Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: Kentucky

Transmittal Number: KY 13-0020

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

KY ABP - New Adult Group

Description:

New Adult Group for Medicaid Expansion

☑ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- ◉ **The population group for this Alternative Benefit Plan includes only** the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- ○ **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.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- ○ **The population for this Alternative Benefit Plan does not include the adult group under section 1902 (a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

☑ Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.* 1

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.* 1

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: Kentucky

Transmittal Number: KY 13-0020

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1

Form Code	Form Name	Uploaded Form Count
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2c	Enrollment Assurances - Mandatory Participants	0
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form:
Uploaded Form Name:
ABP1_Adult.pdf

Support Documents

Document

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form
Please provide a short description of this ABP2a form:
Uploaded Form Name:
ABP2a_Adult.pdf

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form
Please provide a short description of this ABP2b form:
Uploaded Form Name:

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form

Support Documents

Document

Form ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3 Forms List

Form
Please provide a short description of this ABP3 form:
Uploaded Form Name:
ABP3.pdf

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form
Please provide a short description of this ABP4 form:
Uploaded Form Name:
ABP4_Adult.pdf

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form
Please provide a short description of this ABP5 form:
Uploaded Form Name:
ABP5_Adult.pdf

Support Documents

Document
Please provide a short description of this support document:
Uploaded Document Name:
ABP 5 Attachment.xlsx

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form
Please provide a short description of this ABP6 form:
Uploaded Form Name:
ABP5.pdf

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form
Please provide a short description of this ABP7 form:
Uploaded Form Name: ABP7_Adult.pdf

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form
Please provide a short description of this ABP8 form:
Uploaded Form Name: ABP8.pdf

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form
Please provide a short description of this ABP9 form:
Uploaded Form Name: ABP9_Adult.pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form
Please provide a short description of this ABP10 form:
Uploaded Form Name: ABP10_Adult.pdf

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form
Please provide a short description of this ABP11 form:
Uploaded Form Name: ABP11_Adult.pdf

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: Kentucky

Transmittal Number: KY 13-0020

☐ **One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.**

- ☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**
- ☐ **The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- ☐ **Indian Tribes**
- ☐ **Indian Health Programs**

☐ Urban Indian Organization

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Indicate the key issues raised in Indian consultative activities:

☐ Access

Summarize Comments

Summarize Response

☐ Quality

Summarize Comments

Summarize Response

☐ Cost

Summarize Comments

Summarize Response

☐ Payment methodology

Summarize Comments

Summarize Response

☐ Eligibility

Summarize Comments

Summarize Response

☐ Benefits

Summarize Comments

Summarize Response

☐ Service delivery

Summarize Comments

Summarize Response

☐ Other Issue

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Kentucky

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

KY 13-0020

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Affordable Care Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$563000000.00
Second Year	2015	$1193000000.00

Subject of Amendment

Medicaid expansion to include new adult group

Governor's Office Review

- ○ Governor's office reported no comment
- ○ Comments of Governor's office received
  Describe:
- ○ No reply received within 45 days of submittal
- ◉ Other, as specified
  Describe:

Signature of State Agency Official

Submitted By:	**Sharley Hughes**
Last Revision Date:	**Oct 14, 2013**
Submit Date:	**Oct 1, 2013**

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: KyHealth Choices-New Adult Group

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:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

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

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.

V.20130724

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	ABP2a
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Kentucky has reviewed the EHB's Anthem PPO and added or supplemented Medicaid benefits where Medicaid was less rich than the benchmark plan. The state has provided a detailed attachment in ABP5 showing the mapping of the EHB benefits to Medicaid Benefits. The Alternative Benefit Plan includes all the same benefits, which are included in the Medicaid State Plan.

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.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: KyHealth Choices

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.
- ○ Benchmark-Equivalent Benefit Package.

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):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Please refer to the state's approved State Plan

Selection of Base Benchmark Plan

Alternative Benefit Plan

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

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

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.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Anthem Blue Cross Blue Shield Small Group PPO

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

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.

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

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.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

Att. 4.18-A will be updated with current cost sharing

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.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Benefits Description — ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. [No]

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. [Yes]

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan 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.

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Anthem PPO

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All ☐

Benefit Provided: Physician Services: Outpatient
Source: State Plan 1905(a) — Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For recipients in the Lock-in Program, specialty physician services require referral by the designated primary care provider.
This represents Outpatient physician services.

Benefit Provided: Outpatient Hospital Services
Source: State Plan 1905(a) — Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for some services. See State Plan

Benefit Provided: Clinic Services
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Certified Pediatric or Family Nurse Practitioner S

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Certified pediatric or family Nurse Practitioner services

Benefit Provided: Any other medical care: emergency transportation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary
This represents emergency transportation/ambulance

Benefit Provided: Family Planning Services and Supplies for Individu

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Limited to individuals of child-bearing age

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age

Benefit Provided:

Home health services; nursing and therapy visits

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

PT/OT/ST: 20 visits per calendar year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This represents the home health visit, including PT/OT/SLT (if applicable)
20 visits per calendar year each for physical, occupational, and speech therapy; benefit limits are aggregated between habilitation and rehabilitation services

Benefit Provided:

Dental Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

1 cleaning and 1 x-ray per year

Scope Limit:

Dental services for adults 21 years of age or older

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Dental services for children under 21 years of age is included in EHB 10.

Benefit Provided:

Case Management Services

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: Some case management services are limited to specific groups of individuals. Please see the State Plan.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some case management services require a prior authorization. Please see the State Plan.

Benefit Provided: Hospice Care

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Private duty nursing

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: 2000 hours / year

Scope Limit: Services in an inpatient setting excluded

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Medical care & any other type of remedial:podiatry

Source: State Plan 1905(a)

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Exclusions are listed in the State Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Full State Plan Service Title: Medical care and any other type of remedial care
This represents podiatry services

Benefit Provided:
Medical care & any other type of remedial: APRN

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Full State Plan Service Title: Medical care and any other type of remedial care
This represents services provided by Advanced Practice Registered Nurse (APRN)

Benefit Provided:
Medical care & any other type of remedial; Other

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Full State Plan Service Title: Medical care and any other type of remedial care
This represents services provided by other licensed practitioners' (opthalmic dispensers' services & pharmacists)

Alternative Benefit Plan

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided:

Emergency hospital services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided: Inpatient Hospital Services
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service.

Benefit Provided: Physician Services: Inpatient
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This represents Inpatient Physician Services

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care — Collapse All

Benefit Provided: Ambulatory prenatal care for pregnant women furni
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Ambulatory prenatal care for pregnant women furnished during a presumptive eligiblity period

Benefit Provided: Face-to-face Tobacco Cessation for Pregnant Women
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: 4 face-to-face sessions per quit attempt with a minimum of 2 quit attempts
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Inpatient psychiatric facility services for indivi

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Limited to children under 21 years of age

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Inpatient psychiatric facility services for individuals under 21 years of age

Benefit Provided: Rehabilitative services for pregnant women

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Limited to pregnant and postpartum women for a 60 day period after the pregnancy ends

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This includes substance abuse assessment and prevention services for pregnant women

Benefit Provided: Other diagnostic, screening: IP Mental Health

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents Inpatient Mental Health services.

Remove

Benefit Provided:

Other diagnostic, screening: OP Mental Health

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents Outpatient Mental Health services.

Benefit Provided:

Other diagnostic, screening: IP Substance Use

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents IP Substance Use Disorder Services

Benefit Provided:

Other diagnostic, screening: OP Substance Use

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:	Duration Limit:	
None	None	Remove

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents OP Substance Use Disorder Services

Add

Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☐ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Unlimited prescriptions. Drugs not included on the PDL may be provided with prior authorization. Trial and failure of preferred drugs may be required before the non-preferred drug is approved.

State Plan Service Title: Prescribed drugs, dentures, prosthetic devices, and eyeglasses

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Physical therapy &related svcs, including OT, SLT

Source: State Plan 1905(a) — Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 20 visits per calendar year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Service Title: Physical therapy and related services

Increases current benefit limits from 15 to 20

20 visits per year each for physical, occupational and speech therapy; benefit limits are aggregated between habilitation and rehabilitation services.

Benefit Provided: Durable Medical Equipment, medical supplies, prost

Source: State Plan 1905(a) — Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Specific restrictions and exclusions are found in the fee schedule

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Durable Medical Equipment, medical supplies, prosthetics, and orthotics
Prior authorization is required for items of equipment or repairs greater than $500 and certain other specified items.

Benefit Provided: Home health services: supplies

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan