would also gain access to over-the-counter drugs.

Family Health Plus as a Benchmark Option

FHP is a benefit package that has been used by a large number of New Yorkers over the last decade, providing a comprehensive set of benefits. While it does not have all the long-term care benefits available through Medicaid, those with significant long-term care needs have the option of obtaining Medicaid through other eligibility provisions. If New York adopts FHP as its Medicaid benchmark, a number of people currently enrolled in Medicaid will lose access to some benefits. While the mental health parity requirement under the ACA eliminates current utilization limits for behavioral health services, lesser levels of coverage for long-term care will remain.

Different Benchmark Options for Different Sub-Populations

The multiple benchmark option examined would extend current program eligibility forward, allowing current enrollees in public coverage to continue to receive the benefits they are currently receiving. It would continue to provide the Medicaid benefit to individuals who are currently eligible for Medicaid; it would continue to provide the FHP benefit to those currently eligible for FHP; and it would provide the FHP benefit to the newly eligible, because their income (100 percent to 133 percent of FPL) would put them in the FHP-eligible category.

A Commercial Plan as a Benchmark Option

HMA examined three commercial options as part of its review: the Blue Cross Blue Shield Federal Employee Health Insurance Coverage, NYSHIP Empire State Employee Health Plan, and the HIP Prime Commercial HMO. Using a commercial benchmark would be a significant change in coverage for individuals currently enrolled in New York's public programs. All benchmark populations that are currently eligible for public coverage would lose some benefits.

1 Introduction

The New York State Department of Health engaged Health Management Associates (HMA) to conduct an analysis of the options available to the state in selecting a Medicaid benchmark benefit for individuals who fall within the new mandated adult category for Medicaid established under the Affordable Care Act (ACA). This analysis reviews the revisions to Medicaid eligibility established by the ACA as it affects populations already covered under New York's Medicaid and Family Health Plus programs as well as those currently ineligible for public coverage. It then identifies and describes the options for a Medicaid benchmark benefit as defined by the ACA. The report reviews the current Medicaid benefit package against the Essential Health Benefit standard and compares it with each of the Medicaid benchmark options. The report concludes with a discussion of the implications of selecting a Medicaid benchmark in terms of the impact on currently covered groups and the comprehensiveness of the scope of benefits offered.

2 Background: Affordable Care Act

On March 23 and 30, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as the Affordable Care Act (ACA). Among other changes described below, the ACA creates new competitive health insurance markets (Exchanges) that will give millions of Americans and small businesses access to affordable coverage. An Exchange must be operational in each state by January 1, 2014. States must demonstrate Exchange readiness by January 1, 2013. An Exchange must be ready to begin accepting applications by October 2013.

2.1 Medicaid Eligibility Changes under the ACA

2.1.1 Expanded Medicaid Coverage under the ACA

The ACA established a new mandatory Medicaid eligibility category, effective January 1, 2014, that provides coverage to individuals with modified adjusted gross incomes (MAGI)[1], not exceeding 133 percent of the federal poverty level (FPL) who:

1. are age 19 or older and under age 65;
2. are not pregnant;
3. are not entitled to or enrolled in Medicare Part A or Medicare Part B; or,
4. are not otherwise enrolled in or eligible for mandatory coverage under a state's Medicaid State Plan, such as certain parents, children, or disabled persons receiving Supplemental Security Income (SSI) benefits.

To qualify for Medicaid prior to federal health reform, in addition to meeting financial eligibility criteria, individuals also had to belong to specific categorical groups: children, parents, pregnant women, people with a severe disability, and seniors. Non-disabled adults under age 65 without dependent children

(childless adults) were generally excluded from Medicaid unless a state obtained a waiver to cover them. Prior to the ACA, eligibility standards varied widely across the nation, depending on state-specific coverage of certain optional and waiver populations. The effect of the ACA is to create consistency across states by filling in gaps in Medicaid coverage.

2.1.2 Current New York Public Health Insurance Coverage

The new mandatory Medicaid eligibility category, as well as other provisions in the ACA regarding benefit coverage (see Section 2.2), will impact certain non-disabled, non-pregnant adults, ages 19-64, for whom New York already provides public health insurance coverage. Current coverage for these groups is described below.

2.1.2.1 New York Public Insurance Coverage for Parents & Adult Children

Historically, Medicaid provided health care coverage to families with dependent children who received cash assistance through the Aid to Families with Dependent Children (AFDC) program (the precursor program to Temporary Assistance for Needy Families, TANF). While Medicaid has since been expanded to cover other populations, Section 1931 of the Social Security Act (SSA) requires states to cover at least those families, including caretaker relatives and parents, with incomes below each state's 1996 state AFDC income thresholds. Section 1931 also allows states to cover families with higher incomes and receive federal reimbursement. Under Section 1931, New York is able to provide Medicaid coverage to families, including parents and adult children (ages 19 to 20), with incomes up to 85 percent of the federal poverty level (FPL) under its federally approved Medicaid state plan.

Family Health Plus (FHP) is a public health insurance program for adults, including parents and adult children, ages 19 to 64 whose income is too high to qualify for Medicaid but less than 150 percent of FPL. (Note that for the purposes of eligibility, individuals ages 19 to 20 are divided into two distinct eligibility groups: adult children, who live with their parents, and childless adults, who live independently. Adult children are eligible for FHP at the parent threshold of 150 percent FPL; childless adults are eligible for FHP at the single adult threshold of 100 percent FPL). This expanded coverage is authorized under New York's 1115 Medicaid demonstration waiver, the Partnership Plan, which allows New York to receive federal reimbursement for a portion of FHP's costs. FHP is provided to eligible adults through participating managed care plans.

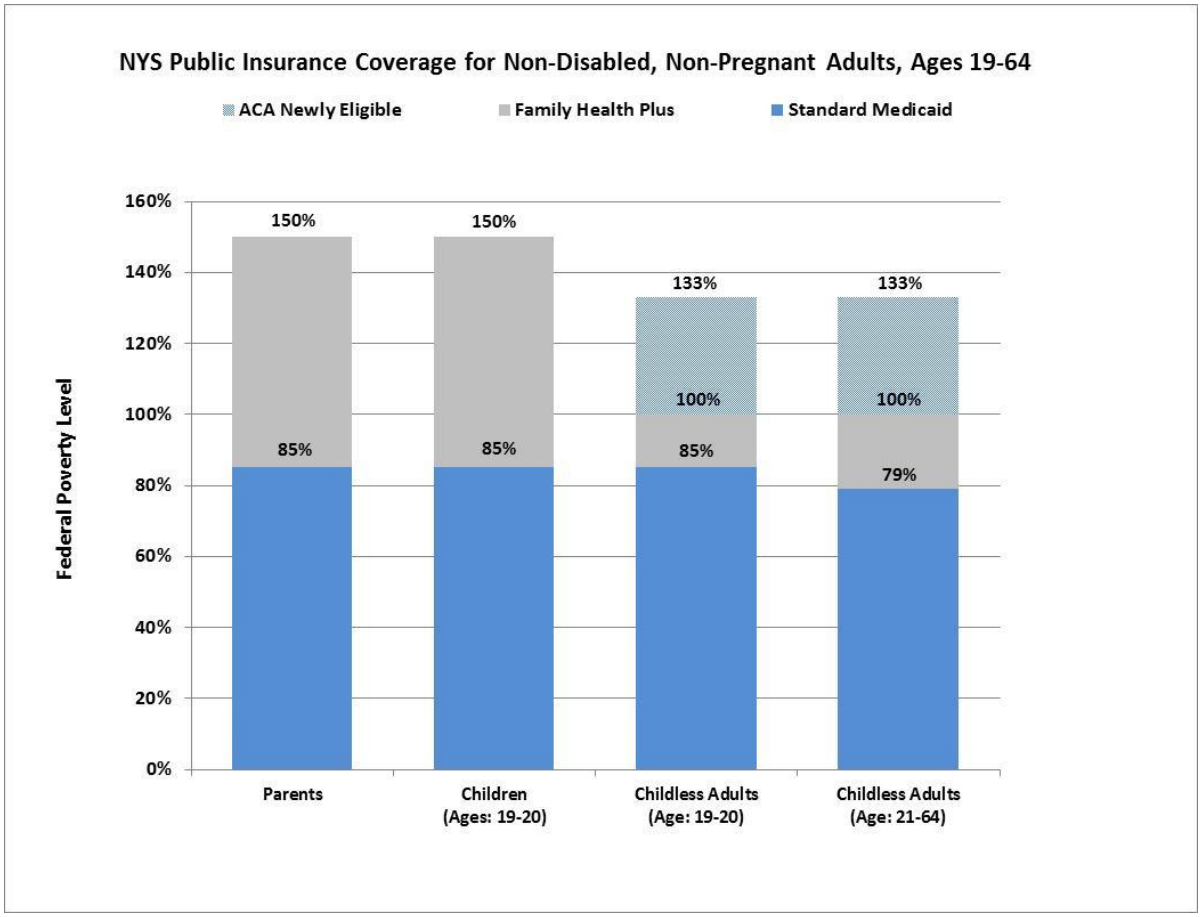
2.1.2.2 New York Public Insurance Coverage for Childless Adults, Ages 19 to 64

A number of states, including New York, expanded Medicaid eligibility prior to the enactment of the ACA to include groups that were historically outside of federal Medicaid categorical eligibility. States that had opted to cover parents and non-pregnant childless adults with incomes of at least 100 percent of FPL as of March 23, 2010 (the effective date of the ACA), are defined as "expansion states." Under the law, expansion states will receive different levels of federal Medicaid reimbursement for different coverage groups, as further described in Section 2.3.2.

In a way that is similar to the provisions that provide health care coverage for parents, childless adults in New York are covered by either Medicaid or FHP; however, income limits are lower. Childless adults whose income is under 79 percent of FPL (85 percent for adults ages 19 to 20) are covered by Medicaid,

whereas childless adults who have income too high to qualify for Medicaid but have incomes less than 100 percent of FPL are covered under FHP. (See Figure 2.1: New York Medicaid/FHP Eligibility for Parents & Childless Adults, Ages 19-64.)

FIGURE 2.1: NEW YORK MEDICAID/FHP ELIGIBILITY FOR PARENTS & CHILDLESS ADULTS, AGES 19-64



2.1.3 ACA Enrollment Impacts on New York Public Insurance Coverage

Enrollment of non-disabled, non-pregnant adults, ages 19 to 64, in New York's Medicaid and FHP programs is projected to grow by 404,000 individuals (50 percent) under full implementation of the ACA. Most of that growth is among individuals already eligible for public coverage but not currently enrolled. Less than 20 percent of total projected growth, about 77,000, is anticipated among individuals who are newly eligible for coverage as a result of the ACA Medicaid expansion.

Table 2.1 illustrates current and projected enrollment by coverage group. New York's Department of Health provided data on calendar year 2010 program enrollment and the distribution of enrollment across eligibility groups. The Urban Institute provided data on projected enrollment for the benchmark population, including those currently enrolled, those currently eligible for public health coverage but not enrolled, and the newly eligible. Appendix A provides detailed information on how these estimates were derived. It is worth noting that the Urban Institute modeling is a static model. Its simulations "are done

as if the reforms were fully implemented and behavior fully phased-in in the year 2011," which facilitates comparisons across options. It does not incorporate the gradual ramp-up in enrollment that can be expected.

TABLE 2.1: ESTIMATED ACA IMPACTS ON NYS MEDICAID/FHP ENROLLMENT ESTIMATES FOR NON-DISABLED, NON-PREGNANT ADULTS, AGES 19-64

Coverage Groups	Enrolled 2011	Eligible – Not Enrolled 2011	Newly Eligible	Enrolled 2014
Newly Eligible				
Childless Adults not currently eligible for Medicaid/FHP (between 100 and 133% FPL)	N/A	N/A	77,000	77,000
Expansion Population				
Childless Adults currently Medicaid eligible (below 79% FPL)	455,700	226,000		681,700
Childless Adults currently FHP eligible (≥79% FPL)	78,800	39,000		117,800
Previously Eligible Adults				
Parents & Adult Children (ages 19-20) currently FHP eligible (between 85 and 133% FPL)	275,500	62,000		337,500
TOTAL *(% change)*	**810,000**	**327,000**	**77,000**	**1,214,000** *50%*

Notes:

Estimate of currently enrolled from New York State administrative data. Estimates of eligible but not enrolled and of newly eligible from Urban Institute modeling.

2.2 Medicaid Benefit Changes under the ACA

2.2.1 Medicaid Benchmark and Benchmark-Equivalent Plans (Alternative Benefit Plans)

The ACA required that most individuals covered under the new mandatory eligibility group be enrolled in Medicaid "benchmark" or "benchmark-equivalent" plans consistent with the requirements of Section 1937 of the SSA (recent proposed rules suggest that these plans be called Alternative Benefit Plans[2]). The concept of a Medicaid benchmark benefit was established under the Deficit Reduction Act (DRA) of 2005 as a way of allowing states to modify and narrow Medicaid coverage for certain populations. As a result, these plans have traditionally been less comprehensive than standard Medicaid benefits. The DRA gave states the authority to limit coverage to one of several named benchmarks, which can be drawn from three approved comparison private plans or by developing their own plan:

1. The standard Blue Cross/Blue Shield preferred provider option for federal employees in the state;

2. A health plan that is offered and generally available to state employees in the state;
3. Coverage offered by the largest commercial, non-Medicaid HMO in the state; or
4. Coverage approved by the Secretary of Health and Human Services.

Medicaid benchmark-equivalent plans must include basic benefits (i.e., inpatient and outpatient hospital services, physician services, labs, imaging, well-child care including immunizations, and other appropriate preventive services designated by the Secretary) and must cover at least 75 percent of the actuarial value of coverage under the selected benchmark option for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).[3] Benchmark and benchmark-equivalent coverage must include Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and non-emergency transportation, as well as access to services provided by rural health clinics and federally qualified health centers.

2.2.2 Essential Health Benefits

The ACA required that all Section 1937 Medicaid benchmark plans provide at least "essential health benefits" (EHB), a set of minimum standard coverage requirements, effective January 1, 2014. (Qualified health plans offered through a state health insurance exchange, as well as most individual and small-group health plans sold outside of an Exchange will also be required to meet the EHB standard.) To implement this provision, Section 1302 of the ACA directed the Secretary of the Department of Health and Human Services (HHS) to define the EHB; however, the law specifically required the Secretary to include "at least the following general categories and the items and services within the categories":

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance abuse disorder services, including behavioral health
- prescription drugs
- rehabilitative and habilitative services and devices
- lab services
- preventative and wellness services and chronic disease management
- pediatric services, including oral and vision care

In addition to the EHB package, the ACA amended title XXVII of the Public Health Service Act (PHSA) by mandating coverage of the following preventive services:

- ''Evidence-based'' preventive items or services having an ''A'' or ''B'' rating from the U.S. Preventive Services Task Force (USPSTF).[4]

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.[5]
- Preventive care for infants, children, and adolescents as delineated in the comprehensive guidelines published by the Health Resources and Services Administration (HRSA).[6]
- Preventive care and screenings for women as delineated in Health Resources and Services Administration's (HRSA) comprehensive guidelines.

The ACA required that all Medicaid benchmark plans provide family planning services and supplies.

The ACA also expanded the reach of federal mental health parity laws. If New York utilizes full-service managed care plans to serve its benchmark population, all federal mental health parity requirements will apply. If New York utilizes a non-managed care delivery system for its benchmark population, certain specific mental health parity rules will apply.[7]

2.2.3 Qualified Health Plans and the Essential Health Benefit

The Obama administration announced on December 16, 2011, that it plans to give states the discretion to select an existing health plan to set a reference benchmark for the items and services included in the EHB package.[8] The EHB serves as a reference plan for Qualified Health Plans offered through the state's health insurance exchange, as well for as most individual and small-group health plans sold outside of the Exchange. States may choose one of the following health insurance plans as an EHB reference plan:

- one of the three largest small group plans in the state;
- one of the three largest state employee health plans;
- one of the three largest federal employee health plan options; or
- the largest HMO plan offered in the state's commercial market.

On October 1, 2012, NYS formally submitted to HHS its selection of an EHB benchmark for Qualified Health Plans offered through its Exchange. New York selected the benefits of the state's largest small group plan, Oxford EPO, as the benchmark plan.[9] In addition to the selection of a benchmark plan, the state indicated four coverage areas in which benefits will be supplemented in order to meet ACA requirements, including pediatric dental/vision, habilitative services, mental health/substance abuse parity limits, and removal of annual/lifetime dollar limits.

2.2.4 Federal Guidance on Medicaid Benchmark Benefits & Essential Health Benefits

On November 20, 2012, CMS issued further guidance regarding implementation of EHB with regard to Section 1937 Medicaid benchmark benefits.[10] Specifically, CMS clarified that it intends to propose the following parameters through future rule-making:

1. A state may select a different EHB benchmark reference plan for its Medicaid benchmark plan(s) than it selects for the individual and small-group markets.

2. A state may develop more than one EHB benchmark reference plan for Medicaid, if for example, a state were to develop more than one Medicaid benchmark plan.

3. A state may select its traditional Medicaid benefit package as its Medicaid benchmark plan.

The letter also proposes a process by which states will meet the statutory provisions pertaining to EHB and Medicaid benchmark plans. CMS proposes that states will first choose a Medicaid benchmark option from the choices set forth under Section 1937. The next step would be to determine whether the 1937 Medicaid benchmark selected is one of the options available for defining EHBs in the individual and small group market. There is considerable overlap between the 1937 Medicaid benchmark options and the EHB reference plan. CMS intends to propose, in forthcoming regulations, the following:

- If the Medicaid benchmark selected is one of the options available for defining EHBs, the state would be deemed to have met the requirement for EHB coverage for the Medicaid benchmark plan to the extent that the selected coverage option includes all EHB categories.

- If the state selects a Medicaid benchmark 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 reference plan options and will then compare the coverage between the Medicaid benchmark option and the selected EHB reference plan and, if needed, supplement the Medicaid benchmark coverage.

Under either approach, CMS proposes that if a state chooses an EHB benchmark reference plan for its Medicaid benchmark plan(s) that does not include all of the ten statutory categories of EHB, the state will have to ensure that the ten statutory categories of EHB are covered. If, for example, a state chose its traditional Medicaid benefit package as its Medicaid benchmark plan, it will have to ensure, either through that benefit plan or as a supplement to that plan, that all ten statutory categories of EHB are covered. This "supplementation" policy will extend to other benefits required under the ACA, including federal mental health parity laws as well as the preventive health services described above and family planning services and supplies.

The guidance includes one point of ambiguity that may become clearer through the rule-making process. One interpretation of the proposed process for comparing the selected 1937 Medicaid benchmark plan and the EHB reference plan is that a state would have to supplement the Medicaid benchmark plan to ensure *every* benefit in the EHB reference plan is included. A second interpretation of this guidance is that a state would have to compare the two plans across the ten statutory categories of EHB, and to the extent the Medicaid benchmark plan is missing a category of benefits, the state would need to supplement the Medicaid benchmark option with one or more benefits from the EHB reference plan. Given that CMS policy in this area has largely been to provide states with flexibility around EHB, we believe the second interpretation is more likely. However, CMS could adopt the more expansive interpretation.

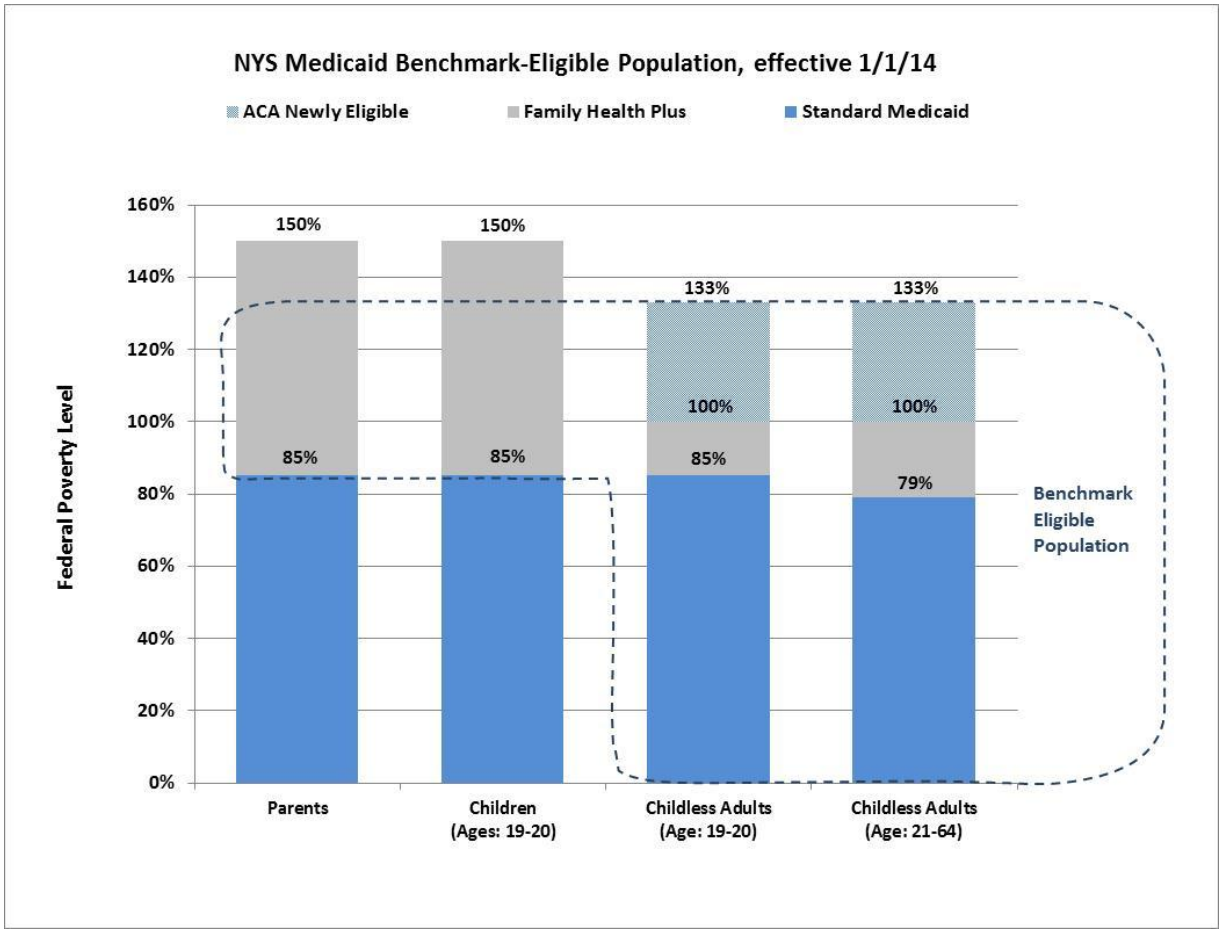
2.2.5 The Benchmark-Eligible Population in New York

As described in section 2.2.1, the ACA required that most individuals covered under the new mandatory eligibility group be enrolled in Medicaid benchmark plans (the "benchmark-eligible population"). The

DRA made certain groups exempt from required participation in a benchmark plans, and the ACA extended those exemptions to those same groups among the newly eligible. Exempt groups include blind or disabled individuals (regardless of SSI eligibility); individuals who are dually eligible for Medicaid and Medicare; inpatients in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR); and individuals who are medically frail or have special needs.[11] Children up to the age of 21 can be enrolled in benchmark plans, but they must be provided with the full children's EPSDT Medicaid benefit package, either directly or through wrap-around coverage. The ACA also exempts Medicaid-eligible former foster care children from participation in Medicaid benchmark plans.

In New York, the benchmark-eligible population includes non-disabled, non-pregnant adults ages 19 to 64 who were not previously covered under the state's Medicaid state plan (as of December 1, 2009). This includes parents and adult children with household incomes between 85 percent and 133 percent of FPL (those currently enrolled in FHP), as well as all childless adults with household incomes less than 100 percent of FPL (regardless of whether they are receiving Medicaid or FHP). Figure 2.2 illustrates how the Medicaid benchmark population intersects with current coverage groups.

FIGURE 2.2: NYS MEDICAID BENCHMARK-ELIGIBLE POPULATION, EFFECTIVE 1/1/14



2.3 Federal Financial Participation under the ACA

The ACA provides a significant increase in the federal medical assistance percentage (FMAP) for federal matching funds for adults covered by the new mandatory eligibility category.

2.3.1 Newly Eligible Adults – Enhanced FMAP

For the purposes of federal financing, "newly eligible" individuals are defined as non-elderly, non-pregnant individuals with family income below 133 percent FPL who not entitled to or enrolled in Medicare Part A, not enrolled in Medicare Part B, and not eligible under any other mandatory Medicaid eligibility category.[12] For these "newly eligible" individuals, the federal government will pay 100 percent of health care costs between 2014 and 2016. This enhanced FMAP percentage will phase down to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter. In New York, this newly eligible group, as defined for the purposes of federal financing, is limited to childless adults with incomes between 100 percent and 133 percent of FPL. According to the Urban Institute modeling, this group includes 77,000 individuals.[13]

2.3.2 Expansion Population – Expansion FMAP

A number of states, including New York, had expanded Medicaid eligibility prior to the enactment of the ACA to include groups that were historically outside of federal Medicaid categorical eligibility. States that had opted to cover parents and non-pregnant childless adults with incomes of at least 100 percent of FPL as of March 23, 2010 (the effective date of the ACA) are defined as "expansion states." These states will receive a phased-in increase in their federal matching rate for the childless adults in their expansion population, bringing them in line with newly eligible FMAP rates after 2019. The expansion population FMAP formula is as follows:

- 2014: 50 percent + (50 percent x Base FMAP)
- 2015: 60 percent + (40 percent x Base FMAP)
- 2016: 70 percent + (30 percent x Base FMAP)
- 2017: 76 percent + (20 percent x Base FMAP)
- 2018: 84.6 percent + (10 percent x Base FMAP)
- 2019: 93 percent
- 2020: 90 percent

In New York, this expansion population includes childless adults ages 21 to 64 who are currently eligible for coverage, either through Medicaid (individuals with incomes below 79 percent of FPL) or through FHP (individuals with incomes between 79 percent and 100 percent of FPL). Urban Institute modeling indicates this group includes 681,700 individuals currently enrolled in or eligible for Medicaid and 117,800 individuals currently enrolled in or eligible for FHP.[14]

2.3.3 Previously Eligible Adults – Base FMAP

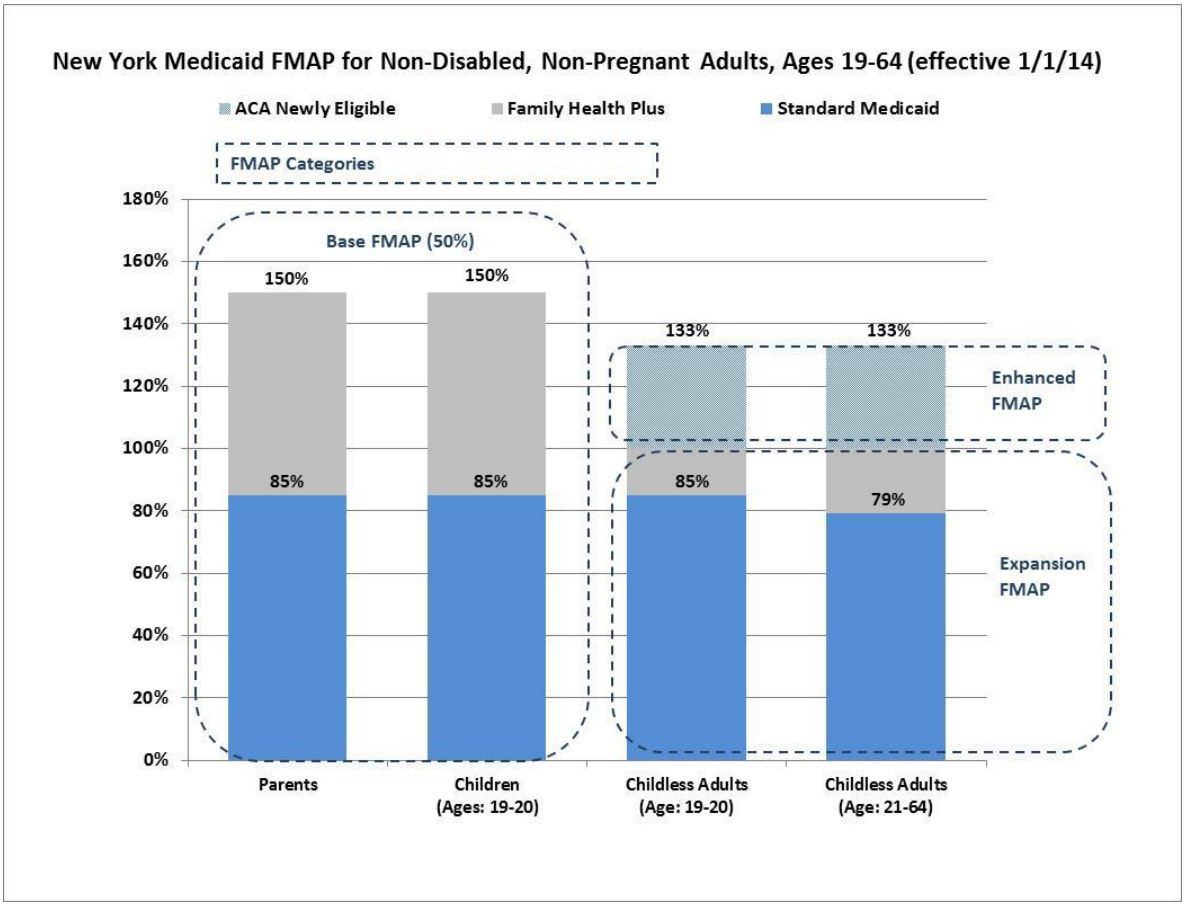
States will continue to receive their base FMAP rates for non-disabled individuals, ages 19 to 64, who were previously eligible for Medicaid (as of December 1, 2009). In New York, the base FMAP rate is 50

percent. This group includes parents covered under Medicaid (with incomes below 85 percent of FPL), parents covered through FHP (with incomes between 85 percent and 133 percent of FPL)[15] and pregnant women. It is important to note that FHP income eligibility for parents currently goes to 150 percent FPL, while the newly expanded Medicaid income eligibility only goes to 133 percent FPL. FHP parents between 133 and 150 percent FPL will not be part of the new adult Medicaid category. The remaining parents covered through FHP are part of the Medicaid benchmark population and will receive the Medicaid benchmark benefit, even though they do not qualify the state for an enhanced FMAP (the exception is parents with income over 133 percent FPL, as noted). See Table 2.2 for 2014-2020 FMAP rates by year. Figure 2.3 provides a graphic depiction of FMAP rates by coverage group.

Table 2.2: New York Medicaid Federal Medical Assistance Percentages (FMAP), CY2014 – CY2020

Coverage Groups	2014	2015	2016	2017	2018	2019	2020
Newly Eligible - Enhanced FMAP Childless Adults with incomes less than 133% who were Medicaid/FHP ineligible as of 3/23/10	100%	100%	100%	95%	94%	93%	90%
Expansion Population – Expansion FMAP Childless Adults who were Medicaid/FHP eligible as of 3/23/10	75%	80%	85%	86%	89.6%	93%	90%
Previously Eligible Adults – Base FMAP Parents & Adult Children (ages 19-20) who were Medicaid/FHP eligible as of 12/1/09	50%	50%	50%	50%	50%	50%	50%

FIGURE 2.3: NEW YORK MEDICAID FMAPS FOR NON-DISABLED, NON-PREGNANT ADULTS, AGES 19-64



3 Medicaid Benchmark Options in New York

3.1 Overview of Medicaid Benchmark Options

The choice of a Medicaid benchmark plan will affect the services that are available to the benchmark population and the cost of that population to New York. In most states, the population that will be covered by a Medicaid benchmark plan are individuals previously not eligible for Medicaid or other public health insurance. In New York, by contrast, a substantial portion of the Medicaid benchmark-eligible population is already covered. That coverage is provided through one of two benefit packages: the standard Medicaid package for very low-income adults and FHP for higher-income individuals, including both childless adults and parents. As a result, benchmark options must be evaluated with regard to current benefits that qualifying individuals in New York receive today. In addition, the ACA sets different FMAP levels for the currently covered populations after 2014, which will influence state costs of any particular Medicaid benchmark plan option. Figure 3.1 below illustrates populations that will receive benchmark benefits and the ACA's treatment of federal financing for those benefits.

FIGURE 3.1: NEW YORK MEDICAID BENCHMARK-ELIGIBLE POPULATIONS WITH ENROLLMENT AND FMAP RATES

Coverage Group	Current Coverage	Estimated 2014 Enrollment	FMAP
Newly Eligible			
Childless Adults not currently eligible for Medicaid/FHP	None	77,000	2014 – 2019:100%→93% 2020 and thereafter: 90%
Expansion Population			
Childless Adults currently Medicaid eligible (below 79% FPL)	Medicaid	681,700	2014 – 2019: 75%→93% 2020 and thereafter: 90%
Childless Adults currently FHP eligible (≥79% FPL)	FHP	117,800	2014 – 2019: 75%→93% 2020 and thereafter: 90%
Previously Eligible Adults			
Parents & Adult Children (ages 19-20) currently FHP eligible (between 85 and 133% FPL)	FHP	337,500	50%
TOTAL Benchmark-Eligible Population		**1,214,000**	

The remainder of this report addresses the relative benefits of these Medicaid benchmark choices. After discussions with New York Health Benefit Exchange planning staff, and consistent with HMA's opinion of the most necessary and fruitful analysis, we organize this report using four specific options for New York's Medicaid benchmark selection:

1. Multiple benchmark selections by population;
2. Medicaid as the benchmark option;
3. FHP as the benchmark option;
4. A commercial insurance benchmark option.

This report supplies an analysis of the option of choosing multiple Medicaid benchmarks based on the coverage that individuals currently receive. Because New York already provides coverage through Medicaid and FHP to a significant portion of the benchmark-eligible population, choosing either Medicaid or FHP as a Medicaid benchmark plan merits analysis. Finally, it is important for NYS to understand the implications of choosing one of the commercial benchmark options as well.

For the "multiple benchmark" option, a number of approaches are conceivable. Federal guidance permits the state to select more than one Medicaid benchmark and to associate that benchmark with a clearly defined population. This option may be attractive in New York, where benchmark-eligible populations already receive different benefit packages. The multiple benchmark approach in this

analysis assumes NYS exercises its authority to select more than one benchmark to keep coverage standards essentially as they are for currently covered population groups in Medicaid and FHP. With respect to this option, the report assigns newly eligible adults to FHP as their benchmark, consistent with coverage currently provided to parents at comparable income thresholds.

Figure 3.2 represents the change in coverage standards that would result for each of the four options addressed in this report. Coverage groups as defined in Section 2 are listed in the first column. The second column indicates their current benefit. The four right-hand columns illustrate the four benchmark options that are analyzed in this report, with a brief bullet that reflects the direction of change for each coverage group under each benchmark..

FIGURE 3.2: NEW YORK MEDICAID BENCHMARK OPTIONS AND CHANGE FROM CURRENT COVERAGE

Coverage Group	Current Coverage	Medicaid Benchmark Options and Impacts on Current Coverage			
		Standard Medicaid Benefit	FHP Benefit	Commercial Benefit	Multiple Benefit Packages
Newly Eligible					
Childless Adults not currently eligible for Medicaid/FHP (between 100 and 133% FPL)	None	↑↑↑ Medicaid Benefits	↑↑ FHP benefits	↑ Commercial benefits	↑↑ FHP benefits
Expansion Population					
Childless Adults currently Medicaid eligible (below 79% FPL)	Medicaid	= No change in benefits	↓ Fewer benefits	↓↓ Significantly fewer benefits	= Medicaid benefits (No change)
Childless Adults currently FHP eligible (≥79% FPL)	FHP	↑ More benefits	= No change in benefits	↓ Fewer benefits	= FHP benefits (No change)
Previously Eligible Adults					
Parents & Adult Children (ages 19-20) currently FHP eligible (between 85 and 133% FPL)	FHP	↑ More benefits	= No change in benefits	↓ Fewer benefits	= FHP benefits (No change)

As noted in Section 1, certain benefits are mandated by the ACA, which requires that every benchmark plan include, or is supplemented to include, all ten statutory categories of EHB. Appendix B provides a detailed description of benefits for each of the benchmark options. HMA reviewed each of the potential benchmark benefit packages and determined that all are likely to meet the EHB requirement. In addition, all benchmarks must provide EPSDT benefits for 19- and 20-year olds, non-emergency

transportation services, the benefits required under the Mental Health Parity and Addiction Equity Act of 2008, and the ACA-required preventive health and family planning services and supplies.

HMA's interpretation of the November 20, 2012 guidance from CMS[16] leads us to conclude that New York would not have to supplement its Medicaid benchmark benefit based on comparisons with the Essential Health Benefits options. If subsequent rule-making indicates a more expansive interpretation of the guidance, then New York would have to supplement its benchmark. The Essential Health Benefit option requiring the fewest changes would be the Federal Employee Health Benefit Package, which provides coverage for chiropractic care, a benefit not offered by Medicaid or FHP. Should CMS guidance require that the Medicaid benchmark offer all benefits offered through an EHB option, New York would at a minimum have to add a chiropractic benefit to its Medicaid benchmark plan. The rehabilitative/ habilitative benefit under FEHBP is slightly more generous (75 visits per year for any combination of physical therapy, occupational therapy and speech, compared with a limit of 20 per year for each under Medicaid). New York's Medicaid program does not provide coverage for "medical care, services and supplies [that] are … furnished solely to promote fertility."[17] FEHBP covers infertility treatments but not assisted reproductive technology. A more detailed review would be necessary to determine whether New York would have to add services to its Medicaid benefit in this area.

3.2 Current Utilization Patterns

An examination of the utilization patterns of individuals currently enrolled in the New York Medicaid program enhances our understanding of what utilization will look like for the benchmark population post-2014. Most of the people who will be covered through the benchmark are already eligible for public coverage. Reviewing the utilization experience of certain eligibility categories in the current Medicaid program helps to identify those benefits that are used by a large number of members, which is useful information when evaluating benchmark alternatives.

In thinking about the population that will be covered by the benchmark, we look at the experience of a subset of the adult Medicaid population. This subset includes non-dually eligible Medicaid individuals between the ages of 21 and 64, FHP parents, and FHP childless adults. The Department of Health Office of Quality and Patient Safety provided utilization data for these groups for calendar year 2010. This represents a cohort of 1,174,000 individuals.

3.3 Current Utilization by Benefit

Table 4.2 shows the number of individuals using a given benefit and the percentage of total enrollees using that benefit over the course of the year.

TABLE 4.2: UTILIZATION OF SELECT MEDICAID BENEFITS

Service	Unique Enrollees	% Using Benefit
Home Health	6,117	0.93%
Bariatric Surgery	708	0.06%
Mental Health – Inpatient	5,217	0.44%

Mental Health – Outpatient	68,275	5.81%
Substance Use Disorder – Inpatient	7,848	0.67%
Substance Use Disorder – Outpatient	48,987	4.17%
Prescription Drugs	817,995	69.66%
Over-the-Counter Drugs	370,087	31.52%
Physical Therapy	74,638	6.36%
Occupational Therapy	5,697	0.49%
Speech Therapy	1,017	0.09%
Dental Care	382,435	32.57%
Skilled Nursing Facility	330	1.48%

We note that since the long-term care benefits (skilled nursing and home health) are not offered under FHP, the percent of the eligible group actually using the benefit is limited to the experience of the Medicaid cohort for those two benefits.

These data provide a useful perspective for evaluating the various benchmark options. Differences in prescription drug benefits, utilized by almost seven in ten beneficiaries, will have far greater consequences for enrollees than differences in long-term care services, utilized by less than one percent of the population. Differences in dental coverage will also have a material impact on access to care for those covered by the benchmark. Behavioral health utilization on the inpatient side is very low, with less than one percent of beneficiaries utilizing those services. Outpatient behavioral health services are more heavily utilized, with 4 percent to 6 percent of beneficiaries utilizing those benefits. Similarly, more than 6 percent of beneficiaries utilize physical therapy over the course of the year, so a benchmark plan that places limits on physical therapy (PT) benefit could create access problems. While we do not have data on the number of beneficiaries whose use of PT rose above plan threshold limits, we do know the mean number of PT visits per person was 8.2.

4 Policy Considerations for Benchmark Options

In assessing the policy implications of each of the four Medicaid benchmark options, we address the effect on benefits for current populations of each option. In general, we use the existing coverage pattern in New York as a baseline for comparison.

It is important to note that an assessment of the overall financial effect of the ACA in New York is beyond the scope of this analysis. This report does not include an actuarial analysis of the benchmark population, nor does it include changes in program caseload.

4.1 Medicaid as a Benchmark Option in New York

New York can choose to provide its current Medicaid benefit package as the benchmark.[18] It is the most comprehensive option from a benefits perspective. It would allow for continuity of coverage for those individuals currently enrolled. It would provide equity of coverage between Medicaid and FHP, as well as for the new enrollees coming into the program. It would assure that all the health care needs of the population are met. A complete description of the New York Medicaid benefit is included as Appendix C.

A single benchmark benefit has the advantage of administrative simplicity in determining eligibility and administrating benefits. It also assures continuity of coverage for individuals whose eligibility may change based on changes in income. Low-income populations experience a high degree of income volatility, which can lead to changes in program eligibility. To the extent that the state offers a single benefit package across all its public coverage programs, changes in eligibility will not affect utilization or disrupt provider relationships and continuity of care. The state would be able to address eligibility shifts between programs in a way that is invisible to the beneficiary—it would be the source of funding for their coverage that changes, not their program enrollment or benefits.

An additional consideration is coverage for individuals who are considered "medically frail" under the ACA, and therefore exempt from benchmark coverage. Recent CMS guidance clarifies who is considered medically frail, providing a broadened definition that encompasses all people with disabilities, including disabling mental disorders.[19] This group must be allowed to move from benchmark coverage to full Medicaid coverage as their health care needs increase. Using Medicaid as the benchmark benefit relieves the state of the need to move individuals across program eligibility. It also provides a financial benefit to the state by allowing high-need individuals to remain in benchmark coverage, where the state receives an enhanced federal match, rather than moving to a current Medicaid eligibility category with a lower FMAP.

4.1.1 Access and Benefits

If current Medicaid becomes the benchmark, individuals currently enrolled in FHP would become eligible for certain long-term care services that they currently do not receive. Given the rapid increase in the use of home care services over the last decade, especially personal care services, the state has a well-founded concern about expanding eligibility for those benefits. To the extent that demand for personal care services can be provider-induced, that concern is legitimate. Individuals currently enrolled in FHP do not currently have access to personal care services, and it is hard to determine what impact that has on their well-being. It is important to note the very low utilization of long-term care services among the current Medicaid population. As shown in Table 4.1, less than 1 percent of this group of beneficiaries utilizes any kind of home care, including personal care. Although the state Medicaid program continues to experience increases in the utilization and cost of personal care, it does not appear that this population that is driving those increases. Expanding comprehensive long-term care services to this population is not likely to generate a large increase in the utilization of those benefits.

Individuals currently eligible for FHP would also gain access to over-the-counter drugs. This is not an insignificant enhancement as currently almost one-third of the Medicaid childless adult population uses the over-the-counter drug benefit.

Single adults with incomes above the current Medicaid eligibility level make up a large part of those who will be eligible for the Medicaid benchmark benefit. A review of FHP indicates that individuals with even slightly higher income generate lower health care costs. This is due in part to the limits to the FHP benefit package, but it is also because of different patterns of utilization. Even a slight increase in income changes the utilization profile of the beneficiary, leading to lower cost. While we cannot quantify those differences within the context of this analysis, a study by the United Hospital Fund[20]

provides one point of comparison. They estimate that the annual cost of coverage for a non-disabled, non-elderly individual currently eligible for coverage but not enrolled in Medicaid would be 40 percent less than the average non-disabled, non-elderly Medicaid enrollee. Another large share of individuals who will be part of the benchmark population includes those who are currently eligible for public coverage, but not enrolled. These individuals are likely to be healthier than those who have chosen to enroll and to maintain coverage. Other research by the United Hospital Fund compared individuals who were eligible for public coverage but uninsured with their counterparts who enrolled in Medicaid. They found that the eligible but unenrolled adults were more likely to be younger, working, and in better health.[21]

4.2 Family Health Plus as a Benchmark Option in New York

FHP is a benefit package that has been used by a large number of New Yorkers over the last decade, providing a comprehensive set of benefits. While it does not have all the long-term care benefits available through Medicaid, those with significant long-term care needs have the option of obtaining Medicaid through spend-down and other eligibility provisions.

This option retains an element of administrative complexity as the state would continue to provide Medicaid benefits to those who are not part of the Medicaid benchmark group, and will remain in Medicaid, requiring that the state manage two distinct programs within the Medicaid agency. It also requires the state shift some individuals currently covered under Medicaid into the FHP benchmark program, and reduce their benefits. Some of those individuals with higher health needs will need assistance to identify other pathways to full Medicaid eligibility, either through a different categorical eligibility, through the "medically frail" exemption, or through spend-down. While federal rules allow a state to enroll individuals into the benchmark using the MAGI eligibility criteria while pursuing alternative Medicaid eligibility through non-MAGI eligibility, this creates a burden both on the state and on the individual applicant.

4.2.1 Access and Benefits

The principal differences between the FHP benefit package and the standard Medicaid benefit package is in the areas of behavioral health and long-term care services. In FHP, behavioral health services, including mental health and substance use disorders, have an annual limit of 30 inpatient days and 60 outpatient visits. Detoxification services are not included in those limits. Home health services are limited: personal care and private duty nursing are not covered, and permanent nursing home stays are not covered. Non-emergency transportation is limited to beneficiaries under age 21. Experimental treatment is not covered.

If New York adopts FHP as its Medicaid benchmark, a number of people currently enrolled in Medicaid will lose access to some benefits. However, while the current FHP behavioral health benefits are more restrictive than Medicaid, the mental health parity requirement under the ACA requires that those benefit limits be eliminated. Differences in long-term care will remain. Given the very low utilization of long-term care services among the Medicaid population representing benchmark eligibility, this is not likely to cause significant access-to-care issues for this population. A review of utilization of home care in this population shows a mean of 5 visits per user, well below the 40 visits per year covered by FHP.

(Note this does not address the question of how many FHP beneficiaries hit the 40-visit limit). While FHP currently does not provide coverage for non-emergency transportation, imposing a potentially significant access barrier to all health services, that benefit is required under the ACA benchmark definition.

4.3 Different Benchmark Options for Different Sub-Populations

Federal guidance has indicated that states may choose more than one Medicaid benchmark plan as long as the population to which the benchmark is related is clearly defined. This option may be attractive in New York, where benchmark-eligible populations already receive different benefit packages. New York could continue to cover currently enrolled populations with essentially the same benefit package (with the caveat that *every* benchmark must meet the EHB test).

The multiple benchmark option proposed here would extend current program eligibility forward. It would continue to provide the Medicaid benefit to individuals who are currently eligible for Medicaid (whether they are currently enrolled or not). It would continue to provide the FHP benefit to those currently eligible for FHP (whether they are currently enrolled or not). Finally, it would provide the FHP benefit to the newly eligible, because their income (100 percent to 133 percent of FPL) would put them in the FHP-eligible category. This option would allow New York to continue providing current beneficiaries with the same benefits they are currently receiving. It does not, however, provide the administrative simplicity that a single benchmark would provide, but the state has been operating FHP in parallel with Medicaid since FHP was established in 2001 and has proven that it has the systems and administrative capacity required.

Having multiple benchmark options adds a level of complexity to program administration. As an individual's income shifts, they will be required to move between programs. Additionally, the "medically frail" exemption from benchmark coverage requires the state to develop a mechanism to move individuals to full Medicaid coverage should they develop a disabling condition and their health care needs increase.

4.3.1 Access and Benefits

The multiple benchmark option represents the least change for New York. Current enrollees in public coverage would continue to receive the benefits they are currently receiving. It is reasonable to presume that individuals currently eligible but not enrolled in public coverage have health care needs that are no higher than individuals who are already enrolled; in fact, it is likely that their health care needs are lower, which would help to explain why they have not enrolled. The expansion in eligibility to the newly eligible group would finally provide parity in eligibility between parents and childless adults. Those parents have found the FHP benefit adequate to meet their health care needs, and it is likely that the childless adults at those same income levels, who would likely have similar demographic characteristics, would have the same experience.

4.4 A Commercial Plan as a Benchmark Option in New York

As discussed in Section 4.2, in reviewing the benchmark benefit options available to the state, we identified differences in benefits attributable to differences in visit limits or to the fact that a benefit is

not offered at all by at least one of the options. We also noted where benefits are required by the ACA but not included by a benchmark (notably, EPSDT standards and mental health parity). We did not include differences in cost sharing across the options, as cost-sharing requirements are not walked over from the private insurance market to the Medicaid benchmark program.

4.4.1 Federal Employee Plan: Blue Cross Blue/Shield Standard Option

Federal Employee Health Benefits Plans include the Blue Cross/Blue Shield Standard Option and the Basic Option, which have the same covered benefits, as well as the Government Employees Health Association plan option. This analysis reviewed the Blue Cross/Blue Shield plan because it represents the largest enrollment. The federal employee plan includes many limitations in its coverage. Many benefits are capped—among them, home health services and rehabilitative services. Preventive care visits are limited to one per year, which may run counter to the mandated ACA preventive care benefits. Prior approval is required for a number of services, including bariatric surgery and transplant services. All behavioral health services have a precertification process and, in the case of outpatient care, approval is for a specified number of visits, after which time approval must be renewed. In some cases a benefit is offered only if it is related to injury or illness. Examples of this include vision care, audiology and podiatry. The federal employee skilled nursing benefit is offered only as a secondary benefit to individuals with Medicare Part A. Some services are excluded from coverage, including experimental and investigational treatment and personal care services. No coverage is available for abortion (except to save the life of the mother, or in cases where the pregnancy is the result of rape or incest).

4.4.2 State Employee Plan: NYSHIP Empire Plan

The New York state employee benefit plan with the largest enrollment is the NYSHIP Empire Plan. NYSHIP Empire Plan is a more robust plan than the federal employee plan, but it is not as comprehensive as the Medicaid benefit. All preventive care services mandated by the ACA are covered. The plan contains limits on home health services based on medical necessity criteria rather than a visit limit. Dental care is covered through a separate plan, but since all employees must enroll in that plan, it is considered part of the Empire Plan coverage. Skilled nursing care is covered only as an alternative to an inpatient stay. Second opinions are limited to cancer diagnoses. Prior approval is required for certain diagnostic imaging services. Certain services are not covered, including experimental and/or investigational treatment. It is hard to determine whether some services are covered or not, as they are not mentioned in any of the material that we reviewed. These include HIV testing, and bariatric and transplant surgeries.

4.4.3 HMO Plan: HIP Prime

The largest non-Medicaid HMO plan in New York is HIP Prime, part of Emblem Health. The HMO benefit offered through HIP Prime is particularly rich in wellness care—offering smoking cessation, a special Healthy Beginnings prenatal program, as well as discounts for weight loss programs and hearing aids. Eye exams and glasses are covered, as is dental care. Outpatient behavioral health services are covered as long as they are in-network. Second opinions are limited to cancer diagnoses. Abortion services are covered. It is unclear whether HIV testing is covered. Many services are covered but require prior approval, including home health services, skilled nursing, rehabilitative services, inpatient behavioral

health services, and certain diagnostic imaging services. Emblem Health does not provide coverage for experimental or investigational treatment.

4.4.4 Implications of a Commercial Benchmark

Using a commercial benchmark would be a significant change in coverage for individuals currently enrolled in New York's public programs. It would also create a new administrative challenge, as the state would have to construct an entirely new benefit package. It would also require that the state continue to operate two different benefits packages within the Medicaid program, which also carries the consequent churning issues. Should New York select a commercial benchmark that provides substantially fewer benefits than Medicaid, as eligibility fluctuates between Medicaid and the Medicaid benchmark, individuals would experience sometimes dramatic changes in benefits and potentially in provider networks as well. The greater the difference in benefits, the greater the potential impact this would have.

4.4.5 Access and Benefits

Any of the commercial benchmarks would provide a less robust benefit package. All benchmark populations that are currently eligible for public coverage would lose some benefits. It is unclear whether New York would choose to impose the utilization management approaches that are common in the commercial benchmarks, such as prior approval, pre-certification and restricted drug formularies. Including these practices would generate cost savings but reduce access to care; allowing the current Medicaid utilization management approaches could lessen the cost savings but mitigate the impact on access. This is a particular concern with prescription drugs, as utilization of prescription drugs is high (70 percent of current Medicaid beneficiaries who will fall under benchmark coverage utilized the drug benefit in 2010, see Table 4.1), and spending for prescription drugs is high.

The commercial benchmarks do offer some services that are not covered through Medicaid. Chiropractic services are offered by all three commercial benchmark options. Acupuncture is provided through the FEHBP. Assisted reproductive technology is not a Medicaid-covered benefit, but is provided by the Empire Plan. Should New York choose one of the commercial options, those services would be a part of the benefit package.

5 Children ages 19-20

The ACA requires that all children under age 20 receive all services provided through the Early and Periodic Screening, Diagnostic and Treatment program (EPSDT). EPSDT covers not only preventive and primary health care but comprehensive coverage for conditions that affect growth and development. EPSDT ties coverage to medical need based on a child's individual condition and requires coverage consistent with the goal of ensuring healthy child development. When looking at the 19- and 20-year old population, it is hard to know what services might be required that fall within the broad scope of EPSDT. Both FHP and commercial plans do impose limits on physical, occupational and speech-related therapies which would be prohibited under the EPSDT standard. Limits on hearing and vision services, which exist in all of the commercial plans, would also be proscribed. We conclude that in order to be compliant with ACA regulation, this cohort should be provided the current Medicaid benefit.

6 Conclusions

The Medicaid expansion established by the ACA provides New York the opportunity to tailor the Medicaid benefit to different eligibility groups. For those individuals who are newly eligible for public coverage any benefit selected will leave them better off than being uninsured. The state needs to consider the clinical needs not only of the newly eligible group, however, but also of groups currently covered, and what a reduction in benefits might mean. Two of the options available to New York leave no groups worse off than they are under the current benefit structure, and leave some groups better off. Offering the current Medicaid benefit to all coverage groups would mean no change for those currently enrolled in Medicaid, and better coverage to all other groups. Providing the multiple benefit option would leave everyone currently enrolled with their same level of coverage, and the newly eligible childless adults with a benefit package comparable to the currently eligible parents at the same income level. Two of the options would lead to an erosion in benefits for some groups. A commercial benefit would leave all coverage groups currently eligible for benefits worse off in terms of the scope of benefits provided; only the newly eligible would receive enhanced benefits. Providing the FHP benefit to the benchmark population would lead to a reduced benefit package for the childless adults who are currently eligible for Medicaid in New York State; other currently eligible coverage groups would experience no change in their benefits, while the newly eligible group would receive the benefit package provided to other childless adults.

Providing a single benefit for all Medicaid beneficiaries, whether eligible through the benchmark or through standard eligibility criteria, has the advantage of administrative simplicity. One of the goals of the ACA is a seamless eligibility and enrollment system that integrates public and private insurance options. New York has stated its intent to provide a consumer-focused front door to health care coverage. Complexity deriving from offering multiple benefit packages does not only affect state administrative costs, it also affects consumers and health plans. A single Medicaid benefit would allow for a simpler eligibility determination process, as well as making the program easier for enrollers to explain and for consumers to understand. From a cost perspective, while parents enrolled in the Medicaid benchmark population will continue to receive their current federal match, this option presents the state with an opportunity to receive a higher match for childless adults, including those with special health care needs or who are medically frail, since these individuals would not be required to move to a category with a lower FMAP to receive increased medical services.

APPENDIX A

Medicaid Benchmark Population Buckets
Enrollment Status Pre- and Post-ACA Implementation

	Enrolled 2011	Eligible but Not Enrolled 2011	Newly Eligible	Enrolled 2014
Medicaid	455,700	226,000		681,700
FHP Parents	275,500	62,000		337,500
FHP Childless	78,800	39,000		117,800
Newly Eligible			77,000	77,000
Total Enrolled	810,000			1,214,000

Definitions:
Medicaid includes childless adults up to 79 percent FPL.

FHP Parents includes parents between 86 percent FPL and 133 percent FPL (note that parents are eligible for Medicaid up to 85 percent FPL; Medicaid parents are NOT part of the benchmark population).

FHP Childless includes childless adults between 80 percent FPL and 100 percent FPL.

Newly Eligible includes childless adults between 100 percent FPL and 133 percent FPL.

Notes:

Enrolled 2011. The total enrolled 2011 is provided by the Urban Institute estimate of the number of individuals currently enrolled in Medicaid and FHP who will become part of the benchmark population.[1] In order to distribute enrollment between these three groups we applied the proportion of enrollees categorized as Childless SN/Childless TANF compared with Parents FHP and Childless FHP from administrative data provided by NYS. That split is 56.3 percent Medicaid/34.0 percent Parents FHP and 9.7 percent Childless FHP.

Eligible but Not Enrolled 2011 The eligible but not enrolled numbers are taken from an Urban Institute HIPSM analysis prepared for NYS (September 12, 2012). They provide data on individuals currently eligible for coverage but not enrolled, their demographic (child, non-parent, parent) and whether they are eligible for standard or enhanced FMAP under the ACA benchmark benefit. In order to distribute enrollment of the expansion population (eligible but not enrolled and eligible for enhanced FMAP) between Medicaid and Family Health Plus we applied the proportion of enrollees categorized as Childless SN/Childless TANF compared with Childless FHP from administrative data provided by NYS. That split is 85 percent Medicaid/15 percent FHP.

Newly Eligible comes from the Urban Institute analysis.

[1] Fredric Blavin, Linda Blumberg, Matthew Buettgens. Estimated *New York State Medicaid Savings Under the Patient Protection and Affordable Care Act (ACA).* Urban Institute, March 2012.

Appendix B: Comparison of Benefits

To perform our review of the potential benchmark plans, HMA relied on various websites with summary of coverage documents for information on the state and federal employee benefit plans. These summary descriptions varied significantly in the level of detail provided on specific benefits and policy exclusions, with some documents providing fairly detailed information and others providing more limited summaries. To the extent the information was available, our review included an analysis of benefits described in the summary of coverage, the policy description of covered benefits, the definitions of benefits and covered providers, and the list of exclusions and services not covered by the plan. We also compared our findings with those reported in Milliman's report on Essential Health Benefits options for NYS.

Based on our review of the documents listed above, we developed a summary table of the benefits we identified as most likely to be included within the 10 broad categories of coverage required in EHB benchmark plans. The table below summarizes that information. If the plan documents clearly indicated that a benefit is provided, the table notes that the benefit is included. If we identified limitations or exclusions for that benefit, we included information describing the limitations. If the documents identified a specific exclusion that shows a benefit is not included, the table shows that no coverage is available for the benefit. In cases where we could not determine whether a benefit was covered or not because it was not mentioned in the material available for review, the benefit is left blank.

Comparison of Benefits for New York State Medicaid Benchmark Option

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
AMBULATORY SERVICES					
Primary Care	Covered	Covered	Covered	Covered	Covered
Specialty Care	Covered	Covered	Covered	Covered	Covered
Outpatient Surgery	Covered	Covered	Covered	Covered	Covered
Abortion	Covered if medically necessary.	Covered if medically necessary.	Life of the mother, rape or incest.	Covered	Covered
Sterilization	Covered	Covered	Covered	Covered	
Therapy Treatments (chemo, radiation)	Radiation and nuclear medicine are covered.		Covered	Covered	
Second Opinion	Covered	Covered	Covered	Covered	Covered for cancer diagnoses; covered in-network for all other.
Home Health Services	Covered	Up to 40 visits per year, typically encourage early hospital discharge.	Limited to 2 hours/day up to 25 visits/year. RN/LPN only.	Members are covered for medically necessary visits by nurses from accredited Home Care advocacy Program (HCAP) participating nursing agencies. Care must be prescribed by, and under the supervision of, a physician. The services rendered must be medically necessary and must require the skills of nursing care when that care is needed to manage medical problems of acutely ill patients.	Limited to 200 visits per year. Requires prior approval
EMERGENCY SERVICES					
Emergency Room	Covered	Covered	Covered	Covered	Covered in-network and out-of-network if medically necessary, if the member (or someone on his/her behalf) notifies the PCP within 48 hours, and the plan can move the patient to an in-network provider as soon as it is safe to do so.
Ambulance	Covered if included in contractor's benefit package.	Covered	Covered	Covered	
HOSPITALIZATION					
Inpatient	Covered	Covered	Covered	Covered	
Bariatric Surgery	Covered only in CMS certified centers.		Limited to cases where BMI is over 40, or BMI is over 35 and a n existing comorbidity; AND failed attempts to lose weight under medical supervision.		
Transplant			Requires prior approval.		Requires prior approval.

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
MATERNITY AND NEWBORN					
Prenatal & Postnatal Care	Covered	Covered	Covered	Covered	Covered
Delivery & Inpatient Maternity	Covered	Covered	Covered	Covered	Covered
Newborn Inpatient	Initial PCP office visit for newborns: within two (2) weeks of hospital discharge.	N/A	• Healthy newborn visits and screenings (inpatient or outpatient). • Routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • Care of an infant who requires non-routine treatment only if infant is covered under a Self and Family enrollment. • Surgical benefits, not maternity benefits, apply to circumcision.	Covered	
Nutrition Counseling	Covered	Covered	Covered		
Midwifery Services	Covered	Covered	Covered	Covered	Covered
MENTAL HEALTH, SUBSTANCE USE DISORDER & BEHAVIORAL HEALTH TREATMENT					
Mental Health - Inpatient	Covered	Behavioral health services limit of 30 days per year (includes mental health and substance use disorders).	Covered, precertification required.	Covered (OptumHealth)	Covered, 30 inpatient days per year. Requires prior authorization.
Mental Health - Outpatient	Covered	Behavioral health services limit of 60 visits per year (includes mental health and substance use disorders).	Covered	Covered (OptumHealth)	Covered in-network, 30 outpatient visits per year.
Substance Use Disorder - Inpatient	Covered subject to stop loss.	Behavioral health services limit of 30 days per year (includes mental health and substance use disorders).	Covered, precertification required.	Covered (OptumHealth)	Covered. Requires prior authorization.
Substance Use Disorder - Outpatient	Carved out	Behavioral health services limit of 60 visits per year (includes mental health and substance use disorders).	Covered	Covered (OptumHealth)	Covered in-network, no referral needed.
Detoxification	Covered	Detoxification Services (Inpatient Detoxification and Inpatient or Outpatient Withdrawal Services) do not count towards behavioral health limits.	Covered	Covered (OptumHealth)	Covered, requires prior authorization.

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
PHARMACY					
Prescription Drugs	Covered	Covered	Covered-tiered benefit	Formulary-tiered benefit	Covered through an optional rider
Non-prescription Drugs	Covered when medically necessary.	Select over the counter drugs and vitamins necessary to treat an illness or condition.	Not covered.	Not covered.	Not covered.
REHABILITATIVE AND HABILITATIVE SERVICES and DEVICES					
Physical Therapy	Limited to 20 visits per year (except for under 21, developmentally disabled or TBI)	Limited to 20 visits per year	Limited to 75 visits per year for any combination of physical therapy, occupational therapy and speech therapy.	Covered, must be related to a hospitalization or surgery.	Limited to 90 days of inpatient care and 90 outpatient visits per year for any combination of physical therapy, occupational therapy and speech therapy.
Occupational Therapy	Limited to 20 visits per year(except for under 21, developmentally disabled or TBI)	Limited to 20 visits per year	Limited to 75 visits per year for any combination of physical therapy, occupational therapy and speech therapy.	Covered	Limited to 90 days of inpatient care and 90 outpatient visits per year for any combination of physical therapy, occupational therapy and speech therapy.
Speech Therapy	Limited to 20 visits per year(except for under 21, developmentally disabled or TBI)	Limited to 20 visits per year. Limited to conditions amendable to significant improvement within 2 months.	Limited to 75 visits per year for any combination of physical therapy, occupational therapy and speech therapy.	Covered	Limited to 90 days of inpatient care and 90 outpatient visits per year for any combination of physical therapy, occupational therapy and speech therapy.
Durable Medical Equipment	Covered	Covered	Covered	HCAP approved decives are covered.	Covered under an optional rider.
Prosthetics	Covered	Covered	Hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy.	May be covered.	Requires prior approval.
LABORATORY SERVICES					
Diagnostic Lab Tests	Covered	Covered	Covered	Covered	Covered
X-rays	Covered	Covered	Covered	Covered	Covered
Diagnostic Imaging (MRI, CT, PET)	Covered	Covered	Covered	Requires prior approval.	Requires prior approval.

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
PREVENTIVE SERVICES, WELLNESS SERVICES & CHRONIC DISEASE MANAGEMENT					
Preventive Care - Adults	Covered	Covered	Preventive care services for adults age 22 and older including the preventive services recommended under the Patient Protection and Affordable Care Act. Routine physical exams, including a history and risk assessment, chest X-ray, EKG, urinalysis, CBC, cholesterol tests and metabolic and general health panel tests annually Preventive screenings: • Pap smears • Mammograms • Stool tests for blood • Prostate specific antigen tests • Sigmoidoscopies • STD screenings • Genetic counseling in certain situations • Related office visits	General medical care includes routine and preventative adult care including gynecologic exams. All preventive care services mandated by ACA are covered.	Coverage offers many preventive health services to help reduce risk for certain diseases and conditions.
- *Routine Check-up*	Covered	Covered	One per year.		Covered
- *Immunizations*	Covered	Covered	Routine immunizations for adults age 22 and older [as licensed by the U.S. Food and Drug Administration (FDA)], limited to: • Hepatitis (Types A and B) for patients with increased risk or family history • Herpes Zoster (shingles) • Human Papillomavirus (HPV) • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus-diphtheria, pertussis booster (one every 10 years) • Varicella	• Influenza • Pneumonia • Measlesmumps- rubella (MMR) • Varicella • Tetanus • HPV(females; 19 – 26) • Herpes Zoster (shingles) for 55+	Routine immunizations are covered.

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
Routine Vision Care					
- *Eye exam*	Examinations for diagnosis and treatment for visual defects and/or eye disease are provided only as necessary and as required by the Enrollee's particular condition. Examinations which include refraction are limited to once every twenty four (24) months unless otherwise justified as medically necessary.	1 covered per year.	Eye examinations related to a specific medical condition are covered. Routine vision care is covered through an optional rider.	Not covered.	Eye examinations related to a specific medical condition are covered. Routine vision care is covered through an optional rider.
- *Eyeglasses*	Eyeglasses, medically necessary contact lenses, low vision aids and low vision services. Eye care coverage includes the replacement of lost or destroyed eyeglasses. Glasses will not be replaced more than once every 24 months unless there has been a change in percription or damage to the glasses.	Either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary; and one pair of medically necessary occupational eyeglasses.	Only in response to accident or • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition. Routine prescription	One pair of prescription eyeglasses or one contact lens and one eye examination are covered medical expenses per affected eye per cataract surgery.	Covered through an optional rider.
Audiology					
- *Hearing test*	Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations, as medically indicated.	Covered	Hearing tests related to illness or injury.	Hearing aids, including evaluation, fitting and purchase, are covered up to $1,500 per hearing aid, per ear, once every four years.	Discounts provided to TruHearing.
- *Hearing aid*	Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts. Batteries are covered only in Medicaid Fee-for-Service.	Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts. Hearing aid batteries are covered as part of the prescription drug benefit.	Covered, limited to $1,500 per ear every 3 years	Covered up to $1,500 per hearing aid, per ear, once every four years.	Discounts provided to HearUSA.
Nutritional Counseling	Nutrition counseling, with targeted outreach for diabetics and pregnant women.				

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
Dental Care	Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability. Orthodontic services are not covered.	Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care. *	Covered, 2 dental exams and cleanings per year.	Covered.	Emergency services are covered, routine services are not covered.
Smoking Cessation	Pregnant and post-partum women and for children and adolescents aged 10 to 21.	Counseling is covered for pregnant women; smoking cessation products, both prescription and OTC, are covered.	Online BCBS program, prescription drugs covered.	Prescription drugs covered.	Covered
Contraceptives	Drugs and supplies, including emergency contraception are covered when furnished or administered under the supervision of a physician, licensed midwife or certified nurse	Covered (except by Fidelis)	Prescribed drugs and devices are covered.	Drugs and devices are covered when dispensed in a doctor's office.	

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
HIV Testing and Counseling	HIV testing and pre-and post-test counseling when performed as part of a Family Planning and Reproductive Health encounter. STD diagnostic and treatment services. (Covered if included in Contractor's Benefit Package).	Covered	Screening only		
Podiatry					
- *Foot exam*	Covered when enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine care is not covered.	Routine footcare is not covered for those 21 years and older.	Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot is only covered for individuals under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	Routine foot care is not covered.	Routine foot care is not covered.
Orthotics	Covered	Covered	Covered	Members are covered for one prosthesis an and/or orthotic device per affected body part meeting an individual's functional needs.	Not covered.
Chronic Disease Management	Case management.		Covered	Covered	Covered

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE					
Primary and Preventive Care	Well child. Annual well adolescent preventive visits which focus on health guidance, immunizations, and screening for physical, emotional, and behavioral conditions.	N/A	Well Child Care up to age 22, including preventive services recommended under the Patient Protection and Affordable Care Act. These services include but are not limited to routine physical examinations, routine hearing tests, laboratory tests, immunizations, and related office visits, and nutrition counseling.	Covered	Well child visits are covered
- *EPSDT*	Covered	?			
- *Immunizations*	Covered	N/A	Covered	Covered	Covered
Routine Vision Care		N/A	Covered		
- *Eye exam*	Examinations for diagnosis and treatment for visual defects and/or eye disease are provided only as necessary and as required by the Enrollee's particular condition. Examinations which include refraction are limited to once every twenty four (24) months unless otherwise justified as medically necessary.	N/A	For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18.	Not covered.	Not covered.
- *Eyeglasses*	Eyeglasses, medically necessary contact lenses, low vision aids and low vision services. Eye care coverage includes the replacement of lost or destroyed eyeglasses. Glasses will not be replaced more than once every 24 months unless there has been a change in percription or damage to the glasses.	N/A			

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
Dental Care	Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability. Orthodontic services are not covered.	N/A	Covered, 2 exams and cleanings per year.	Covered.	Not covered.
Audiology					
- *Hearing test*	Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations, as medically indicated.	N/A	Covered		
- *Hearing aid*	Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts. Batteries are covered only in Medicaid Fee-for-Service.	N/A	Covered, $1,500 per year.	Children age 12 years and under are eligible to receive a benefit of up to $1,500 per hearing aid, per ear, once every two years when it is demonstrated that a covered child's hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child's hearing loss.	Not covered.
Early Intervention	Shall be coordinated.	N/A			

BENEFIT	Medicaid NY Medicaid Manged Care	Family Health Plus NY Family Health Plus	Federal Employee Health Insurance Coverage Blue Cross Blue Shield	State Employee Plan NYSHIP Empire	Commercial HMO HIP Prime
OTHER SERVICES					
Skilled Nursing Care Facility	Residential Health Care Facility Services: covered, except for individuals in permanent placement.	Permanent nursing home stays are not covered.	Only as a secondary benefit to individuals with Medicare Part A.	Covered only as an alternative to inpatient stay.	Requires prior approval.
Hospice	Carved out	Covered	Covered	Covered	Covered, 210 day limit.
Non-Emergency Transportation	Covered when transportation is essential in order for a MMC Enrollee to obtain necessary medical care and services which are covered under the Medicaid program.	Non-emergency transportation is not covered (unless patient is 19 or 20 and in the C/THP program).	Not covered		
Experimental and/or Investigational Treatment	Covered on a case by case basis.	Not covered	Not covered: Experimental or investigational procedures, treatments, drugs, or devices.	Not covered	Not covered: EmblemHealth will not provide coverage for any procedure or service, which in EmblemHealth's sole judgment is experimental or investigational or for rare diseases, unless required by an external appeals agent.

Appendix C: New York Standard Medicaid Package Benefits

Benefit	Description
Ambulatory Services Appendix K-3	Physician Services a) “Physicians’ services,” whether furnished in the office, the Enrollee’s home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician b) Physician services include the full range of preventive care services, primary care medical services and physician specialty
Emergency Services Appendix K-17	Emergency Services a) Emergency conditions, medical or behavioral, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment of such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person are covered. Emergency services include health care procedures, treatments or services, needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol. Emergency Services also include hospital emergency room observation services provide in a SDOH approved hospital emergency room observation unit that meets New York State regulatory operating standards and Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency, provided in accordance with protocols issued by the SDOH, when rendered in emergency departments.
Hospitalization Appendix K-1	Inpatient Hospital Services Inpatient hospital services, as medically necessary, shall include, except as otherwise specified, the care, treatment, maintenance and nursing services as may be required, on an inpatient hospital basis, up to 365 days per year (366 days in leap year). Among other services, inpatient hospital services encompass a full range of

Benefit	Description
	necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.
Maternity and Newborn Appendix K-5	Covered through ambulatory services and hospitalization benefits. In addition: Midwifery Services Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the Enrollee's home as appropriate. The midwife must be licensed by the NYS Education Department and have a collaborative relationship with a physician or hospital that provides obstetric services, as described in Education Law § 6951.1, that provides for consultation, collaborative management and referral to address the health status and risks of patients and includes plans for emergency medical OB/GYN coverage.
Mental Health, Substance Use Disorders and Behavioral Health Treatment Appendix K – 28-31	Mental Health Services a) Inpatient Services - All inpatient mental health services, including voluntary or involuntary admissions for mental health services. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the PHL. b) Outpatient Services - Outpatient services including but not limited to: assessment, stabilization, treatment planning, discharge planning, verbal therapies, education, symptom management, case management services, crisis intervention and outreach services, chlozapine monitoring and collateral services as certified by the New York State Office of Mental Health (OMH). Detoxification Services a) Medically Managed Inpatient Detoxification b) Medically Supervised Withdrawal

Benefit	Description
	i) Medically Supervised Inpatient Withdrawal ii) Medically Supervised Outpatient Withdrawal Chemical Dependence Inpatient Rehabilitation and Treatment Services a) Services provided include intensive management of chemical dependence symptoms and medical management of physical or mental complications from chemical dependence to clients who cannot be effectively served on an outpatient basis and who are not in need of medical detoxification or acute care. Outpatient Chemical Dependency Services a) Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs b) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs c) Outpatient Chemical Dependence for Youth Programs e) Buprenorphine and Buprenorphine Management
Prescription Drugs Appendix K-10	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas Effective October 1, 2011, medically necessary prescription and non-prescription (OTC) drugs, medical supplies, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider.
Rehabilitative and Habilitative Services and Devices Appendix K-12	Rehabilitation Services Rehabilitation services are provided for the maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Rehabilitation services include care and services rendered by physical therapists, speech-language pathologists and occupational therapists. Rehabilitation services may be provided in an Article 28 inpatient or outpatient facility, an Enrollee's home, in an approved home health agency, in the office of a qualified private practicing therapist or speech pathologist, or for a child in a school, pre-school or community setting, or in a Residential Health Care Facility (RHCF) as long as the Enrollee's stay is classified as a rehabilitative stay and meets the requirements

Benefit	Description
	for covered RHCF services as defined herein. Effective October 1. 2011, outpatient visits for physical, occupational and speech therapy are limited to twenty visits per calendar year. Limits to not apply to enrollees under age 21, enrollees who are developmentally disabled, and enrollees with traumatic brain iinjury. Habilitative services are not a covered benefit under the Medicaid managed care program; they are available to individuals enrolled in Home and Community-Based Services Waivers.
Laboratory Services Appendix K-8	Laboratory Services Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.
Preventive Services, Wellness Services and Chronic Disease Management Appendix K- 6	Preventive Health Services a) Preventive health services means care and services to avert disease/illness and/or its consequences. b) The Contractor must offer the following preventive health services essential for promoting health and preventing illness: i) General health education classes. ii) Pneumonia and influenza immunizations for at risk populations. iii) Smoking cessation counseling and treatment iv) Childbirth education classes. v) Parenting classes vi) Nutrition counseling, with targeted outreach for diabetics and pregnant women. vii)Extended care coordination, as needed, for pregnant women. viii)HIV counseling and testing. ix) Asthma Self-Management Training (ASMT) x) Diabetes Self-Management Training xi) Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency
Pediatric Services including Oral and Vision Care	EPSDT Services Child/Teen Health Program (C/THP) is a package of early and

Benefit	Description
Appendix K – 13 (EPSDT) Appendix K-19 (Vision Care) Appendix K – 25 (Oral Care)	periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905(a) of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance. Dental Services Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability. Orthodontic services are not covered. Eye Care and Low Vision Services Emergency, preventive and routine eye care services are covered. Eye care includes the services of ophthalmologists, optometrists and ophthalmic dispensers, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Eye care coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses must duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.

This description of current New York Medicaid benefits is taken from the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract dated August 1, 2011.

Endnotes

[1] Effective January 1, 2014, the ACA required states to adopt a consistent method for counting income based on an applicant's modified adjusted gross income (MAGI). The law specified that an income disregard in the amount of 5 percent FPL will be used to determine Medicaid eligibility based on MAGI; thus, the effective maximum income-eligibility threshold for such individuals in this new eligibility group will be 138 percent FPL. This report references the new income standard as 133 percent FPL for the purposes of consistency with the ACA. Certain groups are exempted from MAGI-based income eligibility standards, and states may continue to use pre-ACA income counting rules and asset tests for these groups.

[2] Recent proposed rules suggest that these plans be called Alternative Benefit Plans. See: Centers for Medicare & Medicaid Services. "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule." Federal Register / Vol. 78, No. 14

[3] Julie Stone, et al. *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA*. Congressional Research Service, April 2010.

[4] See: http://www.healthcare.gov/center/regulations/prevention/taskforce.html

[5] See: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/mmwr-adult-schedule.pdf

[6] Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. See: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf and http://www.hrsa.gov/heritabledisorderscommittee/SACHDNC.pdf

[7] Prior to the ACA, federal law required all full-service Medicaid managed care plans (meaning those that provide both medical and behavioral/substance abuse benefits) to comply with the federal mental health parity requirements found in the PHSA. This requirement applies to any full-service managed care plan, whether traditional Medicaid or based on a benchmark plan. The ACA expands certain of the federal mental health parity requirements to all Medicaid benchmark plans, including those not offered through full-service managed care plans. Specifically, the ACA requires any Medicaid benchmark-based benefit to comply with the parity requirements for treatment limitations and financial requirements. Treatment limitations are defined as "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." Financial requirements are defined as "deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit." The ACA therefore has the effect of expanding the requirement for compliance with certain substantial federal mental health parity requirements to all newly eligible Medicaid populations who will be enrolled under Medicaid benchmark plans. See Amanda Sarata. *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*. Congressional Research Service, December 2011 for a comprehensive discussion of mental health parity changes under the ACA.

[8] *Essential Health Benefits Bulletin.* Center for Consumer Information and Insurance Oversight, December 16, 2011

[9] Donna Frescatore, Executive Director, New York State Health Benefit Exchange, Letter to Gustavo Seinos, Center for Consumer Information and Insurance Oversight, October 1, 2012. New York State Department of Health.

[10] Cindy Mann, State Medicaid Director Letter #12-003, Center for Medicaid and CHIP Services, November 20, 2012.

[11] Jocelyn Guyer and Julia Paradise. *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries*. Kaiser Family Foundation, August 2010.

[12] Deborah Bachrach and Emily Lee. *Designing Medicaid Benchmark Benefits for New Adult Beneficiaries*. Bloomberg BNA Health Care Policy Report, 2012.

[13] Urban Institute HIPSM analysis for New York State, September 12, 2012.

[14] Ibid.

[15] FHP income eligibility for parents currently goes to 150 percent FPL, while the newly expanded Medicaid income eligibility only goes to 133 percent FPL. Therefore, FHP parents between 133 and 150 percent FPL will not be part of the new adult Medicaid category. The state may wish to maintain FHP for this group under federal provisions for optional Medicaid coverage (and continue to receive the state's 50 percent base FMAP); transition this population into a qualified health plan through the Exchange, or create a Basic Health Program (BHP), as authorized by the ACA, which allows states to provide BHP coverage to individuals between 133 percent and 200 percent FPL.

[16] Cindy Mann, State Medicaid Director Letter #12-003, Center for Medicaid and CHIP Services, November 20, 2012.

[17] 18 NYCRR Section 505.1 - Scope of medical assistance.

[18] See Appendix B for a description of New York's current Medicaid benefits.

[19] Centers for Medicare & Medicaid Services. "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule." Federal Register / Vol. 78, No. 14

[20] Michael Birnbaum, Kathryn Haslanger, et al. *Estimating the Cost of Enrolling New York City's Eligible but Uninsured Adults in Medicaid*. United Hospital Fund, 2004.

[21] Danielle Holahan, Allison Cook, Leslie Powell. *New York's Eligible but Uninsured.* United Hospital Fund, 2008.