ABP5 – Benefits Description

Statute: 1937(b)(1)(A), (B), (C) and (D); 1937(b)(5)
Section 1302(b) of the Affordable Care Act

Regulation: 42 CFR 440.330; 42 CFR 440.345; 42 CFR 440.347; 42 CFR 440.360
45 CFR Part 156

INTRODUCTION

This fillable PDF (state plan page) is designed for the state/territory to indicate if the Alternative Benefit Plan's (ABP) 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.

BACKGROUND

Overview

This state plan fillable PDF captures information about the benefits that are included in the ABP. States and territories are required to provide the benefits included in the section 1937 coverage option and also the Essential Health Benefits (EHBs) defined by the benefits included in the base benchmark plan. The state/territory identified its selection of these plans in one of the following fillable PDFs: **ABP3 – Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package** or **ABP3.1 – Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package**. The state/territory has the option of providing benefits from other benefit sources for the ABP as described below:

- The state's/territory's selected base benchmark plan's EHBs;
- The state's/territory's selected section 1937 coverage option (if different from the base benchmark plan);
- Supplemental benefits chosen from the base benchmark plan options, if all ten EHB categories are not provided by the selected base benchmark plan;
- Added benefits from the section 1937 coverage options, the base benchmark plans, or the state's/territory's approved Medicaid state plan through Secretary-approved coverage for the Adult eligibility group under section 1902(a)(10)(A)(i)(VIII) (hereinafter referred to as the Adult group) and other eligibility groups or "additional" benefits, as described in section 1937, for all eligibility groups other than the Adult group;
- Optional substituted benefits, in which the state/territory substitutes a benefit or group of benefits for one of the benefits used to define an EHB in the base benchmark plan; and
- Habilitation services and devices if these are not provided by the base benchmark plan or as supplemental benefits.

Supplemental Benefits

Supplemental benefits are provided if any EHB categories are missing from the base benchmark plan. In this case the state/territory must add all of the services in that EHB category from another base benchmark plan to assure that all ten EHB categories and services are included in the ABP.

Additional Benefits

The state/territory may also include in the ABP benefit package additional benefits from its selected base benchmark plan, another base benchmark plan, or other sources listed below. Additional benefits may not be added to benefit packages for an ABP that provides coverage to participants in the Adult group. States/territories may, however, include these benefits in Secretary-Approved benefit packages due to the flexibility inherent in the definition of that type of section 1937 coverage option.

The state/territory can choose to include additional benefits to the ABP, or construct a Secretary approved benefit package from:

- The three section 1937 public employee/commercial plan coverage options;
- Section 1905(a) state plan benefits;
- Section 1915(i) home and community-based state plan services;
- Section 1915(j) personal care attendant state plan services;
- Section 1915(k) Community First Choice state plan services and supports;
- Section 1945 Health Homes services;
- Any other Medicaid state plan benefits enacted under Title XIX;
- Any benefits from any of the base benchmark plans.

Substituted Benefits

As provided by 45 CFR 156.115(b) the state/territory may also provide substituted benefits by replacing an EHB from the base benchmark plan with another benefit in the same EHB category from one of the sources listed above under additional benefits, or from another source. In this case the substituted benefit must be at least the actuarial equivalent of the benefit from the base benchmark plan used to define an EHB that it is replacing, it must be in the same EHB category as the benefit that is being replaced; and it may not be a prescription drug benefit. The state/territory must assure CMS that the actuarial equivalence calculations have been conducted and are available to CMS upon request, and the actuarial equivalence of the benefits must be determined regardless of cost-sharing.

Duplicate Benefits

In the event the base benchmark plan and the section 1937 coverage option are different and include one or more benefits that are the same, the state/territory only needs to enter the duplicated benefit one time. Generally, the state/territory must use an EHB from the base

benchmark plan. However, if the section 1937 coverage option benefit that is from one of the three public employee or commercial products provides a service in a greater amount, duration, or scope than the EHB provided in the base benchmark plan, the state/territory must utilize the section 1937 standard for that service. A less generous benefit from the section 1937 coverage option for a base benchmark plan EHB as the base benchmark coverage is the minimum level of coverage may not be used. If the section 1937 coverage option is Secretary-approved coverage, then the state/territory may choose which benefit to use as long as the benefit is at least the same as the base benchmark coverage.

Other Requirements

The state/territory may specify limitations on amount, duration or scope or any authorization requirements for a benefit that is being added that is not already in the state/territory's approved Medicaid state plan. As previously mentioned, additional benefits cannot be provided to participants in the Adult group.

The state/territory must use the limitations prescribed by the commercial benchmark plans for those section 1937 coverage options, but it may prescribe its own authorization requirements for the benefit. For these benefits, the state/territory has the option of using the provider qualifications requirements of the section 1937 coverage option or base benchmark plan, or the state/territory's approved Medicaid plan, or a combination of these.

If state plan benefits are included in a proposed Secretary-Approved Coverage benefit package, they can be from those included in the approved state plan or a variation, including state plan benefits not included in the state plan, a partial list of the approved state plan benefits, or approved state plan benefits with different limitations or authorization requirements. The Secretary-Approved section 1937 option benefit package must also include the EHBs from the base benchmark plan designated by the state/territory and any supplemental benefits necessary to assure that benefits are provided in all ten EHB categories.

In completing this state plan page, the state/territory first indicates whether benefits are provided as a benchmark benefit package or a benchmark-equivalent benefit package. If provided through a benchmark benefit package, a section is presented for the state/territory to record the details concerning the benefits included in the package. This section of the state plan page is organized by each of the ten EHB categories. Within each EHB category, the state/territory provides the following information concerning the benefits included in the ABP:

- The name of each benefit included;
- The source of the benefit (1937 coverage option, base benchmark plan, state plan, etc.;
- Amount, duration and scope limitations for each benefit;
- Specific authorization requirements related to the benefit (the state/territory should type in "none" if applicable; and
- The source for provider qualification requirements for each benefit (state plan, commercial plan or both, or "Other" if it is from a state plan authority not included in the state/territory's approved Medicaid state plan or a state-defined habilitation service or device)

The state/territory must record all benefits from its section 1937 coverage option and all benefits that define EHBs from the selected base benchmark plan. In addition, there are sections for the state/territory to indicate other benefits that are (or are not) included in the benefit package. These include those described in more detail above:

- ***Other Covered Benefits from Base Benchmark Plan:*** The state/territory may choose to include base benchmark plan benefits that it asserts are not an EHB as an additional benefit.
- ***Base Benchmark Benefits Not Covered Due to Substitution or Duplication:*** The state/territory may propose to not include certain base benchmark plan benefits if it is providing a substituted benefit that is actuarially equivalent to the benefit not provided and is in the same EHB, or it is providing a duplicate benefit from the section 1937 coverage option plan.
- ***Other Base Benchmark Benefits Not Covered:*** The state/territory must record benefits included in the base benchmark plan that it asserts are not an EHB and which it is not choosing to include in the benefit package as ***Other Covered Benefits from the Base Benchmark Plan***.
- ***Other 1937 Covered Benefits that are not Essential Health Benefits:*** In this section the state/territory must record any benefits from the selected section 1937 coverage option that are not an EHB.
- ***Additional Covered Benefits:*** The state/territory may provide additional benefits from other section 1937 coverage options, base benchmark plan options, its approved Medicaid state plan or other state plan options. The state/territory may not provide this type of benefit to individuals in the Adult group, except through a Secretary-Approved section 1937 benchmark benefit package.

This section does not have to be completed if the state/territory elects to provide a benchmark-equivalent benefit package, instead of a benchmark benefit package. Instead, it will complete a different state plan page with information about the benchmark-equivalent benefit package and attach to the State Plan Amendment (SPA) a detailed chart describing the benefits

provided, amount, duration, and scope limitations for each benefit, and provider qualifications. The state/territory will also need to submit supporting actuarial reports, if applicable.

Note: The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2019 Final Regulation (referred to in this Bulletin as the CMS 2019 Payment Notice) published on April 17, 2018 replaces the phrase 'base benchmark' with 'EHB-benchmark' when describing benefit packages used to define the ABP.

TECHNICAL GUIDANCE

Indication of Benchmark or Benchmark-Equivalent Benefit Package

First, the state/territory indicates, ***Yes*** or ***No,*** if it is proposing a benchmark-equivalent benefit package.

- If ***Yes***, this state plan page is complete, and the user will proceed to the **ABP6 - Benchmark-Equivalent Benefit Package** state plan page to provide the details concerning the benchmark-equivalent benefit package.
- If ***No***, then the state/territory is providing one or more benchmark benefit packages for the ABP and must complete the subsequent sections to describe the benefits provided in each benefit package.

Review Criteria

The state/territory must indicate, Yes or No, if the benefit package is a benchmark-equivalent benefit package. If a selection is not made, the SPA cannot be approved. The selection made must be the same as that indicated in ABP3, Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package. If it is not the same, the SPA cannot be approved.

Benefits Included in Alternative Benefit Plan

For every benchmark benefit package (including Secretary-Approved section 1937 benefit packages) the state/territory must provide the name of its selected base benchmark plan that will be used to define the EHBs in the text box provided.

Next, the state/territory must provide the name of the section 1937 coverage option benchmark plan that will be used to define the benefits of the ABP in the text box provided. If the section 1937 coverage option is Secretary-Approved Coverage, enter "Secretary-Approved" in the text box.

Review Criteria

The state/territory must provide the names of the base benchmark plan and the section 1937 coverage option benchmark plan that it is using to define benefits for the Alternative Benefit Plan. The names of these plans must match those provided in the ABP3, Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package state plan page. If the names of the plans are not provided or if they do not match those provided in ABP3, the SPA cannot be approved.

The state/territory must next complete sections providing the details of benefits included in the ABP benchmark benefit package. The first section of the ABP5 fillable PDF captures the ten EHB categories.

In this fillable PDF the state/territory records EHBs from the following sources:

- The selected base benchmark plan;
- Any supplemental benefits from another base benchmark plan if the indicated base benchmark plan does not include benefits in all ten EHB categories;
- The section 1937 coverage option benchmark plan, eliminating any duplicate benefits that are included in the base benchmark plan (see further discussion below);
- Any substituted benefits – actuarially-equivalent benefits being substituted for a base benchmark plan and in the same EHB category;
- Any habilitation services and devices, if these are not provided by the base benchmark plan or as supplemental benefits; and
- Any additional benefits from another base benchmark plan, section 1937 coverage option, or Medicaid state plan authority that are EHBs and are added at state/territory option. The state/territory must not add additional benefits to an ABP that provides coverage to the Adult group, except in a Secretary-Approved section 1937 option benefit package.

Note: There is also a "Secretary-Approved – Other" option for the ***Source*** field. This selection is reserved for use at CMS discretion. States should not use this option unless approved by CMS.

The state/territory must identify all benefits in its ABP that are EHBs and include them in the appropriate one of the ten EHB categories.

The guidance is the same for completing the first group of EHBs below, except for assurances required for ***EHB5. Mental health and substance use disorder services including behavioral health services*** and ***EHB7. Rehabilitative and habilitation services*** EHBs***.*** Instructions for the assurance immediately follow the first set of instructions.

Note: There are separate instructions for ***EHB6. Prescription drugs, EHB9. Preventive and wellness services and chronic disease management,*** and ***EHB 10. Pediatric services including oral and vision care*** following those for EHBs 1-5, 7, and 8.

Essential Health Benefits – (1. Ambulatory patient services, 2. Emergency services, 3. Hospitalization, 4. Maternity and newborn care, 5. Mental health and substance use disorder services including behavioral health treatment, 7. Rehabilitative and habilitative services and devices, 8. Laboratory services)

Benefit Provided
Provide the name of each benefit provided for each of the EHB categories. To add more benefits to a category, click on the ***Add*** button to add a subsection for another benefit.

Source of the Benefit
Indicate the benefit plan that is the source of the benefit from the list of options provided. If the source of a benefit being used for substitution purposes is not from one of the available choices, please select "Secretary approved other" and describe the source of the benefit in the "Other Information Regarding this Benefit" text box below.

Authorization

- If the benefit requires any kind of authorization, select the authorization type from the drop-down list.
- If ***Other*** is selected, describe it in the ***Other information regarding this benefit…*** text box section.

- If the benefit does not require an authorization, select *"None."*

Provider Qualifications

- Select the type or types of provider qualifications that apply to the benefit. The state/territory has the option of using the provider qualifications requirements of the public employee/commercial benchmark plan or the state/territory's approved Medicaid plan, a combination of the two, or from an ***Other*** source.

  Other
- This source should be selected if the benefit is a state plan benefit not included in the state/territory's approved state plan or a state-defined habilitation service or device. Provide the following details in the ***Other information regarding this benefit…*** text box:
  - The type of provider(s) to which the qualification applies;
  - Any specific services within the benefit to which the qualifications apply;
  - The type of qualification(s) required, including:

- License;
- Certification;
- Education-based requirement; and/or
- Other requirement.

o Provide an explanation of any provider qualification requirements if not a state license.

Amount Limit, Duration Limit, Scope Limit

- Briefly describe any limitations in the amount, duration or scope of the benefit in the text boxes provided. An example of a hard limitation on amount of service is 22 visits per year. If the limitation is a soft limit, the state would indicate that there is a 22-visit limit per year and also designate the authorization process used for the benefit that allows for provision of service in excess of the limit based on medical necessity. If there are no limitations, please indicate "no limitations" in the text box provided. States and territories may use the limitations established by a commercial plan for benefits from the public employee/commercial plan base benchmark plans or section 1937 coverage options. For benefits authorized under Medicaid state plan sources, states/territories are cautioned to assure that any limitation on the scope of the benefit or service is not discriminatory and has a basis in medical necessity. States and territories must assure, to the satisfaction of the CMS reviewer, that any limitations imposed under Secretary-approved coverage will allow coverage sufficient for the benefit or service to achieve its purpose.

Other information regarding this benefit

Use this text box to provide additional details or an explanation of any of the choices selected.

Note: For states/territories whose ABP benefits align with the approved Medicaid State plan, the state/territory can reference the section of the approved Medicaid state plan where the benefit detail can be found. For example, *"Attachment 3.1-A, item 6d.- Other Licensed Practitioner"*

Review Criteria

The state/territory must provide the name and source for each Essential Health Benefit included in the Alternative Benefit Plan. For each such benefit it must also;

- ***Indicate for each benefit if authorization requirements apply and if Yes, indicate the type of authorization used or, if Other, provide a description of the authorization requirement.***
- ***Indicate the provider qualifications that apply or, if Other, provide the details concerning the provider qualifications in the Other information text box.***
- ***Provide any amount, duration, and scope limitations for each benefit.***

If the state/territory does not comply with these requirements the SPA cannot be approved.

Assurances

For ***EHB5. Mental health and substance use disorder services including behavioral health treatment***, select the assurance indicating that the state/territory does not apply requirements and limitations on mental health or substance use disorder benefits that are more restrictive than those for medical/surgical benefits in the same classification.

For ***EHB7. Rehabilitative and habilitation services*** select the assurance concerning not imposing limits in habilitative services that are more stringent than those on rehabilitative services and that the combined limit on habilitative services cannot be exceeded based on medical necessity.

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

Review Criteria

The state/territory must acknowledge these assurances by checking the box next to each one. If these boxes are not checked the SPA cannot be approved.

6. Essential Health Benefits – Prescription Drugs

For prescription drugs, states and territories must provide coverage that is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and case as the base benchmark plan. States/territories must also have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the ABP.

States and territories are not required to provide a detailed listing of the prescription drugs it covers in the ABP. The state/territory must provide the following regarding its prescription drug coverage:

Assurance

The state/territory provides this affirmative assurance by checking the box next to the assurance.

ABP5 – Benefits Description

This assurance applies to states providing the same prescription drug benefit as the state plan. The state selects the assurance indicating that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Review Criteria

The state/territory must acknowledge the assurance by checking the box next to it. If this box is not checked the SPA cannot be approved.

Prescription Drug Limits

- Indicate, by checking the box, if the state/territory imposes limits on the number of days' supply of drugs.
  - If selected, specify these limitations in the ***Coverage that exceeds the minimum requirements or Other*** text box.
- Indicate, by checking the box**,** if the state/territory imposes a limit on the number of prescriptions each month or for another time period.
  - If selected, specify these limitations in the ***Coverage that exceeds the minimum requirements or Other*** text box.
- Indicate, by checking the box, if the state/territory imposes a limit on brand drugs.
  - If selected, specify the number of brand fills permitted in the ***Coverage that exceeds the minimum requirements or Other*** text box.
- Indicate, by checking the box, if the state/territory imposes other prescription drug coverage limits.
  - If selected, describe these other limits in the ***Coverage that exceeds the minimum requirements or Other*** text box.
- Indicate, by checking the box, if the state/territory will use a preferred drug list for the ABP. If selected, describe its PDL and provide the website where the PDL can be viewed in the ***Coverage that exceeds the minimum requirements or Other*** text box.

Authorization

- Indicate, ***Yes*** or ***No***, if the state/territory requires prior authorization for any of its prescription drugs.
- If ***Yes***, generally describe the state/territory's prior authorization processes in the ***Coverage that exceeds the minimum requirements or Other*** text box.

Provider Qualifications

- Select the ***State licensed*** item.

Coverage that exceeds the minimum requirements or other

The state/territory must use this text box to describe any of the limitations or authorization requirements selected above. It must also record in this text box any prescription drug coverage that the state/territory intends to cover under its ABP that falls under the category of drugs that can be excluded or restricted. **Note:** These drugs are only permitted to be restricted or excluded to the extent the state/territory has met the minimum coverage requirements of section 1937 of the Act. That is, the state/territory provides prescription drug coverage that is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark plan and has procedures in place that allow an enrollee to gain access to clinically appropriate drugs:

- Agents when used for anorexia, weight loss or weight gain;
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair growth;
- Prescription vitamins and mineral products except prenatal vitamins and fluoride preparations;
- Non-prescription drugs (Over-the-Counter), except in the case of pregnant women when recommended in accordance with Guidelines referred to in Section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote tobacco cessation;
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

Note: The text box in this section labeled ***Coverage that exceeds the minimum requirements or other.*** This text box should be used by the state/territory to explain any limitations that pertain to the Prescription Drugs benefit and to also describe any prescription drug coverage that the state/territory provides in excess of minimum Medicaid requirements.

Review Criteria

The state/territory must indicate if it places any of the following limits on its Prescription Drug benefit including whether it has a preferred drug list:

- ***A limit on the number of days' supply of drugs;***
- ***A limit on the number of prescriptions each month or for another time period;***
- ***A limit on brand drugs; and***
- ***Any other applicable prescription drug coverage limits.***

If the state/territory selects one or more of these limitations, it must provide a description of the limit(s) it imposes. The state/territory must also indicate, Yes or No, if it has a preferred

drug list. If the state/territory fails to indicate if any of the specified limits apply or, if selected, does not provide a complete and thorough description of the limitation imposed, the SPA cannot be approved. Also, if the state/territory does not indicate if it has a preferred drug list, the SPA cannot be approved.

The state/territory must also indicate, Yes or No, if it has prior authorization requirements that pertain to the Prescription Drugs benefit and describe the prior authorization requirements in the text box. The state/territory must select State licensed as the provider qualification. Finally, the state/territory must describe any prescription drug benefits that are provided in the categories listed above that exceed the minimum requirements. If the state/territory fails to indicate if prior authorization requirements apply and, if Yes, does not provide a complete and thorough description of the authorization requirements; or fails to elect the provider qualifications; or indicate when prescription drug coverage exceeds the minimum requirements and provide a complete and thorough explanation; the SPA cannot be approved.

9. Essential Health Benefits – Preventive and Wellness Services and Chronic Disease Management

For this EHB, follow the instructions above under the ***Essential Health Benefits – (1. Ambulatory patient services, 2. Emergency services, 3. Hospitalization, 4. Maternity and newborn care, 5. Mental health and substance use disorder services including behavioral health treatment, 7. Rehabilitative and habilitative services and devices, 8. Laboratory services) EHBs.*** However, for preventive services states and territories must comply with the requirements of 45 CFR 147.130. This means the state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Review Criteria

The description of preventive services included in the ABP must include all of the following preventive services: A broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM). If this EHB does not include these mandatory preventive services, the SPA cannot be approved.

10. Essential Health Benefits – Pediatric Services

Because Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services requirements apply to all ABPs that serve individuals under the age of 21, states and territories are required to provide their approved Medicaid state plan EPSDT benefits to all such participants in the ABP. Therefore, the benefit name section is prefilled with this statement. States and territories may indicate in the Limitations and Authorization sections any that apply to their EPSDT benefits following the instructions above in the ***Essential Health Benefits – (1. Ambulatory patient services, 2. Emergency services, 3. Hospitalization, 4. Maternity and newborn care, 5. Mental health and substance use disorder services including behavioral health treatment, 7. Rehabilitative and habilitative services and devices, 8. Laboratory services)*** sub-section. The ***Other Information regarding this benefit…*** text box may also be used to expand on the description of the state/territory's EPSDT benefit and any limitations applicable to it.

Review Criteria

If the state/territory imposes any limitations or authorization requirements on EPSDT services, it must provide a complete and thorough explanation of any such limitations and how they will not prevent EPSDT individuals from receiving medically necessary services. If the state/territory does not provide this explanation the SPA cannot be approved.

11. Other Covered Benefits from Base Benchmark

States and territories may, at their option, provide benefits from the base benchmark plan that are not EHBs. These should be listed in this section along with the source, any limitations, authorization requirements, provider qualifications and other description (at state/territory option) using the instructions listed above in the ***Essential Health Benefits – (Other than Prescription Drugs, Preventive Services, and Pediatric Services)*** sub-section.

Review Criteria

If the state/territory includes in its benchmark benefit package other benefits from the base benchmark plan that are not Essential Health Benefits, it must

- ***Indicate if any limitations apply and, if so, provide a description of the limitations;***
- ***It must indicate for each benefit if authorization requirements apply by selecting from the options presented or, if "Other", provide a description of the authorization requirement; and***
- ***For each benefit it must indicate the provider qualifications that apply.***

If the state/territory does not comply with these requirements, the SPA cannot be approved.

12. Base Benchmark Benefits Not Covered Due to Substitution or Duplication

States and territories may substitute benefits from another source for a base benchmark EHB as long as the substituted benefit(s) is actuarially equivalent to the benefit for which it is being substituted and is in the same EHB category.

In addition, if there are duplicate benefits in both a commercial section 1937 option and the base benchmark plan, the state/territory must use the commercial section 1937 benefit if it provides more generous coverage. This requirement also applies if the state/territory is intending to either partially or entirely align the ABP including EHBs and subject to subject 1937 requirements with the ABP that is the state/territory's approved Medicaid state plan and not subject to section 1937 requirements. In this section the state/territory must provide the name of any base benchmark benefit that is not covered due to substitution and identify the EHB category from which it was removed. In addition, the state/territory must provide the name of any base benchmark plan benefit that is not provided because a duplicate benefit with more generous coverage is provided from the section 1937 coverage option plan.

Review Criteria

If the state/territory chooses to substitute a benefit for an Essential Health Benefit from the base benchmark plan the state/territory must provide the name of the benefit or benefits that are not covered. If the state/territory is not providing coverage of a base benchmark plan Essential Health Benefit, as a duplicate benefit with more generous coverage is included in the ABP from the section 1937 coverage option plan, it must identify the benefit that is not being provided. If the state/territory does not provide this information the SPA cannot be approved.

13. Other Base Benchmark Benefit Not Covered

States and territories are only required to include in the ABP benefit package those benefits from the base benchmark plan that are EHBs. States and territories have the option of including base benchmark benefits that are not EHBs. If the state/territory does not elect to do this because it asserts that the benefit is not an EHB, it must list the name of any such benefits in this section and provide an explanation and justification for why it doesn't think the benefit fits into any of the 10 EHB categories for the ABP.

Review Criteria

If the state/territory chooses to not include a base benchmark plan benefit that it asserts is not an Essential Health Benefit in its benchmark benefit package, it must name any such benefits and provide an explanation and justification for why the benefit is not an EHB. This determination is subject to approval by the CMS reviewer. If the state/territory does not

provide an explanation or justification, or if the explanation does not support a determination that the benefit is not an EHB, the SPA cannot be approved.

14. Other Section 1937 Covered Benefits that are not Essential Health Benefits
States and territories are required to include in the ABP benefit package any benefits from the selected section 1937 coverage option. If there are any such benefits that are not EHBs and are covered based on the selected commercial section 1937 coverage option, the names must be listed in this section along with their source, any limitations, authorization requirements, provider qualifications, and any optional explanation the state/territory wishes to provide concerning the benefit. This requirement also applies to states/territories using Secretary-approved coverage to either partially or entirely align its ABP with the services in the state/territory's approved Medicaid plan. Use the instructions from the ***Essential Health Benefits – (Other than Prescription Drugs, Preventive Services, and Pediatric Services)*** sub-section to complete this section.

Review Criteria

If the selected section 1937 coverage option includes benefits that are not Essential Health Benefits, the state/territory must name these benefits as part of the ABP in this section and must;

- ***Indicate if any limitations apply by providing a description of the limitations in the text boxes provided; and***
- ***Indicate for each benefit if there are authorization requirements by selecting the type of authorization used and, if Other, provide a description of the authorization requirement.***
- ***For each benefit it must indicate the provider qualifications that apply.***

If the state/territory does not comply with these requirements the SPA cannot be approved.

15. Additional Covered Benefits
States and territories may, at their option, include additional benefits in the ABP from any of the base benchmark plans, section 1937 coverage options, or Medicaid state plan authorities. States and territories must not include any additional benefits if the ABP population includes individuals from the Adult group. List any such additional benefits in this section using the instructions from the ***Essential Health Benefits – (Other than Prescription Drugs, Preventive Services, and Pediatric Services)*** section to complete this section.

Review Criteria

If the state/territory includes in its benchmark benefit package additional benefits from the base benchmark plans, section 1937 coverage options or Medicaid state plan authorities that are not Essential Health Benefits, it must; indicate if any limitations apply by providing a

description of the limitations in the text boxes provided; indicate for each benefit if authorization requirements apply by selecting the type of authorization used, if "Other"; provide a description of the authorization requirement; for each benefit indicate the provider qualifications that apply; and not include additional benefits for any ABP population that includes individuals from the Adult group.
If the state/territory does not comply with these requirements, the SPA cannot be approved.

Requirements Pertaining to Secretary-Approved Benchmark Benefit Packages

Secretary-Approved benchmark benefit packages must contain benefits that are appropriate to meet the needs of the ABP population. Furthermore, if the state/territory wants to align the ABP that includes EHBs and is subject to section 1937 requirements and the ABP that is the state/territory's approved Medicaid state plan not subject to section 1937 requirements, then the state/territory must insure that the benefit packages are "equal to" one another. This means that the benefit packages are in alignment in terms of covered benefits and any limitations on amount, duration and scope.

The state/territory must assure that the benefits provided are sufficient given the level and type of needs for medical services of the population. Benefits that are already in the state's/territory's approved Medicaid state plan will not be subject to CMS benefit sufficiency requirements. However, if a significant issue is discovered with a benefit currently approved in the state plan, then CMS retains the ability to further discuss a plan for correcting the issue. If the state/territory is proposing a new benefit that is not in the state/territory's approved Medicaid state plan using Secretary-approved coverage, then these benefits will be subject to a CMS review based on requirement that any limitations will not prevent the benefit from achieving its purpose. The state must submit a clear identification and description of the benefit, limitations on amount, duration and scope and provider qualifications of these benefits. CMS will review these benefits according to applicable rules, such as, 1905(a) rules for services that could otherwise be approved under 1905(a).

Review Criteria

The benefits approved using Secretary-Approved coverage for the Alternative Benefit Plan benefit package must be sufficient and meet the needs of the population. If the state/territory is trying to achieve complete alignment between the ABP that includes EHBs and is subject to section 1937 requirements and the ABP that is the state/territory's approved Medicaid state plan not subject to section 1937 requirements, then the benefit packages must be "equal to" one another. The reviewer must be satisfied that the benefit package meets these requirements. Therefore, the state/territory should be careful to ensure that the benefits provided are sufficient to achieve their purpose, given the level of need for medical services of

the population. The benefits used from the base benchmark plan to define Essential Health Benefits are a minimum requirement and state/territory should review the benefits in each EHB category and supplement, or replace benefits with duplicate benefits or substitution, or add benefits using Secretary-Approved coverage. Individual benefits proposed to CMS that are not part of the state/territory's approved Medicaid state plan, may be subject to CMS benefit sufficiency requirements.