ABP7 – Benefit Assurances

Statute: 1937; 1927; 1905(r); 1902(bb)

Regulation: 42 CFR 440.345; 42 CFR 440.347; 42 CFR 440.365; 42 CFR 440.390; 42 CFR Part 447, Subpart I; 45 CFR 115(a)(4) and 45 CFR 147.130

INTRODUCTION

On this state plan page (fillable PDF) the state/territory provides a number of assurances concerning benefits provided under the Alternative Benefit Plan (ABP). These assurances include providing access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services, and non-emergency medical transportation services. If the ABP provides services to individuals under age 21 the state/territory 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, the provision of family planning services and supplies, and preventive services.

BACKGROUND

Section 1937 of the Act and regulations in 42 CFR Part 440 Subpart C contain provisions requiring that the state/territory provide full EPSDT services to any individuals under age 21 participating in an ABP and also comply with requirements concerning access to and payment for RHC and FQHC services. Assurances are provided so that the state/territory can assure it complies with these requirements.

Specific to the EPSDT requirements, the state/territory must indicate how it will provide the EPSDT services and how any other benefits that are not covered in the ABP or the state's approved Medicaid state plan may be provided to meet this requirement.

The state/territory must also provide assurances that it will comply with the covered outpatient drug requirements of section 1927 of the Act and 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act. The state/territory's coverage under the Alternative Benefit Plan does not need to be identical to its coverage of the Prescribed Drug benefit in the state/territory's approved state plan. For example, the state/territory could have two preferred drug lists - one for traditional Medicaid and one for the Alternative Benefit Plan. Coverage must be at least the greater of one

drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark plan.

The state/territory must also provide assurance of its compliance with several other requirements of the Social Security Act or other provisions in Federal law:

- Substituted benefits must be actuarially equivalent to the benefit that is replaced and in the same Essential Health Benefit category.
- Individuals participating in an ABP must have access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Payments to FQHCs and RHCs must be in compliance with the prospective payment methodology requirements of 1902(bb) of the Social Security Act.
- ABPs must include Essential Health Benefits in each of the ten EHB categories.
- Mental health and substance use disorder benefits must be provided in parity with medical/surgical benefits.
- Family planning services and supplies must be provided to individuals of child-bearing age.
- The state/territory must assure the provision of emergency and non-emergency transportation services to medical services for ABP individuals.
- The ABP benefit package must include a broad range of preventive services as specified in federal law.

TECHNICAL GUIDANCE

EPSDT Assurances

Indicate, ***Yes*** or ***No***, whether or not the ABP will serve individuals under age 21. If ***Yes***;

- The state/territory must affirmatively indicate by selecting the first assurance that the notice to individuals participating in Alternative Benefit Plans includes a description of the method for ensuring access to EPSDT services, consistent with 42 CFR 440.345.
- The state/territory must affirmatively elect the second assurance indicating that EPSDT services will be provided to individuals less than 21 years of age.

The state/territory provides these affirmative assurances by checking the box next to the assurances

Review Criteria

The state/territory must affirmatively indicate its agreement with the first two assurances related to EPSDT services by selecting them. If these assurances are not selected the SPA cannot be approved.

The state/territory must then select from the two options presented to indicate how it will comply with the second assurance. This can be done by either providing EPSDT benefits:

- Through the Alternative Benefit Plan by covering all EPSDT services through the ABP because the ABP is aligned with the state plan and therefore, all services that could be covered in the state plan are available to individuals eligible for EPSDT even if the state does not provide these services to the rest of the Medicaid population, or
- Through an Alternative Benefit Plan with other benefits because the 1937 plan does not include coverage of full EPSDT services, as defined in section 1905(r) of the Act. If this option is selected, the state/territory has chosen to supplement the 1937 plan in order to meet the requirement to provide full EPSDT services, and must indicate if it will provide the EPSDT benefits through either:
    - Fee-for-service payments made directly by the Medicaid agency; or
    - Contracted arrangements with a provider or plan to provide the other EPSDT services.
        - If this option is selected, the state/territory must select one of the options provided to indicate the payment method that will be used to reimburse the provider: Risked based capitation, Administrative services contract or Other. If other payment method is selected, the state/territory must provide in the text box a description of the other payment method that will be used.
- **We note**: Other benefits provided under section 1937 to meet the assurance of full access to EPSDT services are not available to be provided to mandatory participants in the Adult eligibility group under section 1902(a)(10)(A)(i)(VIII) of the Act. However, for nineteen and twenty year old beneficiaries in the Adult group, states and territories are required to meet EPSDT requirements by providing all necessary section 1905(a) services that could be covered in the state plan even if the state does not provide these services to the rest of the Medicaid population

Review Criteria

The state/territory must select one of the two options to indicate the EPSDT services that will be provided. If one of these options is not selected, the SPA cannot be approved.

If the second option is selected, to provide the benefits through an Alternative Benefit Plan with other services, the state/territory must choose one of the two options for how these services will be provided: through fee-for-service or through a contracted provider. If one of these options is not selected, the SPA cannot be approved.

If the contracted provider option is chosen, the state/territory must select one of the three available options to indicate the payment method that will be used. If "Other" is selected the state/territory must provide a clear and thorough description of the other payment method. The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state/territory's election meets applicable federal statutory, regulatory and policy requirements.

If the state/territory does not choose one of the options, or if "Other" is selected a clear and thorough description is not provided, the SPA cannot be approved.

States and territories may then add additional information in the text box provided to describe how EPSDT services will be provided. If full EPSDT benefits are provided through a combination of the Alternative Benefit Plan and other services, the state is encouraged to include in this text box additional information required by §440.345 about how benefits are coordinated and how beneficiaries and providers will be informed in order to ensure individuals have access to the full EPSDT benefit.

Prescription Drug Coverage Assurances

The state/territory then must affirmatively select the four assurances pertaining to Prescription Drug Coverage under the Alternative Benefit Plan.

- It must affirm that it meets the minimum requirements for drug coverage under section 1937 of the Act and 42 CFR 440.347 by providing coverage that is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark plan.
- It must affirm that it has procedures in place to allow the beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- It must assure that it meets the requirements of section 1927 of the Act and 42 CFR 440.345 when paying for outpatient prescription drugs under the Alternative Benefit Plan, except for requirements that are directly contrary limitations on coverage permitted by section 1937.
- It must assure that it will comply with prior authorization requirements in section 1927(d)(5) of the Act when conducting prior authorization activities for the Alternative Benefit Plan.

The state/territory provides these affirmative assurances by checking the box next to the assurances.

Review Criteria

The state/territory must affirmatively indicate that it agrees to the four Prescription Drug assurances by selecting each of them. If the state/territory does not select all four of these assurances, the SPA cannot be approved.

Other Benefit Assurances

Next the state/territory must provide the following affirmative assurances:

- That substituted benefits are actuarially equivalent to the benefits from the base benchmark plan that they replace and in the same EHB category and the state/territory has actuarial certification of actuarial equivalency available for CMS inspection if requested.
- That Alternative Benefit Plan enrollees will have access to services in Rural Health Clinics and Federally Qualified Health Centers.
- That the Alternative Benefit Plan will use the prospective payment methodology for RHCs and FQHCs prescribed by section 1902(bb) in the same manner as with its approved state plan.
- Provide that effective January 1, 2014 it will comply with section 1937(b)(5) of the Act by providing at a minimum the Essential Health Benefits described in section 1302(b) of the Affordable Care Act.
- Provide that it will comply with section 1937(b)(6) of the Act concerning mental health and substance use disorder parity requirements by ensuring that the financial requirements and treatment limitations applicable to such services meet the requirements of section 2705(a) of the Public Health Service Act.
- Provide that it will comply with section 1937(b)(7) of the Act by providing family planning services and supplies.
- That it assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan.
- That, in accordance with 45 CFR 115(a)(4) and 45 CFR 147.130 it will provide as Essential Health Benefits a broad range of preventive services as indicated in the assurance.

The state/territory provides these affirmative assurances by checking the box next to the assurances.

Review Criteria

The state/territory must affirmatively indicate that it will comply with all of these assurances by selecting each one. If the state/territory does not select each of these assurances, the SPA cannot be approved.