Medicaid - Introduction to the Implementation Guide for the Alternative Benefit Plan Section

The following guide provides useful information for completion of the Alternative Benefit Plan (ABP) section of the Medicaid state plan in OneMAC. The guide is intended to be used in conjunction with the ABP fillable PDFs (state plan pages) and provides statutory and regulatory background, in addition to guidance regarding what information is to be provided by the states and territories.

Guidelines

Below are important guidelines to follow when completing the PDFs:

- The ABP content in these PDFs is effective January 1, 2014. The PDFs cannot be used to submit new ABPs or make changes to existing ABPs that are effective prior to that date. To submit new ABPs or make changes to existing ABPs that are effective prior to January 1, 2014, use the existing paper pre-prints.
- The PDFs are designed to reduce the number of questions states/territories have to answer by presenting secondary questions only based on the answers to primary questions. In order to avoid having to answer secondary questions that do not apply to your state/territory, make sure to answer primary questions accurately, based on your state/territory policy.
- Make sure to check all boxes that use the wording "assures," "attests," or "assurance." These are statements about which there is no choice, and by checking these, the state/territory is confirming that it will follow the requirement described. The SPA cannot be approved unless you have checked all assurance boxes. When you check the box, a "check" will appear on the screen, rather than an "X."
- An ABP is made up of three components;
    - An **ABP population** that is defined in the **ABP1 – Alternative Benefit Plan Populations** state plan page and for which related enrollment or selection assurances must be completed in the **ABP2a**, **ABP2b**, and/or **ABP2c** state plan pages, as appropriate.
    - One or more **ABP benefit packages**, for which an **ABP3 – Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package** state plan page, must be completed to identify the sources of the benefits and the type of benefit package, either a benchmark benefit package or a benchmark-equivalent benefit package.
        - For benchmark benefit packages **ABP 4 – Alternative Benefit Plan Cost-Sharing** is completed if there is any cost-sharing associated with each benefit package and **ABP5 - Benefits Description** is completed to define the specific benefits in each benefit package.

        - For benchmark-equivalent benefit packages **ABP 6 – Benchmark Equivalent Benefit Package** state plan page must be completed related to the benchmark-equivalent benefits and assurances.
        - For all benchmark or benchmark-equivalent benefit packages **ABP 7 – Benefit Assurances** must be completed with assurances related to the benefit package and **ABP 9 – Employer Sponsored Insurance and Payment of Premiums** may be completed, at state/territory option, if benefits will be provided through employer-sponsored insurance or payment of premiums for commercial insurance products.
    - One or more **ABP service delivery systems**, for which the state/territory must complete the **ABP8 – Service Delivery Systems** state plan page for each such service delivery system that will be used to deliver the services defined in the benefit package. The same service delivery system can be used for multiple benefit packages or the state can define separate service delivery systems for each benefit package if it has more than one benefit package.
    - The state/territory must also complete **ABP10 - General Assurances** and **ABP11 - Payment Methodology** for each ABP submitted.
- Included in the header of each fillable PDF is a label; Attachment 3.1C. ☐.
  The state/territory should use the same number or letter in the box to designate state plan pages for the same ABP. If there is more than one ABP benefit package or ABP service delivery system associated with a particular ABP identify these different benefit packages and/or service delivery systems in the text field for a description of the form when uploading the PDF in OneMAC.
- Payment exclusions in section 1905(a) and 1903(i) apply to the provision of services in the ABPs that are not offered via a premium assistance model.
- States and territories are required to provide public notice including identification of EPSDT protections and solicit comments for each ABP prior to the submission of the SPA. Tribal notice requirements also apply. Copies of the public notice(s) must be attached to the ABP SPA submission. See the instructions for this in the **ABP1 – Alternative Benefit Plan Populations** implementation guide.

Alternative Benefit Plan State Plan Pages

This ABP implementation guide includes sections for the following state plan pages:

ABP1 – Alternative Benefit Plan Populations

This state plan page is used to identify and define eligible Medicaid populations that will receive their Medicaid coverage through an Alternative Benefit Plan (ABP). It should be the first state plan page completed when submitting an ABP State Plan Amendment (SPA).

ABP2a - Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

This is the first of three state plan pages in which the state or territory provides assurances concerning the enrollment of Medicaid beneficiaries into an ABP or, for the Adult eligibility group, the selection of an ABP. This particular state plan page must be completed if the ABP population includes the Adult eligibility group under section 1902(a)(10)(A)(i)(VIII) of the Act, either alone or in combination with other eligibility groups, unless the state/territory has fully aligned its section 1937 ABP for the Adult group with its approved Medicaid state plan benefit package.

ABP2b - Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act

This is the second of three state plan pages in which the state/territory provides assurances and descriptions of its procedures related to the enrollment of individuals in ABPs. This state plan page is presented and must be completed if the state/territory indicates that the ABP population includes eligibility groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII). It is presented regardless of whether such groups are designated for voluntary or mandatory enrollment, as even those groups designated for mandatory enrollment will include some individuals who are exempt and therefore subject to voluntary enrollment requirements.

ABP2c – Enrollment Assurances – Mandatory Participants

The state/territory must provide assurances concerning its processes related to individuals who are subject to mandatory enrollment in an ABP if it has designated any eligibility groups for such enrollment, with the exception of section 1937 ABPs that only for the Adult group and are fully aligned with the state/territory's approved Medicaid state plan benefit package. In this state plan page the state/territory provides these assurances and information concerning how it identifies individuals who are potentially exempt from mandatory enrollment at time of enrollment, as well as how it identifies individuals who were previously mandatory enrollees but have become

exempt from mandatory enrollment. It must be completed if the state/territory indicates that one or more eligibility groups are designated for mandatory enrollment.

ABP3 - Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

This state plan page is used to select the ABP's section 1937 coverage option and its base benchmark plan, that are used to establish the benefit package provided through the ABP.

ABP4 - Alternative Benefit Plan Cost-Sharing

In this state plan page the state/territory provides assurances related to the imposition of any cost-sharing or premium requirements on beneficiaries participating in the ABP and indicates if it includes cost-sharing that is different from that in its standard, approved Medicaid state plan for individuals with income greater than the federal poverty level.

ABP5 - Benefits Description

This state plan page is used first to indicate if benefits are provided as part of a benchmark benefit package or a benchmark-equivalent benefit package. If benchmark benefit package is selected, the state/territory must then record details concerning the benefits that are included in the benefit package or benefit packages provided to individuals participating in the ABP.

ABP6 - Benchmark-Equivalent Benefit Package

In this state plan page states and territories describe the benchmark-equivalent benefit package they will provide as the ABP's section 1937 coverage option, if the state/territory has elected to provide such a benefit package. In addition, states and territories provide certain assurances related to their benchmark-equivalent benefit package. It also captures information concerning whether the comparison benchmark plan, used to calculate equivalency, includes vision and/or hearing services and, if so, presents additional assurances concerning required coverage of these services in the benchmark-equivalent benefit package.

ABP7 - Benefits Assurances

In this state plan page the state/territory provides a number of assurances concerning benefits provided under the ABP. These assurances include providing access to Early and Periodic, Diagnostic and Treatment (EPSDT) services, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services, and non-emergency medical transportation services. If individuals under age 21 will be enrolled in a state/territory's ABP, it is required to provide specific information concerning how it will comply with the EPSDT requirements. In addition, assurances are provided concerning prescription drug coverage, the actuarial equivalency of any substituted benefits, payments to RHCs and FQHCs, compliance with other payment methodology requirements, provision of Essential Health Benefits (EHB), mental health and

substance use disorder services parity requirements, and the provision of family planning services and supplies, and preventive services.

ABP8 - Service Delivery Systems

In this state plan page the state/territory indicates and describes the service delivery system or systems it will use to deliver benefits to the ABPs participants, including managed care options, fee-for-service, or another form of service delivery.

ABP9 - Employer Sponsored Insurance and Payment of Premiums

States and territories may provide for ABP coverage in whole or in part by paying for employer sponsored health plans for individuals with access to such employer sponsored private health insurance, or by purchasing other commercial insurance coverage directly. These models must be voluntary for the beneficiaries when using section 1937. In this state plan page the state/territory indicates if it elects these options and, if so, provides additional information and assurances concerning such arrangements.

ABP10 - General Assurances

This state plan page is used to record the state/territory's assurances concerning compliance with general Medicaid requirements for the ABP.

ABP11 - Payment Methodology

This state plan page is used to provide the state/territory's assurance concerning the payment methodologies used for the ABP's benefits, if they are provided through a service delivery system other than managed care. This page is not used for ABPs that are benchmark-equivalent plans. Payment methodologies for benefits included in benchmark-equivalent plans are described in the documents that are attached following completion of the **ABP6 – Benchmark Equivalent Benefit Package** state plan page.