IOWA HBE PMO PROJECT

MEDICAID BENCHMARK BENEFITS

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CSG Government Solutions

180 N. Stetson
Suite 3200
Chicago, IL 60601

Phone: 312.444.2760
Fax: 312.938.2191
www.CSGdelivers.com

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1. SUMMARY

This report provides Iowa with information relevant to the decision it faces regarding selection of a Medicaid benchmark benefit. It begins with a review of the scope of benefits currently provided under Iowa's Medicaid program. It then examines three alternative Medicaid benchmark benefits that may be considered. It provides an analysis of differences in benefits from the perspective of health care and access, from the perspective of administrative complexity, and from the perspective eof cost. While final guidance on the Medicaid benchmark benefit has not been released, this report provides a framework for thinking about the selection of a Medicaid benchmark.

2. INTRODUCTION

2.1 Purpose

This report examines the options available to Iowa in selecting a Medicaid benchmark benefit. It reviews the current Medicaid benefit package, and compares it with options for a Medicaid benchmark benefit as defined by the ACA. It discusses the implications of the selection of a Medicaid benchmark from a scope of benefits perspective, and from the perspective of administrative complexity to the Iowa Medicaid program. It provides a framework for understanding the cost of benchmark options, and potential savings based on those options, relative to overall Medicaid program costs.

2.2 Background

The ACA establishes a new Medicaid eligibility group and mandates coverage for that group by 2014. The intent of the expansion is to assure Medicaid eligibility to all individuals whose income falls below 138 percent of the federal poverty level (the leigislation establishes eligibility at 133 percent, with a five percent income disregard). The new eligibility group fills in gaps in existing Medicaid by expanding coverage to those who fall outside of traditional categorical eligibility. It is largely defined by who it is not: it is not individuals over 65, it is not pregnant women, it is not individuals eligible and/or enrolled in Medicare, it is not any Medicaid-defined categorically needy. What it is in essence is non-disabled childless adults under age 65, and parents above the state's 1996 welfare level. The ACA does not require that states offer this newly eligible group its current Medicaid benefit; rather, it allows states to provide this newly eligible population with a Medicaid benchmark benefit.

The law provides states with significant flexibility in defining their benchmark benefit. The concept of a Medicaid benchmark benefit was established under the Deficit Reduction Act of 2005 as a way of allowing states to modify and narrow Medicaid coverage for certain populations. States were given authority to limit coverage to one of several named benchmarks. These include:

- The standard Blue Cross/Blue Shield preferred provider option for federal employees in the state;
- A health plan that is offered and generally available to state employees in the state;
- Coverage offered by the largest commercial, non-Medicare HMO in the state; or
- Secretary-approved coverage.

The ACA revises the DRA definition of benchmark benefits in several key ways. The ACA requires that Medicaid benchmark benefit packages must provide at least the ten categories of Essential Health Benefits described in the ACA.[1] It further specifies that the benchmark plans must comply with federal laws regarding mental health and substance abuse parity, and must offer family planning services and supplies. The ACA also requires Medicaid benchmarks to provide EPSDT to all enrollees under 21 years of age.

Federal guidance regarding the Medicaid benchmark benefit is pending. It is important to note, however, that in a recent bulletin on the Essential Health Benefit, CMS explicitly indicated that a state

[1] ACA §2102(c)

may choose to offer its standard Medicaid benefit as its benchmark under the Secretary-approved coverage option.[2]

In fact, this option available to Iowa helps to defines the nature of this report. In a state option paper entitled "Benchmarking – Impact on Eligibility Process Design," state staff outlined ACA rules associated with Medicaid benchmark coverage generally, and recommended that the state maintain its standard Medicaid benefit as its Medicaid benchmark benefit for the expansion population. The option paper largely addresses the significant operational challenges associated with defining and managing a separate benefit package.

However, there are financial implications to the decisions that are important to review as well. In essence, the question is how much additional spending the state would be taking on as a result of a decision to offer its newly eligible benchmark-eligible population the full Medicaid benefit. It is worth noting at the outset two points that frame the question, involving the population that may be required to enroll in benchmark coverage and the basic federal financing arrangement for the expansion population.

2.2.1 The Benchmark-Eligible Population

Certain (commonly higher-cost) populations are "exempted" from mandatory enrollment in a benchmark benefit and must be enrolled in the traditional Medicaid benefit package. These groups include pregnant women; blind or disabled individuals, regardless of SSI eligibility; dual (Medicaid/Medicare) eligibles; terminally ill individuals receiving benefits for hospice care; individuals eligible based on institutionalization; and medically frail and special medical needs individuals.

These "exempted" populations are also more typically high-cost, high-utilization populations. As a result, the financial impact of defining and requiring enrollment in a different benchmark benefit package is limited insofar as it does not include additional state spending for these relatively more complex populations.

2.2.2 Federal Financing of the Expansion Population

In order to ease the financial burdens on states, the federal government is financing much of the cost of care for the expansion group. The federal government will initially cover all costs related to the expansion group, gradually tapering off to a 90 percent match. The formula for federal matching rates for the expansion population is as follows:

- 2014-16 100%
- 2017 95%
- 2018 94%
- 2019 93%
- 2020/beyond 90%

One implication of this financing scheme is that the impact to the state of any additional spending as a result of offering more generous traditional Medicaid benefits to otherwise benchmark-eligible individuals is limited. For the first three years of implementation, all spending for the expansion population is federal, regardless of the benchmark option selected. In the long run the state share of

[2] *Frequently Asked Questions on Essential Health Benefits Bulletin*, February 17, 2012

the difference between Medicaid benchmark spending and the traditional package will not exceed 10 percent. Put another way, there is no state fiscal impact of Iowa choosing to utilize its traditional benefit as the Medicaid benchmark package until 2017. At that point the state share of the cost of services for the Medicaid expansion population will grow from 5 percent to 10 percent between 2017 and 2020. Because the state has to provide at least minimum benchmark coverage to the expansion population, the state fiscal impact of Iowa chosing to provide traditional Medicaid benefits to that population is 5-10% of the difference in cost of those traditional benefits compared to a minimum benchmark plan.

2.3 Data Sources

Information on Iowa's Medicaid benefits was largely derived from the Medicaid provider manuals. The Iowa Medicaid program does not have a compilation of covered benefits except through provider manuals that describe the benefits for which a given provider can bill the Iowa Medicaid program. Discussions with individuals in the Iowa Insurance Division and the Department of Health Services, provided important clarification of current benefits.

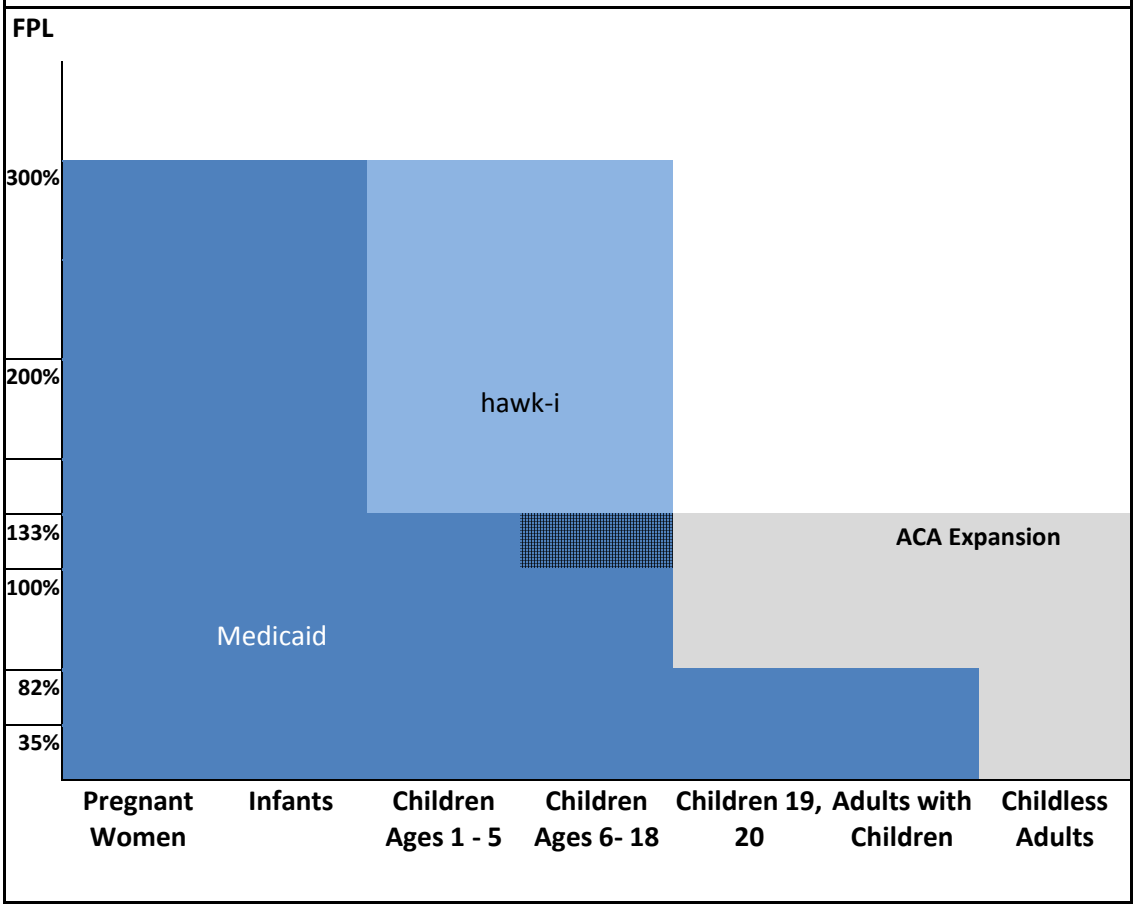
To perform our review of the potential Medicaid benchmark plans, HMA relied primarily on documents provided by the state for the largest commercial HMO, and various websites with summary of coverage documents for information on the state and federal employee benefit plans. These summary descriptions 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. It is important to note that these sources were not organized uniformly, and did not track with the ten categories of benefits defined by the ACA's essential health benefit. In some cases benefits are described by what is included; in other cases in terms of what is excluded. It is also important to note that just because a certain service is not described in plan documents, it does not mean that it is not covered. It is possible that except in cases where a benefit is specifically excluded, all services are covered as long as they meet medical necessity criteria. The fact that a service is not mentioned does not necessarily mean that it is not covered.

Information about Iowa's current Medicaid eligibility levels was provided by Iowa IME.

3. ELIGIBILITY FOR PUBLIC COVERAGE AND THE EXPANSION POPULATION

In order to understand the population that will be covered by the Medicaid benchmark, it is helpful to understand who is currently covered under Iowa's public programs. Figure One provides a diagram of current Medicaid and CHIP eligibility in Iowa by population/age group and income level. It also indicates the population newly eligible for Medicaid as a result of the ACA expansion. This diagram provides a useful way to identify the population that will be covered by the benchmark benefit. Iowa currently provides coverage, through Medicaid or through Iowa's CHIP program, hawk-i, to pregnant women and to children up to 18 years to 300 percent of the federal poverty line (children ages 6 – 18 between 100 and 133 percent FPL are covered through Medicaid if they have other health insurance, and through CHIP if they are uninsured). Coverage for children 19 and 20 years old, and to parents, is limited to those up to 82 percent FPL. Iowa does not cover single adults in its Medicaid program, although IowaCare covers adults aged 19-64 with incomes up to 200 percent FPL.

Figure One
Current Iowa Medicaid and CHIP Eligibility
and Medicaid Expansion under the Affordable Care Act (ACA)



4. Comparison of Benefits for Benchmark Coverage

4.1 Current Iowa Medicaid Benefits

Table 1 provides a detailed description of benefits offered through the Iowa Medicaid program. HMA worked closely with staff from Iowa DHS to review assumptions underlying the chart and assure that the benefits description was comprehensive. We conducted an extensive review of the Iowa Medicaid Provider Manual, including a detailed examination of 35 separate manuals, to identify and catalog the current Medicaid benefit package. Particular attention was paid to details about benefit-specific limitations in duration and/or scope. Appendix A provides a list of the provider manuals reviewed in developing the description of the current Medicaid benefit.

The chart is organized into the categories of benefits identified by the Essential Health Benefit. These categories are: ambulatory services; emergency services; hospitalization; maternity and newborn; mental health, substance use disorders and behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive services, wellness services and chronic disease management; and pediatric services including oral and vision care. Using the categories supplied by the EHB provides a useful framework for comparing benefits, both in discussions about the Medicaid benchmark, and also when comparing Medicaid and Medicaid benchmark benefits with the EHB offerings of Qualified Health Plans through the health exchange.

The ACA requires that a Medicaid benchmark benefit provide at least the 10 categories of benefits required as Essential Health Benefits. It is quickly apparent that Iowa's current Medicaid benefit easily meets the EHB standard.

4.1.1 Table One: Iowa Medicaid Benefits

Ambulatory Services	
Primary Care	✓
Specialty Care	✓
Outpatient Surgery	✓
Abortion	Limited to cases where: (1) the life of the pregnant woman would be endangered if the fetus was carried to term, (2) the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness, (3) the pregnancy resulted from incest.
Sterilization	✓
Chiropractic	Limited to hands-on manual manipulation of the spine for symptomatology associated with spinal subluxation.

Therapy Treatments (chemo, radiation)	✓
Second Opinion	✓
Home Health Services	Intermittent services (2-3 hours, 2-3 times/week), including skilled nursing care, home health aide. Private duty nursing and personal care for children with special needs.
Emergency Services	
Emergency Room	✓
Ambulance	Covered for emergency transportation and for non-emergency transportation when medically necessary.
Hospitalization	
Inpatient	✓
Bariatric Surgery	Requires prior authorization from the IME Medical Services Unit
Transplant	♦ Kidney, cornea, skin, and bone transplants. ♦ Allogeneic bone marrow transplants for specified conditions. ♦ Autologous bone marrow transplants for treatment of specified conditions. ♦ Liver transplants require preprocedure review by the IME Medical Services Unit. ♦ Heart transplants require preprocedure review by the IME Medical Services Unit. Artificial hearts and ventricular assist devices are not covered. ♦ Lung transplants for members having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME Medical Services Unit. Heart-lung transplants are not covered.
Maternity and Newborn	
Prenatal & Postnatal Care	✓
Delivery & Inpatient Maternity	✓
Newborn Inpatient	✓
Nutrition Counseling	For high-risk pregnancies.
Midwifery Services	✓
Mental Health, Substance Use Disorder and Behavioral Health Treatment	
Mental Health - Inpatient	✓
Mental Health -	♦ Individual and group psychotherapy

Outpatient	♦ Drugs and biological products ♦ Family counseling services ♦ Partial hospitalization services designed to reduce or control a member's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the member's level of functioning, and minimize regression. ♦ Occupational therapy services ♦ Activity therapies ♦ Day treatment services designed to assist in restoring, maintaining, or increasing levels of functioning, minimizing regression and preventing hospitalization.
Substance Use Disorder - Inpatient	✓
Substance Use Disorder - Outpatient	✓
Detoxification - Inpatient	✓
Detoxification - Outpatient	✓
Prescription Drugs	
Prescription Drugs	Excluded Drugs: ♦ Drugs used to cause weight gain or weight loss. ♦ Drugs used for cosmetic purposes or hair growth. ♦ Drugs used for symptomatic relief of cough and colds. ♦ Drugs used to promote smoking cessation (see exception below). ♦ Drugs used for fertility purposes or for male sexual enhancement. ♦ Drugs prescribed for a use other than the drug's medically accepted use. ♦ Drugs classified as less than effective by CMS. Prior authorization is required for many other drugs.
Non-prescription Drugs	✓
Contraceptives	Prescription and non-prescription
Enteral Formula	Requires prior authorization and on-going certification.
Rehabilitative and Habilitative Services and Devices	
Physical Therapy	Coverage mirrors Medicare coverage. No specific limits. Medical necessity criterion. Reviewed every 30 days.
Occupational Therapy	Coverage mirrors Medicare coverage.

	No specific limits. Medical necessity criterion. Reviewed every 30 days.
Speech Therapy	Coverage mirrors Medicare coverage. No specific limits. Medical necessity criterion. Reviewed every 30 days.
Durable Medical Equipment	Generally follows Medicare coverage criteria. Prior authorization is required for the following items: ♦ Augmentative communication systems (speech-generating devices) ♦ Automated medication dispensers ♦ Enclosed beds ♦ Enteral products, feeding pumps, and supplies ♦ External insulin infusion pumps ♦ Oral nutritional products ♦ Vest airway clearance systems
Prosthetics	✓
Cardiac Rehab	✓
Pulmonary Rehab	✓
Laboratory Services	
Diagnostic Lab Tests	✓
X-rays	✓
Diagnostic Imaging (MRI, CT, PET)	✓
Preventive Services, Wellness Services and Chronic Disease Management	
Preventive Care - Adults - Routine Check-up - Immunizations	✓
Routine Vision Care - Eye exam - Eyeglasses	✓ One per year Every 2 years
Audiology	

- Hearing test - Hearing aid	✓ ✓
Nutritional Counseling	Limited to certain diagnoses, i.e. diabetes.
Dental Care - Routine preventive care - Emergency dental care	Care that is reasonable and necessary for the prevention, diagnosis and treatment of dental disease.
Smoking Cessation - Treatment Prescription drugs - Non-prescription drugs	Iowa Medicaid Smoking Cessation program is comprised of two components: • Quitline Iowa, a counseling/cessation treatment for tobacco users who want to quit (protocols are evidence based/best practices), available free of charge to all Iowans age 18 and over. • With prior authorization, payment will be made for varenicline (Chantix™), generic bupropion sustained-release products that are FDA-indicated for smoking cessation, and nonprescription nicotine patch, gum, and lozenge.
Family Planning - Prescription drugs - Non-prescription drugs	 ✓ ✓
HIV Testing and Counseling	✓
Podiatry - Foot exam - Orthotics	Coverage limited to certain diagnoses.
Chronic Disease Management	Iowa Medicaid Disease Management program focuses on high-risk, high-cost members with multiple chronic conditions, providing a health coach to assist in care coordination, post-discharge follow up, member education and engagement with providers and community-based organizations. This is an administrative function within Medicaid; providers cannot bill for this service.
Pediatric Services Including Oral and Vision Care	
Primary and Preventive Care - EPSDT - Immunizations	 ✓ ✓
Routine Vision Care - Eye exam	✓

- Eyeglasses	✓
Dental Care - Routine preventive care - Emergency dental care	 ✓ ✓
Audiology - Hearing test - Hearing aid	 ✓ ✓
Early Intervention	For children under 3 years experiencing developmental delays.
Other Services	
Skilled Nursing Care Facility	✓
Hospice	✓
Non-Emergency Transportation	Limited to cases where no service exists in the community.
Experimental and/or Investigational Treatment	Drugs prescribed for a use other than the drug's medically accepted use are not covered.
Personal Care Services	Covered for children with special needs; requires prior authorization.

4.2 Comparison of Medicaid Benchmark Options

This section reviews the scope of benefits offered by three options available as Medicaid benchmarks. The intent of this review is to identify areas where benchmark options differ from Medicaid. It identifies those benefits that are available through Medicaid that are not included at all in each of the benchmark benefit options. It also identifies those benefits where differences exist in terms of limitations to a given benefit, and describes those limitations.

In developing this comparison HMA reviewed the benchmark benefit options available to the state. The Iowa state employee benefit plans with the largest enrollment are the Blues plans: Blue Access, Blue Advantage and Program 3 Plus. The benefits covered by the three plans are virtually identical; the difference between them is in cost-sharing arrangements. The second benchmark available to the state is the Federal Employee Health Benefits Plans. Two plans were reviewed, the Standard Option and the Basic Option, and again, the difference between the plans is in cost-sharing and not in benefits covered. Finally, we reviewed the largest non-Medicaid HMO plan in Iowa, the Wellmark HMO plan. Although Wellmark offers five plans, HMA review determined their benefits were the same across the five plans.

After careful review of the benchmark options, HMA identified a discrete number of benefits for more detailed examination. While many categories of benefits had small differences in coverage, they are not likely to lead to significant variation in the scope of coverage offered through a benchmark plan, nor in the cost of that coverage. The list of benefits that HMA considers worth reviewing is provided below.

Note that the list is organized to follow the schema of the 10 categories of service mandated by the Essential Health Benefit, allowing for easy comparisons between the Medicaid benchmark and the EHB.

Ambulatory Services

- Home Health – Although all benchmark options provide some home health services, the Medicaid benefit is more robust and has fewer limitations.

Hospitalization

- Bariatric Surgery – Not covered by the State Employee Benefit Plan
- Transplant- Although uncommon, it is included due to the high cost of the benefit and its life-saving potential.

Mental Health, Substance Use Disorder and Behavioral Health Treatment

Substantial difference in benefits is seen across the various benchmark options. These differences will be explored in light of the mental health parity requirements of the ACA.

- Mental Health – Inpatient
- Mental Health – Outpatient
- Substance Use Disorder – Inpatient
- Substance Use Disorder – Outpatient

Prescription Drugs

- Prescription Drugs – Benchmark benefits include tiered benefit structures and drug formularies.
- Non-Prescription Drugs – None of the benchmarks covers non-prescription drugs.
- Contraceptives – None of the benchmarks covers non-prescription contraceptives.

Rehabilitative and Habilitative Services and Devices

Benchmark options all have limits on rehabilitative services. It is not clear whether benchmarks cover therapies for habilitation as well as for rehabilitation.[3]

- Physical Therapy
- Occupational Therapy
- Speech Therapy

Preventive Services, Wellness Services and Chronic Disease Management

Benchmark options all have limits on preventive and wellness services.

- Vision Care
- Audiology
- Dental Care

[3] A bulletin on Essential Health Benefits released by CCIIO articulates the difference between habilitation and rehabiloitation: "There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions." ESSENTIAL HEALTH BENEFITS BULLETIN, Center for Consumer Information and Insurance Oversight. December 16, 2011

- Smoking Cessation Treatment
- Family Planning

Pediatric Services Including Oral and Vision Care

All benchmark plans have limits on pediatric preventive and wellness services. The EPSDT requirement provides a challenge as it incorporates any medically necessary service, a very broad array of benefits. Note that none of the benchmark options cover Early Intervention services, but since the expansion population does not include infants and toddlers, it is not discussed here.

- Vision Care
- Audiology
- Dental Care

Other Services

- Skilled Nursing Care Facility – Provided as a secondary benefit to individuals with Medicare, or provided with limits.
- Non-Emergency Transportation – None of the benchmarks cover non-emergency transportation.
- Personal Care Services – None of the benchmarks cover personal care services.

A comprehensive description of benefits provided by each of the three benchmarks being considered, compared against the current Iowa Medicaid benefit, is included as Attachment One.

4.2.1 Federal Employee Plan: Blue Cross Blue Shield Standard Option

The federal employee plan includes many limitations in its coverage. Many benefits are capped. Among capped benefits are chiropractic visits, 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. Bariatric surgery and transplantservices require prior approval. 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.

4.2.2 State Employee Plan: Blue Access

The Iowa employee plan Blue Access is a more robust plan that the federal employee plan, but it is not as comprehensive as the Medicaid benefit. The plan contains limits on rehabilitative services, but not on chiropractic or home health services, or on visits for preventive care. Prior approval is not required for any services. Certain services are not covered, including smoking cessation, dental care, and eyeglasses (although eye exams are covered). 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. This includes bariatric surgery, experimental and investigational treatment, and personal care services.

4.2.3 HMO Plan: Wellmark

The Wellmark HMO benefit is the most restrictive of the three benchmark options. The chiropractic benefit is limited to 12 visits/year. Behavioral health services (including mental health and substance use disorders combined) are limited to 14 inpatient days and 20 outpatient visits per year. Rehabiliative visits are capped at 35 visits/year. Vision care is limited to one visit per year, and glasses are not covered. Only emergency dental care is covered. Smoking cessation services are not covered; podiatry services are not covered; personal care services are not covered.

4.3 Selection of a Medicaid Benchmark

4.3.1 Issues to Consider

Several categories of benefits are required under any benchmark plan. As Iowa considers it options for a benchmark plan it is not necessary to address in detail these benefits, as the benefits, and their associated costs, will be virtually the same under any benchmark scenario. EPSDT benefits must be provided to all children. Family planning services and supplies must be covered. While all the plans being considered as a Medicaid benchmark benefit do cover contraceptives, Iowa Medicaid covers non-prescription contraceptives as well, which none of the benchmark plans offer. The cost of this difference in coverage, assumed to be very small, should be noted in the final analysis.

The ACA requires mental health parity and substance abuse parity in all Medicaid benchmark plans. Iowa's Medicaid program provides rich and comprehensive coverage of behavioral health services. The state will need to make some judgment about expected use of behavioral health services by the newly eligible Medicaid population covered under the benchmark. It is expected that behavioral health needs of the newly eligible population will be significantly lower than that of the current Medicaid population for two reasons. One is that individuals with a severe behavioral health condition will fall under coverage through the disability provisions of SSI, and thus will not be part of the newly eligible population. The second reason to expect lower utilization patterns among the benchmark benefits users is that individuals with significant mental health needs become known to the provider community, who work with them to become Medicaid-eligible through spend-down and medically needy provisions. Evidence from states across the country indicates that individuals with severe behavioral health needs are more likely to have already found a path to Medicaid eligibility, and those individuals newly diagnosed with serious and persistent mental illness will similarly find alternate paths to eligibility. The uninsured individuals who will be newly eligible are unlikely to suffer from severe mental illness, or to become high users of behavioral health services.

Research from the Urban Institute[4] reports that the expansion population is likely to be healthier than nondisabled adults currently enrolled in Medicaid. The report raises a concern about adverse selection, whereby the least healthy and older among the new eligibles will be more likely to enroll in coverage. A high rate of adverse selection is especially likely in the initial period following implementation of the Medicaid expansion, because those with the greatest health needs are likely to be among the first to enroll. Nonetheless, the report concludes that as states move beyond initial implementation of reform, new enrollees will not be markedly different than the nondisabled adults currently on Medicaid since they draw from a population healthier than that currently served by Medicaid. Certainly by the time

[4] Urban Institute. *The Health Status of New Medicaid Enrollees Under Health Reform*, August 2010.

Iowa is responsible for paying for part of the cost of the expansion population any adverse selection issues will have been played out.

4.3.2 Health Care and Access

Iowa's Medicaid benefit provides a more robust benefit package than any of the ACA-defined benchmark options. While all the alternatives cover a core of essential health care services, differences in the provision of ancillary services (many of which are optional benefits under Medicaid) varies significantly. This section of the report addresses the policy implications (in terms of access to services) of selecting a benchmark plan different from the traditional Medicaid benefit.

Services that are covered by Medicaid and not by benchmark options tend to fall into two categories. One category of services includes a broad range of disability-related services including case management, rehabilitative and habilitative services, and personal care. These services, while costly, are not services likely to be in high demand by the Medicaid expansion population. Even though each of the benchmark alternatives puts some limits on physicial and occupational therapy, these services are not commonly required by a non-elderly, non-disabled population. The limits imposed by the benchmark options in this category of services are not likely to cause significant problems with access to services.

The second category of services are benefits that are not typically included under employer-sponsored coverage and includes things like dental and vision care. While it is sometimes argued that these benefits are not critical, and are typically not mandated benefits under Medicaid, many states would argue that they are essential to their Medicaid programs. States have chosen to expand coverage to include dental and vision benefits in light of the recognition that if they are not covered by Medicaid, then beneficiaries will simply go without. Individuals and families with income below 138 percent of the federal poverty line who will be eligible for Medicaid coverage under the ACA expansion are unlikely to have discretionary income that would cover the cost of dental services or of eyeglasses. This economic reality remains true even for the expansion population whose income is slightly higher. The decision to select a Medicaid benchmark option that does not provide routine dental care means it is likely that individuals covered by the benchmark will not obtain that care. If glasses are not included in the benchmark, this group will do without.

A final area where the selection of the benchmark could have an impact on access to care is in the area of prescription drugs. The federal Blue Cross-Blue Chield plan includes pharmacy benefits management in the form of tiered co-pays, preferred providers, and mail order discounts. It is hard to evaluate how that compares with the current Iowa Medicaid pharmacy benefit, which includes both a preferred drug list and prior authorization for a number of drugs. The Wellmark plan offers drug coverage through a separate plan, and it is limited to a formulary. It is unclear how benefits offered through a rider will be evaluated under the Medicaid benchmark option (under the Essential Health Benefit they are not considered as part of the benefit). Furthermore, none of the benchmark options covers non-prescription drugs, a limited benefit under Medicaid. The prescription drug benefit is widely used across all Medicaid populations, and differences in drug formularies and utilization management management could create barriers to prescription and non-prescriptions drugs.

4.3.3 Administrative Complexity

The ACA requires that states create a single eligibility system for individuals seeking coverage through the newly created health exchanges, which on top of determining eligibility for subsidized insurance

coverage must also evaluate eligibility for Medicaid. To the extent that the benchmark benefit is different than the Medicaid benefit, it also means the eligibility system must be able to determine whether an individual is someone who had always been eligible for Medicaid, but had not been enrolled, or whether he or she is newly eligible based on the ACA expansion. This greatly complicates the eligibility determination process.

An Iowa ACA Option Paper on benchmarking that was prepared by state staff observes that Iowa has had the option to provide a benchmark benefit to some groups of Medicaid eligibles since 2005, and has chosen not to, in part due to a desire for administrative simplicity. The paper goes on to state that "Creating different benefit packages would complicate eligibility determinations on several levels… From an eligibility perspective it is critical that the expansion group receive the same benefit package as other coverage groups." This was in large part because of the need to determine at the point of application whether an individual was previously eligible for Medicaid but not enrolled, in which case they would be eligible for full Medicaid, or whether they were newly eligible under the ACA expansion, in which case they would be eligble only for the benchmark. This would require that all applicants go through a complete Medicaid eligibility determination, and not the more streamlined MAGI eligibility determination envisioned by the ACA. Subsequent guidance from CMS has clarified that a state can enroll new applicants into the benchmark plan while they continue to evaluate Medicaid eligibility, so individuals are not delayed in their enrollment. Nonetheless, a single Medicaid benefit that is provided to both the traditional Medicaid-eligibles and the expansion-eligibles would eliminate the need to shift people between plans should the full eligibility determination result in a change in the program for which they are ultimately eligible.

4.3.4 Cost

This report does not determine what it would cost Iowa to provide its current Medicaid benefit to the expansion population. It does not attempt to determine the per capita cost of each of the benchmark options, or the overall difference in cost to the state of Iowa. We have discussed in some detail with the state potential approaches to quantifying the fiscal impact of choosing the traditional Medicaid plan as the Medicaid benchmark, including the data necessary to the analysis. As noted earlier in this report, it is important to remember that by design, the federal government will be covering most of the cost of care to the Medicaid population that is newly eligible as a result of the ACA. For the first three years, Iowa will have no financial responsibility for the cost of the newly eligible population. Subsequent to 2017 the state share for the expansion population will gradually rise to ten percent of total spending, when the federal matching rate will be 90 percent. The fiscal impact of the selection of a benchmark benefit is effectively 10% of the difference between the total cost of the selected benchmark and the total cost of the Medicaid benefit for the expansion population.

Recognizing that a full analysis of Iowa-specific data is necessary to estimate this fiscal impact, we illustrate in this section the logic and potential effect of the calculation of state costs. The Kaiser Family Foundation collects data on Medicaid spending and enrollment by four categories of beneficiary.Table Two presents this information for the state of Iowa from FFY 2009.[5]

[5]Henry J. Kaiser Family Foundation State Health Facts, Individual State Profiles: Iowa http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=17&cmprgn=1

Table 2: Current Medicaid Spending by Beneficiary

	Spending	Beneficiaries	Spending per Enrollee
Aged	$610,599,538	42,978	$14,207
Disabled	$1,412,764,183	77,473	$18,236
Adult	$320,618,679	152,008	$2,109
Child	$498,852,464	250,287	$1,993
Total	$2,842,834,863	522,746	$5,438

Broadly speaking, the Medicaid expansion population will be most comparable to the non-disabled, non-aged adult population. For illustrative purposes only, we assume that a benchmark plan costs 10% less than current Medicaid per-capita spending. Table 3 is a simplified representation of how, based on that assumption in 2009 dollars, the state would calculate costs in a year in which the state share is 10% of total costs.

Table 3: Illustrative Calculation of State Fiscal Impact; 10% State Share; 2009 Basis

A	**Base Spending per Enrollee**	**$2,109**
B	**Less 10% (A*.90)**	$1,898
C	**Difference (A-B)**	$211
D	**Enrollees (from Urban Institue estimate)** [6]	71,000
E	**Total annual cost to state (C*D)**	**$14,910,000**

We emphasize that the calculation demonstrated above is intended only to illustrate how the state should analyze the impact of a benchmark choice other than the traditional Medicaid benefit. Further analysis, using both state-specific spending data, estimates of spending trends, and based on the selected benchmark plan's benefits, is essential in order to arrive at a valid cost estimate. That analysis is beyond the scope of this report – we provide the illustration in order to demonstrate that, in any case, choosing a benchmark option other than the current Medicaid benefit will be less costly to the state.

[6] Urban Institute. *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on Medicaid and the Exchanges*, March 2011.

APPENDIX A – MEDICAID PROVIDER MANUALS

Acute Care Hospital
Nursing Facility
Skilled Nursing Facility
Advanced Registered Nurse Practitioner
Ambulance
Ambulatory Surgical Center
Area Education Agency
Audiologist and Hearing Aid Dispenser
Behavioral Health Intervention Services
Behavioral Health Services
Birth Center
Case Management
Chiropractic Services
Community Mental Health Center
Dental Services
Family Planning Services
Federally Qualified Health Center
Home Health Services
Hospice
Independent Laboratory
Independently Practicing Physical Therapist
Local Education Agency
Maternal Health Center
Medical Equipment and Supply Dealer
Optometrist and Optician Services
Orthopedic Shoe Dealer
Physician
Podiatric Services
Prescribed Drugs
Psychologist Services
Rehabilitation Agency
Remedial Services
Rural Health Clinic
Screening Center

APPENDIX B: COMPARISON OF BENEFITS

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
Ambulatory Services				
Chiropractic	Limited to hands-on manual manipulation of the spine for symptomatology associated with spinal subluxation.	Limited to spinal and extra-spinal manipulation. 12 visits/year.	✓	Manipulation or related procedures to treat musculoskeletal injury or disease 12 visits/year
Home Health Services	Intermittant services (2-3 hours, 2-3 times/week), including skilled nursing care, home health aide. Private duty nursing and personal care for children with special needs.	Limited to 2 hours/day up to 25 visits/year. RN/LPN only.	✓	Home health aide (in conjunction with skilled service) Home skilled nurse (RN/LPN) 60 visits/year
Hospitalization				
Bariatric Surgery	Requires prior authorization from the IME Medical Services Unit	Prior approval for outpatient procedure. Limited to cases where BMI is over 40, or BMI over 35 and comorbidity AND Failed attempts to lose weight under medical supervision	X	Prior approval required
Transplant	♦ Kidney, cornea, skin, and bone transplants.	Prior approval and precertification	✓	Limited: Certain bone

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
	♦ Allogeneic bone marrow transplants for specified conditions. ♦ Autologous bone marrow transplants for treatment of specified conditions. ♦ Liver transplants require preprocedure review by the IME Medical Services Unit. ♦ Heart transplants require preprocedure review by the IME Medical Services Unit. Artificial hearts and ventricular assist devices are not covered. ♦ Lung transplants for members having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME Medical Services Unit. Heart-lung transplants are not covered.	required for all except kidney and cornea. Blood and stem cell transplants limited to specific diagnoses.		marrow Heart Heart-Lung Kidney Liver Lung Pancreas Pancreas-Kidney Small bowel
Mental Health, Substance Use Disorder and Behavioral Health Treatment				
Mental Health - Inpatient	✓	Precertification required	✓	Limited to certain diagnoses: Schizophrenia Bipolar disorder Major depressive disorders Schizo-affective disorders Obsessive-compulsive

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
				disorders Pervasive developmental disorders Autistic disorders 14 day limit/year (including treatment of substance use disorders)
Mental Health - Outpatient	♦ Individual and group psychotherapy ♦ Drugs and biological products ♦ Family counseling services ♦ Partial hospitalization services designed to reduce or control a member's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the member's level of functioning, and minimize regression. ♦ Occupational therapy services ♦ Activity therapies ♦ Day treatment services designed to assist in restoring, maintaining, or increasing levels of functioning, minimizing regression and preventing hospitalization.	Prior approval/approval is given for a specified number of visits and then additional approval is required.	✓	20 visits/year (including treatment of substance use disorders)

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
Substance Use Disorder - Inpatient	✓	Precertification required	✓	14 days/year (including treatment of mental health disorders)
Substance Use Disorder - Outpatient	✓	✓	✓	20 visits/year (including treatment of mental health disorders)
Prescription Drugs				
Prescription Drugs	Excluded Drugs: ♦ Drugs used to cause anorexia, weight gain or weight loss. ♦ Drugs used for cosmetic purposes or hair growth. ♦ Drugs used for symptomatic relief of cough and colds. ♦ Drugs used to promote smoking cessation (see exception below). ♦ Drugs used for fertility purposes or for male sexual enhancement. ♦ Drugs prescribed for a use other than the drug's medically accepted use. ♦ Drugs classified as less than effective by CMS. Prior authorization is required for many other drugs.	Tiered benefit Preferred providers, mail order discounts	✓	Drugs are covered through a separate drug plan Drug coverage is limited to formulary
Non-prescription Drugs	✓	X	X	X

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
Contraceptives	Prescription and non-prescription	Prescription only		Prescription only
Rehabilitative and Habilitative Services and Devices				
Physical Therapy	Coverage mirrors Medicare coverage. No specific limits. Medical necessity criterion. Reviewed every 30 days.	Therapies are limited to 75 visits/year across the 3 categories.	Therapies are limited to 60 visits/year across the 3 categories.	Therapies are limited to 35 visits/year across the 3 categories.
Occupational Therapy	Coverage mirrors Medicare coverage. No specific limits. Medical necessity criterion. Reviewed every 30 days.	Therapies are limited to 75 visits/year across the 3 categories.	Therapies are limited to 60 visits/year across the 3 categories.	Therapies are limited to 35 visits/year across the 3 categories.
Speech Therapy	Coverage mirrors Medicare coverage. No specific limits. Medical necessity criterion. Reviewed every 30 days.	Therapies are limited to 75 visits/year across the 3 categories.	Therapies are limited to 60 visits/year across the 3 categories.	Therapies are limited to 35 visits/year across the 3 categories.
Laboratory Services				
Diagnostic Lab Tests	✓	✓	✓	✓
X-rays	✓	✓	✓	✓
Diagnostic Imaging (MRI, CT, PET)[7]	✓	✓	✓	✓
Preventive Services, Wellness Services and Chronic Disease Management				
Preventive Care - Adults - Routine Check-up - Immunizations		One visit per year	✓ ✓	One visit/year
Routine Vision Care				

[7] I think we might have prior approval issues here

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
- Eye exam - Eyeglasses	One per year Every 2 years	If related to injury	✓	One eye exam/year Not covered
Audiology - Hearing test - Hearing aid	 ✓ ✓	 If related to illness/injury Hearing aids limited to 1 every 3 years	 ✓ Hearing aids not covered	 If related to illness/injury Hearing aids not covered
Nutritional Counseling	Limited to certain diagnoses, i.e. diabetes.	X	Diabetes only	Diabetes only
Dental Care - Routine preventive care - Emergency dental care	Care that is reasonable and necessary for the prevention, diagnosis and treatment of dental disease.	Basic dental – in-network only. Emergency dental – covered	 X ?	Basic dental not covered Emergency dental covered
Smoking Cessation - Treatment - Prescription drugs - Non-prescription drugs	Iowa Medicaid Smoking Cessation program is comprised of two components: • Quitline Iowa, a counseling/cessation treatment for tobacco users who want to quit (protocols are evidence based/best practices), available free of charge to all Iowans age 18 and over. • With prior authorization, payment will be made for varenicline (Chantix™), generic bupropion sustained-release products that are FDA-indicated for smoking cessation, and nonprescription nicotine patch, gum, and lozenge.	 Treatment and counseling. Prescription drugs covered, not clear if non-prescription drugs covered.	 X X X	X
Family Planning				

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
- Prescription drugs - Non-prescription drugs	✓ ✓	Prescription only		Prescription only
HIV Testing and Counseling	✓	✓		✓
Podiatry - Foot exam - Orthotics	Coverage limited to certain diagnoses.	Related to specific conditions - metabolic or peripheral vascular disease		 X X
Chronic Disease Management	Iowa Medicaid Disease Management program focuses on high-risk, high-cost members with multiple chronic conditions, providing a health coach to assist in care coordination, post-discharge follow up, member education and engagement with providers and community-based organizations. This is an administrative function within Medicaid; providers cannot bill for this service.	✓		
Pediatric Services Including Oral and Vision Care				
Primary and Preventive Care - EPSDT - Immunizations	 ✓ ✓	?	Well-child care up to age 7	Well-child care up to age 7 One routine physical per year after age 7
Routine Vision Care - Eye exam - Eyeglasses	 ✓ ✓	 ✓ X	 ✓ X	One routine exam per year X
Dental Care				

	Current Iowa Medicaid Benefit	Federal Employee Health Insurance Coverage	State Employee Health Insurance Coverage	HMO with Largest Commercial Enrollment in Iowa
- Routine preventive care - Emergency dental care	✓ ✓	Basic dental	X	X ✓
Audiology - Hearing test - Hearing aid	✓ ✓	✓ Hearing aids limited to 1/year for children	✓	✓ X
Early Intervention	For children under 3 years experiencing developmental delays.	X		
Other Services				
Skilled Nursing Care Facility	✓	Only as a secondary benefit to individuals with Medicare Part A	120 days/year	30 Days/year
Hospice	✓	Requires prior approval	✓	Same as home health benefit Includes hospice respite care of 15 days/lifetime
Non-Emergency Transportation	Limited to cases where no service exists in the community.	X		X
Experimental and/or Investigational Treatment	Drugs prescribed for a use other than the drug's medically accepted use are not covered.	X		?
Personal Care Services	Covered for children with special needs; requires prior authorization.	X		X