

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

FINAL

ORDER

Medicaid Expansion under the Affordable Care Act 2014 – Delaware Medicaid Program – Alternative Benefit Plan

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services (“Department”) / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to provide notice to the public of its intent to file a state plan amendment with the Centers for Medicare and Medicaid Services (CMS) to establish an Alternative Benefit Plan (ABP) for the eligibility category created pursuant to section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, effective January 1, 2014. The Department’s proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the December 2013 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 31, 2013 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that the Division of Medicaid and Medical Assistance (DMMA) intends to file a state plan amendment with the Centers for Medicare and Medicaid Services (CMS) to establish an *Alternative Benefit Plan (ABP)* for the eligibility category created pursuant to section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, effective January 1, 2014.

Statutory Authority

- Patient Protection and Affordable Care Act (Pub. L. No. 111-148 as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152)), together known as the *Affordable Care Act*
- Section 1937 of the Social Security Act, *State Flexibility in Benefit Packages*
- 45 CFR 156.110, *Essential Health Benefits-Benchmark Plan Standards*
- 42 CFR 440.305(d), *Advance Public Notice*

Background

Enacted as part of the Deficit Reduction Act of 2005, section 1937 of the Social Security Act (hereafter referred to as the Act) provides states with significant flexibility to design Medicaid benefit packages under the State plan. There are many options in selecting an Alternative Benefit Plan, including the option to offer the Medicaid state plan adult benefit package, and states may offer different Alternative Benefit Plans to targeted populations to appropriately meet their needs.

Through section 1937 Alternative Benefit Plans, State Medicaid programs have the option to provide certain groups of Medicaid enrollees with “benchmark” or “benchmark-equivalent” coverage based on one of three commercial insurance products, or a fourth, “Secretary-approved” coverage option. “Benchmark” means that the benefits are at least equal to one the statutorily specified benchmark plans, and “benchmark-equivalent” means that the benefits include certain specified services, and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. The four benchmarks are:

- 1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program (hereafter referred to as “FEHBP”);
- 2) State employee coverage that is offered and generally available to state employees (hereafter referred to as “State Employee Coverage”);
- 3) The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state (hereafter referred to as “Commercial HMO”) and
- 4) Secretary-approved coverage, which, as noted above, can include the Medicaid state plan - benefit package offered in that state.

These section 1937 benchmark options are minimum standards and states can augment coverage with additional benefits as described below. In addition, for children under age 21, states must ensure Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are included either as part of the benefit package itself or through a

combination of the benefit package and additional services. Services provided to individuals age 21 or older will be deemed to meet Medicaid amount, duration and scope requirements when provided in accordance with the parameters of the commercial market product selected by the state, as reflected in items (1)-(3) above.

Certain populations such as people who are blind and disabled are exempt from mandatory enrollment in an Alternative Benefit Plan, as identified at section 1937(a)(2)(B) of the Act and 42 CFR 440.315. States are, however, permitted to offer voluntary enrollment in an Alternative Benefit Plan to those exempt groups. 42 CFR 440.320 outlines the procedures that apply when such voluntary enrollment is offered.

The Affordable Care Act made a number of changes related to section 1937 that are effective on January 1, 2014. These changes include:

- Any Alternative Benefit Plan must cover Essential Health Benefits (EHBs) as described in section 1302(b) of the Affordable Care Act and applicable regulations;
- EHBs include the following ten benefit categories, recognizing that some of the benefit categories include more than one type of benefit: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.
- The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to Alternative Benefit.

Administrative Procedures Pertaining to the Alternative Benefit Plan

Medicaid State Plan Amendments (SPAs) describing section 1937 Alternative Benefit Plans must be submitted to CMS for individuals in the new adult group effective January 1, 2014. Three major sections pertaining to *eligibility* for the program, *benefits/services* covered by the program, and *fee-for-service reimbursement methodology* must be submitted together as a package and approved by CMS through the SPA process.

States implementing Alternative Benefit Plans in a managed care delivery system will also need to submit for CMS review any contracts with health plans, consistent with current practice. The vehicle for submitting these 2014-related SPAs are a set of “fillable” preprint documents. CMS has asked states to submit these plan amendments together in order to provide a more comprehensive picture of the state’s proposed benefit/services framework.

Summary of Proposal

Section 2001 of the Affordable Care Act requires State Medicaid agencies to design and implement an Alternative Benefit Plan (ABP). The proposed amendments to the State Plan effective January 1, 2014 will establish an alternative benefit plan (ABP) for the new adult group in accordance with section 1902(a)(10)(A)(i)(VIII) of the Social Security Act in compliance with the Affordable Care Act (ACA).

The ABP intends to cover the ten (10) essential health benefits as described in 42 C.F.R. 440.347 to include family planning services, early periodic screening, diagnostic and treatment services for individuals under age 21 years; mental health or substance use disorder benefits in accordance with the Mental Health Parity and Addiction Equity Act; and, a compliance statement regarding section 5006(e) of the American Recovery and Reinvestment Act. In fact, the alternative benefit plan will be an identical plan with the Delaware Medicaid State Plan in effect on January 1, 2014 and will include all of the same Medicaid benefits and services provided to current Medicaid beneficiaries.

Cost Sharing

Cost sharing in the Alternative Benefit Plan (ABP) is the same as in the Medicaid State plan. Delaware’s ABP will have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules of 42 CFR §§447.51 through 447.59.

DMMA is in the process of completing a draft version of the corresponding ABP State Plan Amendment (SPA) incorporating continuing guidance from the Center for Medicaid Services (CMS).

The provisions of the ABP state plan amendment are subject to approval by CMS.

Fiscal Impact

As these eligible populations are to be covered with 100% federal funding through September 2016, there is no immediate State fiscal impact as a result of the establishment of the alternative benefit package.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

DMMA received no public comments regarding this state plan amendment.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the December 2013 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to establish and implement Delaware Medicaid Program Alternative Benefit Plan (ABP), is adopted and shall be final effective February 10, 2014.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #14-01

ALTERNATIVE BENEFIT PLAN

The Patient Protection and Affordable Care Act (ACA) defines a new, mandatory eligibility group of non-pregnant adults, between ages 19 and 65, with modified adjusted gross income up to 138 percent of the federal poverty level. Section 2001 of the ACA requires State Medicaid agencies to design and implement a plan that offers this population an alternative benefits package that covers the essential health benefits described under section 1937 of the Social Security Act, and modified by the ACA, including early periodic screening, diagnostic and treatment services for individuals under age 21 years and mental health or substance use disorder benefits in accordance with the Mental Health Parity and Addiction Equity Act.

To satisfy the requirements of 42 CFR 440.305(d) and all other federal notice requirements, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) announces its intent to file a federally required state plan amendment with the Centers for Medicare and Medicaid Services (CMS) to define and implement the Delaware Medicaid Program's Alternative Benefit Plan (ABP), cost sharing and enrollment assurances to conform to the requirements under the Affordable Care Act (ACA).

Effective January 1, 2014, Delaware's Alternative Benefit Plan (ABP) intends to cover the required ten (10) Essential Health Benefits (EHB) as described in section 1302(b) of the ACA and in 42 CFR 440.347. The ABP will be an identical plan with the Delaware Medicaid State Plan in effect on January 1, 2014 and will include all of the same Medicaid benefits and services provided to current Medicaid beneficiaries.

To assure compliance with the provisions of 42 CFR 440.345 and in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009, DHSS/DMMA provides the following assurances:

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) Assurance (42 CFR 440.345)

The State assures that there will be full access to EPSDT services (42 CFR 440.345) for individuals under 21 years of age through the adoption of a benchmark plan which will mirror the State's current Medicaid State Plan benefits, including the provision of the EPSDT benefit. EPSDT services include all medically necessary, federally allowed services for individuals under age 21 regardless of their avenue of Medicaid eligibility. As such, newly eligible adults under age 21 will automatically be covered for EPSDT services. These services are covered both as fee-for-service benefits and through the State's Managed Care delivery system. EPSDT services are described in the managed care organization (MCO) member handbooks. The State's Diamond State Health Plan 1115 Demonstration Waiver and MCO contracts require coverage of EPSDT medical services. Dental services are covered as FFS. The State will alert providers about the continuity of EPSDT services for qualifying newly eligible individuals through its periodic provider alerts and newsletters.

Compliance with Section 5006(e) of the American Recovery and Reinvestment Act

The Division of Medicaid and Medical Assistance (DMMA) did not seek advice regarding its alternative benefit plan from an Indian Health Program or Urban Indian Organization as no Indian Health Program or Urban Indian Organization exists in Delaware.

Cost Sharing

Cost sharing in the Alternative Benefit Plan (ABP) is the same as in the Medicaid State plan. Delaware's ABP will have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules of 42 CFR 447.51 through 447.59.

State Plan Amendment

DMMA is in the process of completing a draft version of the corresponding ABP State Plan Amendment (SPA), incorporating continuing guidance from the Center for Medicaid Services (CMS).

The provisions of this state plan amendment are subject to approval by CMS.

Public Comments

The public is invited to comment on the State's proposed Alternative Benefit Plan amendment request. Written comments may be sent to: Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or via fax to 302-255-4425. For consideration, written comments must be received by 4:30 p.m. on December 31, 2013. Please identify in the subject line: Proposed Delaware Medicaid Program Alternative Benefit Plan Amendment.

Fiscal Impact Statement

As these eligible populations are to be covered with 100% federal funding through September 2016, there is no immediate State fiscal impact as a result of the establishment of the alternative benefit plan package.

Stephen M. Groff 11/5/13
Director, Division of Medicaid and Medical Assistance
17 DE Reg. 841 (02/01/14) (Final)