DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **SPA 17-041**

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SSA 1905(a)(10) and 42 CFR 440.100

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $30,393,750
b. FFY 2019 $41,360,349

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-L, ABP 5, pages 1-57

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-L, ABP 5, pages 1-57

10. SUBJECT OF AMENDMENT:
SPA 17-041 will fully restore adult dental services in the Alternative Benefit Plan.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

ORIGINAL SIGNED

13. TYPED NAME:
Mari Cantwell

14. TITLE:
Chief Deputy Director
Health Care Programs
State Medicaid Director

15. DATE SUBMITTED:
12/8/2017

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, MS 4506
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Alternative Benefit Plan

State Name: California | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: CA - 17 - 0041 | OMB Expiration date: 10/31/2014

Benefits Description	ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

The Standard Blue Cross/Blue Shield Preferred Provider Option-Federal Employees Health Benefit Program (FEHBP)

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

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Hospital Outpatient & Outpatient Clinic Services
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: See below
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:

The following outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month: acupuncture, audiology, occupational therapy, podiatry, and speech therapy; may exceed limit for medical necessity with Treatment Authorization Request (TAR). Includes Indian Health Services.

Benefit Provided: Outpatient Hospital: Outpatient Surgery
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: See below
Duration Limit: None
Scope Limit: Frequency limits of once per lifetime on some surgeries.

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

Includes anesthesiologist services.

Benefit Provided: Other Licensed Practitioners: Podiatry
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: 2 per month
Duration Limit: None
Scope Limit: Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics, FQHCs and RHCs.

Alternative Benefit Plan

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

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Remove

Benefit Provided: Other Licensed Practitioners: Chiropractic

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 2 per month

Duration Limit: None

Scope Limit: Pregnant women and EPSDT covered. Other beneficiaries are only covered in FQHCs and RHCs.

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

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Remove

Benefit Provided: Physician Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Scope of licensure.

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

Remove

Benefit Provided: Outpatient Hospital: Treatment Therapies

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

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

Chemotherapy, radiation therapy, Intensive-Modulated Radiation Therapy (IMRT), renal dialysis, IV/ infusion therapy, medication management.

Benefit Provided:

Physician Services: Allergy Care

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

8 injections within 120 days

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:

Emergency treatment does not require TAR.

Benefit Provided:

Outpatient Hospital: Dialysis/Hemodialysis

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:

Chronic dialysis covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs and laboratory tests. Hemodialysis routine test can be conducted per treatment, weekly or monthly.

Benefit Provided:

Non-Emergency Ambulance Transportation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
As related to program covered services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Other Medical Care: Air transportation only covered when ground transportation is not feasible; transportation covered from non-contract hospital to nearest contract hospital when patient is stable.

Benefit Provided:
Hospice

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Six months, but may be longer with TAR

Scope Limit:
Any Medi-Cal eligible recipient certified by a physician as having a life expectancy of six months or less. Includes routine home care, continuous home care, respite care and general inpatient care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Children may receive concurrent palliative care.

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Outpatient Hospital: Emergency
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:

All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including emergency dental services, as certified by the attending physician or other appropriate provider.

Benefit Provided: Medical Transportation: Ambulance Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Nearest hospital capable of meeting patient's need.

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

Air transportation only covered when ground transportation is not feasible.

Add

Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization — Collapse All

Remove

Benefit Provided: Inpatient Hospital/Surgical Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Frequency limits of once per lifetime on some surgeries.

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

Room and Board. Professional services performed by physicians, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME and medical supplies; and Indian Health Services. These facilities are not Institutions for Mental Disease (IMD) and the IMD payment exclusion applies.

Remove

Benefit Provided: Inpatient Hospital: Bariatric Surgery

Source: State Plan 1905(a)

Authorization: Prior Authorization

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:

Patient must be at or above specified BMI levels and meet certain conditions to qualify.

Remove

Benefit Provided: Other Lic. Practitioner:Anesthesiologist Services

Source: State Plan 1905(a)

Authorization: Other

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:

Benefit Provided: Inpatient Hospital: Organ & Tissue Transplantation

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

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:

Transplant surgery, pre-transplant evaluation, post-operative care and laboratory services for bone morrow, heart, liver, kidney, heart-lung, simultaneous kidney-pancreas, single lung, double lung, pancreas, small bowel and combined liver-small bowel surgeries.

Benefit Provided: Inpatient Hospital: Reconstructive Surgery

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Cosmetic surgery is not a covered benefit.

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

Surgery is limited to that performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function and/or to create a normal appearance, to the extent possible. Includes breast reconstruction after mastectomy.

Add

Alternative Benefit Plan

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

Remove

Benefit Provided: Physician Service: Prenatal Care
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: Date of conception through delivery.
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Diagnostic services include sonography, genetic testing and cordocentesis; genetic screening of father for cystic fibrosis if he is a Medi-Cal beneficiary.

Remove

Benefit Provided: Inpatient Hospital: Delivery and Postpartum Care
Source: State Plan 1905(a)
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: Delivery through 60 days after delivery.
Scope Limit: Medical services related to delivery and postpartum care.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Hospital stay 48 to 96 hours post delivery.

Remove

Benefit Provided: Physician Services: Breastfeeding Education
Source: State Plan Other
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: Other
Duration Limit: Birth through discharge visit
Scope Limit: Mother of newborn.

Alternative Benefit Plan

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

May be provided by physician, a registered nurse or a registered dietician working under physician.

Benefit Provided:

Nurse Midwife Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Date of conception through 60 days after delivery.

Scope Limit:

Under supervision of physician

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

Collapse All ☐

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

Remove

Benefit Provided: Rehabilitation: Outpatient Mental Health

Source: State Plan Other

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:

Professional/Outpatient Mental Health Services. Includes individual and group psychotherapy, psychological testing and medication management.

Remove

Benefit Provided: Rehabilitation:Outpatient Specialty Mental Health

Source: State Plan Other

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:

Other/Outpatient Specialty Mental Health Services. Includes day treatment services; crisis intervention and stabilization; adult crisis residential; mental health services; medication management and targeted case management.

Remove

Benefit Provided: Rehabilitation: Inpatient Mental Health

Source: State Plan Other

Authorization: Other

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:

Inpatient Specialty Mental Health Services. Acute psychiatric inpatient hospital services, psychiatric health facility services and psychiatric inpatient professional services. The IMD payment exclusion applies to acute psychiatric inpatient hospital services, psychiatric health facility services, and psychiatric inpatient professional services only when those services are provided in a facility that is considered an IMD based on 42 CFR Sections 435.1009 and 435.1010.

Benefit Provided: Rehabilitation: Substance Use Disorder 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:

Outpatient Substance Use Disorder Services. Services include Outpatient Drug Free; Intensive Outpatient Treatment; Naltrexone Treatment; Narcotic Treatment Program. Post periodic review. Prior authorization is required for Narcotic Treatment Program counseling more than 200 minutes per month.

Benefit Provided: Physician Service: Heroin/Opioid Detoxification

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: 21 consecutive days per treatment

Scope Limit: None

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

Outpatient heroin/opioid detoxification. Services include Narcotic Treatment Program. When medically necessary, additional 21-day treatments are covered after 28 days have passed since beneficiary completed a preceding course of treatment. Includes medically necessary services to diagnose and treat diseases that are concurrent with, but not part of, outpatient heroin or other opioid detoxification services.

Benefit Provided: Inpatient Hosp.:Voluntary Inpatient Detoxification

Source: State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization:

Prior Authorization

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:

Room and Board. Professional services performed by physicians to aid detoxification, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME, and medical supplies. These facilities are not IMDs and the IMD payment exclusion applies.

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: 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:

The State of California's ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Alternative Benefit Plan

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

Remove

Benefit Provided: Physical Therapy
Source: State Plan 1905(a)
Authorization: Prior Authorization
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:

Authorizations is valid for up to 120 days and must include a treatment plan. Prior authorization is not granted for more than 30 treatments at any one time.

Remove

Benefit Provided: Home Health: Durable Medical Equipment
Source: State Plan 1905(a)
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Replacement limits vary by type of equipment.

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

Remove

Benefit Provided: Home Health: Hearing Aids
Source: State Plan 1905(a)
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: $1,510 cap per person, per year; some exceptions
Duration Limit: None
Scope Limit: $1,510 annual cap may be exceeded for medical necessity.

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

Replacement hearing aids for those that are lost, stolen or damaged are not subject to the $1,510 cap.

Alternative Benefit Plan

Benefit Provided:
PT and Related Services: Speech Therapy/Audiology

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
2 per month

Duration Limit:
None

Scope Limit:
Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Benefit Provided:
PT and Related Services: Occupational Therapy

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
2 per month

Duration Limit:
None

Scope Limit:
Pregnant women and EPSDT covered. Other beneficiaries are only covered in hospital outpatient departments and organized outpatient clinics.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Benefit Provided:
Other Licensed Practitioner: Acupuncture

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
2 per month

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

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

Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Benefit Provided:

Rehabilitative Services: Cardiac Rehabilitation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

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:

Benefit Provided:

Rehabilitative Services: Pulmonary Rehabilitation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Pulmonary rehabilitation for acute airway obstruction or sputum induction for diagnostic purposes is limited to 6 in 30 days; aerosol inhalation of pentamadine for pneumoocystis carinii pneumonia treatment or prophylaxis is limited to 1 in 30 days.

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

May exceed limit for medical necessity.

Benefit Provided:

Home Health:Medical Supplies,Equipment, Appliances

Source:

State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Cochlear implant for one ear only; frequency limits on replacement parts.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes surgically implanted hearing devices, prior authorization required. Certain medical supplies require TAR.

Benefit Provided:
Orthotics/Prostheses

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Frequency limits on replacements

Duration Limit:
None

Scope Limit:
TAR required when cumulative costs of orthotics exceed $250 and prosthetics exceed $500.

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

Benefit Provided:
Home Health Services

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Written plan of care reviewed by physician every 60 days, provided by home health agency that meets conditions for participation for Medicare.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Authorization requirements vary based upon type of service. Services include nursing services which may be provided by a registered nurse when no home health agency exists in area; home health aid services; medical supplies and equipment; and therapies.

Alternative Benefit Plan

Benefit Provided: Skilled Nursing Facility and Other

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: 90 days

Scope Limit: Benefit provided only as a short stay.

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

Nursing care, bed and boarding care, physical therapy, occupational therapy, speech-language pathology services, medical social services, drugs, biologicals, supplies, appliances, and equipment. Patient must need daily care.

Benefit Provided: FQHC Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Rehabilitative/Habilitative Services

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

Only the rehabilitative and/or habilitative portion of the FQHC benefit is offered through this EHB.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Remove

Benefit Provided:
Outpatient Laboratory and X-Ray Services

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See below

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:

Laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month by the Laboratory Services Reservation System (LSRS). Up to four of the following radiological ultrasound procedure codes for each beneficiary per year based on medical necessity: ultrasound, chest ultrasound, abdominal, and retroperitoneal. More than four requires documentation of medical necessity or by report. Prior authorization required for portable X-ray unless performed in SNF or ICF. Various advanced imaging procedures are covered, based on medical necessity. Many of the procedures require a TAR and are subject to frequency limitations.

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, 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).

Benefit Provided: Family Planning Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: See below

Duration Limit: See below

Scope Limit: Individuals of childbearing age; must be 21 to receive sterilization

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

Includes family planning visits and counseling, invasive contraceptive procedures/devices, tubal ligations, vasectomies, contraceptive drugs or devices, and laboratory procedures, radiology and drugs associated with family planning procedures. TAR required for inpatient sterilization. Frequency limits on certain contraceptives and other services. Informed consent required for sterilizations.

Benefit Provided: Physician Services: Smoking Cessation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: By or under supervision of physician

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

Includes diagnosis, treatment, smoking cessation products when used in conjunction with behavior modification support, referral to 1-800 helpline and one face-to-face counseling session per quit attempt for specific populations.

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: See below

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:

Up to age 21, or to finish treatment that began before beneficiary turned 21. Some outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Add

Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Cognitive Rehabilitation Therapy (CRT)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 substitution: Rehabilitation, Cognitive Rehabilitation Therapy. Federally Qualified Health Center (FQHC) services are being used from the existing State Plan for substitution purposes. Cognitive Rehabilitation Therapy would be considered "Rehabilitation and Habilitative Services and Devices" EHB7 category. CRT aims to rehabilitate lost or altered cognitive skills, enabling individuals to reach functional and independent daily living. FQHCs provide numerous rehabilitative services.

Base Benchmark Benefit that was Substituted: Outpatient Hospital Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Outpatient Hospital and Clinic Services -- The following hospital outpatient and clinic services are limited to a maximum of two services in any one calendar month or any combination of two services per month: acupuncture, audiology, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with Treatment Authorization Request (TAR). Includes Indian Health Services.

Base Benchmark Benefit that was Substituted: Ambulatory Surgical Center Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Outpatient Hospital Services, Outpatient Surgery -- Outpatient surgery includes anesthesiologist services.

Base Benchmark Benefit that was Substituted: Podiatry
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Other Licensed Practitioners, Podiatry. Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Base Benchmark Benefit that was Substituted: Chiropractic
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Other Licensed Practitioners, Chiropractic -- Outpatient services are limited to a

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maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Base Benchmark Benefit that was Substituted: Allergy Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Physician Services, Allergy Care -- Emergency treatment for allergy care does not require TAR.

Base Benchmark Benefit that was Substituted: Treatment Therapies

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Outpatient Hospital Services, Treatment Therapies -- Chemotherapy, radiation therapy, Intensive-Modulated Radiation Therapy (IMRT), renal dialysis, IV/infusion therapy, medication management.

Base Benchmark Benefit that was Substituted: Emergency Services/Accidents

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 2 duplication: Outpatient Hospital Services, Emergency -- All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including emergency dental services, as certified by the attending physician or other appropriate provider.

Base Benchmark Benefit that was Substituted: Ambulance

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 2 duplication: Medical Transportation, Ambulance Service -- Emergency Medical Transportation. Air transportation only covered when ground transportation is not feasible; emergency transportation does not require TAR.

Base Benchmark Benefit that was Substituted: Surgical Procedures

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 3 duplication: Inpatient Hospital Services, Surgical Services -- Room and Board. Professional services performed by physicians, including surgery and consultation, within the scope of practice of

medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME and medical supplies; and Indian Health Services.

Base Benchmark Benefit that was Substituted: Gastric Restrictive Procedures

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 3 duplication -- Inpatient Hospital Services, Bariatric Surgery: Patient must be at or above specified BMI levels and meet certain conditions to qualify for bariatric surgery.

Base Benchmark Benefit that was Substituted: Anesthesia

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 3 duplication -- Anesthesiologist Services: medically necessary services by an anesthesiologist.

Base Benchmark Benefit that was Substituted: Organ/Tissue Transplants

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 3 duplication: Inpatient Hospital Services, Organ & Tissue Transplantation -- Transplant surgery, pre-transplant evaluation, post-operative care and laboratory services for bone marrow, heart, liver, kidney, heart-lung, simultaneous kidney-pancreas, single lung, double lung, pancreas, small bowel and combined liver-small bowel surgeries.

Base Benchmark Benefit that was Substituted: Reconstructive Surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 3 duplication: Inpatient Hospital Services, Reconstructive Surgery -- Reconstructive surgery is limited to that performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function and/or to create a normal appearance, to the extent possible. Includes breast reconstruction after mastectomy.

Base Benchmark Benefit that was Substituted: Hospice Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Hospice Care -- Hospice includes routine home care, continuous home care, respite care and general inpatient care. Children may receive concurrent palliative care.

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Base Benchmark Benefit that was Substituted: Prenatal Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 4 duplication: Physician Services, Prenatal Care -- Diagnostic services include sonography, genetic testing and cordocentesis; genetic screening of father for cystic fibrosis if he is a Medi-Cal beneficiary.

Base Benchmark Benefit that was Substituted: Delivery and Postpartum Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 4: Inpatient Hospital Services, Delivery and Postpartum Care -- Medical services related to delivery and postpartum care. Hospital stay 48 to 96 hours post delivery.

Base Benchmark Benefit that was Substituted: Breastfeeding Education
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 4 duplication: Physician Services, Breastfeeding Education -- Breastfeeding education may be provided by physician, a registered nurse or a registered dietician working under physician.

Base Benchmark Benefit that was Substituted: Maternity Care by a Nurse Midwife
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 4 duplication: Services Furnished by a Nurse-Midwife -- services provided by nurse midwife from conception through 60 days after delivery.

Base Benchmark Benefit that was Substituted: Outpatient Hospital Services: Mental Health
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 5 duplication: Rehabilitation, Outpatient Mental Health -- Includes individual and group psychotherapy, psychological testing and medication management.

Base Benchmark Benefit that was Substituted: Outpatient Hospital Services: Mental Health
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 5 duplication: Rehabilitation, Outpatient Specialty Mental Health -- Includes day treatment services;

crisis intervention and stabilization; adult crisis residential; mental health services; medication support; and targeted case management.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services: Mental Health
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 5 duplication: Rehabilitation, Inpatient Specialty Mental Health Services -- Acute psychiatric inpatient hospital services, psychiatric health facility services and psychiatric inpatient professional services. The IMD payment exclusion applies to acute psychiatric inpatient hospital services, psychiatric health facility services, and psychiatric inpatient professional services only when those services are provided in a facility that is considered an IMD based on 42 CFR Sections 435.1009 and 435.1010.

Base Benchmark Benefit that was Substituted: Outpatient Hospital Services: SUD
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 5 duplication -- Rehabilitatiou: Outpatient Substance Use Disorder Services. Services include Outpatient Drug Free; Intensive Outpatient Treatment; Naltrexone Treatment; Narcotic Treatment Program. Post periodic review. Prior authorization is required for Narcotic Treatment Program counseling more than 200 minutes per month.

Base Benchmark Benefit that was Substituted: Physician Services: Heroin/opioid detoxification
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 5 duplication -- Rehabilitation: Outpatient heroin/opioid detoxification. Services include Narcotic Treatment Program. When medically necessary, additional 21-day treatments are covered after 28 days have passed since beneficiary completed a preceding course of treatment. Includes medically necessary services to diagnose and treat diseases that are concurrent with, but not part of, outpatient heroin or other opioid detoxification services.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services: Detoxification
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 5 duplication: Inpatient hospital, Voluntary Inpatient Detoxification -- Room and Board. Professional services performed by physicians to aid detoxification, including surgery and consultation, within the scope of practice of medicine or osteopathy as defined by State law. Includes case management; respiratory care; laboratory and X-ray services; prescriptions for medication, DME, and medical supplies. These facilities are not Institutions for Mental Disease (IMD) and the IMD payment exclusion applies.

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Base Benchmark Benefit that was Substituted: Prescription Drug Benefits
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 6 duplication: Prescribed Drugs -- TAR required for more than six prescriptions per month.

Base Benchmark Benefit that was Substituted: Physical Therapy
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Physical therapy -- Authorizations for physical therapy is valid for up to 120 days and must include a treatment plan. Prior authorization is not granted for more than 30 treatments at any one time.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Home Health Services, Durable Medical Equipment -- durable medical equipment prescribed by physician.

Base Benchmark Benefit that was Substituted: Hearing Aids
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Home Health Services, Hearing Aids -- $1,510 annual cap for hearing aid benefits may be exceeded for medical necessity.

Base Benchmark Benefit that was Substituted: Speech Therapy/Audiology
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Physical Therapy and Related Services, Speech Therapy/Audiology -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy; may exceed limit for medical necessity with a TAR.

Base Benchmark Benefit that was Substituted: Occupational Therapy
Source: Base Benchmark
Remove

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Physical Therapy and Related Services, Occupational Therapy -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Base Benchmark Benefit that was Substituted:	Source:	
Alternative Treatments: Acupuncture	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Other Licensed Practitioners, Acupuncture -- Outpatient services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy; may exceed limit for medical necessity with a TAR.

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Cardiac Rehabilitation	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Rehabilitative Services, Cardiac Rehabilitation

Base Benchmark Benefit that was Substituted:	Source:	
Pulmonary Rehabilitation	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Rehabilitative Services: Pulmonary Rehabilitation

Base Benchmark Benefit that was Substituted:	Source:	
Medical Supplies, Equipment, Devices	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Home Health Services, Medical Supplies and DME; and Prosthetic Devices -- Certain medical supplies require TAR. Cochlear implant for one ear only; frequency limits on replacement parts. Includes surgically implanted hearing devices, prior authorization required. Certain medical supplies require TAR.

Base Benchmark Benefit that was Substituted:	Source:	
Orthopedic and Prosthetic Devices	Base Benchmark	Remove

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Prescribed Prosthetic Devices -- TAR required when cumulative costs of orthotics exceed $250 and prosthetics exceed $500.

Base Benchmark Benefit that was Substituted: Home Health Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Home Health Services -- Authorization requirements for home health services vary based upon type of service. Services include nursing services which may be provided by a registered nurse when no home health agency exists in area; home health aid services; medical supplies and equipment; and therapies.

Base Benchmark Benefit that was Substituted: Lab, X-Ray, and Other Diagnostic Tests

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 8 duplication: Other Laboratory and X-Ray Services -- Laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month by the Laboratory Services Reservation System (LSRS). Up to four of the following radiological ultrasound procedure codes for each beneficiary per year based on medical necessity: ultrasound, chest ultrasound, abdominal, and retroperitoneal. More than four requires documentation of medical necessity or by report. Prior authorization required for portable X-ray unless performed in SNF or ICF. Various advanced imaging procedures are covered, based on medical necessity. Many of the procedures require a TAR and are subject to frequency limitations.

Base Benchmark Benefit that was Substituted: Family Planning

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 9 duplication: Family Planning Services -- Includes family planning visits and counseling, invasive contraceptive procedures/devices, tubal ligations, vasectomies, contraceptive drugs or devices, and laboratory procedures, radiology and drugs associated with family planning procedures. TAR required for inpatient sterilization. Frequency limits on certain contraceptives and other services. Informed consent required for sterilizations.

Base Benchmark Benefit that was Substituted: Treatment Therapies: Dialysis/Hemodialysis

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Outpatient Hospital, Dialysis/Hemodialysis -- Chronic dialysis covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs and laboratory tests. Hemodialysis routine test can be conducted per treatment, weekly or monthly.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Educational Classes & Programs: Smoking Cessation

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 9 duplication: Physician Services, Smoking Cessation -- Includes diagnosis, treatment, smoking cessation products when used in conjunction with behavior modification support, referral to 1-800 helpline and one face-to-face counseling session per quit attempt for specific populations.

Base Benchmark Benefit that was Substituted: Skilled Nursing Care Facility

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 7 duplication: Skilled Nursing Facility and Other -- Nursing care, bed and boarding care, physical therapy, occupational therapy, speech-language pathology services, medical social services, drugs, biologicals, supplies, appliances and equipment. Patient must need daily care.

Base Benchmark Benefit that was Substituted: Medical Services Provided by Physician

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB1 duplication: Physician Services -- physician services within license.

Base Benchmark Benefit that was Substituted: Ambulance Transport Service

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

EHB 1 duplication: Medical Transportation, Non-Emergency Ambulance Service -- Air transportation only covered when ground transportation is not feasible; transportation covered from non-contract hospital to nearest contract hospital when patient is stable.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered — Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Hearing Screening
Source: Base Benchmark
Remove

Explain **why** the state/territory chose not to include this benefit:
Not applicable to New Adult Group.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Nursery Care
Source: Base Benchmark
Remove

Explain why the **state/territory** chose not to include this benefit:
Not applicable to New Adult Group.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Adult Dental
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Base benchmark adult dental services are not an Essential Health Benefit, and are not covered. Medicaid State Plan dental services are described in the 'Other 1937 Covered Services' section of this template.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Federally Qualified Health Centers (FQHC) services
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: Varies
Duration Limit: None
Scope Limit: None
Other: Includes services by physicians, PA, NP, CNM, visiting nurses, Comprehensive Perinatal Services Program, LCSW, psychologists, and acupuncturists. Rehabilitative and/or habilitative services are not included as part of the Other 1937 Benefits.

Other 1937 Benefit Provided: Rural Health Clinic (RHC) services
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: Varies
Duration Limit: None
Scope Limit: None
Other: Includes services by physicians, PA, NP, CNM, visiting nurses, Comprehensive Perinatal Services Program, LCSW, psychologists, and acupuncturists.

Other 1937 Benefit Provided: Indian Health Services
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Other
Amount Limit: Varies
Duration Limit: None
Scope Limit: None

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Other:

Includes services by physicians, PA, NP, CNM, visiting nurses, Comprehensive Perinatal Services Program, LCSW, psychologists, and optometrists.

Other 1937 Benefit Provided: Alternative Birth Centers

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Conception through discharge.

Scope Limit: None

Other:

Licensed or Otherwise State-Approved Free Standing Birthing Centers.

Other 1937 Benefit Provided: Transportation Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Lowest cost type to cover patient's need

Duration Limit: None

Scope Limit:

Nonemergency medical transportation (NEMT), see "Other" below.
Nonmedical transportation (NMT), see "Other" below.

Other:

Transportation is subject to utilization controls and permissible time and distance standards, to obtain covered Medi-Cal services.

NEMT is provided via ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contra-indicated and transportation. Prior authorization is required for NEMT and must include a written prescription by a licensed provider.

NMT includes round trip transportation by any other form of public or private conveyance and requires prior authorization and appointment verification by a licensed provider.

Other 1937 Benefit Provided: Adult Vision

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 routine eye exam in 24 months

Duration Limit:
None

Scope Limit:
Orthoptics, pleoptics and glasses are not covered.

Other:
Glasses and contact lenses are covered for EPSDT and pregnant women.

Other 1937 Benefit Provided:
Local Education Agency Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Medi-Cal eligible public school children up to age 22 or end of school year beneficiary turns 22.

Other:
Services provided by Individualized Education Plan, Individualized Family Service Plan, California Children Services, Short-Doyle, or prepaid health plan. Services include health and mental health evaluation and education, individualized education plan, individualized family service plan, physician services, physical therapy, occupational therapy, speech therapy, audiology services, psychology and counseling, nursing services, school health aid services, medical transportation/mileage and targeted care management services.

Other 1937 Benefit Provided:
TCM: Children at Risk of Medical Compromise

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Children up to age 21.

Other:
1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes children who need assistance to access medical, social and education services when

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comprehensive case management is not provided elsewhere. Only available in specific areas Prior authorization is not required.

Other 1937 Benefit Provided: TCM: Medically Fragile with Multiple Diagnoses

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Beneficiaries 18 and older

Other: 1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes individuals transitioning to a community setting. Services available for up to 180 consecutive days of a covered stay in a medical institution. Prior authorization is not required. Only available in specific counties.

Other 1937 Benefit Provided: Case Management: Children with IEP/IFSP

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Children up to age 21 with an Individualized Education Plan or Individualized Family Service Plan.

Other: 1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Prior authorization is not required.

Other 1937 Benefit Provided: TCM: Individuals at Risk of Institutionalization

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

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Scope Limit:
Individuals 18 or older in frail health who meet specific criteria.

Other:
1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes individuals transitioning to a community setting. Services available for up to 180 consecutive days of a covered stay in a medical institution. Only available in specific counties. Prior authorization is not required.

Other 1937 Benefit Provided:
TCM: Persons in Jeopardy of Negative Outcomes

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
People in jeopardy of negative health or pysche-social outcomes due to disparity factors.

Other:
1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes people who need assistance to access medical, social and education services when comprehensive case management is not provided elsewhere. Only available in specific counties. Prior authorization is not required.

Other 1937 Benefit Provided:
TCM: Individuals with a Communicable Disease

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Until risk of exposure has passed; limited to eligible individuals.

Other:
1915(g) State Plan. Services to assist eligible individual access medical, social and educational services. Includes people who need assistance to access medical, social and education services when comprehensive case management is not provided elsewhere. Only available in specific counties. Prior authorization is not required.

Other 1937 Benefit Provided:
Case Management: Lead Poisoned

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Children up to age 21 with laboratory test results showing elevated lead blood levels.

Other:
1915(g) State Plan. Services to assist eligible individual access medical, social and educational services. Prior authorization is not required.

Other 1937 Benefit Provided:
TCM: Individuals with Developmental Disability

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Individuals diagnosed with a developmental disability.

Other:
1915(g) State Plan. Services to assist eligible individuals access medical, social and educational services. Includes individuals transitioning to a community setting. Services available for up to 180 consecutive days of a covered stay in a medical institution. Prior authorization is not required.

Other 1937 Benefit Provided:
Skilled Nursing Facility

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Medical necessity as described in "other."

Other:
The individual is unable to perform some activity of daily living independently and patient must need daily care. Services include nursing care, bed and boarding care, physical therapy, occupational therapy, speech-language pathology services, medical social services, drugs, biological, supplies, appliances and equipment. An initial authorization may be granted for periods up to one year from date of admission and shall be required prior to the transfer of a beneficiary between skilled nursing facilities. The attending physician

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must re-certify at least every 60 days.

Other 1937 Benefit Provided: Personal Care Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 283 hours per month

Duration Limit: None

Scope Limit: Medical necessity as described in "other."

Other: Beneficiary has chronic, disabling disease expected to last at least 12 months and requires assistance in performing some activities of daily living, is unable to obtain, retain or return to work, and is at risk of institutional placement. Authorized by county based upon assessment in accordance with plan of treatment prepared by physician. Services may include activities such as assistance with administration of medication, basic personal hygiene, eating, grooming, etc. Beneficiary must not be an inpatient or resident of a hospital, NF, ICF-DD, or ICF-MD.

Other 1937 Benefit Provided: Self-Directed Personal Assistance Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 283 hours per month

Duration Limit: None

Scope Limit: Medical necessity as described in "other."

Other: 1915(j) State Plan. Beneficiary has chronic, disabling disease expected to last at least 12 months and requires assistance in performing some activities of daily living, is unable to obtain, retain or return to work, and is at risk of institutional placement. Authorized by county based upon assessment in accordance with plan of treatment prepared by physician. Services include personal care and related services, to be self-directed by the beneficiary. Beneficiary may not be an inpatient or resident of a hospital, NF, ICF-DD, or ICF-MD.

Other 1937 Benefit Provided: Community First Choice Option

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

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Amount Limit:
None

Duration Limit:
None

Scope Limit:
Medical necessity as described in "other."

Other:
1915(k) State Plan. Effective on July 1, 2013, an individual is eligible for CFCO services when, (1) he or she is in an eligibility group under the State Plan that includes nursing facility services or has an income that is at or below 150 percent of the Federal Poverty Level, and in addition, (2) it is determined that in the absence of home and community-based attendant services and supports, he or she would otherwise require a Medicaid-covered level of care furnished in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, an institution providing psychiatric services (for individuals under age 21), or an institution for mental diseases (for individuals age 65 and over). The individual is unable to perform some activity of daily living independently and without access to this service would be at risk of placement in out-of-home care. Services include assistance with Activities of Daily Living; and acquisition, maintenance and enhancement of skills necessary for the individual to accomplish activities of daily living and health related tasks. The California Department of Social Services will complete authorization by annual review or as needed when the individual's support needs or circumstances change, or at the request of the individual or the individual's representative. EPSDT beneficiaries may receive additional services for medical necessity.

Other 1937 Benefit Provided:
Home and Community Based Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Medical necessity as described in "other."

Other:
1915(i) State Plan. Must have developmental disability and need habilitation services. Individual must have a condition that results in major impairment of cognitive and/or social functioning and is likely to retain new skills through habilitation. Services include habilitation – community living arrangement services, supported living services, day services, behavioral intervention services, respite care, supported employment, prevocational services, homemaker services, home health aide services, community based adult services; personal emergency response systems; and vehicle modification and adaptation services. A developmental disability is a condition that originated before the age of 18, expected to continue indefinitely and constitute a substantial disability for the individual. It includes mental retardation, cerebral palsy, autism and any other disabling conditions similar to mental retardation, but not handicapping conditions solely physical in nature.

Other 1937 Benefit Provided:
Adult Dental Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
As described in 'other' information below

Duration Limit:
None

Scope Limit:
Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not covered. $1,800 annual cap, as described below.

Other:
Emergency and essential diagnostic and restorative dental services; medically necessary dental services for EPSDT-eligible individuals. For beneficiaries 21 years of age or older, $1,800 annual cap does not apply to emergency dental services, pregnancy-related services, dentures, complex oral surgery, dental implants, and implant-retained prostheses. The cap may exceed limit for medical necessity with a TAR.

Remove

Other 1937 Benefit Provided:
Preventive Services - Behavioral Health Treatment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Children up to age 21

Other:
Behavioral Health Treatment (BHT) services, such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services, prevent or minimize the adverse effects of Autism Spectrum Disorder (ASD) and promote to the maximum extent practicable, the functioning of a beneficiary. Services that treat or address ASD will be provided to all children up to age 21 who meet the medical necessity criteria for receipt of the service(s). Services include behavioral assessment and development of treatment plan, delivery of evidence-based BHT services, training of parents/guardian, and observation and direction, as set forth on Limitations on Attachment 3.1-A pages 18b-18c and on Supplement 6 to Attachment 3.1-A, page 1. No limitations.

Remove

Other 1937 Benefit Provided:
Other Licensed Practitioners: Licensed Midwives

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None.

Duration Limit:
See "Other" below.

Scope Limit:
All services permitted under the scope of practice.

Alternative Benefit Plan

Other:

Obstetrical and delivery services throughout pregnancy and through the end of the month following 60 days after the pregnancy ends.

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

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.

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