

Why are we talking about Benchmark Medicaid?

The Affordable Care Act (ACA) establishes a new, mandatory Medicaid eligibility group of non-pregnant adults aged 19-64 with incomes $\leq 133\%$ FPL. (Functionally, with the 5% income disregard required by the ACA, this category will include populations up to 138% FPL in countable income.) States will receive enhanced FMAP for these “new eligibles,” beginning at 100% in 2014 and remaining there for three years, then gradually tapering down to 90% in 2020 and years following. **States must provide at a minimum Benchmark or Benchmark-equivalent coverage to this group.** Benchmark Medicaid was first established as an alternative to standard Medicaid by the Deficit Reduction Act of 2006. Parameters for Benchmark Medicaid were further articulated by the ACA, though open policy questions remain and additional federal guidance is reportedly forthcoming.

How do Benchmark Medicaid requirements relate to the Essential Health Benefits (EHB) Benchmark plan required for the Exchange?

Illinois recently selected an EHB Benchmark Plan which establishes minimum essential coverage for individual and small group plans to be sold on the Exchange. Both the Exchange benchmark and Benchmark Medicaid are required to cover essential health benefits in the same ten *categories* specified by federal CMS. No further alignment is required.

How do states formulate a Benchmark Medicaid plan?

States may propose to HHS Secretary coverage appropriate for the targeted population. Alternately, coverage may be established using one of three reference plans:

- Standard Blue Cross Blue Shield PPO for federal employees.
- Largest non-Medicaid commercial HMO in the state.
- Any generally available state employee plan.

Approximately 12 states have already established a benchmark Medicaid plan, and all but one have used the “Secretary-approved” option. Regardless of the approach, benefits must be provided in accordance with principles of economy and efficiency.

What does Benchmark Medicaid cover?

Benchmark Medicaid must cover:

- Ten categories of Essential Health Benefits (EHBs): ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care
- EPSDT for any child under age 21 covered under the state plan
- Services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Non-emergency transportation
- Family planning services and supplies

What is required of Illinois?

- The State must specify its Benchmark benefits (and EHB reference plan, if applicable) as part of 2014-related Medicaid State Plan changes.
- The State must provide public notice and opportunity to comment **before** submitting Benchmark plans to CMS.
- Further federal guidance on when these must be submitted is not expected until late November 2012, and it is unclear how we would coordinate public notice requirements and any state legislation.

Options in Designing Benchmark Medicaid

- The table below broadly outlines three potential approaches to a Benchmark Medicaid benefits package.
- Cost-sharing is permitted in Benchmark Medicaid, in accordance with federal guidelines and with some exceptions. All cost-sharing is subject to an aggregate cap of 5% of family income.

Option	Services Covered	Considerations
Medicaid Benchmark Option #1	Full alignment between Benchmark Medicaid and Standard Medicaid. Includes long term services and supports (LTSS), and assumes rigorous determination of need (as for current seniors and persons with disabilities – SPDs).	Pro: <ul style="list-style-type: none"> • Eases administrative burden on clients and staff. • Will allow Illinois to claim some enhanced FMAP for expensive LTSS services—but will not be large dollars. Con: <ul style="list-style-type: none"> • Because there is no asset test for new eligibles, theoretically a person with significant financial resources could receive expensive services at taxpayers’ expense.
Medicaid Benchmark Option #2	Partial alignment between Benchmark Medicaid and Standard Medicaid. Covers same medical and behavioral health services, but no LTSS.	Pro: <ul style="list-style-type: none"> • Clearly defined. Con: <ul style="list-style-type: none"> • Creates incentive for clients in need of some LTSS to have to qualify as seniors or persons with disabilities (SPDs), at which point Illinois cannot receive enhanced FMAP for those services and will be responsible at 50/50 FMAP.
Medicaid Benchmark Option #3	Partial alignment between Benchmark Medicaid and Standard Medicaid. Covers same medical and behavioral health services, as well as “LTSS light,” a package of home and community based services targeted to the needs of the new eligibles (assumes rigorous determination of need). This option is expected to be clarified in federal guidance anticipated in late November 2012.	Pro: <ul style="list-style-type: none"> • Allows Illinois to claim enhanced FMAP. • Allows Illinois to target services to the newly eligible population (LTSS limited to home and community based care and exclude institutional care, if this option is approved by federal CMS). Con: <ul style="list-style-type: none"> • Because there is no asset test for new eligibles, theoretically a person with significant financial resources could receive certain expensive services at taxpayers’ expense.