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CENTERS FOR MEDICARE & MEDICAID SERVICES
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CMCS Informational Bulletin

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SUBJECT: **Alternative Benefit Plan Conforming Changes**

Purpose

This informational bulletin provides information to states about recent regulatory changes in Essential Health Benefit (EHB) standards affecting Medicaid Alternative Benefit Plans (ABPs). The bulletin includes information about conforming changes that may be needed in the following areas: EHB coverage standards for habilitative services and devices; updating the benchmark plan year used to define EHBs; prescription drug benefits and preventive services and supplies. This bulletin also address the state-required actions as a result of these changes, including state plan amendment (SPA) submissions and ABP public notice requirements.

Background

The Affordable Care Act (ACA) amended section 1937 of the Social Security Act (the Act), to require that ABP coverage packages meet EHB standards. A regulation published in 2015 made several regulatory changes to EHB standards that impact Medicaid ABPs (The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016, Final Regulation (CMS-9944-F), published by the Center for Consumer Information and Insurance Oversight (CCIIO) on February 27, 2015, (hereby called the CCIIO 2016 Payment Notice)). In addition, the Department of Labor issued an interpretive information that also impacts preventive and contraceptive services under Medicaid ABPs.

EHB-Benchmark Coverage Standards for Habilitative Services & Devices

The CCIIO 2016 Payment Notice revised the EHB referred to as Rehabilitative and Habilitative Services and Devices by adding a definition for habilitative services. The following definition is now used to define habilitative services and devices at 45 CFR section 156.115(a)(5)(i): "health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." States will therefore need to determine if the habilitative coverage in their

approved ABP meets this definition. If not, states will need to amend the ABP to bring it into compliance with the new requirement. CMS will expect state plans to be in compliance for ABP coverage offered on or after April 1, 2016 (or under managed care contracts entered into on or after that date). States desiring to offer habilitative services and devices in parity with rehabilitative services and devices can continue to use the same services for rehabilitative and habilitative purposes, but coverage of habilitative services and devices must meet the definition above and meet the requirements for treatment limits as described below.

The state must not impose limits on habilitative services and devices that are more stringent than limits on rehabilitative services and devices (see 45 CFR 156.115(a)(5)(ii)). This provision is effective immediately and requires that states review the coverage in the ABP to ensure that limits are in compliance with this provision.

Separate coverage limits must also be established for rehabilitative and habilitative services and devices (see 45 CFR 156.115(a)(5)(iii)) for plan years beginning on or after January 1, 2017. A combined limit that cannot be exceeded based on medical necessity is not permissible. States will need to assess any existing limits on this coverage to determine if an amendment to the ABP SPA is required.

The provisions discussed in this section do not change a state's ability to define habilitative services and devices through the process called supplementation, where a state can add benefits that are not present in the plan used to define EHBs according to requirements at 45 CFR 156.110(f), if the base benchmark plan does not include habilitative services and devices.

Updating EHB Benchmark Plans

The CCIIO 2016 Payment Notice provided that states would select a new benchmark plan to define EHBs or default to the largest small group plan, and that revised benchmark plans would be based on 2014 plans (see 45 CFR 156.110). Issuers will start using the new benchmark plans as a reference plan for designing EHB-compliant benefit packages starting with the 2017 plan year. For Medicaid purposes, states will be required to select a new base benchmark or update the base benchmark plan already in use to plan year 2014 from plan year 2012, for ABPs that are offered on or after January 1, 2017 (or managed care contract years beginning on or after that date), and update the ABP benefit package accordingly. This will require states to submit an ABP amendment to record the change in base benchmark selection and make any other changes to benefit design that may result from using the new plan year.

Pediatric Age

The CCIIO 2016 Payment Notice specified that for EHBs, required pediatric services means services until at least the end of the month when the enrollee turns 19 years of age (see 45 CFR 156.115(a)(6). This change does not affect Medicaid ABPs, because they are required to provide all medically necessary services that would be covered under a traditional Medicaid program, including pediatric oral and vision services, under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which applies to children under 21 years old.

Prescription Drug Benefit

The CCIIO 2016 Payment Notice added new requirements for plans to use a pharmacy and therapeutics (P&T) committee starting in plan years beginning on or after January 1, 2017. The rule also included provisions regarding the P&T committee structure and operations, the formulary exceptions process, and the accessibility of formulary information.

States that establish preferred drug lists (PDLs) or formularies (for either traditional Medicaid, ABPs or managed care) consistent with the requirements of section 1927 of the Act will comply with the formulary exceptions process and new P&T committee requirements, as long as the Drug Utilization Review board or the P&T committee meeting occurs at least quarterly to ensure that the state's meeting standards comply with the meeting standards provided at 45 CFR 156.122(a)(3)(ii).

Publication of List of Covered Drugs

The CCIIO 2016 Payment Notice specified that for plan years beginning on or after January 1, 2016, in order to be considered to provide EHB prescription drug coverage, health plans must publish up-to-date, accurate, and complete lists of all covered drugs on their formulary drug lists, including any tiering structures that have been adopted, and any restrictions on the manner in which certain drugs can be obtained (see 45 CFR 156.122(d)). A state that adopts an ABP formulary should publish on its website the list and tiering structure (if applicable) of ABP covered drugs. As long as the formulary or PDL is publicly available in a manner consistent with the public notice requirements for Medicaid premiums and cost sharing set forth at 42 CFR 447.57(b), such requirements fulfill the standards at section 45 CFR 156.122(d).

Network Access Standards

The CCIIO 2016 Payment Notice specified that for plan years beginning on or after January 1, 2017, health plans must allow enrollees access to prescription drug benefits at in-network retail pharmacies, unless the drug is subject to restricted distribution by the Food and Drug Administration (FDA), or the drug requires special handling (see 45 CFR 156.122(e)). To the extent that a Medicaid ABP is furnished through a fee-for-service delivery system, under section 1902(a)(23), beneficiaries have access to any willing pharmacy provider who will accept Medicaid payment. However, states must also continue to ensure that payments are sufficient to enlist enough providers so that prescription drug coverage is available under the state plan at least to the same extent as is available to the general population, per the statutory requirement at 1902(a)(30)(A). To the extent that a Medicaid ABP is furnished through a managed care network (including a pharmacy benefit manager), the ABP will satisfy the requirements of 45 CFR 156.122(e) by maintaining access to in-network retail pharmacies.

Coverage of Certain Preventive Services

In May 2015, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury jointly released Frequently Asked Questions (FAQs)[1] related to coverage of preventive services, which are an EHB. The FAQs clarify that plans and issuers must cover at least one form

[1] See FAQs about Affordable Care Act Implementation, Part XXVI, available at http://www.dol.gov/ebsa/pdf/faq-aca26.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.

of contraception within each method identified by the FDA. This information also applies to Medicaid ABPs, which are required to cover preventive services through the EHB standards. Additionally, CMS reminds states that there is a requirement to cover a broad range of preventive services, and cost sharing may not be applied to preventive services described under section 2713 of the Public Health Service Act and its implementing regulations.

State-Required Actions

As a result of the required changes identified in this CIB, states should assess the need to take the following actions:

1) After January 1, 2017 (or for ABP managed care contract years beginning on or after that date) ABPs must be compared to an EHB base benchmark plan from plan year 2014. Therefore, states must update and amend current ABPs by March 31, 2017 in order to secure the required effective date of January 1, 2017. States submitting a new ABP with a January 1, 2017 effective date and thereafter, will also be required to reference updated base benchmark plans when determining EHB-compliant ABP coverage. Additionally, states must determine if their selected 1937 benchmark plan coverage option should be updated to reflect this change.
2) If states have limits on habilitative services that are more stringent than rehabilitative services, then the state will need to remove or modify the limit and allow for equal limits. States must submit SPAs no later than June 30, 2016 to secure an effective date of April 1, 2016. If the new definition for habilitative services has an impact on ABPs in which the state defined habilitative services previously, then the state will need to submit a SPA to correct the coverage by June 30, 2016 to secure an effective date of April 1, 2016.
3) If the base benchmark or the resulting ABP benefit package applies combined treatment limitations that cannot be exceeded based on medical necessity to habilitative and rehabilitative services and devices, states must separate such limits in a manner such that limitations on habilitative services are no less favorable than rehabilitative services. These changes must be made for coverage provided on or after January 1, 2017, or under ABP managed care contract years beginning on or after that date. A SPA must be submitted by March 31, 2017 to effectuate this change by January 1, 2017.
4) After January 1, 2016, states that adopt an ABP formulary, or for managed care contract years beginning on or after that date for ABP coverage that includes a formulary, must ensure that the state or its contractor publish on its website the list and tiering structure (if applicable) of covered drugs.

Public Notice Requirement

CMS reminds states and stakeholders that prior to submitting a SPA to either establish an ABP or substantially modify an existing ABP, the state must have provided the public with advance notice of the amendment and reasonable opportunity to comment on such amendment as specified at 42 CFR 440.386. Tribal consultation is also required if applicable in the state. The notice published for public comment must include a description of the method for assuring compliance with 42 CFR 440.345 related to full access to EPSDT. If a state is unclear whether a change to its ABP SPA is substantive, we encourage the state to consult with CMS in advance of submission.

For additional information about this Informational Bulletin, please contact Kirsten Jensen, Director, Division of Benefits and Coverage at 410-786-8146.