

Medicaid Alternative Benefit Plans: What They Are, What They Cover, and State Choices



States can take advantage of the flexibility they have in designing Alternative Benefit Plans to provide the Medicaid expansion population with health coverage that is much more comprehensive than what is required.

Every state that takes up the Affordable Care Act's Medicaid expansion will need to decide on one or more benefit plans for residents who will be newly eligible for Medicaid. The Affordable Care Act requires that this group of people, known as the "expansion population," be covered by a set of benefits known as an Alternative Benefit Plan.

While there are broad federal guidelines for what must be included in Alternative Benefit Plans, states have considerable flexibility in how they are designed. This flexibility allows states to provide the expansion population with coverage that is much more comprehensive than what is required.

This brief discusses federal requirements for Alternative Benefit Plans, the decisions that states need to make, and the factors that states should consider when designing an Alternative Benefit Plan so that it works for people gaining coverage through the Medicaid expansion.

What is an Alternative Benefit Plan?

Since the 2005 Deficit Reduction Act, states have been able to substitute their traditional Medicaid benefits with alternative benefit packages. These alternative benefit packages have been referred to as Medicaid benchmark plans or, more recently, as Alternative Benefit Plans (ABPs). With Alternative Benefit Plans, states continue to provide services through their traditional Medicaid programs, but the benefit design is unique, allowing states to go beyond the minimum requirements.

States can use one of the following four **Medicaid coverage options*** as a foundation for developing Alternative Benefit Plans:

1. The standard Blue Cross/Blue Shield preferred provider organization (PPO) option that is offered to federal employees through the Federal Employees Health Benefits (FEHB) Program
2. A plan that is offered and generally available to state employees
3. The commercial health maintenance organization (HMO) with the largest non-Medicaid enrollment in the state
4. Secretary-approved coverage: This is a benefit package developed by the state that the Secretary of Health and Human Services (HHS) approves as providing appropriate benefits for the population being covered. This option gives states substantial flexibility in benefit design, including the opportunity to use their existing traditional Medicaid state plan as an Alternative Benefit Plan for the expansion population.¹

States may also develop a benefits package that is of equal value to any of the listed benefit options. This alternative package is referred to as actuarially equivalent coverage.²

As of July 2012, only 12 states and one territory were using Alternative Benefit Plans as substitutes for traditional Medicaid benefits.³ However, the role these plans play in delivering health coverage to low-income individuals is about to increase dramatically. That is because the Affordable Care Act requires that adults in the Medicaid expansion population be covered through an Alternative Benefit Plan.⁴

States that expand Medicaid will need to make choices about the benefits they will offer to the expansion population and design Alternative Benefit Plans to provide those benefits. Alternative Benefit Plans also remain

an option that states can use for covering the non-expansion population.

** The law governing Alternative Benefit Plans is set out in Section 1937 of the Social Security Act.⁵ The four Medicaid coverage options are often referred to as “Medicaid benchmark options” or “1937 options” because of the section of the Social Security Act that governs their operation. This issue brief uses the term “Medicaid coverage options.”*

What does an Alternative Benefit Plan have to include?

Within broad federal requirements, states have considerable flexibility when designing an Alternative Benefit Plan. The benefits can be different from a state’s existing Medicaid plan, or the two plans can be the same. States can also have different Alternative Benefit Plans for different populations based on the specific health care needs of the group being covered, or different plans can cover people in different geographic areas.⁶

States must submit their Alternative Benefit Plans to the Centers for Medicare and Medicaid Services (CMS) for approval. For a plan to be approved, it must meet certain minimum coverage requirements.

Essential Health Benefits

As of January 1, 2014, the Affordable Care Act requires that every Alternative Benefit Plan include 10 broad categories of coverage called “essential health benefits” (EHB).⁷ (See “Background on the Essential Health Benefits” on page 4 for more information.)

Additional Medicaid Coverage Requirements

Alternative Benefit Plans must also cover certain additional benefits that are tailored to meet the health care needs of the Medicaid

population. The essential health benefits and additional Medicaid coverage requirements are summarized in Figure 1.

Other Federal Requirements

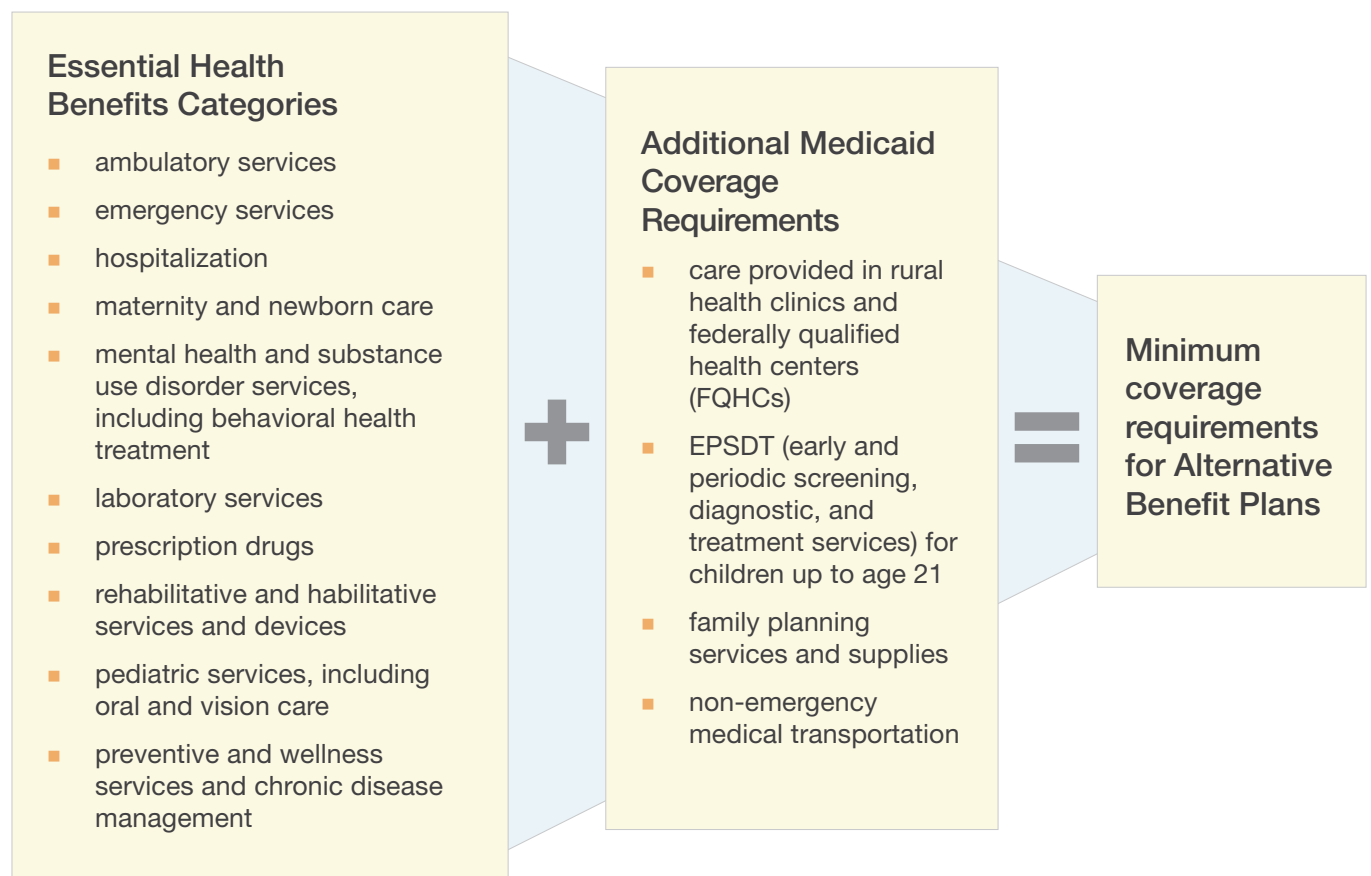
Beyond covering required service categories, there are federal requirements related to benefit design. Benefit design must comply with the Mental Health Parity and Addiction Equity Act.⁸ That law requires that plans cover mental health and substance use disorders at the same level that they cover medical and surgical benefits. Additionally, benefit design cannot discriminate based on an individual’s age, expected length of life, presence or predicted presence of a disability, or any medical condition.⁹ Details related to

specific benefits are highlighted in Appendix 1: Additional Details on Minimum Coverage for Certain Services.

These minimum requirements apply to Alternative Benefit Plans that are already in operation, as well as plans that states develop to cover their Medicaid expansion populations. Since these are new requirements that were added by the Affordable Care Act, states that currently have Alternative Benefit Plans in operation will need to bring those plans into compliance.¹⁰

It is important to note that these are minimum requirements, and states have the option to do more.

Figure 1. Alternative Benefit Plans: Minimum Coverage Requirements



Background on Essential Health Benefits (EHB)

Starting in January 2014, the Affordable Care Act requires most individual and small group health plans, including all of the plans that are certified to operate in a state's health insurance marketplace, to cover the 10 broad categories of services listed in Figure 1 under the heading "Essential Health Benefits Categories."^{*}

The 10 essential health benefit categories do not outline specifics, such as what items and services will be covered in each of the 10 categories, or at what scope. The law left that to the Secretary of HHS.

Rather than developing a federal definition of essential health benefits, for 2014 and 2015, HHS required each state to define the details for its essential health benefits package. That benefit package must be based on one of several health plans operating in the state, referred to as "EHB benchmark options."

To develop its state-specific essential health benefits package, a state chooses the EHB benchmark option on which it wants to base that package. The state then needs to make sure that the benchmark option it selects includes benefits in all 10 essential health benefits categories and meets other federal requirements, such as complying with mental health parity. If not, it must supplement that benefits package. The final package constitutes the state's *EHB benchmark plan*.^{**}

All states have developed their EHB benchmark plans for 2014 through 2015. Forty-five states based their plans on an option from their state's small group market, two states used the largest HMO in the state, and two used a state employee plan. The Secretary of HHS will determine the process for essential health benefits plan design after 2015.

The EHB benchmark options are:

1. Any of the three largest (by enrollment) small group market health plans in the state
2. Any of the three largest (by enrollment) state employee plans
3. Any of the three largest (by aggregate enrollment) national Federal Employees Health Benefits (FEHB) Program plans
4. The largest (by enrollment) non-Medicaid HMO in the state

^{*} A state's benchmark plan options are determined based on enrollment data from the first quarter of 2012. For more information on the essential health benefits package, see Lydia Mitts, *Designing the Essential Health Benefits in Your State* (Washington: Families USA, July 2012), available online at <http://familiesusa2.org/assets/pdfs/Designing-Essential-Health-Benefits.pdf>.

^{**} Ibid.

Designing Coverage to Meet Alternative Benefit Plan Requirements

States will need to make sure that the Medicaid coverage option they select as the basis for the Alternative Benefit Plan includes the essential health benefits and the added Medicaid requirements. The process for doing so is briefly summarized below, followed by a detailed step-by-step process that a state can follow to make sure that its Alternative Benefit Plan meets the minimum requirements.

Make Sure the Essential Health Benefits Are Included

After states select a Medicaid coverage option, they need to make sure that option includes all 10 essential health benefits. States can do that by checking the benefits in their selected Medicaid coverage option against any of the plans that are EHB benchmark options for the state.

“Background on Essential Health Benefits” on page 4 lists the plans that states can use as EHB benchmark options. There is some overlap between the Medicaid coverage options and the EHB benchmark options, but they are not identical (see Appendix 2).¹¹

Confirm that Required Medicaid Benefits Are Included

States must also make sure that all the additional required Medicaid services are included (see Figure 1). If the selected Medicaid coverage option is missing any of those benefits, the state will need to add them. It can pull any missing Medicaid benefits from its Medicaid state plan.

Very few commercial plans cover all of the Medicaid-specific services. If a state is basing an Alternative Benefit Plan on something

other than its Medicaid state plan, it will likely need to add some of these benefits to the Medicaid coverage option it selects.

Ensure that All Other Federal Requirements Are Met

Federal law requires that Alternative Benefit Plans comply with the Mental Health Parity and Addiction Equity Act, and benefit design cannot discriminate. In most cases, states will adjust benefits to meet these requirements as they go through the process outlined below. However, states should review the final benefit design to ensure that these federal requirements are met.

Steps to Ensuring that Alternative Benefit Plans Meet Minimum Requirements

Outlined below are suggested steps a state might go through to ensure that its Alternative Benefit Plan meets minimum requirements. Figure 2 illustrates this process.

States can approach this process differently, as long as, in the end, the Alternative Benefit Plan includes all 10 essential health benefits and the required Medicaid services.¹²

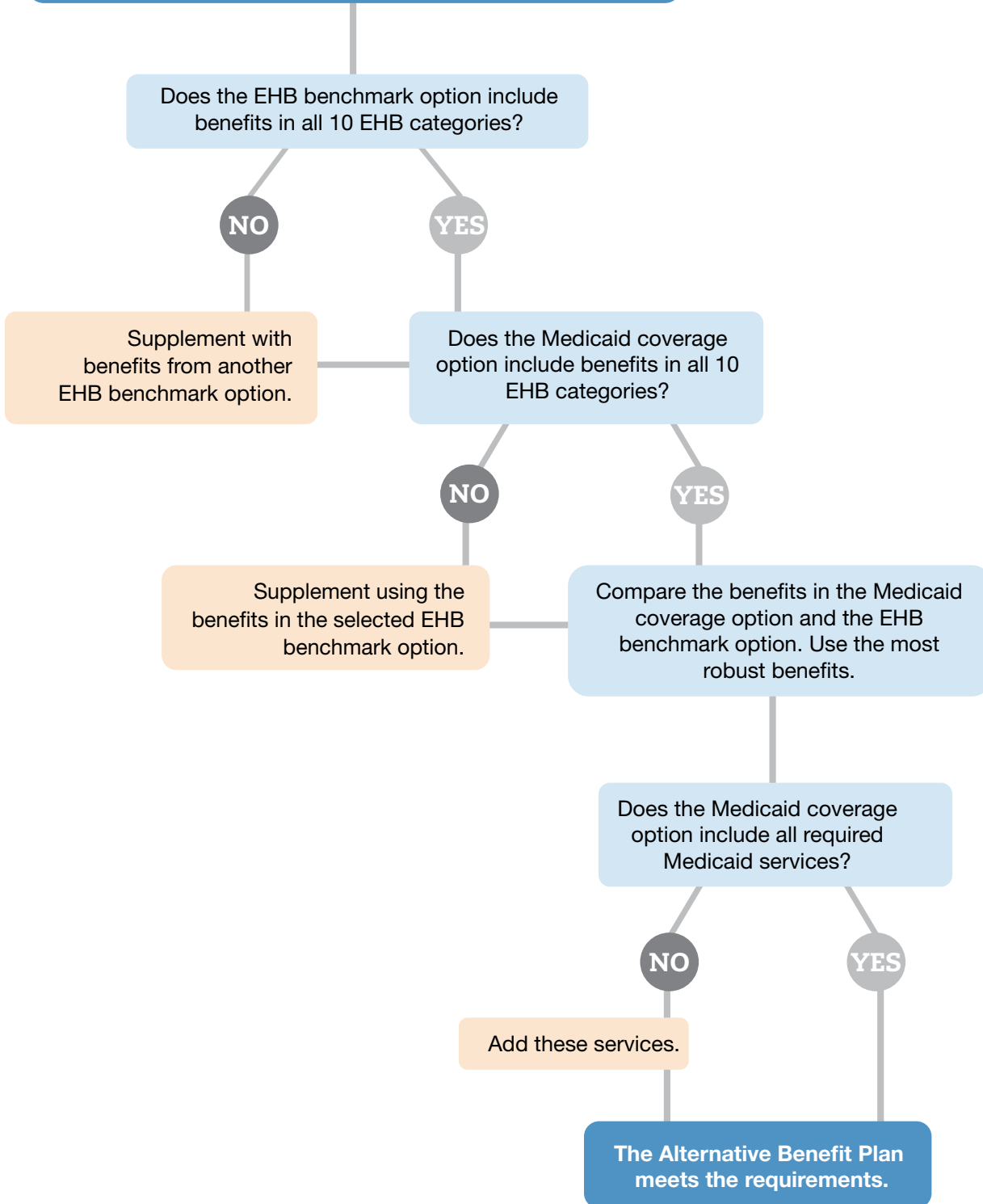
1. Select the Medicaid coverage option that best meets the state’s objectives for the Alternative Benefit Plan package.

This Medicaid coverage option is the base plan. States may need to add benefits to meet the requirement to cover the essential health benefits and certain Medicaid services. However, states cannot take away any benefits from the Medicaid coverage option they select unless they are substituted with benefits of equal value (see step 4).

Figure 2. Building an Alternative Benefit Plan

Step 1: Select a Medicaid coverage option.
Step 2: Select an EHB benchmark option.

The EHB benchmark option will be used as a point of comparison to see if the Medicaid coverage option includes benefits in all 10 EHB categories.



2. Pick an EHB benchmark option to use as a check to make sure all essential health benefits are included.

States need to make sure that their selected Medicaid coverage option includes all the essential health benefits. To do this, they compare it to one of the state's EHB benchmark options.

States have considerable flexibility in their choice of EHB benchmark options for this process:

- The Medicaid coverage option and the EHB benchmark option can be the same. The state does not have to use the same benchmark option it used to develop its EHB benchmark plan.
- If the state does use the same EHB benchmark option, it can use it in its final form (i.e., the EHB benchmark plan, which is the benchmark option after it has been supplemented to meet federal requirements for essential health benefits). If the state uses the EHB benchmark plan, it will already meet the essential health benefits requirements, and it can skip the next step.
- If a state develops multiple Alternative Benefit Plans, it can use a different EHB benchmark option for each plan.

3. Check the selected EHB benchmark option to ensure that it includes all essential health benefits categories.

If the EHB benchmark option the state selected as a check is missing a required category, the state can pull benefits for that category from another benchmark option. Once the selected benchmark option has been supplemented to include all the essential health benefits, it is complete.

DEFINING TERMS

- **EHB Benchmark Options (also referred to as EHB base-benchmark options):** 10 plans in four different categories of insurance that states can choose from as a foundation for creating their essential health benefits package, which is known as an EHB benchmark plan. See “Background on Essential Health Benefits” on page 4 for a list of EHB benchmark options.
- **EHB Benchmark Plan:** State-specific plan that defines its essential health benefits. States create their EHB benchmark plan by supplementing their selected EHB benchmark option so that it includes benefits in all 10 essential health benefit categories and meets mental health parity and other federal requirements for essential health benefits. All states have developed their EHB benchmark plans.
- **Medicaid Coverage Options:** Four options that states can choose from as a foundation for their Alternative Benefit Plan (see page 2).

4. Ensure that the Medicaid coverage option includes all the benefits within each category at least at the same level as the EHB benchmark option.

States need to compare the benefits in the Medicaid coverage option to those in the completed EHB benchmark option to make sure that, in each category, the Medicaid coverage option includes coverage that is at least at the same level as in the EHB benchmark option.

If there is a discrepancy between the benefit packages, states must select the more robust coverage for the Alternative Benefit Plan. For example, if the selected Medicaid coverage option provides better coverage for a service than the EHB benchmark option that the state uses as a benefits check, the state must use the benefits in the Medicaid coverage option.

States can substitute benefits, provided they are in the same benefit category and of equal value.

5. Make sure the required Medicaid benefits are included in the Medicaid coverage option.

If any of the required Medicaid benefits are missing, the state should pull them from its Medicaid state plan and add them to the Alternative Benefit Plan package.

At the end of this process, the Medicaid coverage option that is the basis for the state's Alternative Benefit Plan will include the minimum required benefits.

EXAMPLE

How States Might Design an Alternative Benefit Plan

Use the Medicaid state plan (traditional Medicaid) as the Medicaid coverage option.

A state wants to use its Medicaid state plan as an Alternative Benefit Plan for the expansion population. It selects secretary-approved coverage as its Medicaid coverage option, with its Medicaid state plan as the foundation for the benefits. The state still has to make sure that all the essential health benefits are included, and it can use any of the state's EHB benchmark options as a check. It decides to compare its Medicaid state plan to the benchmark option based on the largest HMO in the state. It confirms that option includes all the essential health benefit categories.

In comparing benefits, the state finds that its Medicaid plan's substance abuse and habilitative services benefits are less than the coverage in the EHB benchmark option. The state must supplement those services, pulling the benefits from the benchmark option it selected. All required Medicaid services are included. After supplementation, its Alternative Benefit Plan is complete.

Use secretary-approved coverage to align the Alternative Benefit Plan with the state's non-Medicaid EHB benchmark plan.

Another state uses one of the largest small group plans in the state as the EHB benchmark option to develop its EHB benchmark plan. Although this is not one of the Medicaid coverage options for Alternative Benefit Plans, the state can select secretary-approved coverage and pick its EHB benchmark plan as the benefit package. Because that plan is its EHB benchmark plan, the state knows that it meets all the essential health benefit requirements. The state still needs to add any missing Medicaid benefits that are required. It pulls those benefits from its Medicaid state plan. The state's Alternative Benefit Plan meets the minimum requirements.

States Can Choose to Do More

States can include additional benefits in their Alternative Benefit Plans or develop plans for specific populations.

States can use secretary-approved coverage to add benefits or use traditional Medicaid as an Alternative Benefit Plan.

States can use secretary-approved coverage either to design a unique benefit package to meet the needs of their residents or to use their existing Medicaid plan as coverage for the expansion population.

Using secretary-approved coverage, states can include any benefits available through one or more of the Medicaid coverage options, benefits available through any of the EHB benchmark

options, the state's current Medicaid state plan, or any Medicaid state plan benefits (see Appendix 3 for a discussion of state plan benefits).¹³ A state could also use its EHB benchmark plan and add Medicaid benefits to build a plan that meets the needs of its expansion population.

The ability to add any Medicaid state plan benefits to an Alternative Benefit Plan gives states substantial flexibility. A state can add a Medicaid state plan benefit to an Alternative Benefit Plan even if the state does not cover that option under its existing Medicaid program. Adding a state plan benefit to an Alternative Benefit Plan will not affect the state's existing Medicaid program. However, states cannot add Medicaid benefits that are available only through waiver or demonstration programs, because those are not considered state plan benefits.

EXAMPLE

Adding Home- and Community-Based Services to an Alternative Benefit Plan

For its Alternative Benefit Plan, a state is using secretary-approved coverage. As the base, it has selected the small group market plan it used to develop its EHB benchmark plan. That plan has already been supplemented, so the state is sure that it covers the essential health benefits. The state also wants to make sure that individuals in the expansion population have access to home- and community-based services.

The state's Medicaid program covers home- and community-based services only through a waiver program, and waiver services cannot be added to an Alternative Benefit Plan. However, using secretary-approved coverage, the state can add any Medicaid state plan benefits to its Alternative Benefit Plan, even if those services are not covered under its traditional Medicaid program. Therefore, the state can add Medicaid's personal care services option and any of the home- and community-based care state plan options to its Alternative Benefit Plan. Making these additions to its Alternative Benefit Plan will not change the state's existing Medicaid program.

States can substitute benefits.

No matter what Medicaid coverage option a state picks, it can replace benefits within essential health benefit categories. For example, a state that is using state employee coverage as the basis of its Alternative Benefit Plan might want to substitute some of that plan's benefits with benefits from its Medicaid program. Benefit substitution has to be within the same essential health benefits category, but the benefits do not have to be similar in nature. For example, ambulatory services can be substituted only with other ambulatory services, but the services themselves can be very different.

Substitutions also need to be "actuarially equivalent," meaning that the value of the benefit for the covered population is the same. States that substitute benefits must conduct an actuarial analysis and certify equivalence. They also need to notify CMS that they have made a substitution.

States can develop more than one Alternative Benefit Plan.

States can develop Alternative Benefit Plans that include benefits that target specific populations based on their medical needs.¹⁴ States can also develop different plans for different geographic areas in the state.

States can target people based only on medical need or geographic area. They cannot develop different plans that target individuals based on their associated federal matching rate.¹⁵

For example, a state could develop a benefits package that targets individuals with diabetes. That plan might include targeted case management, expanded coverage for nutritional and dietary counseling, and medication management.

WHY STATES MIGHT WANT TO GO BEYOND MINIMUM REQUIREMENTS

There are good reasons that states might want to have a benefit package that covers more than the required minimum. Adding services to Alternative Benefit Plans might help people stay healthier, retain function, or remain independent, which may also reduce costs in the long term.

For example, added benefits to help individuals manage and control long-term conditions like diabetes, heart disease, or HIV/AIDS could help people stay healthier and reduce hospital admissions. Adding home- and community-based services might help individuals in the expansion population keep living in the community. In some cases, those added services could mean delayed or averted disability determinations or nursing home admissions. As a result, the added services would reduce costs to the state and to the overall health care system over the long term.¹⁶

Adding more benefits will result in very minimal state costs. The federal government will be covering virtually all of the costs of the Medicaid expansion, and that will not change based on the benefit package a state selects.¹⁷

Vulnerable Populations Covered through the Medicaid Expansion

States must provide residents in the expansion population who have certain special medical needs with the option of enrolling in full Medicaid coverage.

Individuals who fall into one or more categories of high medical needs have always been exempt from mandatory enrollment in Alternative Benefit Plans. “Exempt” individuals must have the option of enrolling in traditional Medicaid. Traditional Medicaid may offer a more comprehensive benefit package, and it may cover services, such as long-term care, that exempt individuals

might need to maintain optimal health and independence.

People in the expansion population must be covered through Alternative Benefit Plans. However, to ensure that those who are in “exempt” categories continue to have access to all Medicaid benefits, federal regulations state that they “must be given the option of an Alternative Benefit Plan that includes all benefits available under the approved State plan.”¹⁸

Therefore, if a state’s Alternative Benefit Plan does not include all of the benefits in the state’s Medicaid plan, exempt individuals must have the option to enroll in the Medicaid state plan.

Exempt Populations¹⁹

- pregnant women
- people who are blind or have a disability
- people who are eligible for both Medicaid and Medicare (“dual eligibles”)
- terminally ill hospice patients
- individuals who become eligible on the basis of a hospitalization
- individuals who are medically frail or who have special medical needs²⁰
- individuals who qualify for long-term care services
- children in foster care receiving child welfare services, and children receiving foster care or adoption assistance
- individuals who would have been eligible for Aid to Families with Dependent Children²¹
- women in the breast or cervical cancer program
- beneficiaries who qualify for limited services, such as tuberculosis or emergency services
- beneficiaries in the medically needy or spend-down program²²
- individuals under age 26 who were formerly in foster care

Process for Plan Approval

CMS must approve states' Alternative Benefit Plans.

States are required to submit amendments to their state Medicaid plans that outline their Alternative Benefit Plan proposal. CMS is developing a template to make the application process easier for states. CMS will evaluate submissions to confirm that they meet the requirements.

CMS will be evaluating Alternative Benefit Plans that are based on the Medicaid coverage options that are commercial plan choices to make sure they meet coverage requirements and that any substituted benefits are of equal value. For secretary-approved coverage, CMS will also review the benefit package to make sure that it provides appropriate benefits for the population being covered.²³

Before submitting a state plan amendment to CMS, states must provide the public with advance notice and “a reasonable opportunity to comment” on the proposed Alternative Benefit Plan.²⁴ This notice and comment period is an opportunity for advocates to make formal comments on the benefits package. CMS approval will follow the review process for state plan amendments.²⁵

States must provide the public with advance notice and “a reasonable opportunity to comment.”

Getting Ready for January 2014

CMS's final regulations outlining the requirements for Alternative Benefit Plans for the Medicaid expansion were published in the *Federal Register* on July 15, 2013. The requirements go into effect on January 1, 2014. States that are expanding Medicaid in January 2014 need to make sure the Alternative Benefit Plans they are developing for the expansion population comply with regulations. Additionally, states that have existing Alternative Benefit Plans for their current Medicaid population must bring those plans into compliance.

CMS recognizes that this is a very tight time frame. Therefore, CMS is providing technical assistance to states and has encouraged states to contact them for help. Additionally, CMS noted in the preamble to the regulations that it will not pursue actions if a state is not in full compliance with the requirements in January 2014, provided that the state is working toward that goal.²⁶

Updating Alternative Benefit Plans

Approved Alternative Benefit Plans that include the essential health benefits will remain in effect through December 31, 2015, without any necessary updates.²⁷ At that time, the Secretary of HHS will consult with states and review the process for defining essential health benefits (see “Background on Essential Health Benefits” on page 4). Since the Alternative Benefit Plans must include the essential health benefits, any changes to that process will also affect Alternative Benefit Plans. As with other Medicaid state plan amendments, states can choose to modify their Alternative Benefit Plans prior to that date.

Conclusion

States need to ensure that their Alternative Benefit Plans meet minimum federal requirements, but they also have the option to go beyond those requirements to design benefit packages that are tailored to meet the health care needs of their residents who will be gaining coverage. Adding more comprehensive benefits to Alternative Benefit Plans could mean better health outcomes for the expansion population, which could reduce health care costs over time. The federal government will pay for most of the Medicaid expansion, so states will incur minimal costs regardless of the benefit package. Therefore, states should take advantage of this opportunity to design Alternative Benefit Plans that are specifically suited to those gaining coverage.

States that expand Medicaid must select one or more Alternative Benefit Plans for the people who will be gaining coverage. Within broad federal guidelines, states have considerable flexibility in plan design. Therefore, states can use this opportunity to develop a plan that will truly meet the needs of those gaining coverage.

Endnotes

¹ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 404.330(d).

² Actuarially equivalent benefits have the same aggregate value. Requirements for meeting actuarial equivalence are outlined in *Social Security Act*, Section 1937(b)(2) [42 U.S.C. 1396u-7(b)(2)].

³ Elicia J. Herz, *Traditional versus Benchmark Benefits under Medicaid* (Washington: Congressional Research Service, August 3, 2012), available online at http://www.cmhda.org/go/portals/0/cmhda%20files/committees/health%20care%20reform/1210_oct/csr%20study%20-%20traditional%20versus%20benchmark%20benefits%20under%20medicaid%209-2012.pdf.

⁴ *Social Security Act*, Section 1902(k) [42 USC 1396a(k)].

⁵ *Social Security Act*, State Flexibility in Benefit Packages, Section 1937 [42 U.S.C. 1396u-7].

⁶ Alternative Benefit Plans do not have to meet Medicaid requirements for comparability (comparable benefits for the same population) or statewideness. See *Social Security Act*, Section 1937(a)(1) [42 U.S.C. 1396u-7(a)(1)].

⁷ The requirement to include the essential health benefits in Alternative Benefit Plans also applies to Alternative Benefit Plans currently in operation in states. For more information on essential health benefits, see Lydia Mitts, *Designing the Essential Health Benefits in Your State* (Washington: Families USA, July 2012), available online at <http://familiesusa2.org/assets/pdfs/Designing-Essential-Health-Benefits.pdf>.

⁸ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.345(c).

⁹ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.347.

¹⁰ Centers for Medicare and Medicaid Services, "Medicaid and Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," Final Rule, 78 Federal Register 42,238 (July 15, 2013): 42,190.

¹¹ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.347.

¹² Centers for Medicare and Medicaid Services, “Medicaid and Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment,” Final Rule, 78 *Federal Register* 42,238 (July 15, 2013): 42,237–42,288. The preamble to this final rule outlines suggested processes for states to ensure that Alternative Benefit Plans include the essential health benefits.

¹³ Secretary-approved coverage can include state plan benefits in the following sections of the Social Security Act: 1905(a); 1915(i), State Plan Amendment Option to Provide Home- and Community-Based Services for Elderly and Disabled Individuals; 1915(j), Self-Directed Personal Assistance Services; 1915(k), State Plan Option to Provide Home- and Community-Based Attendant Services and Supports; or any other Title 19 state plan benefit. Services provided through waivers or demonstration programs are not included.

¹⁴ “Groups must be identified by the characteristics of individuals rather than the amount or level of FMAP.” *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.305(a).

¹⁵ In the preamble to HHS’s final rules covering development of Alternative Benefit Plans, CMS made clear that states can develop different Alternative Benefit Plans, targeting groups based on their health care needs. States cannot develop different plans that target groups based on their associated federal matching rate. Centers for Medicare and Medicaid Services, “Medicaid and Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment,” Final Rule, 78 *Federal Register* 42,238 (July 15, 2013): 42,191.

¹⁶ Wendy Fox-Grage and Jenna Walls, *State Studies Find Home and Community-Based Services to Be Cost-Effective* (Washington: AARP Public Policy Institute, March 2013), available online at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf.

¹⁷ The federal government will pay all of the costs of the Medicaid expansion from 2014 through 2016. After that, the federal share gradually declines to 90 percent in 2020, where it remains.

¹⁸ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.315.

¹⁹ *Ibid.*

²⁰ States can define “medically frail.” However, that definition must include at least: individuals with disabling mental disorders; individuals with chronic substance use disorders; individuals with serious and complex medical conditions; individuals with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; individuals with a disability determination based on Social Security criteria or, in states that apply more restrictive criteria than Social Security criteria, the state’s criteria; or children under age 19 who are eligible for Supplemental Security Income, in foster care, receiving adoption assistance, or receiving services through a family-centered, community-based care system for individuals with special needs. *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.315.

²¹ Aid to Families with Dependent Children (AFDC) was a federal assistance program operating from 1935 until 1996. AFDC was replaced by the Temporary Assistance for Needy Families (TANF) program. States must provide Medicaid coverage to parents whose income meets the state’s AFDC (former welfare program) criteria in place as of July 1996.

²² States have the option to extend Medicaid eligibility to individuals with high medical expenses whose income exceeds the maximum income threshold for Medicaid, but who would otherwise qualify. Individuals in that group are “medically needy.”

²³ Centers for Medicare and Medicaid Services, “Medicaid and Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment,” Final Rule, 78 *Federal Register* 42,205 (July 15, 2013).

²⁴ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.386.

²⁵ For a discussion of the state plan amendment process, see *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs* (Washington: Families USA, June 2012), available online at <http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf>.

²⁶ Centers for Medicare and Medicaid Services, “Medicaid and Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment,” Final Rule, 78 *Federal Register* 42,238 (July 15, 2013).

²⁷ *Code of Federal Regulations*, Benchmark Benefits and Benchmark Equivalent Coverage, Title 42, Section 440.345(e).

Appendix 1: Additional Details on Minimum Coverage for Certain Services

Prescription Drugs

In traditional Medicaid, states must cover most prescription drugs from manufacturers that participate in Medicaid’s drug rebate program.^a Virtually all manufacturers participate in that program. In Alternative Benefit Plans, minimum drug coverage is based on the coverage requirements for the essential health benefits: It must include at least one drug in every drug category and class listed in the U.S. Pharmacopeia.^b

However, there must be procedures in place to allow enrollees to gain access to clinically appropriate drugs that the plan does not cover. States can impose limits on the amount, duration, and scope of coverage through things like prior authorization, mandatory generic substitution, or prescription limits. However, the coverage still has to meet the essential health benefit requirements. Coverage will need to be at least equal to the coverage in the EHB benchmark option the state is using as a check to make sure its Medicaid coverage option includes all the essential health benefits. When states are paying for prescription drugs, payment rules for the traditional Medicaid program apply.^c

Habilitative Services

Habilitative services help a person learn, keep, or improve skills and functional abilities that have not developed normally. In contrast, rehabilitative services help a person restore function lost through illness or injury. Habilitative services have not been well covered by commercial plans. If the EHB benchmark option that a state is using has a benefit for habilitative services, then Alternative Benefit Plan coverage will be based on that benefit. If the EHB benchmark option does not, the state defines the benefit. At a minimum, these services must be covered at the same level as rehabilitative services.

Preventive Care

Medicaid Alternative Benefit Plans must cover preventive care at least at the minimum level required for essential health benefits. That means that they must cover any preventive services that are rated A or B by the U.S. Preventive Services Task Force, immunizations recommended by the Advisory Committee for Immunization Practices, and women’s services recommended by the Health Resources and Services Administration. In Alternative Benefit Plans, no cost-sharing is allowed for these services, even if the state’s traditional Medicaid program imposes cost-sharing on preventive care.

^a Centers for Medicare and Medicaid Services, *Medicaid Drug Rebate Program* (Washington: Department of Health and Human Services), available online at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html> (accessed August 5, 2013).

^b The United States Pharmacopeia is a book containing an official list of pharmaceuticals with articles on their preparation and use. It is the official compendia of drugs in the United States. The website for the U.S. Pharmacopeial Convention is at <http://www.usp.org/about-usp>.

^c Payment must comply with the rules of the Medicaid rebate program. *Social Security Act*, Payment for Covered Outpatient Drugs, Section 1927, [42 U.S.C. 1396r-8].

Appendix 2. Overlap between EHB Benchmark Options and Medicaid Coverage Options

There is not exact overlap between the plans that states can use as their Medicaid coverage option and the plans they can use as their EHB benchmark option. Comparing plans by type of coverage, this chart shows where there is and isn't overlap.

Type of Plan	Base Plans that States Can Select From		Extent of Overlap
	Medicaid Coverage Options for Alternative Benefit Plans	EHB Benchmark Options	
Federal Employees Health Benefits (FEHB) Program	The FEHB BC/BS PPO	Any of the three largest FEHB plans	Not exact. The Medicaid option is likely one of the EHB options.
State employee health plans	Coverage generally available to state employees	Any of the three largest plans	Not exact. The Medicaid option is likely one of the EHB options.
Small group insurance market	N/A	The largest plan in each of the state's three largest small group insurance products	No overlap.
Commercial HMOs	Largest non-Medicaid commercial HMO in the state	Largest non-Medicaid commercial HMO in the state	Exact overlap.
Other options	Secretary-approved coverage	N/A	No overlap, although a state could pick any EHB benchmark option as secretary-approved coverage.

Note: Most states used plans from their small group market to develop the essential health benefits package for their non-Medicaid market.

Appendix 3. Medicaid State Plan Benefits

Every state has a Medicaid state plan. It is the document that outlines how the state will administer its Medicaid program, the individuals who are eligible, and the services that will be covered. The federal government approves each state's plan. A federally approved plan is required for a state to receive federal matching funds for its Medicaid program. States can change their plan with state plan amendments. Those amendments must also be approved by the federal government.

States can add any Medicaid state plan benefits to an Alternative Benefit Plan, whether the benefit is part of the state's traditional Medicaid plan or not.

State Plan Benefits

Federal law requires all states that participate in the Medicaid program to provide a minimum benefit package. The benefits that are required are often referred to as "mandatory benefits." States have the option of providing additional services, referred to as "optional benefits." Each state's Medicaid state plan will include information on all mandatory and optional services that the state provides.

States can add or change state plan benefits through an administrative process called a state plan amendment (SPA). Generally, once a state plan benefit is added, it becomes a permanent part of the state's Medicaid program unless the state files an amendment to change that benefit. On page 18 is a list of mandatory and optional Medicaid state plan benefits. All of these benefits are listed in various sections of Title 19 of the Social Security Act, the statute that governs the Medicaid program.

Waivers

States also have the flexibility to ask the secretary of HHS to waive Medicaid program requirements to provide different services or to experiment with different models of health care delivery. Waivers are time-limited, typically lasting from three to five years depending on the type of the waiver, but states can renew them. They must not increase costs to the Medicaid program. The exact budget impact is measured differently depending on the type of waiver. Waivers must be consistent with the Medicaid program's objectives.

State Plan Benefits, Waivers, and Alternative Benefit Plans

States can add *any* state plan benefits listed in Title 19 of the Social Security Act to an Alternative Benefit Plan, whether or not the benefits are included in the state's traditional Medicaid program. Adding a state plan benefit to an Alternative Benefit Plan will not affect a state's traditional Medicaid program. States cannot add benefits that are covered only through waivers to Alternative Benefit Plans.

For more information on state plan amendments and waivers, see Families USA's *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs*, available online at <http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf>.

Mandatory and Optional State Plan Benefits

Mandatory Benefits	
<ul style="list-style-type: none"> ■ certified pediatric and family nurse practitioner services ■ EPSDT (early and periodic screening, diagnostic, and treatment services) ■ family planning services ■ federally qualified health center services ■ freestanding birth center services (when licensed or otherwise recognized by the state) ■ home health services ■ inpatient hospital services 	<ul style="list-style-type: none"> ■ laboratory and X-ray services ■ nurse midwife services ■ nursing facility services ■ outpatient hospital services ■ physician services ■ rural health clinic services ■ tobacco cessation ■ tobacco cessation counseling for pregnant women ■ transportation to medical care
Optional Benefits	
<ul style="list-style-type: none"> ■ case management ■ chiropractic services ■ clinic services ■ community first choice option - 1915(k)* ■ dental services ■ dentures ■ eyeglasses ■ hospice ■ inpatient psychiatric services for individuals under age 21 ■ occupational therapy ■ optometry services ■ other diagnostic, screening, preventive, and rehabilitative services ■ other practitioner services ■ other services approved by the Secretary of HHS** ■ personal care 	<ul style="list-style-type: none"> ■ physical therapy ■ podiatry services ■ prescription drugs ■ private duty nursing services ■ prosthetics ■ respiratory care services ■ self-directed personal assistance services - 1915(j)* ■ services for individuals age 65 or older in an institution for mental disease (IMD) ■ services in an intermediate care facility for the mentally disabled ■ speech, hearing, and language disorder services ■ state plan home- and community-based services - 1915(i)* ■ tuberculosis-related services

*The number and letter refer to the section of the Social Security Act that relates to this benefit.

**This includes services furnished in a religious non-medical health care institution, a critical access hospital (CAH), and emergency hospital services by a non-Medicare certified hospital.

A list of Medicaid benefits with additional information on specific benefits can be found online at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.

Appendix 4. Medicaid Eligibility Determinations and Benefits

In January 2014, all states will be using a new method to calculate Medicaid eligibility for most people. In states that take up the Affordable Care Act's option to expand Medicaid coverage to more people, the expansion population will be covered under Alternative Benefit Plans.

This chart shows how eligibility determinations and benefits will match up with the new coverage options in January 2014.

Group	Eligibility Determination	Benefits
People who meet the state's Medicaid income eligibility requirements but are not considered part of the expansion population*	Modified adjusted gross income (MAGI)	Traditional (full) Medicaid state plan benefits
Seniors and people who are eligible for Medicaid because of a disability	Non-MAGI	Traditional (full) Medicaid state plan benefits
People who are newly eligible in states that take up the Medicaid expansion (the expansion population)*	MAGI	Alternative Benefit Plan
People who are in the expansion population but are exempt because they are medically frail or have high medical needs*	MAGI	Alternative Benefit Plan, but must have the option of enrolling in full Medicaid coverage

*The Affordable Care Act lets states expand their Medicaid programs to cover all individuals with incomes below 138 percent of the federal poverty level. In states that take up this option, the federal government will pay virtually all of the costs of covering people who gain eligibility. Newly eligible people (those who have incomes between the state's maximum eligibility level on December 1, 2009, and 138 percent of poverty) are known as the "expansion population."

**Medicaid Alternative Benefit Plans:
What They Are, What They Cover, and State Choices**

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