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# MEDICAID ALTERNATIVE BENEFIT PLAN OPTIONS ANALYSIS – DRAFT

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Prepared with funding from the California HealthCare Foundation and The California Endowment

To help the California Department of Health Care Services develop information about the policy decision for the Alternative Benefit Plan options

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# 1

## Introduction

The California HealthCare Foundation contracted with Mercer Government Human Services Consulting (Mercer) to work with the California Department of Health Care Services (DHCS) in an assessment of Medicaid benefit options available as required by the Patient Protection and Affordable Care Act (ACA) for the newly eligible optional expansion population in 2014. Specifically, Mercer assessed coverage among Medicaid benefit options and developed cost estimates with technical assistance from DHCS. Mercer does not take any opinion in this report with respect to which of the benchmark plan options should be selected by the State. Instead, this summary and the supporting detailed analyses are intended to support dialogue among key stakeholders and to inform policy decisions.

In completing this project, Mercer worked closely with DHCS as well as its partners and consultants, the California HealthCare Foundation, The California Endowment, Manatt Health Solutions, Technical Assistance Collaborative, Inc. (TAC), and Human Services Research Institute (HSRI). The California Endowment contracted with TAC and HSRI to provide the behavioral health cost estimates contained in this report. Mercer would also like to acknowledge the contributions of CalPERS and Kaiser in reviewing the benefit coverage used in our review.

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# 2

# Background and Approach

## Medicaid Alternative Benefit Plans and the ACA

In preparation for the optional expansion of Medi-Cal under ACA in 2014, California must select one or more benefit options for the newly eligible optional expansion. States must provide benchmark or benchmark-equivalent coverage described under section 1937 of the Social Security Act, as modified by the ACA, as a Medicaid Alternative Benefit Plan (ABP).

States have options in selecting a Medicaid ABP, including the option to propose offering the current Medicaid state plan benefit package and may offer different ABPs to targeted populations to meet their needs. All Medicaid ABPs must be based upon one of the following four "base benchmark" benefit options:

1. The Standard Blue Cross/Blue Shield (BC/BS) Preferred Provider Option (PPO) offered through the Federal Employees Health Benefit program (FEHBP);
2. State employee coverage that is offered and generally available to state employees;
3. The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state; and/or
4. Secretary-approved coverage, which, as noted above, can include the Medicaid state plan benefit package offered in that state. Under this option, *states may propose to provide the current Medicaid state plan benefit or another benefit other than the three commercial coverage options.*

Furthermore, the following also apply to all Medicaid ABPs:

- Coverage of the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for individuals under age 21
- Coverage of family planning services and supplies
- An assurance from the state that non-emergency medical transportation to and from providers will be made available, through the ABP coverage or otherwise
- Access to services provided at federally qualified health centers (FQHCs) and rural health clinics (RHCs) through the ABP coverage or otherwise
- Compliance with federal mental health parity requirements
- Coverage of all Essential Health Benefits (EHBs)

## Covering EHBs in Medicaid Alternative Benefit Plans

Similar to the requirements for coverage under the Affordable Insurance Exchanges (Exchange) rules, Medicaid ABP coverage must include the EHBs, which includes coverage in each of the following 10 categories[1]:

1. Hospitalization
2. Emergency services

[1] To date, no additional guidance has been provided that further defines these categories or sets a measure by which the State may determine if the provided services in the benchmark plan will amount to satisfactory coverage of the EHB.

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3. Ambulatory patient services
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
10. Pediatric services, including oral and vision care

If a benchmark option does not contain all 10 categories of EHB, that option would need to be supplemented in order to cover any missing EHB. The federal Centers for Medicare & Medicaid Services (CMS), in its November 20, 2012 letter to State Medicaid Directors explained that the resulting ABP must cover all EHB categories. The letter continues to detail the approval options:

- *"If the 1937* [Medicaid ABP] *coverage option selected is one of the options available for defining EHBs, the state would be deemed to have met the requirement for EHB coverage in an Alternative Benefit Plan to the extent that the selected coverage option includes all EHB categories."*

- *"If the state selects a 1937* [Medicaid ABP] *coverage option that is not one of the options for defining EHBs in the individual and small group market, states will select any one of the EHB base benchmark options and will then compare the coverage between the 1937 coverage option and the selected EHB base benchmark plan and, if needed, supplement the section 1937 coverage option."*

Of the base benchmark options, three of the four are currently options for defining EHBs in the individual and small group market. Only the "Secretary-approved" option (which is also the option for providing the current Medi-Cal benefit) may trigger the review process identified in the second bullet above. At present, Mercer assumes that this event is triggered even where the State is simply seeking approval to use its current Medicaid benefits.

States are not restricted to one Medicaid ABP and may tailor ABPs to meet the needs of specific populations. However, California should weigh the additional administrative burden associated with the administration of multiple benefit packages that may make that possibility less appealing. Conversely, aligning the ABP with the current Medi-Cal benefit may reduce the administrative costs associated with the newly eligible optional expansion population and help maximize potential leverage among the benefit administrators.

## Comparison of Benefits Across Potential Medicaid ABP Options

### *Supporting Summaries and Documents*

In order to facilitate the analysis of potential benchmark plan options, Mercer developed a series of summary documents. These documents contain the details regarding which services (including detailed subservice categories within the 10 mandatory EHB service categories) are covered by each of the four base benchmark plan options DHCS selected for review. Mercer worked directly with local carriers that offer the base benchmark plan options to the extent possible. Mercer also participated in several work sessions with DHCS, Manatt, TAC and HSRI wherein we collectively identified ABP options, prepared summaries and established guidelines and principles for assessing the Medicaid ABP options. The following are descriptions of Appendix A and B; these supplemental works were developed to assist the State in the benchmark plan selection process.

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**Medicaid ABP Coverage Summary (attached as Appendix A)** – This analysis was designed to provide the State with a side-by-side comparison of the base benchmark plan options (Medicaid ABP options) including analysis of the current Medi-Cal benefit. Each of the base benchmark plan options are included side by side (horizontally) with details regarding coverage (or non-coverage), as well as, limitations for all category of service detailed line items. Services were categorized according to the 10 EHB categories of service plus additional categories for long-term care (LTC) services and support. In addition, the Medicaid ABP required coverage areas of EPSDT, FQHC services, Mental Health Parity, transportation and family planning services were added as service categories in one of the EHB categories and "other."

The four plans reviewed in the ABP Coverage Summary are:

1. **CalPERS Anthem Choice Preferred Provider Organization (State Employee Plan ABP Option)** – Based on preliminary analysis performed by Milliman[2] for the California Health Benefit Exchange and subsequent review of plan documentation by Mercer, the CalPERS Anthem Choice (Anthem Choice) plan appeared to represent the least comprehensive coverage option available within the category of state employee plan options. Mercer reviewed the coverage under the Anthem Choice plan for the purpose of establishing the least comprehensive option available to California. The Anthem Choice plan information contained in Appendix A is the product of Mercer's analysis and has been fully peer reviewed by the plan administrators at CalPERS.

2. **Standard Blue Cross/Blue Shield Preferred Provider Option (Federal Employee Health Benefit Plan ABP Option)** – The information on the Standard BCBS PPO option is contained in Appendix A and is the product of Mercer's analysis of the benefit brochures for this option. Most information has been peer reviewed by the BCBS plan. Where a peer review was not available, the coverage details remain Mercer's best judgment.

3. **Kaiser Traditional HMO (Largest insured commercial, non-Medicaid ABP option)** – All of the HMO information contained in Appendix A has been provided by Kaiser.

4. **Medi-Cal State Plan Benefit (Secretary-approved coverage ABP Option)** – For purposes of this analysis, DHCS asked Mercer to compare the current Medi-Cal benefit as the potential Secretary-approved base benchmark plan option. All of the Medi-Cal information contained in Appendix A has either been provided or peer reviewed by DHCS staff.

**Medicaid ABP Cost Estimates (attached as Appendix B)** – This analysis was designed to provide the State with relative cost comparisons between the ABP options with the least and most comprehensive benefits and projected costs of both options through state fiscal year (SFY) 2020. Based upon the information gathered in the Medicaid ABP Coverage Summary, Medi-Cal appeared to represent the most comprehensive coverage available among the four options, though not necessarily in each service coverage category. The Anthem Choice plan appeared to represent the least comprehensive coverage available among the four options. These established the "bookends" of our Medicaid ABP Cost Estimate (Appendix B), with benefits provided under the other two ABP benefit options assumed to fall between Anthem Choice and Medi-Cal.

[2] http://www.healthexchange.ca.gov/FederalGuidance/Documents/Milliman-Essential_Health_Benefits_Comparison-Cost_of_Services2-21-2012.pdf



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# Assessment of EHB and ABP Requirements

## Essential Health Benefits

As noted earlier, all Medicaid ABPs must include EHBs, including coverage of services and items in all 10 statutory categories of service. Mercer's assessment of the coverage available under the four ABP benefit options considered as part of this assessment is that each plan option, including Medi-Cal, appears to have some coverage in nine of the 10 EHB categories. For the tenth category of EHB, habilitative services, there remains some ambiguity around what CMS will consider to be coverage of habilitative services in State Medicaid programs.

While each plan appeared to cover services within the nine remaining EHB categories, there may be significant coverage variation among the plans within each of the coverage categories. Treatment and coverage limitations around amount, duration, and scope of the services covered within a category may create important coverage distinctions among the plan options that California should consider in selecting one or more ABPs. For example, DHCS has stated that the Medi-Cal substance use disorder services benefit, while covered, may be less robust than the coverage available in one or more of the commercial options. Similarly, coverage limitations within the commercial plan options may be greater in Rehabilitative and Habilitative Services and Devices category than in Medi-Cal. Additional federal guidance is also needed to understand the parameters and processes for assessing coverage of EHBs when states elect the Secretary-approved ABP option. CMS has not yet said if or how it will establish standards to assess whether or not coverage within each category of EHB in a Medicaid ABP is sufficient or "substantially equal" to the benchmark reference plan.

## Habilitative Services

Most commercial benchmark plan options do not cover habilitative services. In part, this is because of the lack of uniformity in defining habilitative services in the commercial market. CMS has proposed in regulations that states have the opportunity to define habilitative benefits using a transitional approach in which states may either define the habilitative services category or leave it to issuers. Under the proposed rule, if the EHB-benchmark plan does not include coverage for habilitative services and the state does not determine habilitative benefits, a health insurance issuer must select from two options: (1) provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (2) decide which habilitative services to cover and report on that coverage to HHS. Depending upon the outcome of the proposed rule, there is the potential for a cost impact associated with the utilization of services for populations that are in need of habilitative services. However, Mercer is unable to comment on the EHB coverage of habilitative services or quantify any impact at this point.

## Mental Health and Substance Use Disorder Services and Parity

In addition to covering the 10 categories of EHB, all Medicaid ABPs must provide coverage that is in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA)[3]. Under MHPAEA, financial requirements (e.g., deductibles, copayments, coinsurance) and treatment limitations

[3] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf at page 2

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(e.g., visit or day limits) applicable to such Mental Health and Substance Use (MHSU) disorder benefits can be no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage). In addition, the plan or coverage cannot impose separate cost-sharing requirements or treatment limitations that are applicable only with respect to MHSU benefits[4]. Regulations set quantitative and qualitative tests for parity.

The potential ABPs all offer some level of MHSU services. However, Mercer did not assess the coverage for compliance with MHPAEA as federal guidance around Medicaid mental health parity and ABPs is outside of the scope of this report. It is important to note that MHPAEA does not compel coverage of services, but instead creates minimums for how covered services are made available. However, because one of the categories that must be included in the EHB is MHSU, there must be some services included in the ABP and all of those services will have to comply with MHPAEA.

## Pediatric Services, Including Oral and Vision Care

All Medicaid ABPs must cover EPSDT services; therefore, coverage of the pediatric services EHB category is assumed to be met through the EPSDT requirement. Mercer notes that this is expected to impact only those individuals ages 19 and 20 in the newly eligible optional expansion population, which by definition includes only individuals age 19 through 64.

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[4] 29 USC § 1185a

# 4

# Medicaid ABP Option Cost Estimates

As a product of workgroup discussion, Mercer estimated the costs of the least comprehensive ABP option and the most comprehensive option (CalPERS Anthem Choice and Medi-Cal respectively), identified those service category differences that have meaningful impact on the cost comparisons and estimated the cost variances between the two options for those service categories. These estimates are further described in Appendix B. Mercer did not model any offsetting costs such as general fund revenues from additional tax receipts on new federal revenues.

## Estimate of the Population Size and Demographic Characteristics

The newly eligible optional expansion population will consist of currently uninsured California residents below 133% of the Federal Poverty Level (FPL). The uninsured, in general, are assumed to have a higher rate of disability/acuity than the general population. To determine the level of disability among the currently uninsured California residents below 133% FPL, Mercer used the 2010 Current Population Survey (CPS) data for those uninsured, ages 19 through 64, below 125% of FPL (the closest cut of data available). This dataset has three classifications of individuals (based on self-declaration):

- Severe Work Disability
- Non-Severe Work Disability
- No Work Disability

This dataset showed 7% of this uninsured group had a severe work disability, and an additional 2% had a non-severe work disability. As a margin of conservatism, we would classify both the severe and non-severe as a "disabled-like" risk group. This assumption would mean that the total potential newly eligible optional expansion population has a 9% disability rate.

However, because disabled individuals will have greater health care needs, they will be more likely than non-disabled members to enroll, and enroll sooner. At the same time, otherwise healthy individuals (non-disabled) will be less likely to enroll as quickly. Therefore, the "disabled-like" population will make up a larger percentage of the population that actually enrolls than the percentage they make up of the total potentially eligible population. To approximate this behavior, Mercer assumes that 95% of the eligible disabled population will enroll in Medi-Cal immediately in CY 2014, and by CY 2020, 100% of the disabled population will be enrolled under the newly eligible optional expansion.

As a product of workgroup discussion, Mercer used the CalSIM "enhanced" enrollment projections for the newly eligible optional expansion analysis. The UCB-UCLA CalSIM data set and analyses are commonly referenced and broadly available. Given the timeframe required for the analysis, a complete analysis of "take-up" and enrollment projections was not feasible. While total potential total benefit costs are provided in this analysis based on the CalSIM projections, actual costs may be higher or lower than the estimates represented in this analysis. DHCS is completing an analysis of initial and long-term take-up rates and demographics for the newly eligible optional expansion populations. However, it is not anticipated that future refinements would materially affect the range of the differentials on a PMPM basis.

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We calculated how many disabled would enroll in each year (starting with 95% of the disabled in 2014), and assumed the *remainder* would be comprised of the non-disabled population. The results are shown in the subsequent table.

| Year | Disabled Enrolled | Disabled *Enrolled* Pct of Total |
|---|---|---|
| 2014 | 121,410 | 15.6 % |
| 2015 | 122,475 | 14.6 % |
| 2016 | 124,410 | 14.1 % |
| 2017 | 126,360 | 14.2 % |
| 2018 | 128,325 | 14.1 % |
| 2019 | 130,305 | 14.3 % |
| 2020 | 132,300 | 14.5 % |

The existing Medi-Cal program covers non-disabled adults ages 19 through 64 in the Adult & Family Category of Aid (COA) group, and disabled adults ages 19 through 64 in the Seniors and Persons with Disability (SPD) COA group. To estimate the resulting costs of the Medi-Cal newly eligible optional expansion population, Mercer blended the PMPM costs of each of these two groups based on their projected proportion of newly eligible optional expansion enrollment.

## Pricing the Medi-Cal ABP Option

Mercer used the CY 2010 and CY 2011 fee-for-service (FFS) Medi-Cal claims data for enrolled adults, adjusted for the estimated demographics of the newly eligible optional expansion population.

We believe this dataset represents the most reliable and applicable information for estimating costs related to the newly eligible optional expansion population. These historical PMPM costs were then trended forward for cost and utilization trends to CY 2014. It is important to note that the resulting cost estimates included in this report do not represent capitation rates developed in an actuarially sound manner. Specifically, the cost estimates include costs for services and even for some subpopulations that would likely be carved out of managed care and provided on a FFS basis by the State. Actuarially sound capitation rates for the newly eligible optional expansion population would therefore likely be lower than the total cost estimates included in this report.

It is also important to note that Mercer did not include the costs of services provided under California's non-state plan section 1915(c) home and community based waivers in pricing the Medi-Cal Option. Based on discussion with DHCS and the project team members, it was decided to not include these particular waiver services for cost projection purposes. This is consistent with the Governor's budget proposal to not provide LTC services in the benefits for the newly eligible.

TAC/HSRI conducted detailed analyses to estimate the potential utilization and costs of behavioral health services for the newly eligible optional expansion. The data used for the analyses was CY 2009 Medi-Cal claims data, the same data used for the California Mental Health and Substance Use Needs Assessment Report. DHCS noted that no major benefit service or system design changes had occurred and extrapolating data from 2009 (because of time and resource constraints) would be the best option. TAC/HSRI then supplied Mercer with CY 2014 costs which Mercer subsequently trended forward to create cost estimates for state fiscal year (SFY) 2015 through 2020.

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## Pricing the Anthem Choice ABP Option

In order to arrive at an estimate for the Anthem Choice ABP option, Mercer used the amounts calculated for the service category differentials and subtracted those from the Medi-Cal PMPM amount. Although there is a pricing differential calculated for EPSDT[5], this is not intended to imply that California could elect to provide the Anthem Choice benefit without EPSDT coverage. Rather, this amount reflects our estimate of the amount that would be required by federal rules to be added to the Anthem Choice option.

## Pricing Service Category Differentials and Projecting Cost Estimates

From the information gathered in the Medicaid ABP Coverage Summary (Appendix A), Mercer identified nearly all variances in coverage between the two bookend options. For purposes of pricing, only those service coverage differences that would represent a more than nominal cost impact have been considered. The amounts identified in the service category pricing differentials reflect only the amount associated with the coverage differential between the two benefit packages, but do not necessarily reflect the full cost of the benefit line item.

As a product of workgroup discussion, the cost estimates developed assumed payment rates for the newly eligible optional expansion population would be consistent with other Medi-Cal payment rates.

The total cost of the Medicaid benefits for the newly eligible optional expansion to the State general fund is significantly less than for the existing Medicaid program due to the higher Federal Medical Assistance Percentage (FMAP) funding provided by the federal government for this population. For CY 2014 through CY 2016, the federal government will pay 100% of the total cost. Starting in CY 2017 the FMAP is reduced to 95%, and ultimately drops to 90% in CY 2020.

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[5] The EPSDT category encompasses EPSDT supplemental services reported under Vendor code 82, Pediatric Concurrent Care, Pediatric Day Health Care, pediatric dental and vision benefits.

# 5

# Analysis and Considerations

## Results/Findings

### *Cost Estimates and Non-Federal Share for ABP Options*

Mercer estimates the cost of the Medicaid benefits for the newly eligible optional expansion to be $440.92 PMPM in SFY 2014 if Medi-Cal is selected as the ABP and $379.33 PMPM in SFY 2014 if Anthem Choice is selected. From this information, Mercer has established a range in which all of the Medicaid ABP options would be expected to fall.

Using the Medi-Cal ABP estimate, Mercer estimates that the cost of the Medicaid benefits for the newly eligible optional expansion in SFY 2014 is projected to be approximately $2.06 billion, of which all but $3 million[6] will be entirely paid by the federal government. The SFY 2014 cost for the Anthem Choice ABP would be $1.78 billion, of which all but $3 million will be entirely paid by the federal government. It should be noted that these costs represent only one half of the fiscal year because the newly eligible optional expansion would not begin until January 1, 2014.

By CY 2020, when the federal contribution will have reached its lowest level of 90%, Mercer projects the estimated annual cost of the Medicaid benefits for the newly eligible optional expansion to be $6.39 billion if the Medi-Cal benefit is the ABP, including a non-federal share of approximately $639 million. The estimated annual cost for the Anthem Choice ABP in CY 2020 would be $5.56 billion, including a non-federal share of approximately $556 million. This amounts to a cost differential of approximately $834 million, representing a non-federal share differential of approximately $83 million annually.

These estimates do not include amounts associated with Medicaid administrative expenditures. It is our understanding that Medi-Cal administrative costs currently run at or below 2% of total program costs. Mercer expects administrative costs related to the administration of the newly eligible optional expansion population to be relatively consistent with current program administrative costs on a percentage basis[7]. It is assumed that administrative costs borne by the counties will also remain consistent.

Mercer's analysis is intended to quantify the benefit coverage differential and resulting cost differential between Medi-Cal and Anthem Choice. As a product of workgroup discussion, in addition to quantifying the cost differential with respect to LTC service coverage differences, Mercer has identified the aggregate projected cost of the LTC services identified in this analysis (i.e., nursing facility services, IHSS/personal care state plan services, and ADHC/CBAS services). The aggregate cost of LTC services identifiable and included in the data set pulled for this analysis is projected to be approximately $49.93 PMPM in SFY 2014. This does not include all possible LTC services as some LTC services are offered through section 1915(c) HCBS waivers which were excluded from this analysis.

[6] The $3 million is the projected costs related to non-federally eligible abortion services.

[7] The estimates for administration of the county run specialty behavioral health services are up to 13%.

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### *The "Medically Frail"*

These estimates do not contain assumptions about the portion of the newly eligible optional expansion population that may be "medically frail" and exempted from mandatory enrollment in a Medicaid ABP under federal rules. Some newly eligible optional expansion individuals may be entitled to the Medi-Cal state plan benefit even if California were to opt for an ABP that was not the Medi-Cal state plan benefit. Therefore, the aggregate cost differential between Medi-Cal and Anthem Choice may be much less than Mercer's estimate depending upon the outcome in the final regulations on ABP exempted populations and how many individuals in the newly eligible expansion population would qualify for an exemption based on medical frailty.

CMS recently proposed regulations around Medicaid ABP requirements and exempt populations that may impact the cost estimates in this report, but were not available in time for Mercer to assess the impact in this analysis and final regulations have not been issued. Once this guidance is finalized, the results of this analysis may need to be reviewed for consistency with the rules and impact on the projected costs.

## Caveats

### *Caveats Related to the Behavioral Health Analyses from TAC/HSRI*

As with all projections, these estimates are subject to uncertainty.

First, they do not account for supply effects. The estimates assume that current demand is not greatly suppressed because of lack of supply. The increase in users will be smaller if providers are unable or unwilling to increase capacity to fully meet demand.

Second, TAC/HSRI cannot be certain about the proportion of individuals with mental health or substance use disorder service needs that will enroll in Medicaid. In Massachusetts, for example, anecdotal information suggests that adults with substance use disorder service needs are among the last to enroll in Medicaid.

Third, the data on users of behavioral health services come from surveys, and like all surveys, the results have a margin of error. This is the reason the mid-range estimate was selected to estimate potential service users in the total newly eligible optional expansion population.

Fourth, the estimates assume that newly eligible optional expansion population enrollees will have a similar probability of using services[8] once they obtain Medicaid coverage as the current Medi-Cal mental health and substance use disorder service users. However, use rates may differ since the newly eligible optional expansion population is known to be dissimilar from both existing Medicaid disabled population and Medicaid non-disabled populations.

### *General Caveats*

In performing our analysis, Mercer relied on data and other information provided to us by multiple State agencies and insurance carriers. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

[8] Not including inpatient hospitalization.

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All estimates in this report are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any estimates or projection must be interpreted as having a likely range of variability from the estimate. Mercer has prepared these projections exclusively for the California HealthCare Foundation and the California Department of Health Care Services. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. The estimates and projections included in this report are not a guarantee of results which might be achieved.

To the extent that areas identified in this report have supporting rules Mercer has endeavored to identify them. The State recognizes that, at present, ACA rules and guidance are not static and are subject to change. To that end, we believe this report is accurate as of the day of its release.

This report is intended to be read and used as a whole and not in parts. Any and all decisions in connection with the information contained within this report are the sole responsibility of the State.

There are no third party beneficiaries with respect to this report, and the authors, Mercer Health & Benefits LLC, do not accept any liability to any third party. In particular, the authors shall not have any liability to any third party in respect of the contents of this report or any actions taken or decisions made as a consequence of the results set forth herein.

Mercer is not advocating for or against expanding Medicaid in the state of California or for or against selecting any of the ABP options. The results of this study simply illustrate the potential costs for the State to consider as it decides how best to implement the many provisions of the ACA. Implementation of the newly eligible optional expansion would not be without some element of risk to the State, as enrollment and cost projections could differ significantly from actual future results.

Finally, Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that the State secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

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# APPENDIX A

## Medicaid ABP Coverage Summary

Mercer conducted a detailed review of the State employee health benefit and FEHBP plans and developed a comparison of several key aspects. The comparison was then used to collect information from the HMO base benchmark plan options. The comparisons will be a helpful tool to facilitate the State's selection of a base benchmark plan. At this time, the amount of flexibility states will have to alter benefit levels and covered services while maintaining actuarial equivalency is still unclear. This comparison will be a helpful resource to weigh options as more information becomes available. The areas reviewed included:

- EHB Index
- Covered Services
- Limitations

### EHB Index

The EHB Index lists plan information for all of the agreed upon potential base benchmark options. For purposes of review, Mercer has included an additional category, LTC. This category is not one of the 10 EHB categories, but is incorporated in the coverage review and cost estimations.

### Covered Services

Covered Services is the core analysis of the base benchmark options, which may be used to determine the ABP administered by the State. It is organized by LTC, the 10 EHB categories, and includes covered services within each of the categories.

The analysis was completed using plan descriptions for the State employee health benefit and benefit brochures for the FEHBP plan options and other documentation for the State Medi-Cal benefit. All of the HMO analyses were provided by the plan itself.

Covered benefits are fairly consistent across the ABP options as shown in Appendix A. Key variations in covered services include: skilled nursing facility services; non-medical, in-home or in-community support services; adult residential treatment services; family and group therapy; respite care; medication support services; ABA therapy for autism; outpatient drug-free treatment; and personal care services.

The responses provided for the CalPERS Anthem Choice benefit package indicated coverage of targeted case management (TCM) services. However, Mercer used professional judgment in concluding that commercial coverage of case management is unlikely to provide the extensive coordination of services provided under Medi-Cal TCM. As a result, Mercer included both physical health care TCM and behavioral health care specific TCM in the list of services for which there is a difference in coverage between Anthem and Medi-Cal.

Habilitative services were both defined differently and covered at varying degrees among the ABP options. CMS has stated that it intends to propose rules that will give states the authority to define the habilitative benefit for the ABP and seek comments on the parameters of the benefit. As such, the State will need to look for future guidance in this area.

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## Limitations

The Limitations section was developed to assist the State in determining if there are any covered benefit limitations that present potential barriers to service delivery or unreasonably restrict access to medically efficient care that adequately prevents, ameliorates or cures conditions and diseases as effectively as possible. The limitations to covered services offered in the base benchmark options, if selected, will become part of the ABP. The most common limitations among the benchmark plan options include day limits, session limits and frequency limits associate with specific covered services.

The limitations were fairly consistent across the ABP options as shown in Appendix A. Key variances in limitations and exclusions are: home health services; audiology; chiropractic; non-emergency medical transportation and non-medical transportation; and physical, occupational and speech therapies.

MHSU services are provided by all of the ABP options. Notably, Anthem Choice appears to limit several of its MHSU services to coverage only when medically necessary to stabilize an acute psychiatric condition.

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| EHB Plan Option | Network Type | Plan Name |
|---|---|---|
| **The State employee health benefit plans** | | |
| *Under the 1937 authority, the State may select as a benchmark any health benefits coverage plan that is offered and generally available to State employees in the State. For purposes of this analysis, Mercer has included only one plan that was selected by the State and is most likely the leanest of the State employee plan options available.* | | |
| Anthem Choice | PPO | Anthem Choice |
| | | |
| **The largest insured commercial non-Medicaid HMO operating in the State** | | |
| Kaiser Large Group | HMO | Kaiser Traditional |
| | | |
| **FEHBP – Equivalent health insurance coverage** | | |
| Blue Cross/Blue Shield | PPO | Standard Option |
| | | |
| **Medicaid Benefit Package** | | |
| *Under the 1937 authority the State may seek Secretary-approved coverage. This option may be any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.* | | |
| California Medicaid Program | | Medi-cal |
| | | |
| **Non-EHB Categories** | | |
| Long-Term Care | | |
| | | |
| **Essential Health Benefits Categories** | | |
| Hospitalization | | |
| Emergency services | | |
| Ambulatory patient services | | |
| 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 | | |
| Pediatric services, including oral and vision care | | |

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| Y - Yes<br>N - No<br>U - Unknown at this time | State Employee | HMO | Federal Employee | CA Medicaid |
|---|---|---|---|---|
| | PPO | HMO | PPO | |
| | Anthem Choice | Kaiser Traditional | BCBS Standard | Medi-Cal |
| **Long Term Care** | | | | |
| Short-term nursing facility (up to 30 days) | Y | N | N | Y |
| Long-term nursing facility > 30 days (in lieu of hospital) | Y | N | N | Y |
| Non-medical, in-home or in-community support services (e.g., assistance with activities of daily living) | N | N | N | Y |
| Skilled nursing facility | Y | Y | N | Y |
| Hospice care | Y | Y | Y | Y |
| **Hospitalization** | | | | |
| Hospital services | Y | Y | Y | Y |
| Hospital room and board | Y | Y | Y | Y |
| Inpatient physician/surgeon services | Y | Y | Y | Y |
| Assistant surgeon | Y | Y | Y | Y |
| Anesthesiologist services | Y | Y | Y | Y |
| Organ and tissue transplantation | Y | Y | Y | Y |
| **Emergency Services** | | | | |
| Emergency room (not followed by admission) | Y | Y | Y | Y |
| Ambulance services | Y | Y | Y | Y |
| **Ambulatory Patient Services** | | | | |
| Urgent care | Y | Y | Y | Y |
| Office visit | Y | Y | Y | Y |
| Office visit (specialist) | Y | Y | Y | Y |
| FQHC services[1] | Y | N | Y | Y |
| Home health care | Y | Y | Y | Y |
| Christian Science practitioners | Y | N | Y | Y |
| Christian Science facilities | N | N | Y | Y |
| Outpatient surgery | Y | Y | Y | Y |
| Targeted case management[2] | Y | Y | Y | Y |
| Bariatric surgery | Y | Y | Y | Y |
| Reconstructive surgery | Y | Y | Y | Y |
| Cosmetic surgery | N[3] | N | N[3] | N |
| Abortion | Y | Y | Y | Y |
| Anesthesiologist services when provided as an outpatient procedure | Y | Y | Y | Y |
| Dialysis/hemodialysis | Y | Y | Y | Y |
| Audiology | Y | Y | N | Y |
| Chiropractic | Y | N | Y | Y |
| Podiatry | Y | Y | Y | Y |
| TMJ | Y | Y | Y | Y |
| Adult dental | N | N | Y | Y |
| Adult vision | Y | Y | N | Y |
| Second opinion | Y | Y | Y | Y |
| Non-emergency medical transportation (e.g., wheelchair, van) | Y | N | N | Y |
| Non-medical transportation (e.g., bus or taxi to medical appointments) | Y | N | N | Y |
| Sign language interpreter services | N | Y | N | Y |
| **Maternity and Newborn Care** | | | | |
| Maternity and newborn care | Y | Y | Y | Y |
| Birthing centers | Y | N | Y | Y |
| Perinatal Services Program[4] | Y | N | U | Y |
| Newborn hearing screening | Y | Y | Y | Y |

**FOOTNOTES**

1. Federally qualified health centers (FQHC)/rural health centers (RHC): Provider type that includes clinics or health centers commonly known as community health centers, migrant health centers or health care for the homeless programs. Please indicate coverage with a "Y" if FQHCs/RHCs are included in the plan's network providers.

2. Services furnished to assist eligible individuals to gain access to medical, social, educational services. Services include, but are not limited to: assessment of an individual's needs, developing a care plan, referral and related activities that help link eligible individuals to needed services, monitoring and follow-up activities to ensure care plan is adequate and status of the individual. Also includes arranging for appointments and/or transportation, arranging translation services, crisis assistance planning to coordinate and arrange immediate services or treatment needed.

3. Cosmetic services available for reconstructive surgery to restore a bodily function or to correct deformities resulting from documented injury or disease or caused by congenital anomalies, or surgery which is medically necessary following documented injury or disease to restore function.

4. Services for pregnant women can range from conception through 60 days postpartum. Comprehensive Perinatal Services Program (CPSP) services are in addition and meant to supplement the maternity services that are part of the American College of Obstetricians and Gynecologists (ACOG) visit standards. The core services provided under CPSP include, but are not limited to: client education and orientation to comprehensive perinatal services, individual case coordination and linkages to other programs specific to pregnant and nursing women like the Women, Infants and Children Program (WIC).

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|---|---|---|---|---|
| | PPO | HMO | PPO | |
| | Anthem Choice | Kaiser Traditional | BCBS Standard | Medi-Cal |
| **Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment** | | | | |
| **Mental Health Services** | | | | |
| Non-waiver covered mental illness | Y | Y | Y | Y |
| Benchmark plan option offered at parity | U | Y | Y | U |
| Crisis intervention | Y | Y | Y | Y |
| Crisis stabilization-emergency room | Y | Y | Y | Y |
| Crisis stabilization | Y | Y | Y | Y |
| Adult residential treatment services | N | Y | N | Y |
| Mental health day treatment | Y | Y | Y | Y |
| Psychologist services | Y | Y | Y | Y |
| Family mental health therapy | N | Y | N | Y |
| Group mental health therapy | N | Y | N | Y |
| Individual mental health therapy | Y | Y | Y | Y |
| Therapeutic behavioral services (EPSDT only) | Y | N | N | Y |
| Respite care | N | Y | N | Y |
| Medication support services | N | Y | Y | Y |
| Mental health case management/targeted case management | Y | Y | Y | Y |
| Electroconvulsive therapy (ECT) | N | Y | Y | Y |
| Applied Behavior Analysis (ABA) therapy for autism | N | Y | N | Y[5] |
| Psychological and/or neuropsychological testing | Y | Y | Y | Y |
| Psychological and/or neuropsychological evaluation | Y | Y | Y | Y |
| **Substance use Disorder Services** | | | | |
| Inpatient detox | Y | Y | Y | Y |
| Outpatient detox | Y | Y | Y | Y |
| Inpatient substance use disorder services | Y | Y | Y | Y |
| Outpatient substance use disorder services | Y | Y | Y | Y |
| Outpatient drug-free treatment | N | Y | Y | Y |
| Substance use disorder screening[6] | Y | Y | Y | Y |
| Peer/recovery support services | N | Y | N | Y |
| **Prescription Drug** | | | | |
| Prescription drug coverage | Y | Y | Y | Y |
| Smoking cessation drugs (includes over-the-counter smoking cessation drugs for pregnant women) | Y | Y | Y | Y |
| Non-cancer clinical trials | N | N | Y | N |
| Pain medication for the terminally ill | Y | Y | Y | Y |
| Naltrexone | Y | Y | Y | Y |
| Narcotic replacement therapy | Y | Y | Y | Y |
| AIDS/HIV drugs | Y | Y | Y | Y |
| Antipsychotic drugs | Y | Y | Y | Y |
| Blood and blood derivatives | N | Y | Y | Y |
| Prenatal vitamins | N | Y | Y | Y |
| Weight-loss drugs | N | Y | N | Y |
| Erectile dysfunction drugs (off-label use only) | Y | Y | N | Y |
| **Rehabilitative and Habilitative Services and Devices** | | | | |
| Physical therapy | Y | Y | Y | Y |
| Speech therapy | Y | Y | Y | Y |
| Occupational therapy | Y | Y | Y | Y |
| Acupuncture | Y | Y | Y | Y |
| Cardiac rehabilitation | Y | Y | Y | Y |
| Personal care services[7] | N | N | N | Y |
| Pulmonary rehabilitation | Y | Y | Y | Y |
| Respiratory care for vent dependent | Y | Y | U | Y |
| Durable medical equipment | Y | Y | Y | Y |
| Hearing aids | Y | N | Y | Y |
| Surgically implanted hearing devices | Y | Y | Y | Y |
| Orthotics | Y | Y | Y | Y |
| Prostheses | Y | Y | Y | Y |
| Prosthetic devices for laryngectomy | Y | Y | U | Y |
| Dentures | N | N | N | N |

**FOOTNOTES**

5. ABA therapy for autism services are available through the Department of Developmental Services (DDS) Home- and Community-Based Services waiver.

6. Substance use disorder screening is defined as meeting the requirements of the USPSTF A and B recommendations as adopted by PPACA.

7. Personal care services are services furnished to a beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least twelve consecutive months or that is expected to result in death within twelve months and who is unable to remain safely at home without the services. Ancillary services including meal preparation and cleanup, routine laundry, shopping for food and other necessities, and domestic service. Authorized for the individual by a physician in accordance with a plan of treatment.

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|---|---|---|---|---|
| | PPO | HMO | PPO | |
| | Anthem Choice | Kaiser Traditional | BCBS Standard | Medi-Cal |
| **Laboratory Services** | | | | |
| Outpatient laboratory services | Y | Y | Y | Y |
| Outpatient x-ray services | Y | Y | Y | Y |
| Complex imaging services | Y | Y | Y | Y |
| **Preventive and Wellness Services and Chronic Disease Management** | | | | |
| Adult physical exam | Y | Y | Y | Y |
| Adult male screening | Y | Y | Y | Y |
| Adult female screening | Y | Y | Y | Y |
| Well baby | Y | Y | Y | Y |
| Well child (immunizations) | Y | Y | Y | Y |
| Nutritional counseling | Y | Y | Y | Y |
| Assisted reproductive technology (ART) | **N** | **N** | **N** | **N** |
| Infertility services (non-ART) | **N** | Y | Y | Y |
| Family planning office visit | Y | Y | Y | Y |
| Family planning services and supplies[8] | Y | Y | Y | Y |
| Hearing exam | Y | Y | **N** | Y |
| Oxygen | Y | Y | Y | Y |
| Smoking cessation | Y | Y | Y | Y |
| **Pediatric Services, Including Oral and Vision Care** | | | | |
| EPSDT compliant[9] | **N** | **N** | **N** | Y |
| Pediatric concurrent care[10] | **N** | Y | **N** | Y |
| Pediatric day health care (PDHC)[11] | **N** | **N** | **N** | Y |
| Pediatric medical | Y | Y | Y | Y |
| Pediatric dental | **N** | **N** | Y[12] | Y |
| Pediatric vision | **N** | Y | **N** | Y |

**FOOTNOTES**

8. Family-planning services include preconception counseling, maternal and fetal health counseling, and general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability. It also includes sterilization; IUD and IUCD insertions, or any other invasive contraceptive procedures/devices; contraceptive drugs or devices; treatment for complications resulting from previous family planning procedures; and laboratory procedures, radiology and drugs associated with family planning procedures.

9. EPSDT: A comprehensive pediatric benefit for individuals under age 21. Under EPSDT, if medically necessary, coverage is available in excess of benefit limits stated in the Evidence of Coverage for children or adults. Please indicate coverage with a "Y" if you believe your plan is compliant with EPSDT laws.

10. Allows eligible children and their families to receive palliative care services during the course of the child's illness, while concurrently pursuing curative treatment for the child's life limiting or life threatening medical condition. Includes: care coordination, 24/7 on-call nursing, pain and symptom management, expressive therapies (including art, music and massage), family education, pre-and post-death bereavement support and respite.

11. PDHC is a day program of less than 24 hours that is individualized and family-centered, with developmentally appropriate activities of play, learning and social interaction designed to optimize the individual's medical status and developmental functioning so that he or she can remain within the family.

12. Includes coverage of preventative and basic dental services for all ages, not just pediatric enrollees.

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|---|---|---|---|---|
| | PPO | HMO | PPO | |
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| **Long Term Care** | | | | |
| Short-term nursing facility (up to 30 days) | Medically necessary skilled care, not custodial care, in a skilled nursing facility, up to 100 days per calendar year. | | | |
| Long-term nursing facility > 30 days (in lieu of hospital) | Medically necessary skilled care, not custodial care, in a skilled nursing facility, up to 100 days per calendar year. | | FLTCIP (federal long-term care insurance program) is not part of the BCBS Standard plan, must be purchased separately | |
| Non-medical, in-home or in-community support services (e.g., assistance with activities of daily living) | | | | |
| Skilled nursing facility | 100 days per year; 3-day precertification requirement | 100 days per benefit period | Not covered without Medicare Part A | |
| Hospice care | Re-certification required after 90 days | Hospice services are covered inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area | $250 copay per episode, 30 days per admission | |
| **Hospitalization** | | | | |
| Hospital services | Inpatient hospitalization requires 3-day precertification (non-emergency), maxillomandibular musculosketal, septoplasty and sinus-related, and penile implant | | | Includes psychiatric inpatient hospital services. Mental Health and Substance Use Disorder EHBs may not be billed for days when Psychiatric Inpatient Hospital Services are billed except for the following: i) psychology services (as limited above); ii) mental health case management/targeted case management services; and iii) electroconvulsive therapy (ECT) |
| Hospital room and board | | | | Includes psychiatric inpatient hospital services. Mental Health and Substance Use Disorder EHBs may not be billed for days when Psychiatric Inpatient Hospital Services are billed except for the following: i) psychology services (as limited above); ii) mental health case management/targeted case management services; and iii) electroconvulsive therapy (ECT) |
| Inpatient physician/surgeon services | | | | Includes psychiatric inpatient hospital services. Mental Health and Substance Use Disorder EHBs may not be billed for days when Psychiatric Inpatient Hospital Services are billed except for the following: i) psychology services (as limited above); ii) mental health case management/targeted case management services; and iii) electroconvulsive therapy (ECT) |
| Assistant surgeon | | | | |
| Anesthesiologist services | | | | |
| Organ and tissue transplantation | | | | |
| **Emergency Services** | | | | |
| Emergency room (not followed by admission) | Covered for emergency $50 copay; not covered for non-emergency care | | | |
| Ambulance services | | | | |
| **Ambulatory Patient Services** | | | | |
| Urgent care | | | | |
| Office visit | | | | |
| Office visit (specialist) | | | | |
| FQHC services | | | | |
| Home health care | 45 visits per year; 3-day precertification requirement | 100 visits per year<br>Home based services, with the exception of hospice, must be delivered inside the service area | (2) hours per day, up to 25 visits per calendar year | |
| Christian Science practitioners | 24 sessions per person per calendar year | | | |
| Christian Science facilities | Only covered illness or injury in a christian science hospital | | | |
| Outpatient surgery | | | | |
| Targeted case management | | | | |
| Bariatric surgery | 3-day precertification requirement; For California residents, bariatric surgery only at Centers of Medical Excellence. For non-California residents, an additional $250 copayment applies for each admissions to a facility other than designated Centers of Medical Excellence | | | |
| Reconstructive surgery | 3-day precertification | | | |
| Cosmetic surgery | | | | |
| Abortion | Medically necessary | | When life of mother is in danger | Performed as a physician service to protect the life of the mother, or in cases of rape or incest |
| Anesthesiologist services when provided as an outpatient procedure | 3-day precertification for colonoscopy, knee and hip joint replacement | | | |
| Dialysis/hemodialysis | | Home based services, with the exception of hospice, must be delivered inside the service area | | Chronic dialysis covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. Hemodialysis routine test can be conducted per treatment, weekly or monthly |
| Audiology | Hearing aid-one every 36 months | | | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services |
| Chiropractic | 15 visits, combined with acupuncture | | 1 office visit/year, 1 x-ray, 12 osteopathic/chiropractic manipulations/year | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services |
| Podiatry | Routine footcare in conjunction with diabetes and circulatory disorders | | | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services |
| TMJ | 3-day precertification requirement | | Orthodontic care for treatment of TMJ excluded | |
| Adult dental | | | | Exempted Medi-Cal Beneficiaries |
| Adult vision | This benefit is limited coverage for cataract surgery and or the repair or alleviation of accidental injury | Vision screening and refraction only | | Exempted Medi-Cal Beneficiaries |
| Second opinion | Anthem Blue Cross' Telemedicine Network Specialty Center | | | |
| Non-emergency medical transportation (e.g., wheelchair, van) | Bariatric surgery: up to 3 trips (to & from) Center of Medical Excellence (CME) (pre-surgical, initial surgery, 1 follow-up); (initial surgery, 1 follow-up); not to exceed $130 per trip - Transplant Services: ground transportation (to & from) when designated CME is 75 or more miles from the recipient's place of residence. Coach airfare when 300 or more miles from recipient's residence. Amount cannot exceed $10,000 per transplant | | | Non-emergency ground transportation: is covered only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance. Additionally, transportation necessary to obtain medical services is covered subject to the prescription of a physician, dentist or podiatrist |
| Non-medical transportation (e.g., bus or taxi to medical appointments) | Bariatric surgery: up to 2 trips (to & from) for 1 companion (initial surgery, 1 follow-up); not to exceed $130 per trip - Transplant Services: ground transportation (to & from) when designated CME is 75 or more miles from the donor's place of residence. Coach airfare when 300 or more miles from donor's residence. Amount cannot exceed $10,000 per transplant. | | | A TAR is required for all non-emergency ground medical transportation. A TAR is not required for non-emergency transportation from an acute care hospital to a long term care facility. Medi-Cal does not cover waiting time or night calls for transport from an acute care facility to Nursing Facility A (NF-A) care. Non-emergency transportation between a recipient's home and an Adult Day Health Care (ADHC) center is not covered |
| Sign language interpreter services | | | | Medi-Cal does not pay for service in a facility that is required by law provide sign language interpreters. The interpreter may be used for obtaining medical history; obtaining informed consent and permission for treatment; explaining diagnosis, treatment and prognosis of an illness; communicating prior to, during and after medical procedures; providing complex instructions regarding medication; explaining instructions for care upon discharge from a medical facility; providing mental health assessment, therapy or counseling |

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|---|---|---|---|---|
| **Maternity and Newborn Care** | | | | |
| Maternity and newborn care | Plan provides for the first 30 days of the newborn routine nursery care under the subscriber's plan | | | |
| Birthing centers | An alternative birthing center includes the birthing room. The birthing room must be physically located within a hospital. A birthing center must be certified or approved by the state dept of health | | | |
| Perinatal services program | | | | |
| Newborn hearing screening | | | | |
| **Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment** | | | | |
| **Mental Health Services** | 3-day precertification requirement | | | |
| Non-waiver covered mental illness | Treatment of the following conditions is excluded under this Plan:<br>Personality disorders;<br>Sexual deviations and disorders;<br>Abuse of drugs, except as provided in the Substance Abuse benefit description on pages 52-53;<br>Conduct disorders;<br>Mental retardation and developmental delays;<br>Attention deficit disorders;<br>Inpatient treatment for eating disorders is excluded under this Plan, unless the inpatient stay is necessary for the treatment of anorexia nervosa or bulimia nervosa;<br>Marriage and family counseling for the sole purpose of resolving conflicts between a subscriber and his or her spouse, or domestic partner or children;<br>Non-therapeutic treatment, custodial care and educational programs. | | | |
| Benchmark plan option offered at parity | | | | |
| Crisis intervention | Covered when medically necessary to stabilize an acute psychiatric condition | | | Hospitalization Services and Adult Residential Treatment Services may not be billed for the same day. May be provided for no more than 8 hours in any 24-hour period |
| Crisis stabilization-emergency room | | | | Hospitalization Services and Adult Residential Treatment Services may not be billed for the same day. Claiming for this service is limited to 20 hours for any admission |
| Crisis stabilization | Covered when medically necessary to stabilize an acute psychiatric condition | | | Hospitalization Services and Adult Residential Treatment Services may not be billed for the same day. Claiming for this services is limited to 20 hours for any admission |
| Adult residential treatment services | | | | Only one service may be billed per day. Psychology Services, Family/Group/Individual Therapy, Therapeutic Behavioral Services, Mental Health Day Treatment, Crisis Intervention, Crisis Stabilization and Hospitalization Services may not be billed for the same day. Limited to residential care for alcohol and drug exposed-pregnant women and women in the postpartum perinatal period |
| Mental health day treatment | Covered when medically necessary to stabilize an acute psychiatric condition | | | Only one service may be billed per day. Adult Residential Treatment Services and Hospitalization Services may not be billed on the same day |
| Psychologist services | | | | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services |
| Family mental health therapy | | | | Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day |
| Group mental health therapy | | | | Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day |
| Individual mental health therapy | | | | Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day |
| Therapeutic behavioral services (EPSDT only) | Covered when medically necessary to stabilize an acute psychiatric condition | | | Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day |
| Respite care | | | | Part of autism benefit |
| Medication support services | | | | Hospitalization Services may not be billed for the same day |
| Mental health case management/targeted case management | Covered when medically necessary to stabilize an acute psychiatric condition | | | |
| Electroconvulsive therapy (ECT) | | | | |
| Applied Behavior Analysis (ABA) therapy for autism | | | | ABA therapy for autism services are available through the Department of Developmental Services (DDS) Home and Community Based Services waiver |
| Psychological and/or neuropsychological testing | In conjunction with services to stabilize individual | We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license: Psychological testing when necessary to evaluate a Mental Disorder | | |
| Psychological and/or neuropsychological evaluation | In conjunction with services to stabilize individual | | | |
| **Substance Use Disorder Services** | | | | |
| Inpatient detox | Benefits are provided for hospital and physician services medically necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and inpatient stays at residential treatment facilities are not covered. | | | Inpatient detox is available to Medi-Cal beneficiaries only to the extent such services result in general acute inpatient services |
| Outpatient detox | Benefits are provided for hospital and physician services medically necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and inpatient stays at residential treatment facilities are not covered. | | | |
| Inpatient substance use disorder services | Benefits are provided for hospital and physician services medically necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and inpatient stays at residential treatment facilities are not covered. | | | Inpatient substance use services are available to Medi-Cal beneficiaries only to the extent such services result in general acute inpatient services |
| Outpatient substance use disorder services | The intent of this benefit is to provide medically necessary treatment to stabilize an acute substance abuse condition | | | |
| Outpatient drug-free treatment | | | | |
| Substance use disorder screening | | | | |
| Peer/recovery support services | | | | Recovery services limited to services rendered in conjunction with perinatal service |

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|---|---|---|---|---|
| **Prescription Drug** | | | | |
| Prescription drug coverage | | | | |
| Smoking cessation drugs (includes OTC smoking cessation drugs for pregnant women) | $100 per year and excludes OTC | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | Products listed in the Medi-Cal contract drug list subject to utilization controls. Outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guide" |
| Non-cancer clinical trials | | N/A; processed in clinic by trial MD | | |
| Pain medication for the terminally ill | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | |
| Naltrexone | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | |
| Narcotic replacement therapy | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | Narcotic Replacement Therapy medications (LAAM and methadone) are not available via prescription; they are only available in a licensed NTP facility |
| AIDS/HIV drugs | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | |
| Antipsychotic drugs | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | |
| Blood and blood derivatives | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | |
| Prenatal vitamins | Not covered; except prescriptions for single agent vitamin D, vitamin K and folic acid | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | Subject to prior authorization, for use during pregnancy |
| Weight-loss drugs | | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | When approved by a Medi-Cal field consultant as medically necessary |
| Erectile dysfunction drugs (off-label use only) | 50% coinsurance; does not specify off-label use | Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply | | |
| **Rehabilitative and Habilitative Services and Devices** | | | | |
| Physical therapy | 24 visits per year additional services 3-day precertification | | 75 PT/ST/OT combined per year | |
| Speech therapy | 24 visits per year additional services 3-day precertification | | 75 PT/ST/OT combined per year | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology and speech therapy services |
| Occupational therapy | 24 visits per year additional services 3-day precertification | | 75 PT/ST/OT combined per year | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology and speech therapy services |
| Acupuncture | 15 visits, combined with chiropractic care | | 24 visits/year | Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology and speech therapy services. Services are limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition |
| Cardiac rehabilitation | Up to 40 visits per calendar year | | | Requires approved TAR. Services billed by a rehabilitative center must have prior authorization with the exception of the initial and biannual rehabilitative evaluations |
| Personal care services | | | | Beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services |
| Pulmonary rehabilitation | Up to $1,500 per calendar year | | | Medi-Cal does not generally cover pulmonary rehabilitation services; however, pulmonary rehabilitation for acute airway obstruction or sputum induction for diagnostic purposes is limited to six in 30 days, and aerosol inhalation of pentamadine for Pneumocystis carinii pneumonia treatment or prophylaxis is limited to one in 30 days |
| Respiratory care for vent dependent | 45 visits per year; combined with home health care; 3-day precertification requirement | | | Subject to prior authorization except when personally rendered by the physician |
| Durable medical equipment | Up to $350 per calendar year 3-day precertification (limited list) | Home based services, with the exception of hospice, must be delivered inside the service area | | Must be prescribed by a licensed practitioner. DME commonly used in providing SNG and ICF level of care is not separately billable. Common household items are not covered |
| Hearing aids | One every 36 months | | Covered, hearing aids and related services are available for up to $2,500; every 3 calendar years for adults; every calendar year for children | Medi-Cal limits the total hearing cost per fiscal year to $1510. Excluded from the $1510 cap are those eligible individuals enrolled in EPSDT; PACE; SCAN; Aids health care programs and CCS, pregnant women with other conditions that might complicate the pregnancy and recipients in a LTC facility (NF-A/B)(ICF/DD) |
| Surgically implanted hearing devices | Up to $350 per calendar year; combined with DME benefit | Those covered under P&O only | Covered, $5,000 per calendar year for bone-anchored hearing aids for adults and children | |
| Orthotics | Custom molded and cast shoe inserts, limited to 1 pair per calendar year | | | |
| Prostheses | Outpatient prosthetic appliances, including one scalp hair prosthetic up to $350 per calendar year | | | |
| Prosthetic devices for laryngectomy | No coverage for computerized speech generating devices | No coverage for computerized speech generating devices | $1,250 annual limit for speech generating devices | |
| Dentures | | | | |
| **Laboratory Services** | | | | |
| Outpatient laboratory services | | | | |
| Outpatient x-ray services | | | | |
| Complex imaging services | | | | |
| **Preventive and Wellness Services and Chronic Disease Management** | | | | |
| Adult physical exam | | | | |
| Adult male screening | | | | |
| Adult female screening | | | | |
| Well baby | | | | |
| Well child (immunizations) | | Well child exams are periodic through 23 months | | |
| Nutritional counseling | Covered when used to enable proper use of diabetes self-management equipment or when provided as part of a medically necessary comprehensive outpatient eating disorder program | | | Related to breastfeeding |
| Assisted reproductive technology (ART) | | | Excludes assisted reproductive technology (ART) procedures, including but not limited to in vitro fertilization (IVF) | |
| Infertility services (non-ART) | | | | Infertility drugs are covered when approved by a Medi-Cal field consultant as medically necessary |
| Family planning office visit | | | | |
| Family planning services and supplies | | | | |
| Hearing exam | | | | |
| Oxygen | | Home based services, with the exception of hospice, must be delivered inside the service area | | Listed under pediatric subacute care |
| Smoking cessation | up to $100 per calendar year | | | Limited to rx benefit |
| **Pediatric Services, Including Oral and Vision Care** | | | | |
| EPSDT compliant | | | | |
| Pediatric concurrent care | | | | |
| Pediatric Day Health Care (PDHC) | | | | |
| Pediatric medical | | | | |
| Pediatric dental | | | Excludes orthodontic care for treatment of TMJ | |
| Pediatric vision | | Vision screening and refraction exams only | Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed to correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery | |

# APPENDIX B

## Medicaid ABP Cost Estimation

### Summary

In order to develop the cost estimates for the Medi-Cal and Anthem Choice ABP options, Mercer:

- Estimated the size and demographic characteristics of the Medi-Cal newly eligible optional expansion population likely to enroll;
- Developed an estimate of the Medi-Cal PMPM total benefit cost;
- Used the detailed benefit information to identify meaningful coverage differences that would contribute to cost differentials between the bookend coverage options and priced out those differences;
- Reduced the Medi-Cal PMPM by the amount of those differences to arrive at an estimate of the Anthem Choice benefit cost; and
- Projected the PMPM and total costs for the Medi-Cal and Anthem Choice bookend coverage options forward for SFY 2014 through SFY 2020 and calculated the federal and non-federal share of these costs.

### Data

To estimate the cost of covering the Medi-Cal newly eligible optional expansion population for CY 2014 through CY 2020 period, Mercer used the CY 2010 and CY 2011 Medi-Cal FFS claims experience in the non-managed care counties[9]. We also isolated the costs of each one of the benefit differentials between the low “bookend” (Anthem Choice), and the high “bookend” (Medi-Cal) packages using the applicable CPT, HCPCS, ICD-9, DRG and provider type codes to develop PMPM costs separately for each meaningful coverage difference.

The Medi-Cal FFS data do not include claims for adult vision services. DHCS provided Mercer with total vision claim costs for adults ages 21 through 64 incurred in CY 2011. Mercer estimated the number of adults eligible for this benefit in the FFS counties in CY 2011 to develop a PMPM vision cost. In developing this estimate, we increased the resulting vision PMPM cost by 50% as a margin of conservatism, and to account for any EPSDT vision services that might be provided to 19 and 20 year olds in the newly eligible optional expansion population.

Medi-Cal currently covers maternity benefits up to185% FPL. Therefore, Mercer made the assumption that anyone eligible for pregnancy and maternity-related benefits would receive those benefits as part of an existing state plan coverage group and those costs would not be part of the newly eligible optional expansion population benefit. Mercer removed the cost for these benefits from the dataset.

Mercer then removed the PMPM costs for anti-psychotic drugs, Short-Doyle and Mental Health claim categories, which were priced separately by TAC/HSRI.

The remaining pharmacy costs were reduced by 43% to replicate the current Medi-Cal pharmacy rebates.

[9] As indicated in Section 4, the behavioral health costs developed by TAC/HSRI used CY 2009 Medi-Cal claims data for all counties.

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Mercer projected the PMPM costs forward from CY 2011 to CY 2014 using the age/gender demographic mix of the newly eligible optional expansion population and the average of the most recent three years of Medi-Cal managed care trends. We used these trends because most of the newly eligible optional expansion population will be covered by the existing managed care plans.

## Demographics

The Medi-Cal newly eligible optional expansion population will consist of currently uninsured California residents below 133% of the FPL. The uninsured, in general, are assumed to have a higher rate of disability/acuity than the general population. To determine the level of disability among the currently uninsured California residents below 133% FPL, Mercer used the 2010 CPS data for those uninsured, ages 19 through 64, below 125% of FPL (the closest cut of data available). This dataset has three classifications of individuals:

- Severe Work Disability
- Non-Severe Work Disability
- No Work Disability

This dataset showed 7% of this group had a severe work disability, and an additional 2% had a non-severe work disability. As a margin of conservatism, we classify both the severe and non-severe as a “disabled-like” risk group and assume the total newly eligible optional expansion population has a 9% disability rate.

However, because disabled individuals will have greater health care needs, they will be more likely than non-disabled members to enroll, and enroll sooner. At the same time, otherwise healthy individuals (non-disabled) will be less likely to enroll as quickly. Therefore, the “disabled-like” population will make up a larger percentage of the population that actually enrolls than the percentage they make up of the total potentially eligible population. To approximate this behavior in the CalSIM Enhanced enrollment scenario, and as a margin of conservatism, Mercer assumes that 95% of the eligible disabled population will enroll in Medi-Cal immediately in CY 2014, and by CY 2020, 100% of the disabled population will be enrolled in the Medi-Cal newly eligible optional expansion.

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The CalSIM projected eligible and enrolled populations for the SFY 2014 to SFY 2020 period are shown in the table below.

| | Eligible Population | | | Enrolling Population | | |
|---|---|---|---|---|---|---|
| SFY | Total | Disabled | Non-Disabled | Total | Disabled | Non-Disabled |
| 2014 | 1,420,000 | 127,800 | 1,292,200 | 780,000 | 121,410 | 658,590 |
| 2015 | 1,420,000 | 127,800 | 1,292,200 | 810,000 | 121,943 | 688,058 |
| 2016 | 1,425,000 | 128,250 | 1,296,750 | 860,000 | 123,441 | 736,559 |
| 2017 | 1,435,000 | 129,150 | 1,305,850 | 885,000 | 125,383 | 759,617 |
| 2018 | 1,445,000 | 130,050 | 1,314,950 | 900,000 | 127,341 | 772,659 |
| 2019 | 1,455,000 | 130,950 | 1,324,050 | 910,000 | 129,313 | 780,687 |
| 2020 | 1,465,000 | 131,850 | 1,333,150 | 910,000 | 131,301 | 778,699 |

The existing Medi-Cal program covers non-disabled adults ages 19 through 64 in the Adult & Family COA group, and disabled adults ages 19 through 64 in the Medi-Cal Only (not eligible for Medicare) SPD COA group. To estimate the resulting costs of the newly eligible optional expansion population, Mercer blended the PMPM costs of each of these two groups based on their projected proportion of enrollment.

## Relative Health Status of Populations

Generally, health status improves as income increases, resulting in decreasing average health care costs. Conversely, health status declines as income decreases resulting in increasing health care costs. Relative health status also improves for those who are employed, both because employed individuals have higher incomes than the unemployed and because they are healthy enough to work.

Since Medicaid (Medi-Cal) represents the lowest income population, this population group is assumed to have the highest health care risk and utilization levels, with the disabled Medicaid population generating higher costs than the non-disabled Medicaid population. The uninsured population represents a mix of relatively healthier individuals, who view purchasing coverage as uneconomical, and those with existing health conditions representing additional risks that cause health insurers to typically deny coverage or make the premiums unaffordable. This mix has been shown to reflect an overall average health status that is better than the Medicaid population – with lower average health care risk and utilization.

Thus, using the current Medi-Cal costs, from the lowest income population, to project the newly eligible optional expansion costs, from a slightly higher income population, provides a small margin of conservatism to our estimates, as the newly eligible optional expansion population should, on average be slightly healthier than the current comparable Medi-Cal enrolled population.

## Assumptions and Methodology

Mercer used the following assumptions to develop the projected costs for the newly eligible optional expansion population:

- The populations that best reflect the health care risk of those eligible for the newly eligible optional expansion are the current Medi-Cal adults in the Adult & Family COA group and the Disabled Medi-Cal Only (i.e., non-dual eligible) COA group;

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- To be conservative, we assumed that Medi-Cal would not implement any premiums or cost sharing as allowed by Medicaid, for this higher income population;
- We assume health care cost and utilization trends for the five year period from CY 2010 to the first year of the expansion, CY 2014, will be approximately equal to the average of the most recent three years of Mercer estimates used in the pricing of Medi-Cal managed care capitation rates (4.25% annually); and
- Designated Public Hospital (DPH) costs were assumed to be reimbursed at non-DPH Medi-Cal FFS levels of reimbursement, not cost-based reimbursement.

The CY 2010 and CY 2011 FFS claim data were extracted by COA and category of service for eight distinct age and gender brackets: females and males ages 19 and 20, 21 to 24, 25 to 44 and 45 to 64. The resulting data were projected forward using the recent Medi-Cal unit cost and utilization trends to develop estimated SFY 2014 to SFY 2020 health care costs for both the Adult & Family and Disabled COAs. These costs by age and gender band were then projected based on the population demographics provided by the UCLA CalSIM model. The resulting costs by age bracket were then combined in the respective ratios of Adult & Family COA and Disabled COA to develop blended rates for each year in the projection period.

The mental health, behavioral health and substance use disorder services benefits priced by TAC/HSRI were then added to the Mercer blended SFY 2014 PMPM cost to produce a final Medi-Cal average cost for the newly eligible optional expansion population. Mercer considers this PMPM cost developed from FFS data to be a conservative estimate of Medi-Cal managed care costs because we believe the efficiencies and savings from managed care more than offset the approximate 8-10% loading for administrative costs and profit/risk/contingencies that would be loaded into the managed care rates.

## Behavioral Health Assumptions from TAC/HSRI

TAC/HSRI developed the following assumptions with technical assistance from DHCS to be used to extrapolate the 2009 utilization data to the newly eligible optional expansion population for the period 2014 through 2020:

| Assumption Variable | Assumption Adopted |
|---|---|
| Overall Medi-Cal coverage newly eligible optional expansion population size | The CalSIM-enhanced outreach and enrollment assumptions were adopted, resulting in a 2014 starting population of 780,000 adults and a 2020 ending enrollee population of 910,000 adults. |
| Behavioral Health newly eligible optional expansion population | TAC/HSRI prevalence estimates were used to project that 18.64% of the total newly eligible optional expansion population would need mental health services.<br>SAMHSA prevalence estimates were used to project that 10.3% of the total newly eligible optional expansion population would need substance use services. |
| Services included in the benefit | All current Medi-Cal mental health and substance use services benefits were included in the analyses. |
| Newly eligible optional expansion population take-up rates | The CalSIM enhanced take-up rate assumptions were used. The take-up rate for 2014 is estimated to be 55%, increasing to 62% in 2017 and leveling off in the subsequent years. |

| Assumption Variable | Assumption Adopted |
|---|---|
| Users of services | Not all enrollees that need and qualify for mental health and substance use services will actually ask for and access these services. TAC/HSRI estimates that 67% of people needing mental health services will access such services, while 24% of people needing substance use services will access such services |
| Distribution of service use | With the exception of inpatient psychiatric hospitalization, the distribution of utilization of both mental health and substance use services in the current Medi-Cal program is assumed to accurately reflect utilization of various service types for the newly eligible optional expansion population. Inpatient utilization in the current Medi-Cal system is heavily weighted towards people with serious mental illness receiving SSI, which is not projected to be true for the newly eligible optional expansion population. Thus, LIHP plan utilization of inpatient utilization, which is assumed to more accurately reflect the newly eligible optional expansion population, has been used to adjust hospitalization downward by 50% (from 8% to 4% expected utilization of MH users). |
| Adjustment for Medical Cost Inflation | The costs of mental health and substance use services are estimated to increase by 3% per year between 2009 and 2020. |
| Eligible but not enrolled “Woodwork” | There are a number of people currently eligible for Medi-Cal that are not enrolled. This is often referred to as the “woodwork” population. The utilization and cost estimates in this analysis do not include this potential population, which we would assume to be less expensive than the currently enrolled Medi-Cal population. |
| County Administrative Costs | For the Medi-Cal Specialty Mental Health Services (SMHS) Waiver an administration cost of 13% was added to the total costs of these services to reflect the current administration costs of this program. |

The total projected SFY 2014 cost is $2.07 billion for the Medi-Cal benefits and $1.77 billion for the Anthem ABP, resulting in a cost differential of $299 million. It should be noted that these costs represent only one half of the fiscal year because expansion will not begin until January 1, 2014.

The entire cost of the newly eligible optional expansion in SFY 2014 will be paid by the federal government, with the exception of non-eligible abortion services.

## End Notes

- Service costs are expressed as state and federal share, but some “state” costs may be borne by counties and local entities.
- By using the Medi-Cal provider reimbursement rates in the CY 2010 and CY 2011 data, Mercer has not modeled the increased reimbursements for primary care providers to the Medicare levels mandated by the ACA for CY 2013 and CY 2014.

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**Exhibit 1**
**DRAFT Newly Eligible Optional Expansion**
**Alternative Benefit Package Cost Estimation**

| EXHIBIT 1 | SFY 2014 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | CY 2020 |
|---|---|---|---|---|---|---|
| **Projected Medi-Cal PMPM Cost w/o MH/BH/SUD** | $ 386.75 | $ 440.11 | $ 457.45 | $ 480.13 | $ 503.97 | $ 514.57 |
| **Projected MH/BH/SA Services** * | $ 54.17 | $ 61.38 | $ 63.98 | $ 66.70 | $ 69.54 | $ 71.00 |
| **Projected Total Medi-Cal PMPM Cost** | $ 440.92 | $ 501.48 | $ 521.43 | $ 546.84 | $ 573.51 | $ 585.57 |
| **Projected Total Cost for Expansion** | $2,063,487,834 | $5,325,738,667 | $5,631,487,754 | $5,971,455,991 | $6,262,702,224 | $6,394,399,918 |
| | | | | | | |
| **CalSIM Projected Expansion Enrollment** | 780,000 | 885,000 | 900,000 | 910,000 | 910,000 | 910,000 |
| **CalSIM Projected Member Months** | 4,680,000 | 10,620,000 | 10,800,000 | 10,920,000 | 10,920,000 | 10,920,000 |

| **Benefit Differentials** | **Incremental Cost** | **Incremental Total State/Local Share of Benefit Cost** | | | | |
|---|---|---|---|---|---|---|
| **Long-Term Care** | **SFY 2014** | **SFY 2017** | **SFY 2018** | **SFY 2019** | **SFY 2020** | **CY 2020** |
| Nursing Facility > 100 Days | $ (12.10) | (3,542,465) | (8,206,835) | (10,312,902) | (14,059,261) | (16,888,132) |
| HCBS services ** | $ (26.96) | (7,398,843) | (17,064,770) | (21,881,180) | (29,829,939) | (35,832,035) |
| **Ambulatory Patient Services** | | | | | | |
| Targeted Case Management | $ (1.47) | (434,902) | (1,008,280) | (1,262,773) | (1,721,499) | (2,067,883) |
| Home Health Care > 45 visits | $ (0.01) | (2,960) | (6,826) | (8,759) | (11,941) | (14,344) |
| **Mental Health & Substance Use Disorder Services** | | | | | | |
| Adult Residential Treatment Services * | $ (0.31) | (90,780) | (202,164) | (262,626) | (343,434) | (412,537) |
| Family Mental Health Therapy * | $ (0.24) | (69,420) | (160,542) | (198,744) | (259,896) | (312,190) |
| Group Mental Health Therapy * | $ (0.40) | (117,480) | (267,570) | (326,508) | (445,536) | (535,183) |
| Medication Support Services * | $ (7.15) | (2,085,270) | (4,780,584) | (5,877,144) | (7,917,546) | (9,510,639) |
| Other DD Services Including ABA *** | $ (3.64) | (999,224) | (2,304,465) | (2,955,780) | (4,029,523) | (4,840,306) |
| Outpatient Drug-Free Treatment * | $ (1.20) | (349,770) | (802,710) | (986,622) | (1,336,608) | (1,605,548) |
| Targeted Case Management * | $ (4.78) | (1,445,997) | (3,357,044) | (4,177,767) | (5,695,421) | (6,841,399) |
| **Prescription Drugs** | | | | | | |
| Blood & Blood Derivatives | $ (0.82) | (229,094) | (528,891) | (675,251) | (920,550) | (1,105,774) |
| Prenatal Vitamins | $ (0.04) | (10,752) | (24,979) | (30,988) | (42,245) | (50,745) |
| Weight Loss Drugs | $ (0.02) | (6,668) | (15,457) | (19,367) | (26,403) | (31,715) |
| **Pediatric Services** | | | | | | |
| EPSDT **** | $ (0.04) | (10,138) | (23,445) | (29,693) | (40,480) | (48,625) |
| **Rehabilitative & Habilitative Services & Devices** | | | | | | |
| DME > $350 | $ (2.40) | (676,576) | (1,563,254) | (1,988,374) | (2,710,689) | (3,256,108) |
| | | | | | | |
| **Total Differential Cost** | $ (61.58) | $ (17,470,339) | $ (40,317,816) | $ (50,994,478) | $ (69,390,971) | $ (83,353,161) |
| **Projected Anthem PMPM Cost** | $ 379.33 | $ 436.05 | $ 453.63 | $ 474.99 | $ 498.75 | $ 509.24 |

*- Figures provided by TAC and HSRI

**- HCBS services, for the purpose of this analysis, include IHSS/Personal Care Sercies and Adult Day Health Care/Community Baserd Adult Services (ADHC/CBAS).
All waiver services have been excluded.

***- ABA claims were included in this category for therapy related procedural codes that had an associated Autism related diagnosis (299.xx).
All DDS waiver services were excluded. Other non-waiver DDS related services, targeted case management and personal care services are included

****- This represents an estimate of the additional costs to bring the Anthem Choice option into compliance with current EPSDT requirements.

# Exhibit 2
# DRAFT Newly Eligible Optional Expansion
# Alternative Benefit Package Cost Estimation

| EXHIBIT 2 (Enhanced Scanario) | SFY 2014 | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | CY 2020 |
|---|---|---|---|---|---|---|---|---|
| CalSIM Projected Expansion Enrollment* | 780,000 | 810,000 | 860,000 | 885,000 | 900,000 | 910,000 | 910,000 | 910,000 |
| **ABP = Medi-Cal** | | | | | | | | |
| Projected Expansion PMPM Cost | $ 440.92 | $ 466.88 | $ 480.23 | $ 501.48 | $ 521.43 | $ 546.84 | $ 573.51 | $ 585.57 |
| Projected Total Annual Cost | $ 2,063,487,834 | $ 4,538,062,391 | $ 4,956,018,702 | $ 5,325,738,667 | $ 5,631,487,754 | $ 5,971,455,991 | $ 6,262,702,224 | $ 6,394,399,918 |
| FMAP % | 100.0% | 100.0% | 100.0% | 97.5% | 94.5% | 93.5% | 91.5% | 90.0% |
| Federal Share of Total Cost | $ 2,060,483,940 | $ 4,531,230,916 | $ 4,948,108,404 | $ 5,182,999,916 | $ 5,311,662,916 | $ 5,572,597,327 | $ 5,718,728,467 | $ 5,754,959,926 |
| Non-Federal Share of Total Cost | $ 3,003,894 | $ 6,831,474 | $ 7,910,298 | $ 142,738,752 | $ 319,824,839 | $ 398,858,664 | $ 543,973,757 | $ 639,439,992 |
| **ABP = Anthem CHOICE** | | | | | | | | |
| Projected Expansion PMPM Cost | $ 379.33 | $ 414.96 | $ 427.37 | $ 436.05 | $ 453.63 | $ 474.99 | $ 498.75 | $ 509.24 |
| Projected Total Annual Cost | $ 1,775,278,276 | $ 4,033,434,143 | $ 4,410,476,981 | $ 4,630,851,019 | $ 4,899,176,259 | $ 5,186,925,568 | $ 5,446,337,856 | $ 5,560,868,311 |
| FMAP % | 100.0% | 100.0% | 100.0% | 97.5% | 94.5% | 93.5% | 91.5% | 90.0% |
| Federal Share of Total Cost | $ 1,772,274,382 | $ 4,026,602,668 | $ 4,402,566,683 | $ 4,505,582,606 | $ 4,619,669,236 | $ 4,839,061,382 | $ 4,971,755,070 | $ 5,004,781,480 |
| Non-Federal Share of Total Cost | $ 3,003,894 | $ 6,831,474 | $ 7,910,298 | $ 125,268,413 | $ 279,507,022 | $ 347,864,186 | $ 474,582,786 | $ 556,086,831 |
| **ABP Differential** | | | | | | | | |
| Projected Total Annual Cost | $ 288,209,558 | $ 504,628,248 | $ 545,541,721 | $ 694,887,648 | $ 732,311,496 | $ 784,530,423 | $ 816,364,368 | $ 833,531,607 |
| FMAP % | 100.0% | 100.0% | 100.0% | 97.5% | 94.5% | 93.5% | 91.5% | 90.0% |
| Federal Share of Total Cost | $ 288,209,558 | $ 504,628,248 | $ 545,541,721 | $ 677,417,309 | $ 691,993,680 | $ 733,535,946 | $ 746,973,397 | $ 750,178,446 |
| Non-Federal Share of Total Cost | $ - | $ - | $ - | $ 17,470,339 | $ 40,317,816 | $ 50,994,478 | $ 69,390,971 | $ 83,353,161 |

* - While total potential benefit costs are provided in this analysis based on the CalSIM projections, actual costs may be higher or lower than the estimates represented in this analysis.
DHCS is completing an analysis of initial and long-term take-up rates and demographics for the expansion populations.

Notes

The Non-Federal Share amounts for SFY2014-2016 reflect an estimate of projected spending on non-federally eligible abortion services for the expansion population.

FY FMAP percentages are calculated using the CY federally prescribed rate.

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