

Mock-up of Interim Form for Alternative Benefit Plans

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Note: This document is the final mock-up of the forthcoming CMS template for Alternative Benefit Plans and is subject to formatting and other changes in the development process.

Section 1: Alternative Benefit Plan Populations

Adapted from B2

Identify and define the Population that will participate in Alternative Benefit Plan.

Alternative Benefit Plan Population Name:	Text (state names the population)
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Identify eligibility groups that are included in the Alternative Benefit Plan’s Population, and which may contain individuals that meet any targeting criteria used to further define the Population.

Eligibility Groups Included in the Alternative Benefit Plan Population:	<p>Drop down: Display a complete list of non-excluded eligibility groups.</p> <p>State selects first eligibility group, and answers the following for that group:</p>
m/v	Enrollment is mandatory or voluntary for this group?
y/n	Enrollment is for the entire eligibility group?

If yes, skip to the geographic area questions (line 73). If no, include the following targeting questions:

Targeting Criteria (select all that apply)	
●	Income Standard
●	Disease/Condition/Diagnosis/Disorder
●	Other
y/n	Do these targeting criteria apply to all eligibility groups?

If yes, state will complete targeting info (lines 47-69) once. If no, insert the following and allow state to repeat targeting criteria for each eligibility group.

Specify eligibility groups to which the following targeting criteria apply.

For each targeted criteria selected by the state, show the corresponding questions below.

Income Standard

●	Income standard is used to target households with income at or below the standard
●	Income standard is used to target households with income above the standard
The income standard is as follows:	
●	A percentage If selected, show options below:
●	Federal Poverty Level
●	SSI Federal Benefit Amount
●	Other

Show the income standard below (through line 53) that corresponds to the standard selected by the state above.

%	Enter the Federal Poverty Level percentage
%	Enter the SSI Federal Benefit Rate percentage
%	Enter the Other percentage and describe below
	text

●	A specific amount If selected, show options below:
●	Statewide standard
●	Standard varies by region
●	Standard varies by living arrangement
●	Other basis for income standard

Show the option below (through line 64) that corresponds to the option selected by the state above.

●	Statewide standard (show table to be filled by state)	
	Household Size	Income Standard
		\$
		\$
	Expandable to allow additional rows	
Y/N	Additional incremental amount? If yes, show next:	
\$	Enter incremental amount	

●	Standard varies by region (expandable to allow state to enter multiple regions)	
	Name of region	text
	Describe region	text
	Household Size	Income Standard
		\$
		\$
	Expandable to allow additional rows	
Y/N	Additional incremental amount? If yes, show next:	
\$	Enter incremental amount	

●	Standard varies by living arrangement (expandable to allow state to enter multiple living arrangements)	
---	---	--

Name of living arrangement	text		
Describe living arrangement	text		
	Household Size		Income Standard
			\$
			\$
	Expandable to allow additional rows		
Y/N	Additional incremental amount? If yes, show next:		
\$	Enter incremental amount		

●	Other basis for income standard (expandable to allow state to enter multiple other)		
	Name of basis	text	
	Describe basis	text	
	Household Size		Income Standard
			\$
			\$
	Expandable to allow additional rows		
	Y/N	Additional incremental amount? If yes, show next:	
	\$	Enter incremental amount	

Disease/Diagnosis/Disorder/Condition	
●	Physical Disability
●	Brain Injury
●	HIV/AIDS
●	Medically Frail
●	Technology Dependent
●	Autism
●	Developmental Disability
●	Intellectual Disability
●	Mental Illness
●	Substance Use Disorder
●	Diabetes
●	Heart Disease
●	Asthma
●	Obesity
●	Other Disease/Diagnosis/Disorder/Condition (Describe below)
	text

Other Targeting Criteria (Describe below)
text

Geographic Area

y/n	The Alternative Benefit Plan Population will include individuals from the entire State/Territory If no, include the following:
•	By county (specify counties below): Text
•	By region (specify regions and describe below): Text
•	By city or town (specify cities or towns below): Text
•	Other geographic area (specify below) Text

Any other information the state/territory wishes to provide about the population (optional)

text

Section 2: Alternative Benefit Plan Enrollment Assurances

Adapted from B3a and B3b
(this section must be displayed for all submissions)

Select the option that applies.

●	A The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.
●	B The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.
●	C The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.

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

Display this set of assurances if option A or B was selected above.

These assurances must be made by the state/territory.

√	The state/territory shall enroll all participants in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group in the ABP specified in this state plan amendment, except that for individuals who meet the exemption criteria at 42 CFR 440.315, such individuals will be given the option of enrolling in an ABP defined as the state's approved Medicaid state plan that is not subject to section 1937 requirements.
√	The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an ABP defined using section 1937 requirements or an ABP defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.
√	Once an individual is identified, the state/territory assures it will effectively inform the individual of the following: a) Enrollment in the specified ABP is voluntary; b) The individual may disenroll from the ABP defined subject to section 1937 requirements at any time and instead receive an ABP defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and c) What the process is for transferring to the state plan-based ABP.
√	The state/territory assures it will inform the individual of: a) The benefits available as ABP coverage defined using section 1937 requirements as compared to ABP coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and b) The costs of the different benefit packages.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

●	Letter
●	Email
●	Other (describe below)

text

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment. (provide attachment instructions)

When did/will the state/territory inform the individuals?

text

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i) (VIII) eligibility group who meet exemption criteria to disenroll from the ABP defined using section 1937 requirements and enroll in the ABP defined as the state/territory's approved Medicaid state plan.

text

√	The state/territory assures it will document in the exempt individual's eligibility file that the individual: <ul style="list-style-type: none"> a) Was informed in accordance with this section; b) Was given ample time to arrive at an informed choice; and c) Chose to enroll in ABP coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.
---	--

Where will the information be documented? (Check all that apply)

- In eligibility system
- In hard copy of case record
- Other (describe below)

Text

What documentation will be maintained in the eligibility file? (Check all that apply)

- Copy of correspondence sent to individual
- Signed documentation from individual consenting to enrollment in the Alternative Benefit Plan
- Other (describe below)

Text

√	The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either ABP coverage subject to section 1937 requirements or ABP coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.
---	--

Other information related to benefit package selection assurances for exempt participants (optional)

Text

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

Display this set of assurances if option B or C was selected above.

These assurances must be made by the state/territory.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark Equivalent), prior to enrollment:

√	The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.
√	The state/territory assures it will effectively inform the individual the following: <ul style="list-style-type: none"> a) Enrollment is voluntary; b) The individual may disenroll at any time and regain immediate access to full standard state/territory plan coverage; c) What the process is for disenrolling.
√	For all populations/individuals who voluntarily enroll, the state/territory will inform each individual that: <ul style="list-style-type: none"> a) Enrollment is voluntary; b) They may choose at any time not to participate in an Alternative Benefit Plan; and c) They can regain at any time immediate enrollment in the standard full Medicaid program.
√	The state/territory assures it will inform the individual of: <ul style="list-style-type: none"> a) The benefits available under the Alternative Benefit Plan; and b) The costs of the Plan and a comparison of how the Alternative Benefit Plan differs from the standard state/territory plan benefits.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply)

●	Letter
●	Email
●	Other (describe below)
	text

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment. (provide attachment instructions)

When did/will the state/territory inform the individuals?

text
Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.
text

√	The state/territory assures it will document in the exempt individual's eligibility file that the individual:
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	a) Was informed in accordance with this section prior to enrollment; b) Was given ample time to arrive at an informed choice; and c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.
--	---

Where will the information be documented? (Check all that apply)

- In eligibility system
- In hard copy of case record
- Other (describe below)

Text

What documentation will be maintained in the eligibility file? (Check all that apply)

- Copy of correspondence sent to individual
- Signed documentation from individual consenting to enrollment in the Alternative Benefit Plan
- Other (describe below)

Text

√	The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.
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Other Information Related to Enrollment Assurance for Voluntary Participants (optional)

Text

Enrollment Assurances – Mandatory Participants

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark Equivalent Plan) that could have exempt individuals, prior to enrollment:

√	The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of ABP coverage defined using section 1937 requirements or ABP coverage defined as the state/territory's approved Medicaid state plan.
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How will the state/territory identify these individuals? (Check all that apply)

- Review of eligibility criteria (e.g., age, disorder/diagnosis/condition) (describe below)

Text

- Self-identification (describe below)

Text

- Other (describe below)

Text

√	The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in ABP coverage defined using section 1937 requirements or ABP coverage defined as the state/territory's approved Medicaid state plan.
√	The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in ABP coverage defined using section 1937 requirements, or ABP coverage defined as the state/territory's approved Medicaid state plan.
How will the state/territory identify if an individual becomes exempt? (Check all that apply)	
●	Review of claims data
●	Self-identification
●	Review at the time of eligibility redetermination
●	Provider identification
●	Change in eligibility group
●	Other (describe below)
Text	
How frequently will the state/territory review the Alternative Benefit Plan Population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?	
●	Monthly
●	Quarterly
●	Annually
●	Ad hoc basis
●	Other (describe below)
Text	

√	The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in ABP coverage defined using section 1937 requirements, or ABP coverage defined as the state/territory's approved Medicaid state plan.
Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:	
Text	

Other Information Related to Enrollment Assurance for Mandatory Participants (optional)	
Text	

Section 3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

Adapted from B4

Instead of specific answers resulting to skips to specific tables, this section is followed by a generic benefits table.

Select one of the following:

•	The state/territory is amending one existing benefit package for the population defined in Section 1 (provide name of benefit package below):
Text	
•	The state/territory is amending more than one existing benefit package for the population defined in Section 1 (provide names of benefit packages below):
Text (expandable to add more benefit package names)	
•	The state/territory is creating a single new benefit package for the population defined in Section 1 (provide name of benefit package below):
Text	
•	The state/territory is creating more than one new benefit package for the population defined in Section 1 (provide names of benefit packages below):
Text (expandable to add more benefit package names)	

If more than one benefit package is being amended, or more than one being created, the remainder of this Section (3), plus Sections 4,5, and 8 must repeat for each benefit package entered above. (Section 6 must be repeated also if benchmark equivalent is selected below.)

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark Equivalent Benefit Package under this Alternative Benefit Plan (check one):	
•	Benchmark Benefit Package (if selected display options below)
The state/territory will provide the following Benchmark Benefit Package (check one that applies):	
•	The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit program (FEHBP)
•	State employee coverage that is offered and generally available to state employees (State Employee Coverage) (Provide plan name below)
text	
•	A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO) (Provide plan name below)
text	
•	Secretary Approved Coverage
•	Benchmark-Equivalent Benefit Package If selected, display options below.

The state/territory will provide the following Benchmark-Equivalent Benefit Package (check one that applies):	
•	The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit program (FEHBP)
•	State employee coverage that is offered and generally available to state employees (State Employee Coverage) (Provide plan name below)
text	
•	A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO) (Provide plan name below)
text	
•	The Medicaid state plan coverage provided to Categorically Needy (Mandatory and Options for Coverage) eligibility groups

Selection of Base Benchmark Plan Applies to both benchmark and benchmark-equivalent.

The state/territory must select a Base Benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark Equivalent Package.

y/n	The Base Benchmark Plan is the same as the Section 1937 Coverage Option. If yes, this table ends. If no, show the following:
Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:	
•	Largest plan by enrollment of the three largest small group insurance products in the state's small group market (Provide plan name below)
text	
•	Any of the largest three state employee health benefit plans by enrollment (Provide plan name below)
text	
•	Any of the largest three national FEHBP plan options open to federal employees in all geographies by enrollment (Provide plan name below)
text	
•	Largest insured commercial non-Medicaid HMO (Provide plan name below)
text	

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional)
text

Section 4. Alternative Benefit Plan Cost-Sharing

√	Any cost-sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.
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Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

y/n	The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.. If yes, show options below.	
	√	The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.
	(provide attachment instructions)	

Other Information Related to Cost-Sharing Requirements (optional)	
text	

Section 5. Benefits Description

This table replaces most of B4a through B4d, B11 through B14, and B17.

y/n	<p>The state-territory proposes a “Benchmark Equivalent” benefit package. If yes, skip remainder of this section and proceed to Section 6, Benchmark-Equivalent Benefit Package. If no, continue below.</p>
y/n	<p>The state/territory is proposing “Secretary Approved Coverage” as its Section 1937 coverage option. If yes, show instruction below. If no, skip to Table A.</p> <p>Secretary Approved Benchmark Package: Benefit by Benefit Comparison Table</p> <p>The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary Approved ABP with the benefits provided by one of the Section 1937 Benchmark benefit packages or the standard full Medicaid State plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.</p> <p>(provide attachment instructions) (proceed to Table A)</p>

Table A: Benefits Included in Alternative Benefit Plan

Include “ADD” button to allow submitter to add as many rows as needed for each category of benefit. Allow submitter to “DELETE” a row that was added.

Enter the specific name of the Base Benchmark plan selected:
Text
Enter the specific name of the Section 1937 Coverage Option selected, if other than Secretary Approved. Otherwise, enter “Secretary Approved.”
Text

Essential Health Benefit	Benefit Provided ¹	Source ²	Amount Limit	Duration Limit	Scope Limit	Authorization ³	Provider Qualifications ⁴
1. Ambulatory patient services	Text Other: text	Drop down A	Drop down B	Drop down B	Drop down B	Drop down C	Drop down D
2. Emergency services	Other: text						
3. Hospitalization	Other: text						
4. Maternity and newborn care	Other: text						
5. Mental health and substance use disorder services including behavioral health treatment	Other: text						
6. Prescription drugs	Benefit Provided ⁵ Coverage 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. Other: text	Prescription Drug Limits Drop down F			Authorization Drop down G	Provider Qualifications State licensed.	

¹ List the benefits provided for each EHB category. If more than one benefit is offered in a category, use the “add” button to create additional lines.
² Choose the source of this benefit from the drop-down menu. If the source is anything other than your base benchmark, please provide the specific name of the source plan and explain in the “Other” field.
³ If the benefit requires any kind of authorization, pick the applicable type of authorization from the drop-down menu
⁴ Choose the required qualifications for providers delivering this benefit.
⁵ The individual drugs covered are not entered in this table. The state/territory provides assurances of meeting minimum coverage requirements and complying with prior authorization requirements in the Benefits Assurances section of this SPA.

Essential Health Benefit	Benefit Provided ⁶	Source ⁷	Amount Limit	Duration Limit	Scope Limit	Authorization ⁸	Provider Qualifications ⁹
7. Rehabilitative and habilitative services and devices	Text	Drop down A	Drop down B	Drop down B	Drop down B	Drop down C	Drop down D
	Other: text						
8. Laboratory services							
	Other: text						
9. Preventive and wellness services and chronic disease management							
	Other: text						
10. Pediatric services including oral and vision care	Medicaid State Plan EPSDT Benefits				None		
	Other: text						
11. Other Covered Benefits from Base Benchmark¹⁰							
Other Base Benefit Provided ¹¹	Source	Amount Limit	Duration Limit	Scope Limit	Authorization ¹²	Provider Qualifications ¹³	
Text	Base Benchmark	Drop down B	Drop down B	Drop down B	Drop down C	Drop down D	
	Other: text						
12. Base Benchmark Benefits Not Covered Due to Substitution¹⁴							
Base Benchmark Benefit that was Substituted							
Text	Base Benchmark	Explain: text					
13. Other Base Benchmark Benefits Not Covered¹⁵							
Base Benchmark Benefit Not Covered							
Text	Base Benchmark	Explain: text					
14. Other 1937 Covered Benefits that are not Essential Health Benefits¹⁶							

⁶ List the benefits provided for each EHB category. If more than one benefit is offered in a category, use the “add” button to create additional lines.

⁷ Choose the source of this benefit from the drop-down menu. If the source is anything other than your base benchmark, please provide the specific name of the source plan and explain in the “Other” field.

⁸ If the benefit requires any kind of authorization, pick the applicable type of authorization from the drop-down menu

⁹ Choose the required qualifications for providers delivering this benefit.

¹⁰ If the base benchmark includes benefits not captured in the Essential Health Benefits category, the state/territory may choose to include them in the benefit package by listing them here.

¹¹ List the other covered benefits from the base benchmark that are being included in the Alternative Benefit Plan. If more than one benefit is offered in this category, use the “add” button to create additional lines.

¹² If the benefit requires any kind of authorization, pick the applicable type of authorization from the drop-down menu

¹³ Choose the required qualifications for providers delivering this benefit.

¹⁴ List here any base benchmark benefit that was excluded because it was substituted with an actuarially equivalent benefit. Explain the substitution.

¹⁵ If any other base benchmark benefit is NOT included in the Alternative Benefit Plan benefit package, list it here and explain why it is not included.

Other 1937 Benefit Provided ¹⁷	Source	Amount Limit	Duration Limit	Scope Limit	Authorization ¹⁸	Provider Qualifications ¹⁹
Text	Drop down E	Drop down B	Drop down B	Drop down B	Drop down C	Drop down D
Other: text						
15. Additional Covered Benefits²⁰ (This category of benefits not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)						
Benefit Provided ²¹	Source	Amount Limit	Duration Limit	Scope Limit	Authorization ²²	Provider Qualifications ²³
Text	Text	Drop down B	Drop down B	Drop down B	Drop down C	Drop down D
Other: text						

Insert these drop down menus where indicated in table.

Drop down A (Source of EHB)	Drop down B (Limits)	Drop down C (Authorization)	Drop down D (Provider Qualifications)	Drop down E (Source of 1937)
Base Small Group Base Federal Employees Base State Employees Base Commercial HMO 1937 Federal BC/BS 1937 State Employees 1937 Commercial HMO Secretary Approved 1905(a) Secretary Approved 1915(i) Secretary Approved 1915(j) Secretary Approved 1915(k) Secretary Approved 1945 Secretary Approved Other (explain in "other" field) Other Source of Substituted Benefit (explain in "other" field)	Yes No If yes, describe the limit in the "other" field.	Yes No If yes, choose: Prior Authorization Authorization req. in excess of limitation Concurrent Authorization Retroactive Authorization Other If other, describe the authorization in the "other" field:	Medicaid State Plan Base Benchmark Plan Both of the above	1937 Federal BC/BS 1937 State Employees 1937 Commercial HMO Secretary Approved 1905(a) Secretary Approved 1915(i) Secretary Approved 1915(j) Secretary Approved 1915(k) Secretary Approved 1945 Secretary Approved Other (explain in "other" field)

¹⁶ Use this section to include all remaining benefits from your 1937 coverage option that is not already included in the essential health benefits above.

¹⁷ List the 1937 benefits that you are including, and that are not already listed above. If more than one benefit is offered in this category, use the "add" button to create additional lines.

¹⁸ If the benefit requires any kind of authorization, pick the applicable type of authorization from the drop-down menu

¹⁹ Choose the required qualifications for providers delivering this benefit.

²⁰ Use this section to include any additional benefits included to meet the needs of the target population. This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.

²¹ List the additional benefits that you are including, and that are not already listed above. If more than one benefit is offered in this category, use the "add" button to create additional lines.

²² If the benefit requires any kind of authorization, pick the applicable type of authorization from the drop-down menu

²³ Choose the required qualifications for providers delivering this benefit.

field)				
--------	--	--	--	--

Drop down F (Prescription Drug Limits) Multiple choices are possible.	
y/n	Limit on days supply (if Y, specify in "other" field)
y/n	Limit on number of prescriptions (if Y, specify monthly limit in "other" field)
y/n	Limit on brand drugs (if Y, specify number of brand fills permitted in "other" field)
y/n	Other coverage limits (if Y, specify in "other" field)
y/n	Preferred drug list

Drop down G (Prescription Drug Authorization)	
Yes	
No	

Section 6. Benchmark-Equivalent Benefit Package

Adapted from B6 and B7

Complete this section only if the state/territory is proposing a benchmark-equivalent benefit package.

Description of Benefits

\$	Please provide the aggregate actuarial value of the Benchmark plan (e.g., FEHBP, State/Territory Employee Coverage, Commercial Plan, State Plan) to which the state/territory's benefit package is equivalent.
\$	Please provide the aggregate actuarial value of the state/territory's Benchmark-Equivalent plan (must be greater than or equal to the amount entered for the Benchmark plan above).
√	The state/territory has included a chart and a thorough description of all benefits included in its Benchmark-Equivalent Benefit Package with a cross-walk of each benefit to the Essential Health Benefit categories or an indication that the benefit is not an Essential Health Benefit, if appropriate. The state/territory has also included the payment methodology associated with each benefit. (provide attachment instructions)
√	The state/territory has included a copy of the actuarial report (provide attachment instructions)

Other Information Related to this Benchmark-Equivalent Benefit Package:	(optional)
text	

Benchmark-Equivalent Benefit Package Assurances

√	The state/territory assures that the Benefit package has been determined to have an aggregate actuarial value equivalent to the specified Benchmark plan in the actuarial report that has been prepared:
√	By an individual who is a member of the American Academy of Actuaries
√	Using generally accepted actuarial principles and methodologies
√	Using a standardized set of utilization and price factors
√	Using a standardized population that is representative of the population being served
√	Applying the same principles and factors in comparing the value of different coverage (or benefits) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used
√	Recognizing the ability of a state/territory to reduce benefits by taking into account an increase in actuarial value of benefits coverage regardless any differences in coverage based on the method of delivery or means of cost control or utilization used
√	Taking into account the ability of the state/territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the state/territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

√	The state/territory assures, as required by Section 1937(b)(2)(A) and 42 CFR 440.335, benchmark-equivalent coverage shall include coverage for the following categories of services: inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, prescription drugs, well-baby and well-child care, including age-appropriate immunizations, emergency services, mental health benefits, family planning services and supplies and other appropriate preventive services as designated by the Secretary.
√	The state/territory has included a description of the benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the benefits included in the Benchmark-Equivalent Benefit plan.

y/n	The Benchmark Benefit package that is the basis for comparison of the Benchmark-Equivalent benefit package includes vision services. If yes, show the following assurance.
√	The actuarial value of the coverage for vision services in the Benchmark-Equivalent package is at least 75 percent of the actuarial value of the coverage for vision services in the Benchmark Benefit Package used for comparison by the state/territory.
y/n	The Benchmark Benefit package that is the basis for comparison of the Benchmark-Equivalent benefit package includes hearing services. If yes, show the following assurance.
√	The actuarial value of the coverage for hearing services in the Benchmark-Equivalent package is at least 75 percent of the actuarial value of the coverage for hearing services in the Benchmark Benefit Package used for comparison by the state/territory.

Other Information Related to Benchmark-Equivalent Assurances: (optional)
text

Section 7. Benefits Assurances

Adapted from B5

Applies to all submissions.

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the other benefit assurances below.

y/n	The alternative benefit plan includes beneficiaries under 21 years of age. If yes, show the following EPSDT-related assurances and content. Otherwise, skip to Other Benefit Assurances below.
√	The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR §440.345).
√	The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act. Select one:
•	Through an Alternative Benefit Plan
•	Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r). If this option is selected, show the following. Otherwise, skip to 252.
	Per 42 CFR §440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit. Select one:
•	State/territory provides additional EPSDT benefits through fee-for-service.
•	State/territory contracts with a provider for additional EPSDT services. Please specify payment method (select one): If this option is selected, show options below.
•	Risk-based capitation
•	Administrative services contract
•	Other Describe below:
	Text

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age: (optional)
Text

Prescription Drug Coverage Assurances

√	The state/territory assures that it meets the minimum requirements for prescription drug coverage in Section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the
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	base benchmark.
√	The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
√	The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of Section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under Section 1937 of the Act.
√	The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in Section 1927(d)(5) of the Act.

Other Benefit Assurances

√	The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
√	The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
√	The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
√	The state/territory assures that it will comply with the requirement of Section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
√	The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of Section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
√	The state/territory assures that it will comply with Section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
√	The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR §431.53.
√	The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits 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).

Section 8. Service Delivery Systems

adapted from B8

This section will repeat for each benefit package, if the state has indicated more than one benefit package in Section 3.

Provide detail on the type of delivery system the state/territory will use for the Alternative Benefit Plan, including any variation by the participants' geographic area.

Type of Service Delivery System(s) the state/territory will use for this Alternative Benefit Plan(s).
Select one or more:

●	Managed Care If this option is selected, show the following options.
●	Managed Care Organizations (MCO)
●	Prepaid Inpatient Health Plans (PIHP)
●	Prepaid Ambulatory Health Plans (PAHP)
●	Primary Care Case Management (PCCM)
●	Fee-for-Service
●	Other Service Delivery System

Each of the service delivery types above has a corresponding section below which will only be displayed if that type of service delivery has been selected.

Managed Care (display only if “Managed Care” has been selected above.)

Managed Care Assurance

√	The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.
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Please describe the implementation plan for the ABP under managed care including member, provider, and other stakeholder outreach efforts.

text

MCO—Managed Care Organization (show only if MCO selected at 276)

y/n	The managed care delivery system is the same as an already approved managed care program. If yes, show options below. If no, skip to 289.
	The managed care program is operating under (select one):
●	Section 1915(a) Voluntary Managed Care Program

•	Section 1915(b) Managed Care Waiver
•	Section 1932(a) Mandatory Managed Care State Plan Amendment
•	Section 1115 Demonstration Waiver
•	Section 1937 Alternative (Benchmark) Benefit Plan State Plan Amendment
mm/dd/yy	Identify the date the managed care program was approved by CMS: Describe program below:
text	

√	The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR §438, and sections 1903(m), 1932 and 1937 of the Social Security Act).
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y/n	One or more of the Alternative Benefit Plan services will be provided apart from the managed care organization. If yes, show options below. If no, skip to next table.				
	List the services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.				
	<table border="1"> <thead> <tr> <th>Service</th> <th>Description of How Service will be Provided</th> </tr> </thead> <tbody> <tr> <td>text</td> <td>Text (allow additional rows to be added)</td> </tr> </tbody> </table>	Service	Description of How Service will be Provided	text	Text (allow additional rows to be added)
Service	Description of How Service will be Provided				
text	Text (allow additional rows to be added)				

y/n	MCO Service Delivery is provided on less than a statewide basis. If yes, show options below. If no, skip to 297
	The limited geographic area where this service delivery system is available is as follows:
•	MCO service delivery is available only in designated counties. Specify counties: text
•	MCO service delivery is available only in designated regions. Specify regions and describe make-up of each region: text
•	MCO service delivery is available only in designated cities and municipalities. Specify which cities and municipalities: text
•	MCO service delivery is available in some other geographic area. Specify: text

Insert the following procurement questions only if the state has answered “no” to the question about existing managed care authority above at 287.

MCO Procurement or Selection Method

Indicate the method used to select MCOs:	
•	Competitive Procurement Method (RFP, RFA)
•	Other Procurement/Selection Method
Describe the method used by the state/territory to procure or select the MCOs:	
text	

MCO Participation Exclusions

y/n	Individuals are excluded from MCO participation in the Alternative Benefit Plan: select all that apply	If yes,
	<ul style="list-style-type: none"> ● Individuals with other medical insurance ● Individuals eligible for less than three months ● Individuals in a retroactive period of Medicaid eligibility ● Other: (Describe) 	
	text	

General MCO Participation Requirements:

Indicate if participation in the managed care is mandatory or voluntary:		
	<ul style="list-style-type: none"> ● Mandatory Participation. Describe method of assignment to MCOs: 	
	text	
	<ul style="list-style-type: none"> ● Voluntary Participation. Indicate the method for determining participation: 	
	<ul style="list-style-type: none"> ● Opt-In to Managed Care option and to specific MCO ● Opt-Out of Managed Care ● Other: (Describe) 	
	text	

Additional Information: MCO (optional)

Provide any additional details regarding this service delivery system:		
text		

PIHP: Prepaid Inpatient Health Plan (show only if PIHP selected at 276)

	<ul style="list-style-type: none"> ● PIHPs are paid on a risk basis. ● PIHPs are paid on a non-risk basis. 	
y/n	The managed care delivery system is the same as an already approved managed care program. If yes, show options below. If no, skip to 312.	
	The managed care program is operating under (select one):	
	<ul style="list-style-type: none"> ● Section 1915(a) Voluntary Managed Care Program ● Section 1915(b) Managed Care Waiver ● Section 1115 Demonstration Waiver ● Section 1937 Alternative (Benchmark) Benefit Plan State Plan Amendment 	
mm/dd/yy	Identify the date the managed care program was approved by CMS:	
	Describe program below:	
	text	

√	The Alternative Benefit Plan will be provided through a prepaid inpatient health plan (PIHP) consistent with applicable managed care requirements (42 CFR §438, section 1903(m) of the Social Security Act, and section 1937 of the Social Security Act).
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y/n	One or more of the Alternative Benefit Plan services will be provided apart from the PIHP. If yes, show options below. If no, skip to next table.				
	List the services that will be provided apart from the PIHP, and explain how they will be provided. Add as many rows as needed.				
	<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 30%;">Service</th> <th>Description of How Service will be Provided</th> </tr> </thead> <tbody> <tr> <td>text</td> <td>Text (allow additional rows to be added)</td> </tr> </tbody> </table>	Service	Description of How Service will be Provided	text	Text (allow additional rows to be added)
Service	Description of How Service will be Provided				
text	Text (allow additional rows to be added)				

y/n	PIHP Service Delivery is provided on less than a statewide basis. If yes, show options below. If no, skip to 319
	The limited geographic area where this service delivery system is available is as follows:
	<ul style="list-style-type: none"> ● PIHP service delivery is available only in designated counties. Specify counties: text ● PIHP service delivery is available only in designated regions. Specify regions and describe make-up of each region: text ● PIHP service delivery is available only in designated cities and municipalities. Specify which cities and municipalities: text ● PIHP service delivery is available in some other geographic area. Specify: text

Insert the following procurement questions only if the state has answered “no” to the question about existing managed care authority above at 310.

PIHP Procurement or Selection Method

Indicate the method used to select PIHPs:	
●	Competitive Procurement Method (RFP, RFA)
●	Other Procurement/Selection Method
Describe the method used by the state/territory to procure or select the PIHPs: text	

PIHP Participation Exclusions

y/n	Individuals are excluded from PIHP participation in the Alternative Benefit Plan: If yes, select all that apply
	<ul style="list-style-type: none"> ● Individuals with other medical insurance ● Individuals eligible for less than three months ● Individuals in a retroactive period of Medicaid eligibility ● Other: (Describe)
	text

General PIHP Participation Requirements:

Indicate if participation in the managed care is mandatory or voluntary:
--

●	Mandatory Participation. Describe method of assignment to PIHPs:
text	
●	Voluntary Participation. Indicate the method for determining participation:
●	Opt-In to Managed Care option and to specific PIHP
●	Opt-Out of Managed Care
●	Other: (Describe)
text	

Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system: (optional)

text

PAHP: Prepaid Ambulatory Health Plan (show only if PAHP selected at 276)

●	PAHPs are paid on a risk basis.
●	PAHPs are paid on a non-risk basis.
y/n	The managed care delivery system is the same as an already approved managed care program. If yes, show options below. If no, skip to 337.
	The managed care program is operating under (select one):
●	Section 1915(a) Voluntary Managed Care Program
●	Section 1915(b) Managed Care Waiver
●	Section 1115 Demonstration Waiver
●	Section 1937 Alternative (Benchmark) Benefit Plan State Plan Amendment
mm/dd/yy	Identify the date the managed care program was approved by CMS:
	Describe program below:
text	

√	The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR §438, section 1903(m) of the Social Security Act, and section 1937 of the Social Security Act).
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y/n	One or more of the Alternative Benefit Plan services will be provided apart from the PAHP. If yes, show options below. If no, skip to next table.
	List the services that will be provided apart from the PAHP, and explain how they will be provided. Add as many rows as needed.
Service	Description of How Service will be Provided
text	Text (allow additional rows to be added)

y/n	PAHP Service Delivery is provided on less than a statewide basis. If yes, show options below.
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If no, skip to 343	
The limited geographic area where this service delivery system is available is as follows:	
•	PAHP service delivery is available only in designated counties. Specify counties:
text	
•	PAHP service delivery is available only in designated regions. Specify regions and describe make-up of each region:
text	
•	PAHP service delivery is available only in designated cities and municipalities. Specify which cities and municipalities:
text	
•	PAHP service delivery is available in some other geographic area. Specify:
text	

Insert the following procurement questions only if the state has answered “no” to the question about existing managed care authority above at 335.

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:	
•	Competitive Procurement Method (RFP, RFA)
•	Other Procurement/Selection Method
Describe the method used by the state/territory to procure or select the PAHPs:	
text	

PAHP Participation Exclusions

y/n	Individuals are excluded from PAHP participation in the Alternative Benefit Plan: If yes, show the following. If no, skip to 351.
•	Individuals with other medical insurance
•	Individuals eligible for less than three months
•	Individuals in a retroactive period of Medicaid eligibility
•	Other: (Describe)
text	

General PAHP Participation Requirements:

Indicate if participation in the managed care is mandatory or voluntary:	
•	Mandatory Participation. Describe method of assignment to PAHPs:
text	
•	Voluntary Participation. Indicate the method for determining participation:
•	Opt-In to Managed Care option and to specific PAHP
•	Opt-Out of Managed Care
•	Other: (Describe)
text	

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system: (optional)
text

PCCM: Primary Care Case Management (show only if PCCM selected at 276)

y/n	The PCCM delivery system is the same as an already approved PCCM program. If yes, show options below. If no, skip to 359
	The PCCM program is operating under (select one):
•	Section 1915(b) Managed Care Waiver
•	Section 1932(a) Mandatory Managed Care State Plan Amendment
•	Section 1115 Demonstration Waiver
•	Section 1937 Alternative (Benchmark) Benefit Plan State Plan Amendment
mm/dd/yy	Identify the date the PCCM program was approved by CMS: Provide Waiver/SPA Number below:
Text	

√	The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR §438, and sections 1903(m), 1932 and 1937 of the Social Security Act).
---	---

y/n	PCCM Service Delivery is provided on less than a statewide basis. If yes, show options below. If no, skip to 364
	The limited geographic area where this service delivery system is available is as follows:
•	PCCM service delivery is available only in designated counties. Specify counties:
Text	
•	PCCM service delivery is available only in designated regions. Specify regions and describe make-up of each region:
Text	
•	PCCM service delivery is available only in designated cities and municipalities. Specify which cities and municipalities:
Text	
•	PCCM service delivery is available in some other geographic area. Specify:
Text	

PCCM Payments

Specify how payment for services is handled:	
•	Per member/per month case management fee paid to PCCM provider
•	Other
Describe:	
Text	

Additional Information: PCCM (Optional)

Provide any additional details regarding this service delivery system: (optional)

Text

Fee-For-Service Options (show only if FFS selected at 276)

●	Traditional State-Managed Fee-for-Service
	Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, FFS care management models/non-risk, contractual incentives as well as the population served via this delivery system.
	Text
●	Services Managed Under an Administrative Services Organization (ASO) Arrangement
	Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, FFS care management models/non-risk, contractual incentives as well as the population served via this delivery system.
	Text

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system: (optional)

Text

Other Service Delivery Model (show only if "Other Service Delivery System" selected at 276)

Name of service delivery system:
Text
Provide a narrative description of the model:
Text

Section 9. Employer Sponsored Insurance

Adapted from B9.

This page should be displayed for all Alternative (Benchmark) Benefit Plan submissions.

y/n	The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a benchmark or benchmark-equivalent benefit package.
	If yes, provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information.
	Text
	Other (optional)
	Text

Section 10. General Assurances

Adapted from B10.

This page should be displayed for all Alternative (Benchmark) Benefit Plan submissions. All assurances must be checked by the state.

Economy and Efficiency of Plans

√	The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.	
	y/n	Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. If no, please describe your approach below.
	Text	

Compliance with the Law

√	The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.	
√	The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2.	
√	The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.	
√	The state/territory assures that it will comply with the requirements of 42 CFR 435.917(c) by providing in the eligibility notice of participants in an Alternative Benefit Plan information on the level of benefits and services approved, including, if applicable, the notice relating to premiums, enrollment fees, and cost sharing required under 42 CFR Part 447 Subpart A, and the right to appeal the level of benefits and services approved.	

Section 11. Payment Methodology

Adapted from B16.

Alternative Benefit Plans - Payment Methodologies

√	The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.
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Provide attachment instructions.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.