

## **Template B4d – Alternative Benefit Plans – Benchmark Benefit Package – Secretary Approved Benefit Package**

Statute: 1937(b)(1)(D)

Regulation: 42 CFR 440.330

### **INTRODUCTION**

The State may submit an Alternative Benefit Plan benefit package for review and approval by the Secretary that includes any other health benefits that provide appropriate coverage to meet the needs of the population provided that coverage. The benefits included in the proposed benefit package may be those provided under the standard State Plan benefits package, a variation on such State plan benefits, or benefits provided by one of the other three Section 1937 Coverage Options, or a combination of benefits from these sources. This template is used to define the Secretary-Approved Alternative Benefit Plan benefit package.

### **BACKGROUND**

Section 1937 of the Act permits the State to propose an Alternative Benefit Plan benefit package based on its State plan or a combination of Section 1905(a) State plan benefits and benefits from one or more of the other three 1937 Coverage Options. There are six different options offered in the template in two general categories.

- State Plan Benefits
  - Benefits are the same as those in the State plan
  - Benefits include all those provided in the State plan plus additional benefits
  - Benefits are same as provided in the State Plan but in a different amount, duration and/or scope
  - The State offers a partial list of benefits provided in the State plan
  - The State offers a partial list of benefits provided in the State plan plus additional benefits
- The State offers an array of benefits from the Section 1937 Coverage Options or the State Plan, or both.

The State must complete the B14 Base Benchmark Plan administrative table for the Plan selected on the B4 template as the basis for Essential Health Benefits, as well as any supplemental benefits to assure that benefits for all Essential Health Benefit categories are included.

The State must also complete the B17-Alternative Benefit Plan State Plan Benefits Table administrative template to indicate which benefits are included in its State plan. This will form the basis for defining within this template which of these benefits are to be included in the Alternative Benefit Plan or if other Section 1905(a) benefits are to be included that are not currently included in the standard Medicaid State plan. These will be used to

populate a table displayed in this B4d-Secretary-Approved Benefit Package template and thus create the comparison of the Secretary-Approved Benefit Package with the standard State plan. When selecting benefits to be included in the Alternative Benefit Plan the State will also indicate if the benefit is an Essential Health Benefit and which EHB category it falls in. This information will also be displayed in the Secretary-Approved Benefit Package table.

States may then add additional benefits from either the State Plan optional benefits or from one of the three Section 1937 Coverage Options to add to the Secretary-Approved Benefits Package and indicate if the additional benefit is an Essential Health Benefit.

As with all other Alternative Benefit Plans, benefits must be provided in all ten Essential Health Benefit categories and the State must add supplemental benefits to meet this requirement if the table indicates that any Essential Health Benefit categories are not included.

## TECHNICAL GUIDANCE

### **Adding a New Secretary-Approved Benchmark Benefit Package**

**PREREQUISITE:** The State must complete the B17-Alternative Benefit Plan State Plan Benefits Table and B14 Base Benchmark Plan administrative table before completing the B4d-Secretary Approved Benefit Package template.

The State must select one of these two options:

- The State offers the benefits provided in the State Plan, or
- The State offers an array of benefits from the Section 1937 Coverage Options, the State plan, or both.

If the first option is selected the State will be presented with five options for selection:

- Benefits are the same as those in the State plan
- Benefits include all those provided in the State plan plus additional benefits
- Benefits are same as provided in the State Plan but in a different amount, duration and/or scope
- The State offers a partial list of benefits provided in the State plan
- The State offers a partial list of benefits provided in the State plan plus additional benefits

Select one of these options.

### **Benefits are the same as those in the State plan**

If Benefits are the same as those in the State plan,

- Indicate the Essential Health Benefit category that the benefit falls into, or indicate if it is not an Essential Health Benefit.

A table will display these benefits along with any benefits from the Base Benchmark Plan based on the option selected and the benefits and Essential Health Benefit Categories indicated in the B14 Base Benchmark Plan administrative table, as well as any supplemental benefits added in that table.

**Benefits include all those provided in the State plan plus additional benefits**

If this option is selected the State must select benefits from the list of State Plan Benefits presented for the additional benefit(s) that are not included in its State plan. Indicate the Essential Health Benefit category associated with each State plan benefit or that it is not an Essential Health Benefit.

For the benefits that are not in the State plan the State must complete the following sections:

**Limitations on Amount, Duration or Scope of Benefits not in the State Plan**

- Indicate, yes or no, if there are limitations on the amount, duration or scope of the benefit.
  - If no, proceed to the Authorization Requirements section
  - If yes, 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 individuals 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.***

### Authorization Requirements for a Benefit not included in the State Plan

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 a Benefit not included in the State Plan

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 “License 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.***

A table will display these benefits along with any benefits from the Base Benchmark Plan based on the option selected and the benefits and Essential Health Benefit Categories

indicated in the B14 Base Benchmark Plan administrative table, as well as any supplemental benefits added in that table.

**Benefits are the same as provided in the State Plan but in a different amount, duration and/or scope**

If Benefits are the same as those in the State plan, but are provided in a different amount, duration or scope:

- Indicate the Essential Health Benefit category that the benefit falls into, or indicate if it is not an Essential Health Benefit.

**Limitations on Amount, Duration or Scope of Benefits not in the State Plan**

- For each benefit included select those that are provided with limitations on the amount, scope or duration of the benefit that are different from those defined in the State plan. Repeat the following steps for each benefit selected:
- 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.***

A table will display these benefits along with any benefits from the Base Benchmark Plan based on the option selected and the benefits and Essential Health Benefit Categories

indicated in the B14 Base Benchmark Plan administrative table, as well as any supplemental benefits added in that table.

**The State offers a partial list of benefits provided in the State plan**

The list of benefits included in the State plan will be provided based on the State Plan benefits entered on the B17 Alternative Benefit Plan State Plan Benefits Table template. Select the benefits that are to be included in the Secretary-Approved Alternative Benefit Plan Benchmark Benefit Package from the list of these benefits.

A table will display these benefits along with any benefits from the Base Benchmark Plan based on the option selected and the benefits and Essential Health Benefit Categories indicated in the B14 Base Benchmark Plan administrative table, as well as any supplemental benefits added in that table.

**The State offers a partial list of benefits provided in the State plan plus additional benefits**

In this case the State is only including some of the benefits it provides in its standard State plan benefits package, but also is including additional State plan benefits not in its standard package. The list of benefits included in the State plan will be provided based on the State Plan benefits entered on the B17 Alternative Benefit Plan State Plan Benefits Table template as well as other Section 1905(a) benefits that the State does not currently include in its State Plan.

Select the benefits that are to be included in the Secretary-Approved Alternative Benefit Plan Benchmark Benefit Package from the list of these benefits.

For any benefit(s) that are not in the State plan but are included in the Alternative Benefit Plan the State must complete the following sections:

**Limitations on Amount, Duration or Scope of Benefits not in the State Plan**

- Indicate, yes or no, if there are limitations on the amount, scope or duration of the benefit.
  - If no, proceed to the Authorization Requirements section
  - If yes, 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.***

**Authorization Requirements for a Benefit not included in the State Plan**

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 a Benefit not included in the State Plan**

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 “License 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.***

A table will display these benefits along with any benefits from the Base Benchmark Plan based on the option selected and the benefits and Essential Health Benefit Categories indicated in the B14 Base Benchmark Plan administrative table, as well as any supplemental benefits added in that table.

**The State offers an array of benefits from the Section 1937 Coverage Options, the State plan, or both.**

If this second higher level option is selected the State must indicate the benefits to be included from multiple sources.

A list of State plan benefits will be presented based on the B17 Alternative Benefit Plan State Plan Benefits Table template.

- The State may select from this list of benefits or from the Section 1937 Coverage Option benefits as described below.
- If a State Plan benefit is selected the State must indicate if it is an Essential Health Benefit and its category or indicate that it is not an Essential Health 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.
  - If yes, indicate if limitations are the same as in the State plan for the same benefit.

- If no, complete the Limitations 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 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 Section 1905(a) 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.***

#### Provider Qualifications for a 1905(a) Benefit not Included in the State Plan

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 qualification.

#### **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***

For each Section 1937 Coverage Option benefit selected:

- Choose the other 1937 Coverage Option that the benefit comes from.
- Enter the Benefit Name and a description of the benefit.
- 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.

- o 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 Authorization Requirements for a Section 1937 Coverage Option 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.***

A table will display these benefits along with any benefits from the Base Benchmark Plan based on the option selected and the benefits and Essential Health Benefit Categories indicated in the B14 Base Benchmark Plan administrative table, as well as any supplemental benefits added in that table.

#### **Benefit by Benefit Comparison**

Unless the State has elected to provide the same benefits as those in the State Plan or the State Plan benefits plus additional benefits, the State must provide a benefit by benefit comparison of its standard State Plan benefits or those in another Section 1937 Coverage Option and those in its proposed Secretary Approved Coverage Alternative Benefit Plan.

Create a chart of the comparison benefit plan by listing each standard State Plan or other Section 1937 Coverage Option benefit along with any limitations on the amount, duration or scope of the benefit. If a benefit included in the proposed Secretary Approved coverage benefit plan is not included in the comparison benefit plan list the benefit and indicate it is not included.

In columns next to this information list the corresponding benefit in the proposed Secretary Approved Coverage and any limitations on the benefit, or indicate that the benefit is not included in the proposed Secretary Approved Coverage benefit plan.

Provide a narrative explaining why any benefits included in the comparison benefit package are not provided in the proposed Secretary Approved coverage.

Upload with the application a copy of this comparison chart document.

### **Other Information Related to the Secretary-Approved Benchmark Benefit Package**

Finally, the template includes a text box where the State may, at its option, provide additional information about the Secretary Approved Benefit Package.

### **Review of Secretary-Approved 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 a Secretary-Approved Alternative Benefit Plan Benchmark Benefit Package**

The State may amend the Benchmark Benefit Package at any time by navigating to this template and changing the category of Secretary-Approved coverage. The State may add or remove 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.

Whenever changing the benefits included in the Secretary Approved Coverage benefit plan or the limitation placed on such benefits, the State must upload the benefit by benefit comparison chart comparing the revised Secretary Approved Coverage benefit package with the comparison benefit package.

States should review the Benchmark Benefit Package whenever the commercial plan that is the basis for the Base Benchmark Plan changes, typically on an annual basis, to assure that the resulting Secretary-Approved 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.