



CMCS Informational Bulletin

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SUBJECT: Process for Amending Alternative Benefit Plans

This informational bulletin provides information on the timeframes and requirements for amending Medicaid Alternative Benefit Plans (ABP) when states are in full or partial alignment between the ABP benefit package and the state's approved Medicaid state plan package for other categorically or medically needy eligible. This bulletin also includes information about expectations for public and tribal notification, as well as the system to use for state plan amendment (SPA) submissions.

Background

Under section 1937 of the Social Security Act, states have the flexibility to design an ABP entirely based on commercial market benefits or the state's approved Medicaid state plan, or a combination of both. When a state designs its ABP benefit package to be the same benefits or richer benefits than the state's approved Medicaid state plan, the state has achieved alignment between the ABP benefit package and the state's approved underlying Medicaid state plan. To date, most states have chosen the path of aligning their ABP benefit package fully or in part with the state's approved Medicaid state plan.

Section 1302 of the Affordable Care Act, as codified at 45 CFR 156.110 of the [Essential Health Benefit regulation](#) published by the Center for Consumer Information and Insurance Oversight (CCIIO), requires that beginning in 2014, qualified health plans offered on Exchanges and non-grandfathered individual and small group coverage offered by insurers must include the 10 broad categories of coverage called Essential Health Benefits (EHBs). The regulation's preamble language further specified that the benchmark plan selection in 2012 would be applicable for at least the 2014 and 2015 benefit years, thus freezing EHBs at their 2012 level until December 31, 2015.

The suspension of updating EHB benefits for two years was intended to bring stability to the marketplace while the full breadth and depth of the transition to the requirements under Affordable Care Act was realized. CMS carried this suspension over to the benefits from the commercial market base benchmark plan, which are used to define the floor of coverage for EHBs into ABPs. States are therefore not required to update their base benchmark plans in terms

of essential health benefits until at least December 31, 2015. It should be noted that the standard Medicaid state plan is not subject to the “freezing” of benefits because it is not considered a base benchmark plan.

ABP Amendment Requirements

ABPs must be kept in full or partial alignment with the state’s approved underlying state plan on an ongoing basis, not just at the point of initial approval for those states that have chosen to align with their Medicaid state plan. ABP submissions that are aligned with the state’s approved Medicaid state plan are inclusive of all benefits in the state plan, in one submission. In order to maintain alignment, states are required to submit an amendment to update the benefits in the ABP and states will be required to include in the amendments changes that impact the approved ABP. For example, state plan amendments that add, delete or change coverage based on limitations of amount, duration or scope or authorization requirements will need to be included in the new ABP submission. Amendments that affect provider qualifications, for example, will not need to be addressed by amending the ABP, as the ABP does not require an articulation of individual providers.

Appreciating that this is the first year of ABP submissions, we are allowing states extra time to ensure that their SPAs are properly updated to maintain alignment. States should submit updates to the ABP submission that includes all changes for the first three calendar quarters no later than December 31, 2014. Thereafter, states will be required to update the ABP submissions on a quarterly basis to keep the ABP in alignment with the state’s approved underlying Medicaid state plan. We recognize that state plan amendments for the state’s approved state plan may have different effective dates even if submitted in the same quarter. Therefore, we will need to reflect those effective dates for each benefit within the ABP, which will result in the ABP having an overall effective date for the submission and potentially different effective dates by benefit category within the ABP.

With regard to the timing of amendments to the ABP related to essential health benefits, CMS will be issuing additional information regarding updating of the benefits in the underlying commercial market benefit package used to define essential health benefits, as these benefits are frozen until 12/31/15.

Public Notice and Tribal Notification

States are required to issue public notice prior to submission of a new ABP or changes to an existing ABP. Publication of such notice must provide for a reasonable opportunity to comment and have included in the notice a description of the method for assuring compliance with § 440.345 related to full access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. This requirement affects the timing of the ABP submission, as states have until the last day of the calendar quarter to submit SPAs to preserve the effective date for the first day of the quarter.

States are also required to notify Tribes prior to the submission of a new ABP or changes to an existing ABP. Tribal notification must be conducted according to the tribal notification process that has been specified in the state plan. We believe that the tribal notice that state will need to conduct for regular state plan benefits will suffice for this process in ABPs.

The public notice process and the tribal notification process can be quite lengthy in some state, (up to 60 days) and state should plan accordingly. States that do not publish the public notice or provide tribal notification prior to submitting a new ABP or an amendment to an existing ABP will be required to revise the effective date of the submission, which could jeopardize the ongoing alignment between the ABP and underlying Medicaid state plan.

New SPA Submission Process

States should continue to use the MMDL to submit SPAs until the MACPro system is implemented. MACPro is an online system CMS is developing to facilitate submission of applications to amend existing Medicaid and CHIP state plans and waivers. It will be phased-in over time, with Phase I including ABP SPAs. Additional information will be issued on the status of MACPro and its use for ABP submissions. As part of this activity, we will also continue to work with states to implement changes to SPA templates to make the process of maintaining alignment as smooth as possible.