

Template B4a – Alternative Benefit Plans – Benchmark Benefit Package – Federal Employees Health Benefit Plan (FEHBP)

Template B4b – Alternative Benefit Plans – Benchmark Benefit Package – State/Territory Employee Coverage

Template B4c – Alternative Benefit Plans – Benchmark Benefit Package – Commercial HMO Coverage

Statute: 1937(b)(1)(A), (B) and (C).

Regulation: 42 CFR 440.330

INTRODUCTION

These three templates work in the same way by building and displaying the Alternative Benefit Plan using up to four different sources of benefit information. These are ~~the selected 1937 Coverage Option Benchmark Benefit Package,~~ the Base Benchmark Plan, the selected 1937 Coverage Option Benchmark Benefit Package, (if different from the ~~1937 Coverage Option Base Benchmark Plan~~), Supplemental Benefits from one of the 1937 Coverage Options or the Medicaid State plan, and additional benefits from one of these sources that the State chooses to add at its option.

The 1937 Coverage Option and Base Benchmark Benefits are entered on MACPro administrative templates where the State maintains and records the benefits provided by these commercial benefit plans. Supplemental Essential Health Benefits are entered on the Base Benchmark Benefits administrative table. Additional benefits are entered within these templates along with any limitations on amount, duration, or scope and any authorization requirements.

BACKGROUND

Based on the 1937 Coverage Option selected in the B4- Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package and Cost Sharing template, the State will complete these templates if one of the first three Benchmark Benefit Package options is chosen. All three templates work in an identical manner by building a table of benefits from the four sources of benefits,

- ~~the 1937 Coverage Option Benchmark Benefit Package,~~
- ~~the Base Benchmark Plan (if different from the 1937 Coverage Option),~~
- the 1937 Coverage Option (if different from the Base Benchmark Plan)
- Supplemental Benefits chosen from the Base Benchmark Plan options, if all ten Essential Health Benefits are not provided by the Base Benchmark Plan, and,
- At State option, additional benefits from the 1937 Coverage Options or the Medicaid State plan.

States must first complete the administrative template corresponding to their selected 1937 Coverage Option Benchmark Benefit Package, unless the Base Benchmark Plan is the same as the Benchmark Benefit Package, in which case the benefits will be listed in the Base Benchmark administrative table only. These Benchmark Benefit Package templates are:

- B11-FEHBP Coverage
- B12-State Employee Coverage, or
- B13-Commercial HMO Coverage
- B17-State Plan Benefits Table for Secretary-Approved Coverage

Next, the State completes the B14-Base Benchmark Plan template to record the Essential Health Benefit (EHB) coverage for its benefit package. If any EHB categories are missing from Base Benchmark Plan or Benchmark Benefit Package, the State must add Supplemental EHB benefits from another Base Benchmark Plan in the B14-Base Benchmark Plan template to assure that all ten EHB categories are included.

Can the State cover missing EHBs from the Base Benchmark Plan with EHBs included in its Section 1937 coverage option Benchmark Benefit Package, or must it only provide missing EHBs from another Base Benchmark Plan as supplemental benefits? In other words, if all of the EHBs are already covered from the 1937 option and Base Benchmark Plan, why bother adding Supplemental benefits when there is no gap in the minimum EHB coverage.

Benefits entered on these templates will populate the selected 1937 Coverage Option Benchmark Benefit Package table with most, if not all, of the Alternative Benefit Plan's benefits. Benefits are displayed within each of the Essential Health Benefits categories or as Non-Essential Health Benefits.

If the same benefit is provided in both the Section 1937 Option and the Base Benchmark Plan, the State must determine which plan's benefit provides substantially more coverage and include coverage based on that benefit in the Alternative Benefit Plan.

Finally, the State can choose to add Additional benefits to the Alternative Benefit plan from the three Section 1937 Coverage Options or the Section 1905(a) benefits included in its Medicaid State plan, including any limitations on amount, duration or scope, any authorization requirements, and provider qualifications if a 1905(a) benefit that is being added is not already in the standard Medicaid State plan.

For other 1937 Coverage Option Additional benefits the State must use the limitations prescribed by the commercial Benchmark Plan, but it may prescribe its own authorization requirements for the benefit. The State has the option of using the provider qualifications requirements of the Benchmark Plan or the standard State Medicaid plan, or a combination of the two.

TECHNICAL GUIDANCE

Adding a New Alternative Benefit Plan Benchmark Benefit Package

PREREQUISITE: The State must complete the B14 Base Benchmark Plan administrative table and, if the Section 1937 Coverage Option Benchmark Benefit Package is different, the B11 FEHBP Coverage, B12 State Employee Coverage or B13 Commercial HMO Coverage administrative tables, as appropriate, before completing the B4d-Secretary Approved B4a FEHBP, B4b State Employee Coverage, or B4c Commercial HMO Coverage Benefit Package template.

Most of the benefits in the Benchmark Benefit Package are derived from the benefits entered in the Base Benchmark Plan and Section 1937 Coverage Option Benchmark Benefit Package administrative tables. The MACPro system will display in the B4a-FEHBP Coverage, B4b-State Employee Coverage, or B4c-Commercial HMO Coverage templates a table listing these benefits within each Essential Health Benefit category. The table will also display any limitations on amount, duration and scope imposed by the commercial plan that ~~these apply to these benefits are based on.~~

Adding Additional Benefits

The State may elect to add additional benefits to the Alternative Benefit Plan from the Section 1905(a) Medicaid State plan benefits or from one of the three commercial Section 1937 Coverage Options.

To add an additional benefit:

- Select one of the benefits from the list of Section 1905(a) benefits or select “Other” benefit.
- If a 1905(a) benefit is selected from the listing of State plan benefits the 1905(a) benefit option and Benefit Name will be displayed by the system. Provide a description of the additional benefit in the text box provided.
- Next indicate, yes or no, if there are limitations on the amount, scope or duration of the benefit ~~or if there are authorization requirements associated with it.~~
 - If yes, indicate if limitations are the same as in the State plan for the same benefit.
 - If no, complete the Limitations ~~and/or Authorization~~ content as described below.
- Next indicate, yes or no, if there are authorization requirements for the benefit.
 - If yes, indicate yes or no if the authorization requirements are the same as those in the standard Medicaid State Plan
 - If no, complete the Authorization section described below.
- ~~Next indicate, yes or no, if the 1905(a) benefit is included in the standard Medicaid State plan~~

- If no, follow the instructions below to provide the provider qualifications for the benefit.
- If “Other” benefit is selected,
 - Choose the [1905\(a\)](#) or other 1937 [Benchmark Plan Coverage Option](#) that the benefit comes from.
 - Enter the Benefit Name and a description of the benefit.
 - [If the benefit is an “other” 1905\(a\) benefit not on the list of such benefits, provide the information as described directly above’](#)
 - [If the benefit is from one of the other 1937 Benchmark Plans:](#)
 - Indicate if there are authorization requirements for the benefit.
 - If yes, indicate if the authorization requirements are the same as those prescribed by the Benchmark Plan.
 - If no, complete the Authorization Requirements sections following the instructions below.
 - Indicate if provider qualifications are based on the Benchmark Plan or the State Plan, or both. The State is permitted to select both options.

Adding Limitations to Additional Benefits

- First, indicate if the limitations apply to all services within the benefit
 - If yes, proceed to the next section.
 - If no, the State has two options. It can indicate that limitations apply only to certain services within the benefit category or it can indicate that they apply to all services except those indicated. Choose one of the options based on how many specific services have limitations.
 - Regardless of the option chosen, provide the name of the specific service to which limitations either apply or do not apply and its description.
 - Next indicate if there are limitations on the Amount or Duration of the benefit, service or services.
 - If no, proceed to the next section.
 - If yes, select whether there are limitations on the number of services or if there is a limitation on the amount of the Medicaid payment.
 - If the limitation is to the number of services,
 - Indicate the number in the box provided and what type of service it applies to from the list provided.
 - If “Other” describe the type of the service in the text box provided.
 - Indicate the duration of any limitation on the amount of service by selecting one of the options presented.
 - If “Other” specify the duration.
 - If the limitation is to the amount of the Medicaid payment:
 - Enter the dollar amount of the limitation
 - Indicate if the limitation is per year or an “Other” duration.
 - If “Other” specify the duration.

- Next, indicate if there is a limitation on the Scope of the Benefit or Service.
 - If no, proceed to the next section.
 - If yes, indicate if there are specific services within the benefit that are excluded.
 - Provide the name of the specific service and a description
 - If more than one specific service is excluded, repeat by providing the name and description of each other service that is excluded.
 - Next, indicate if the benefit or service may only be provided by certain types of providers or cannot be provided by certain types of providers. If either is selected indicate the provider types who may or may not provide the service.
 - Next, indicate if the benefit or service may only be provided to certain individuals within the Alternative Benefit Plan.
 - If no, proceed to the next item.
 - If yes, indicate if individuals are provided the service based on a specific disease, condition or diagnosis. If so, indicate the condition, disease or diagnosis that is a precondition for receiving the service.
 - Indicate and describe any “Other” criteria that may be used to limit which individuals receive the service.

Review Criteria

The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the State’s election meets applicable federal statutory, regulatory and policy requirements. States are cautioned to be judicious in deciding to limit the provision of services to individual based on disease, diagnosis or condition. There generally must be basis in medical necessity for imposing such a limitation and States may not discriminate against individuals based on their age or certain other circumstances.

Next, indicate if there are specific circumstances under which the benefit or service may be provided. If yes, describe the circumstances.

- Finally, indicate if the scope of the benefit or service is limited in another way and provide a description of the limitation.

Review Criteria

The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the State’s election meets applicable federal statutory, regulatory and policy requirements. Again, States are cautioned to assure that any limitation on the scope of the benefit or service described in these last two options is not discriminatory and has a basis in medical necessity. States must assure, to the satisfaction of the CMS reviewer, that any limitations imposed will not prevent medically necessary services from being provided and will allow coverage sufficient for the benefit or service to achieve its purpose.

Adding Authorization Requirements to an Additional Benefit

If the State indicated that there are authorization requirements for a benefit that are different from those in the underlying 1937 Coverage Option, this section will be presented for completion.

- Select from the options presented the type or types of authorization required for the additional benefit.
- If the option selected is “Other authorization requirement” describe the requirement in detail.

Review Criteria

The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the State’s election meets applicable federal statutory, regulatory and policy requirements.

Provider Qualifications for an Additional Benefit

The State must affirmatively assure that all providers shall meet the requirements of 42 CFR 431.107 concerning required provider agreements.

The State provides this affirmative assurance by checking the box next to the assurance. If the State does not check this box, the system will not accept this template for review and approval.

Next, complete the following:

- Indicate, yes or no, if the State has additional requirements for providers of the benefit.
 - If no, ~~no~~ proceed to the next section.
 - If yes, indicate if the requirements apply to one or more specific services or specific types of providers. This section may be repeated for specific services and providers types, or combinations thereof, as many times as necessary to define the provider qualifications for each specific service or type of provider.
 - For each provider or service indicated, select the type of qualifications required.
 - For any selection other than “Licensed Required” provide a description of the provider qualifications.

Review Criteria

For each provider qualification, the description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the State’s election meets applicable federal statutory, regulatory and policy requirements.

Other Information Related to the Benchmark Benefit Package

At its option the State may provide additional information related to the Benchmark Benefit Package described in this template.

Review of Benchmark Benefit Package

Review Criteria

The benefits provided under the Alternative Benefit Plan benefit package must be appropriate to meet the needs of the Alternative Benefit Plan population. The reviewer must be satisfied that the benefit package meets this requirement. Therefore the State should be careful to assure that the benefits provided are sufficient given the level of need for medical services of the population. The Essential Health Benefits are a minimum requirement and State should review the benefits in each EHB category and consider adding additional benefits if the benefits provided by the commercial plan are not sufficient to meet the needs of the population being covered. It is recommended that the State consider adding in the final narrative text box additional information concerning how it has met this sufficiency test.

Amending an Alternative Benefit Plan Benchmark Benefit Package

The State may amend the Benchmark Benefit Package at any time by navigating to this template and adding or removing Additional Benefits in the package associated with a previously approved Alternative Benefit Plan and any related limitations, authorization or provider qualification requirements, or by changing the Supplemental Benefits indicated on the B14-Base Benchmark Plan administrative table. For changes to Supplemental Benefits the State must assure that the resulting Benchmark Benefit Package continues to include benefits in all Essential Health Benefit categories.

States should review the Benchmark Benefit Package whenever the commercial plan that is the basis for the Base Benchmark Plan or Section 1937 Coverage Option changes, typically on an annual basis, to assure that the resulting Benchmark Benefit Package is sufficient to meet the needs of the population, as described in the review criteria above, and that all Essential Health Benefits continue to be included.