Table of Contents

State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 21-0015

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages



Medicaid and CHIP Operations Group

November 02, 2021

VIA E-MAIL

Dr. Deidre Gifford, Commissioner Department of Social Services 55 Farmington Avenue Hartford, CT 06105

Dear Commissioner Gifford:

For your records, this is an approved copy of Connecticut's Alternative Benefit Plan (ABP) State plan amendment (SPA) CT 21-0015. This ABP amendment submitted through the Medicaid Model Data Lab (MMDL No. CT.0627.R00.08) on March 30, 2021 meets all federal statutory and regulatory requirements for establishing an ABP.

The state submitted this SPA to update the Standard Alternative Benefit Plan (ABP) to add the mandatory Medication-Assisted Treatment (MAT) benefit category required by section 1905(a)(29). This SPA was approved October 29, 2021 with an effective date of October 1, 2020.

Attached are copies of the approved Alternative Benefit plan pages for incorporation into the Connecticut State plan.

If you have questions concerning this letter, please contact Marie DiMartino, Division of Program Operations (South Branch) at (617) 565-9157 or via e-mail at Marie.DiMartino@cms.hhs.gov.

Sincerely,

James G. Scott, Director	
Division of Program Operations	

State/Territory name:

Connecticut

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. CT-21-0015

Proposed Effective Date

10/01/2020

(mm/dd/yyyy)

Federal Statute/Regulation Citation

Social Security Act Sections 1902(a)(10)(A)(i)(VIII); 1902(k)(1); 1937; and 1905(a)(29)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2021	\$ 0.00
Second Year	2022	\$ 0.00

Subject of Amendment

Effective October 1, 2020, SPA CT-21-0015 amends the ABP to add the mandatory Medication-Assisted Treatment (MAT) benefit category required by section 1905(a)(29) of the Social Security Act, which is effective from October 1,

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:	Joel Norwood
Last Revision Date:	Aug 3, 2021
Submit Date:	Mar 30, 2021



_	ON	MB Control Number: 0	9381148
Attachment 3.1-C-	OM	AB Expiration date: 10	/31/2014
Alternative Benefit Plan Populations			ABP1
Identify and define the population that will par	ticipate in the Alternative Benefit Plan.		
Alternative Benefit Plan Population Name:	Medicaid Coverage for the Lowest-Income Populations (N	MCLIP)	
Identify eligibility groups that are included in t targeting criteria used to further define the pop	he Alternative Benefit Plan's population, and which may conulation.	ntain individuals that n	neet any
Eligibility Groups Included in the Alternative F	Benefit Plan Population:		
	Eligibility Group:	Enrollment is mandatory or voluntary?	
+ Adult Group		Mandatory	X
Enrollment is available for all individuals in th	ese eligibility group(s). Yes		
Geographic Area			
The Alternative Benefit Plan population will in	clude individuals from the entire state/territory.	es	
Any other information the state/territory wishe	s to provide about the population (optional)		
	PRA Disclosure Statement		
valid OMB control number. The valid OMB control number is estimated to averate resources, gather the data needed, and complete	1995, no persons are required to respond to a collection of in ontrol number for this information collection is 0938-1148. age 5 hours per response, including the time to review instruc- e and review the information collection. If you have comme ing this form, please write to: CMS, 7500 Security Boulevard and 21244-1850.	The time required to co ctions, search existing nts concerning the accu	omplete data uracy of

V.20130724



OMB Control Number: 09381148

Attachment 3.1-C-

OMB Expiration date: 10/31/2014

ABP2a

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

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 Yes 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.

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.

Connecticut has fully aligned the benefits in its ABP with its approved Medicaid state plan by selecting Secretary-approved coverage as its benchmark and using duplication and substitution for the EHB benefits in its base benchmark plan, Blue Cross and Blue Shield Service Benefit Plan - Basic Option (FEHBP), and including remaining Medicaid state plan services as other 1937 covered benefits that are not EHBs.

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



		OMB Control Number: 09381148
Attachment 3.1-C-	enefit Package or Benchmark-Equivalent Benc	OMB Expiration date: 10/31/2014 efit Package ABP3
Select one of the following:		
○ The state/territory is ame	ending one existing benefit package for the population defin	ned in Section 1.
• The state/territory is crea	ating a single new benefit package for the population define	ed in Section 1.
Name of benefit packag	e: ABP for MCLIP	
Selection of the Section 1937 Co	overage Option	
-	ection 1937 Coverage option the following type of Benchm er this Alternative Benefit Plan (check one):	ark Benefit Package or Benchmark-
Benchmark Benefit Packa	ige.	
○ Benchmark-Equivalent B	enefit Package.	
The state/territory will p	rovide the following Benchmark Benefit Package (check or	ne that applies):
C The Standard B Program (FEHH	lue Cross/Blue Shield Preferred Provider Option offered th 3P).	rough the Federal Employee Health Benefit
○ State employee	coverage that is offered and generally available to state em	ployees (State Employee Coverage):
C A commercial H HMO):	HMO with the largest insured commercial, non-Medicaid en	arollment in the state/territory (Commercial
 Secretary-Appr 	oved Coverage.	
• The state/te	erritory offers benefits based on the approved state plan.	
	erritory offers an array of benefits from the section 1937 co kages, or the approved state plan, or from a combination of	
○ The sta	ate/territory offers the benefits provided in the approved sta	te plan.
⊖ Benefi	ts include all those provided in the approved state plan plus	additional benefits.
⊖ Benefi	ts are the same as provided in the approved state plan but in	n a different amount, duration and/or scope.
○ The st	ate/territory offers only a partial list of benefits provided in	the approved state plan.
○ The sta	ate/territory offers a partial list of benefits provided in the a	pproved state plan plus additional benefits.
Please briefly i	dentify the benefits, the source of benefits and any limitation	ons:
	fits are the same as in and are from Connecticut's Medicaid in the state plan.	state plan, and the limitations are the
Selection of Base Benchmark P	lan	



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.
C Largest insured commercial non-Medicaid HMO.
Plan name: BC and BS Service Benefit Plan - Basic Option
Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):
Connecticut selected the Secretary-approved coverage and the Blue Cross and Blue Shield Service Benefit Plan - Basic Option with the
goal of aligning the ABP for MCLIP with the Connecticut Medicaid state plan.
The state assures that all benefits in the Base Benchmark Plan have been accounted for throughout the benefit chart found in ABP5.
The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the
currently approved 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.20130801



	OMB Control Number: 09381148
Attachment 3.1-C-	MB Expiration date: 10/31/2014
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 describ cost sharing must comply with Section 1916 of the Social Security Act.	ed in the state plan. Any such
The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than Attachment 4.18-A.	n that described in No
Other Information Related to Cost Sharing Requirements (optional):	
Connecticut does not require any cost-sharing in Attachment 4.18-A.	

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



	OMB Control Number: 0938114
Attachment 3.1-C-	OMB Expiration date: 10/31/201
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:	
Blue Cross and Blue Shield Service Benefit Plan - Basic Option (FEHBP)	
Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Appro Approved."	oved. Otherwise, enter "Secretary-
Secretary-Approved	



Outpatient Hospital Services State Plan 1905(a) Remove Authorization: Provider Qualifications: Medicaid State Plan None Medicaid State Plan Medicaid State Plan Amount Limit: Duration Limit: None Scope Limit: None None Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Context of the source plan if it is not the base benchmark plan:	Essential Health Benefit 1: Ambulatory patient serv	rices	Collapse All
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mefit Provided:	Source:	
amily Planning Services and Supplies	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
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Amount Limit:	Duration Limit:	
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Scope Limit:		
None		
None Other information regarding this benefit, includi benchmark plan:	ing the specific name of the source plan if it is not the base , female condoms (30) and spermicide (one) - may be	
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36).		
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36), exceeded with authorization	, female condoms (30) and spermicide (one) - may be	Remove
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36), exceeded with authorization enefit Provided:	, female condoms (30) and spermicide (one) - may be Source:	Remove
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36), exceeded with authorization enefit Provided: redical and Surgical Services by a Dentist	, female condoms (30) and spermicide (one) - may be Source: State Plan 1905(a)	Remove
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36), exceeded with authorization enefit Provided: redical and Surgical Services by a Dentist Authorization:	, female condoms (30) and spermicide (one) - may be Source: State Plan 1905(a) Provider Qualifications:	Remove
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36), exceeded with authorization enefit Provided: redical and Surgical Services by a Dentist Authorization: None	, female condoms (30) and spermicide (one) - may be Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan	Remove
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36); exceeded with authorization enefit Provided: redical and Surgical Services by a Dentist Authorization: None Amount Limit: None	, female condoms (30) and spermicide (one) - may be Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
None Other information regarding this benefit, includi benchmark plan: Monthly quantity limits for male condoms (36), exceeded with authorization enefit Provided: redical and Surgical Services by a Dentist Authorization: None Amount Limit:	, female condoms (30) and spermicide (one) - may be Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove



Benefit Provided:	Source:	
Home Health Services - Nursing Svs	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	L.
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other information"	None	
Scope Limit:		
Not covered: Services for well child care or for	or prenatal or postpartum care that is not high risk	
benchmark plan: -The cost of services provided by the home he appropriate institution	ding the specific name of the source plan if it is not the base ealth agency may not exceed the cost if the client were in the n two visits per day and more than two days per week	
Benefit Provided:	Source:	
Podiatrist Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
LAmount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, include benchmark plan:	ding the specific name of the source plan if it is not the base	
Benefit Provided:	Source:	
Dental Services (for Adults)	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Other		
	Medicaid State Plan Duration Limit: See "Other information"	
Other Amount Limit: See "Other information"	Duration Limit:	
Other Amount Limit:	Duration Limit:	
Other Amount Limit: See "Other information" Scope Limit: See "Other information"	Duration Limit:	



for non-emergency dental services based on medica	l necessity; however, prior authorization not required	
for the following dental services: diagnostic, preven	ntion, basic restoration procedures, nonsurgical	
extractions.		
- One set of bitewing films per year and one oral example.		
dental disease is an aggravating factor in person's ov		
- Fluoride treatment limited to adults who have xero	ostomia or have undergone head or neck radiation	
therapy		
- One oral examination and one prophylaxis every y	year (two years for adults living in long-term care	
facilities);		
- Non-emergency Dental services above \$1,000, for		
authorized. Prior authorization is based on medical	s of placement; direct placed restorations that require	
replacement within 2 years.	s of placement, direct placed restorations that require	
- Not covered: Fixed bridges, periodontics (exception	ons for gingiyonlasty and gingivectomy with prior	
	stry, vestibuloplasty, unilateral removable appliances,	
	n occlusion and no missing anterior teeth, restorative	
	esin based composite restorations to the molar teeth and	
orthodontia		
Benefit Provided:	Source:	
Hospice Care Services		D
	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other information"	None	
Scope Limit:		
None		
	he specific name of the source plan if it is not the base	
benchmark plan:	· ·	
	· ·	
benchmark plan:	· ·	
benchmark plan:	· ·	Add



Essential Health Benefit 2: Emergency services		Collapse All
Benefit Provided:	Source:	
Outpatient Hospital Services - Emergency Care	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
benchmark plan: Authorization required within two days of admiss		
Benefit Provided:	Source:	
Other: Transportation - Ambulance	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, includin benchmark plan:	g the specific name of the source plan if it is not the base	
		Add



Essential Health Benefit 3: Hospitalization		
Benefit Provided:	Source:	
Inpatient Hospital Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
See "Other information"		
benchmark plan:	ncluding the specific name of the source plan if it is not the base sion for elective stays (i.e., all admissions that are neither	
benchmark plan: Prior authorization required before admiss emergencies nor maternity). Surgical services to treat morbid obesity (illness is caused by, or aggravated by, the	sion for elective stays (i.e., all admissions that are neither (defined by ICD) are limited to instances in which another medica obesity, including illnesses of the endocrine system or cardio-	1
benchmark plan: Prior authorization required before admiss emergencies nor maternity). Surgical services to treat morbid obesity (sion for elective stays (i.e., all admissions that are neither (defined by ICD) are limited to instances in which another medica obesity, including illnesses of the endocrine system or cardio-	11
benchmark plan: Prior authorization required before admiss emergencies nor maternity). Surgical services to treat morbid obesity (illness is caused by, or aggravated by, the pulmonary system, or physical trauma ass Inpatient hospital stay is not covered when - Tuboplasty and sterilization reversal	sion for elective stays (i.e., all admissions that are neither (defined by ICD) are limited to instances in which another medica obesity, including illnesses of the endocrine system or cardio- sociated with the orthopedic system. n one of the following services or procedures are performed:	1
benchmark plan: Prior authorization required before admiss emergencies nor maternity). Surgical services to treat morbid obesity (illness is caused by, or aggravated by, the pulmonary system, or physical trauma ass Inpatient hospital stay is not covered when - Tuboplasty and sterilization reversal - Inpatient charges related to autopsy	sion for elective stays (i.e., all admissions that are neither (defined by ICD) are limited to instances in which another medica obesity, including illnesses of the endocrine system or cardio- sociated with the orthopedic system. n one of the following services or procedures are performed:	.1
benchmark plan: Prior authorization required before admiss emergencies nor maternity). Surgical services to treat morbid obesity (illness is caused by, or aggravated by, the pulmonary system, or physical trauma ass Inpatient hospital stay is not covered when - Tuboplasty and sterilization reversal - Inpatient charges related to autopsy	sion for elective stays (i.e., all admissions that are neither (defined by ICD) are limited to instances in which another medical obesity, including illnesses of the endocrine system or cardio- sociated with the orthopedic system. In one of the following services or procedures are performed: or cosmetic nature performed for reconstructive purposes	1



Essential Health Benefit 4: Maternity and newbo	m care	Collapse All
Benefit Provided:	Source:	
Freestanding Birth Center Svs	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	7
Scope Limit:		
None		
Other information regarding this benefit, include benchmark plan:	luding the specific name of the source plan if it is not the base	
Benefit Provided:	Source:	
Nurse Midwife Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, include the benchmark plan:	luding the specific name of the source plan if it is not the base	•
Benefit Provided:	Source:	
Inpatient Hospital Services - Maternity	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		



enefit Provided:	Source:	
hysician Services - Maternity	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan]
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		_
None		
Other information regarding this benefit, benchmark plan:	including the specific name of the source plan if it is not the base	
The prior authorization requirements in C apply to maternity care	Connecticut's Medicaid state plan for Physician Services do not	



Essential Health Benefit 5: Mental health and substa behavioral health treatment	ance use disorder services including	Collapse All
Benefit Provided:	Source:	
Inpatient Hospital Services - MH/SUD	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
authorizations.		ı
Benefit Provided:	Source:	
Outpatient Hospital Services - MH/SUD	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other information"	None	
Scope Limit:		
None		
Other information regarding this benefit, includ benchmark plan:	ling the specific name of the source plan if it is not the base	_
medical necessity)	authorization) reevaluation per year per hospital (may be exceeded based o ion, psychological testing, and electroconvulsant shock	n
Benefit Provided:	Source:	
Physician Services - MH/SUD	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
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Amount Limit:	Duration Limit:	
See "Other information"	None	
Scope Limit:		
None		
Other information regarding this benefit, including benchmark plan:	the specific name of the source plan if it is not the base	
(as do consultations and case management beyond	but not authorization) apy and interpretation of test results require authorization threshold amounts) 2 month period per provider for the same client (may be essity)	
nefît Provided:	Source:	
inic Services: MH & SA Clinics	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other information"	None	
Scope Limit:		
None		
Other information regarding this benefit, including benchmark plan:	the specific name of the source plan if it is not the base	
- Routine services require registration (but not auth - No more than one therapy session of the same typ	pe per day per clinic for the same client forming provider per episode of care for the same client patient, day treatment and partial hospitalization	
nefit Provided:	Source:	
inic Services: Methadone Maintenance Clinics	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	



Scope Limit:

One all-inclusive unit, per provider, per member, per week

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

Requires registration

Add



 Essential Health Benefit 6: Prescription drugs 		
Benefit Provided:		
Coverage is at least the greater of one drug in eac same number of prescription drugs in each catego	÷ * *	
 Prescription Drug Limits (Check all that apply.): Limit on days supply Limit on number of prescriptions Limit on brand drugs Other coverage limits 	Authorization: Yes	Provider Qualifications: State licensed
Preferred drug list		
Coverage that exceeds the minimum requirements	or other:	
The State of Connecticut's ABP prescription drug Medicaid state plan for prescribed drugs.	g benefit plan is the same as	; under the approved



Essential Health Benefit 7: Rehabilitative and habilitative services and devices Co		Collapse All
Benefit Provided:	Source:	
Home Health Svs - Med Supplies, Equip & Appliances	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	7
Amount Limit:	Duration Limit:	
See "Other information"	None	
Scope Limit:		
None		7
Other information regarding this benefit, including the benchmark plan: Quantity limits on a number of supplies including wip medical necessity		
Benefit Provided:	Source:	
Home Health Services - PT/OT/ST/Audiology	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	7
Amount Limit:	Duration Limit:	
See "Other information"	None	7
Scope Limit:		
Not covered: Services for well child care or for prena	atal or postpartum care that is not high risk	7
Other information regarding this benefit, including the benchmark plan: -Prior authorization (PA) required for more than nine diagnoses -PT/ST: PA required for more than one initial evaluat -OT: PA required for more than than one initial evalu	visits per provider per calendar year for certain tion per year and more than two visits per week	
Benefit Provided:	Source:	
Orthopedic and Prosthetic Devices	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	



Scope Limit:		
Replacement of a device is covered only if the devic adequate due to a measurable change in the client's	ce is lost, destroyed or is no longer medically usable or condition	
	he specific name of the source plan if it is not the base	
benchmark plan:	e speente nume of the source plan if it is not the base	
-A number of orthotics and prosthetics require prior a -One hearing aid per ear every 3 years - may be excee -Two pairs of shoes per year - may be exceeded base	eeded based on medical necessity	
Benefit Provided:	Source:	
Clinic Services: Rehabilitation Clinics	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other information"	See "Other information"	
Scope Limit:		
None		
benchmark plan: -Limit of one complete evaluation per year involving client		
Benefit Provided:	Source:	
PT/OT/ST/ - Habilitative	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other information"	See "Other information"	
Scope Limit:		
None		
Other information regarding this benefit, including th benchmark plan: - PT/OT/ST services that help a person keep, learn of - These services are provided in a variety of inpatient health agencies, and rehabilitation clinics) to people -The different limitations applicable to the service se	t and outpatient settings (outpatient hospital, home with disabilities	
	Approval Date 10/29/21 ctive Date October 1, 2020	



agencies, or rehabilitation clinic) would apply to the provision of the habilitative service.	
	Add



Essential Health Benefit 8: Laboratory services		Collapse All
Benefit Provided:	Source:	
Other Lab and X-Ray Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, in benchmark plan:	cluding the specific name of the source plan if it is not the base	
-A number of advanced imaging services re- -Genetic testing requires prior authorization		
		Add



Essential Health Benefit 9: 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).

	Source:	_
Physician Services - Preventive and Wellness	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan]
Amount Limit:	Duration Limit:	-
None	None]
Scope Limit:		-
None]
benchmark plan: This includes a broad range of preventive ser United States Preventive Services Task Force recommended vaccines; preventive care and	uding the specific name of the source plan if it is not the base rvices including: "A" and "B" services recommended by the e; Advisory Committee for Immunization Practices (ACIP) screening for infants, children and adolescents recommended and additional preventive services for women recommended orted by HRSA	
Benefit Provided:	Source:	
Preventive Services - Tobacco Counseling	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan]
	Medicaid State Plan Duration Limit:]
None]
None Amount Limit:]
None Amount Limit: None]]
None Amount Limit: None Scope Limit: None Other information regarding this benefit, inclubenchmark plan:	Uuding the specific name of the source plan if it is not the base]]
None Amount Limit: None Scope Limit: None Other information regarding this benefit, inclubenchmark plan:	Duration Limit: Duration Limit: uding the specific name of the source plan if it is not the base d Dependence, a Public Health Service-sponsored Clinical]]]



Source:	
State Plan 1905(a)	Remove
Provider Qualifications:	
Medicaid State Plan	
Duration Limit:	
None	
	_
cluding the specific name of the source plan if it is not the base	
ia]
n-emergency dental services; however, prior authorization not diagnostic, prevention, basic restoration procedures, nonsurgical	
	State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None cluding the specific name of the source plan if it is not the base ia n-emergency dental services; however, prior authorization not



Other Covered Benefits from Base Benchmark

Collapse All



\boxtimes	Base Benchmark Benefits Not Covered due to Substitution or Duplication	Collapse All
	Base Benchmark Benefit that was Substituted:Source:Outpatient Hospital or Ambulatory Surgical CenterBase Benchmark	Remove
	Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate 1937 benchmark benefit(s) included above under Essential Health Benefits:	section
	Duplication: Covered under the Connecticut Medicaid state plan as Outpatient Hospital Services (2.a) Clinic Services: Ambulatory Surgery Center (9.a) and Clinic Services: Dialysis Clinics (9.b) in EHB Ambulatory patient services	
	The Connecticut Medicaid state plan benefit is similar in amount, duration, and scope to the base benchmark benefit.	
	Base Benchmark Benefit that was Substituted: Source: Treatment Therapies Base Benchmark	Remove
	Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate 1937 benchmark benefit(s) included above under Essential Health Benefits:	
	Duplication: Covered under the Connecticut Medicaid state plan as Outpatient Hospital Services (2.a) EHB 1: Ambulatory patient services (Treatment Therapies include, for example, chemo and radiation therapy, renal dialysis and outpatient cardiac rehab)	
	Base Benchmark Benefit that was Substituted:Source:Diagnostic and Treatment ServicesBase Benchmark	Remove
	Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Covered under the Connecticut Medicaid state plan as Physician Services (5.a), Certified	
	Pediatric or Family Nurse Practitioner (23), Other Practitioner: Nurse Practitioner (6.d), Other Practit Physician Assistant (6.d), and Clinic Services: Medical Clinics (9.d) in EHB 1: Ambulatory patient se	tioner:
	Base Benchmark Benefit that was Substituted: Source: Allergy Care Base Benchmark	Remove
	 Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Covered under the Connecticut Medicaid state plan as Physician Services (5.a) in EHB 1 Ambulatory patient services 	
	Base Benchmark Benefit that was Substituted: Source: Anesthesia Base Benchmark	Remove
	Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate 1937 benchmark benefit(s) included above under Essential Health Benefits:	
	Duplication: Covered under the Connecticut Medicaid state plan as Physician Services (5.a) in EHB Ambulatory patient services	1:



Base Benchmark Benefit that was Substituted:	Source: Base Benchmark	
Surgical Procedures		Remove
Explain the substitution or duplication, including india 1937 benchmark benefit(s) included above under Esse	cating the substituted benefit(s) or the duplicate section ential Health Benefits:	
Duplication: Covered under the Connecticut Medicaid Ambulatory patient services		
	nparable because the prior authorization requirements ctive. Services excluded from the Medicaid state plan enefit.	
Base Benchmark Benefit that was Substituted:	Source:	
Family Planning	Base Benchmark	Remove
1937 benchmark benefit(s) included above under Esse		
Duplication: Covered under the Connecticut Medicaid (4.c) and Clinic Services: Family Planning Clinics (9.	d state plan as Family Planning Services and Supplies .c) in EHB 1: Ambulatory patient services	
While under the Connecticut Medicaid state plan auth supplies in excess of the specified limit, these supplie	norization is required to obtain certain family planning as are not covered by the base benchmark plan.	
Base Benchmark Benefit that was Substituted:	Source:	
Oral and Maxillofacial Surgery	Base Benchmark	Remove
Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse Duplication: Covered under the Connecticut Medicaid		
Dentist (5.b) and Physician Services (5.a) in EHB 1: A		
Base Benchmark Benefit that was Substituted:	Source:	
Home Health Services	Base Benchmark	Remove
Explain the substitution or duplication, including indice 1937 benchmark benefit(s) included above under Esse	cating the substituted benefit(s) or the duplicate section ential Health Benefits:	
Duplication: Covered under the Connecticut Medicaid (7.a) in EHB 1: Ambulatory patient services		
The base benchmark benefit is more limited in amour state plan benefit. The base benchmark benefit is limi	nt, duration, and scope than the Connecticut Medicaid ited to 25 visits per year, up to two hours per visit.	
Base Benchmark Benefit that was Substituted:	Source:	
Foot Care	Base Benchmark	Remove
Explain the substitution or duplication, including indice 1937 benchmark benefit(s) included above under Essentiation and the substitution of the	cating the substituted benefit(s) or the duplicate section ential Health Benefits:	
Duplication: Covered under the Connecticut Medicaie Ambulatory patient services.	d state plan as Podiatrist Services (6.a) in EHB 1:	
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Base Benchmark Benefit that was Substituted: Education Classes and Programs	Source: Base Benchmark	Remove
1937 benchmark benefit(s) included above under Ess Duplication: This benefit includes tobacco cessation under the Connecticut Medicaid state plan as Preven	and diabetic counseling. Tobacco cessation covered tive Services - Tobacco Counseling (13.c) in EHB 9: e management. Diabetic counseling covered under the	
Base Benchmark Benefit that was Substituted: Alternative Treatments - Duplication	Source: Base Benchmark	Remove
Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess Duplication: Since this benefit only includes acupun Connecticut Medicaid state plan as Physician Servic	cture by a physician, it is covered under the	
Base Benchmark Benefit that was Substituted: Chiropractic and Manipulative Treatment - Sub	Source: Base Benchmark	Remove
Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess Substitution: Chiropractic was mapped to EHB 1: An Adults) (10) from Connecticut's Medicaid state plan	mbulatory patient services; Dental Services (for	
Base Benchmark Benefit that was Substituted: Infertility Services - Duplication & Substitution	Source: Base Benchmark	Remove
Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess Duplication & Substitution: Infertility Services was diagnosis of infertility is covered by the Connecticut Dental Services (for Adults) (10) from Connecticut's treatment of infertility (which does not include ART	mapped to EHB 1: Ambulatory patient services; the Medicaid state plan as Physician Services (5.a) and Medicaid state plan was used as a substitute for	
Base Benchmark Benefit that was Substituted: Manipulative Treatment - Physician	Source: Base Benchmark	Remove
1937 benchmark benefit(s) included above under Ess	is covered under the Connecticut Medicaid state plan	
Base Benchmark Benefit that was Substituted: Accidental Injury	Source: Base Benchmark	Remove



Explain the substitution or duplication, including indicating the substituted 1937 benchmark benefit(s) included above under Essential Health Benefit Duplication: Covered under the Connecticut Medicaid state plan as Outpa Emergency Care (2.a) in EHB 2: Emergency services;Outpatient Hospital Services (5.a) in EHB 1: Ambulatory patient services, and Inpatient Hosp Hospitalization	s: atient Hospital Services - Services (2.a) and Physician
Base Benchmark Benefit that was Substituted: Source: Medical Emergency Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted 1937 benchmark benefit(s) included above under Essential Health Benefit: Duplication: Covered under the Connecticut Medicaid state plan as Outpa Emergency Care (2.a) in EHB 2: Emergency services; Outpatient Hospita Services (5.a) in EHB 1: Ambulatory patient services, and Inpatient Hospita Hospitalization	s: atient Hospital Services - Il Services (2.a) and Physician
Base Benchmark Benefit that was Substituted: Source: Ambulance Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted 1937 benchmark benefit(s) included above under Essential Health Benefit: Duplication: Covered under the Connecticut Medicaid state plan as Other (24.a.1) in EHB 2: Emergency services	s:
Base Benchmark Benefit that was Substituted: Source: Inpatient Hospital Base Benchmark	Remove
 Explain the substitution or duplication, including indicating the substituted 1937 benchmark benefit(s) included above under Essential Health Benefit: Duplication: Covered under the Connecticut Medicaid state plan as Inpati 3: Hospitalization The Connecticut Medicaid state plan benefit is similar in amount, duration benchmark benefit. Benefits for surgery related to morbid obesity are com authorization requirements associated with the base benchmark benefit are from the Medicaid state plan are similar to the exclusions in the base benchmark benefit are from the Medicaid state plan are similar to the exclusions in the base benchmark 	s: ent Hospital Services (1) in EHB n, and scope to the base nparable because the prior e restrictive. Services excluded
Base Benchmark Benefit that was Substituted: Source: Organ/Tissue Transplants Base Benchmark Explain the substitution or duplication, including indicating the substituted 1937 benchmark benefit(s) included above under Essential Health Benefit	d benefit(s) or the duplicate section
Duplication: Covered under the Connecticut Medicaid state plan as Inpati 3: Hospitalization The base benchmark benefit is more limited in amount, duration, and scop benefit as the base benchmark benefit only covers specific transplants.	



Base Benchmark Benefit that was Substituted:	Source:	
Reconstructive Surgery	Base Benchmark	Remove
1937 benchmark benefit(s) included above under Ess		
Duplication: Covered under the Connecticut Medica 3: Hospitalization (neither base benchmark nor Med	id state plan as Inpatient Hospital Services (1) in EHB licaid covers cosmetic surgery)	
	aration, and scope to the Medicaid state plan benefit. norization requirements for reconstructive surgery are ements under the benchmark plan benefit.	
Base Benchmark Benefit that was Substituted:	Source:	
Maternity Care		Remove
Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess	licating the substituted benefit(s) or the duplicate section sential Health Benefits:	
Duplication: Covered under the Connecticut Medica Inpatient Hospital Services - Maternity (1), Physicia Svs (28) and Nurse Mid-Wife Services (17), all in E	In Services - Maternity (5.a), Freestanding Birth Center	
Base Benchmark Benefit that was Substituted:	Source:	
Lab, X-Ray and Other Diagnostic Tests	Base Benchmark	Remove
Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess	Licating the substituted benefit(s) or the duplicate section sential Health Benefits:	
Duplication: Covered under the Connecticut Medica EHB 8: Laboratory services	id state plan as Other Laboratory and X-Ray (3) in	
Base Benchmark Benefit that was Substituted:	Source:	
Hospice Care	Base Benchmark	Remove
Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess	Licating the substituted benefit(s) or the duplicate section	
	id state plan as Hospice Care Services (18) in EHB 1:	
	Correct	
Base Benchmark Benefit that was Substituted:	Source:	
Base Benchmark Benefit that was Substituted: Durable Medical Equipment (DME)	Base Benchmark	Remove
Durable Medical Equipment (DME)	Base Benchmark licating the substituted benefit(s) or the duplicate section	Remove
Durable Medical Equipment (DME) Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess Duplication: Covered under the Connecticut Medica	Base Benchmark licating the substituted benefit(s) or the duplicate section sential Health Benefits:	Remove
Durable Medical Equipment (DME) Explain the substitution or duplication, including ind 1937 benchmark benefit(s) included above under Ess Duplication: Covered under the Connecticut Medica	Base Benchmark licating the substituted benefit(s) or the duplicate section sential Health Benefits: nid state plan as Home Health Services - Medical	Remove



Supersedes 18-0013

Duplication: Covered under the Connecticut Medicaid EHB1: Ambulatory patient services and Rehabilitatio habilitative services and devices; Physician Services (n Clinics (9.g.) in EHB 7: Rehabilitative and	
The base benchmark plan does not cover routine hear	ing tests for adults.	
Base Benchmark Benefit that was Substituted: Medical Supplies	Source: Base Benchmark	Remove
1937 benchmark benefit(s) included above under Esse		
Duplication: Covered under the Connecticut Medicaid Supplies, Equipment and Appliances (7.c.) in EHB 7:		
Base Benchmark Benefit that was Substituted: Orthopedic and Prosthetic Devices	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse Duplication: Covered under the Connecticut Medicaid		
(12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and pro to the Connecticut Medicaid state plan although the co	osthetic devices, including hearing aids is comparable	
(12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and pro-	osthetic devices, including hearing aids is comparable overage of specific items (e.g., shoes and wigs) may Source:	
(12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and pro to the Connecticut Medicaid state plan although the co vary.	osthetic devices, including hearing aids is comparable overage of specific items (e.g., shoes and wigs) may	Remove
 (12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and proto the Connecticut Medicaid state plan although the covary. Base Benchmark Benefit that was Substituted: PT, OT, ST and Cognitive Therapy 	Source: Base Benchmark	Remove
 (12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and proto the Connecticut Medicaid state plan although the covery. Base Benchmark Benefit that was Substituted: PT, OT, ST and Cognitive Therapy Explain the substitution or duplication, including indice 	Source: Base Benchmark eating the substituted benefit(s) or the duplicate section ntial Health Benefits: d state plan as Outpatient Hospital Services (2.a) in h Services - PT/OT/ST/Audiology (7.d.) and	Remove
 (12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and proto to the Connecticut Medicaid state plan although the covary. Base Benchmark Benefit that was Substituted: PT, OT, ST and Cognitive Therapy Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse Duplication: Covered under the Connecticut Medicaid EHB 1: Ambulatory patient services and Home Health 	Source: Base Benchmark Satisfies and wige of specific items (e.g., shoes and wige) may Source: Base Benchmark Statisfies the substituted benefit(s) or the duplicate section ntial Health Benefits: A state plan as Outpatient Hospital Services (2.a) in h Services - PT/OT/ST/Audiology (7.d.) and and habilitative services and devices A state plan as Coupe than the Medicaid state plan PT/OT/ST visits combined per calendar year whereas	Remove
 (12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and proto to the Connecticut Medicaid state plan although the covary. Base Benchmark Benefit that was Substituted: PT, OT, ST and Cognitive Therapy Explain the substitution or duplication, including indice 1937 benchmark benefit(s) included above under Essen Duplication: Covered under the Connecticut Medicaid EHB 1: Ambulatory patient services and Home Health Rehabilitation Clinics (9.g.) in EHB 7: Rehabilitative The base benchmark benefit is more limited in amount benefit. The base benchmark benefit only allows 50 I the Medicaid state plan allows 86 treatments per moniof medical necessity. 	esthetic devices, including hearing aids is comparable overage of specific items (e.g., shoes and wigs) may Source: Base Benchmark eating the substituted benefit(s) or the duplicate section ntial Health Benefits: d state plan as Outpatient Hospital Services (2.a) in h Services - PT/OT/ST/Audiology (7.d.) and and habilitative services and devices ht, duration, and scope than the Medicaid state plan PT/OT/ST visits combined per calendar year whereas th, which can be exceeded based on a determination Source:	Remove
 (12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and proto to the Connecticut Medicaid state plan although the covary. Base Benchmark Benefit that was Substituted: PT, OT, ST and Cognitive Therapy Explain the substitution or duplication, including indice 1937 benchmark benefit(s) included above under Essee Duplication: Covered under the Connecticut Medicaid EHB 1: Ambulatory patient services and Home Health Rehabilitation Clinics (9.g.) in EHB 7: Rehabilitative The base benchmark benefit is more limited in amount benefit. The base benchmark benefit only allows 50 F the Medicaid state plan allows 86 treatments per monof medical necessity. 	esthetic devices, including hearing aids is comparable overage of specific items (e.g., shoes and wigs) may Source: Base Benchmark eating the substituted benefit(s) or the duplicate section ntial Health Benefits: d state plan as Outpatient Hospital Services (2.a) in h Services - PT/OT/ST/Audiology (7.d.) and and habilitative services and devices at, duration, and scope than the Medicaid state plan PT/OT/ST visits combined per calendar year whereas th, which can be exceeded based on a determination Source: Base Benchmark	Remove
 (12.c.) in EHB 7: Rehabilitative and habilitative servi The state believes that coverage of orthopedic and proto to the Connecticut Medicaid state plan although the covary. Base Benchmark Benefit that was Substituted: PT, OT, ST and Cognitive Therapy Explain the substitution or duplication, including indice 1937 benchmark benefit(s) included above under Essee Duplication: Covered under the Connecticut Medicaid EHB 1: Ambulatory patient services and Home Health Rehabilitation Clinics (9.g.) in EHB 7: Rehabilitative The base benchmark benefit is more limited in amount benefit. The base benchmark benefit only allows 50 F the Medicaid state plan allows 86 treatments per monof medical necessity. 	source: A state plan as Outpatient Hospital Services (2.a) in h Services - PT/OT/ST/Audiology (7.d.) and and habilitative services and devices ht, duration, and scope than the Medicaid state plan PT/OT/ST visits combined per calendar year whereas th, which can be exceeded based on a determination Source: Base Benchmark Source: Base Benchmark	



Base Benchmark Benefit that was Substituted: Outpatient Hospital or Other Covered Facility	Source: Base Benchmark	Remove
1937 benchmark benefit(s) included above under Esse		
Duplication: Covered under the Connecticut Medicaid MH/SUD (2.a), Clinic Services: MH and SA Clinics (Clinics (9.f) in EHB 5: MH and SUD services		
Certain Medicaid limits may be exceeded based on methods benchmark plan through claims processing.	edical necessity and other soft limit probably exists in	
Base Benchmark Benefit that was Substituted:	Source:	
Professional Services	Base Benchmark	Remove
Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse	eating the substituted benefit(s) or the duplicate section ntial Health Benefits:	
Duplication: Covered under the Connecticut Medicaic MH/SUD (2.a), Physician Services - MH/SUD (5.a) a 5: MH and SUD services		
Certain Medicaid limits may be exceeded based on me exist in the base benchmark plan through claims proce		
Base Benchmark Benefit that was Substituted:	Source:	
Covered Medications and Supplies	Base Benchmark	Remove
Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse	eating the substituted benefit(s) or the duplicate section ntial Health Benefits:	
Duplication: Covered under the Connecticut Medicaid Prescription drugs	l state plan as Prescribed Drugs (12.a) in EHB 6:	
Base Benchmark Benefit that was Substituted:	Source:	
Preventive Care, Adult	Base Benchmark	Remove
Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse	eating the substituted benefit(s) or the duplicate section ntial Health Benefits:	
Duplication: Covered under the Connecticut Medicaid Wellness (5.a) in EHB 9: Preventive and wellness ser		
Base Benchmark Benefit that was Substituted:	Source:	
Preventive Care, Children	Base Benchmark	Remove
Explain the substitution or duplication, including indic 1937 benchmark benefit(s) included above under Esse	eating the substituted benefit(s) or the duplicate section ntial Health Benefits:	
Duplication: Covered under the Connecticut Medicaid Wellness (5.a) in EHB 9: Preventive and wellness ser	I state plan as Physician Services - Preventive and vices and chronic disease management and EPSDT vision care	



Add



🔀 Othe	r Base Benchmark Benefits Not Covered		Collapse All
Ben	e Benchmark Benefit not Included in the Alternative efit Plan: ion Services (testing, treatment, and supplies)	Source: Base Benchmark	Remove
]	Explain why the state/territory chose not to include thi	is benefit:	
[Routine non-pediatric eye exam services are an excep	ted benefit pursuant to 45 CFR 156.115(d)	
Ben	e Benchmark Benefit not Included in the Alternative efit Plan: ntal Benefit	Source: Base Benchmark	Remove
-	Explain why the state/territory chose not to include thi		
	Non-pediatric dental services are an excepted benefit	pursuant to 45 CFR 156.115(d)	
			Add



Other 1937 Covered Benefits that are not Essen	tial Health Benefits	Collapse All
Other 1937 Benefit Provided:	Source:	
Optometrist Services (for Adults)	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		_
None]
Other:		-
		7
Other 1937 Benefit Provided:	Source:	_
Other Practitioner: Dental Hygienist	Section 1937 Coverage Option Benchmark Benefit	Remove
Authorization:	Package Provider Qualifications:	
Authorization: Other	Medicaid State Plan	7
Amount Limit: See "Other"	Duration Limit: See "Other"	7
	See Other	
Scope Limit:		7
See "Other"		
Other:		7
services)	ental Services (for Adults)" in EHB 1: Ambulatory patient	
Other 1937 Benefit Provided:	Source:	
Dentures	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	_
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other"	See "Other"	
Scope Limit:		_
	limited to once every seven years, except if medically necessary	7



Other:		
Other 1937 Benefit Provided: Other Medical Care: Non-Emergency Transportation	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	,
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		
Brokered transportation		
Other 1937 Benefit Provided:	Source:	
Eyeglasses	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See "Other"	See "Other"	
Scope Limit:		
None		
Other:		
One pair per clients twenty-one years of age an because of a change in the client's medical con	nd older per two year period unless it is medically necessary idition	
Other 1937 Benefit Provided: FQHCs	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	



Scope Limit:		
See "Other" re dental services		
Other:		
Limits for Dental Services apply to dental services in EHB 1: Ambulatory patient services) Connecticut does not have any Rural Health Clinics	provided by FQHCs (see "Dental Services (for Adults)" s (RHCs)	
Other 1937 Benefit Provided:	Source:	
Home Health Services - Home Health Aide Svs	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Not covered: Services for well child care or for pre	enatal or postpartum care that is not high risk	
Other:		
-The cost of services provided by the home health a appropriate institution -Prior authorization required for more than 14 hours	agency may not exceed the cost if the client were in the s per week	
Other 1937 Benefit Provided:	Source:	
Other Practitioner: Naturopath	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Only for clients under age 21		
Other:		
-Authorization required for more than five visits per	r month to the the same provider	
Other 1937 Benefit Provided:	Source:	
School Based Child Health Services	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Authorization.		



Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Only for clients under age 21		
Other: Only for services described in the IEP and otherwise Medicaid State Plan No other authorization required	coverable under Section 1905(a), as specified in the	
Other 1937 Benefit Provided:	Source:	
TCM for Clients with Chronic Mental Illness	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		
Other 1937 Benefit Provided: Nursing Facility Services	Source: Section 1937 Coverage Option Benchmark Benefit	
	Package	Remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		
Other 1937 Benefit Provided:	Source:	
ICF/IID fka ICF/MR Services	Section 1937 Coverage Option Benchmark Benefit Package	Remove



Habilitative services and devices - Ho	Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and	Remove
None Scope Limit: None Other: Description Other Authorization: Other Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	None Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
Scope Limit: None Other: Other 1937 Benefit Provided: Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None T/ST/OT/Audiology as described in EHB 7: Rehabilitative and	Remove
None Other: Other 1937 Benefit Provided: Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Section 1937 Coverage Option Benchmark Benefit Package F Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and P	Remove
L Other: Other 1937 Benefit Provided: Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Section 1937 Coverage Option Benchmark Benefit Package F Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and P	Remove
Dther 1937 Benefit Provided: Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Section 1937 Coverage Option Benchmark Benefit Package F Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and P	Remove
Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Section 1937 Coverage Option Benchmark Benefit Package F Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and P	Remove
Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Section 1937 Coverage Option Benchmark Benefit Package F Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and P	Remove
Independent Therapies Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Section 1937 Coverage Option Benchmark Benefit Package F Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and P	Remove
Authorization: Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Package Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and	Remove
Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Provider Qualifications: Medicaid State Plan Duration Limit: None PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and	
Other Amount Limit: None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	Duration Limit: None	
None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and	
None Scope Limit: Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho	PT/ST/OT/Audiology as described in EHB 7: Rehabilitative and	
Only for clients under age 21 Other: Prior authorization requirements for P		
Only for clients under age 21 Other: Prior authorization requirements for P Habilitative services and devices - Ho		
Other: Prior authorization requirements for P Habilitative services and devices - Ho		
Prior authorization requirements for P Habilitative services and devices - Ho		
Other 1937 Benefit Provided:	ome Health Services	
	Source:	
Rehab Services: PNMI for Adults	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		



Other 1937 Benefit Provided: Rehab Services: PNMI for Children	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Only for clients under age 21		
Other:		
Other 1937 Benefit Provided:	Source:	
Rehab Services: Psychiatric Svs to Children	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Only for clients under age 21		
Other:		
-Must be an approved rehabilitative model -Requires registration For the IIACPS (Intensive In-Home, Child an authorization is required in specified circumst	d Adolescent Psychiatric Services) model only, concurrent ances	
Other 1937 Benefit Provided:	Source:	
Inpatient Psychiatric Facility Svs for Under 21	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	<u></u>
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
	2 as provided in 42 CFR 441.151(a)(3)	



Other:		
L Other 1937 Benefit Provided: Other Practitioner: Professional Counselor Svs Authorization: Other Amount Limit: None Scope Limit: Other: Registration required	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
Other 1937 Benefit Provided: Other Practitioner: Licensed ADC Svs Authorization:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
Other Amount Limit:	Medicaid State Plan Duration Limit:	
None Scope Limit:	None	
Other: - Other Practitioner: Licensed Alcohol and Drug C - Registration required	Counselor Services	
Other 1937 Benefit Provided: Other Pract: Licensed Marital & Family Therapist Authorization:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
	Medicaid State Plan	
Amount Limit:] [] Duration Limit:	



Scope Limit:		
Other:		
Registration required		
Other 1937 Benefit Provided:	Source:	
Other Practitioner: Psychologist	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Other: Registration required		
Registration required Dther 1937 Benefit Provided:	Source:	
Registration required	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Registration required Dther 1937 Benefit Provided:	Section 1937 Coverage Option Benchmark Benefit	Remove
Registration required Other 1937 Benefit Provided: Licensed Clinical Social Worker	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Registration required Other 1937 Benefit Provided: Licensed Clinical Social Worker	Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
Registration required Dther 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan	Remove
Registration required Dther 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan	Remove
Registration required Dther 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan	Remove
Registration required Other 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan	Remove
Registration required Dther 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Source:	Remove
Registration required Other 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
Registration required Other 1937 Benefit Provided: Licensed Clinical Social Worker Authorization:	Source: Source: Source: Source: Source: Section 1937 Coverage Option Benchmark Benefit	



None	None	
Scope Limit:		
Only for Medicaid beneficiaries under age twenty-	one.	
summary of key provisions in Attachment 3.1-A inc - Medical / physical evaluation covered under the ou- federally qualified health center or clinic State Plan - Comprehensive diagnostic evaluation is covered un- practitioner, federally qualified health center or clinic - Behavior assessment, development of the plan of co- benefit in the preventive services State Plan benefit - Medical/physical evaluation, comprehensive diagni plan of care required before receiving ASD treatment - Board Certified Behavior Analyst (BCBA) or spect services and must supervise all ASD treatment servit Analysts (BCaBAs) or technicians. BCBA or specific	autpatient hospital, physician, other licensed practitioner, benefit category, as applicable. nder the outpatient hospital, physician, other licensed ic State Plan benefit category, as applicable. care, and ASD treatment services covered under this category. nostic evaluation, behavior assessment, and behavioral nt services. cified licensed practitioner provides ASD treatment ices provided by Board Certified Assistant Behavior fied licensed practitioner also provides observation and	
direction of treatment services provided by BCaBAs The effective date of these services are the same as ther 1937 Benefit Provided: CM for Clients with Developmental Disabilities	what is approved in the underlying SPA 15-004. Source: Section 1937 Coverage Option Benchmark Benefit	Remove
Authorization:	Package Provider Qualifications:	Kelilöve
	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other: TCM for Clients with Developmental Disabilities is Attachment 3.1-A(1), Pages 1 through 6.	detailed in the Medicaid State Plan in Supplement 1 to	
ner 1937 Benefit Provided:	Source:	
mmunity First Choice Pursuant to Section 1915(k)	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See Attachment 3.1-K	None	



See Attachment 3.1-K		
Other:		
	nefit (created through approved SPA 15-012), including on.	
Other 1937 Benefit Provided: Behavioral Health Homes Pursuant to Section 1945	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
	Medicaid State Plan	
LAmount Limit:	Duration Limit:	
See Attachment 3.1-H	None	
Scope Limit:		
See Attachment 3.1-H		
Other:		
Other 1937 Benefit Provided: Other Medical Care: Integrated Care Models - PCMH+	Source: Section 1937 Coverage Option Benchmark Benefit	
	Package	Remove
	Provider Qualifications:	
Authorization:	Provider Qualifications:	
Authorization:	Medicaid State Plan	
Authorization: Amount Limit:	Medicaid State Plan Duration Limit:	
	Medicaid State Plan	
Amount Limit:	Medicaid State Plan Duration Limit:	
Amount Limit: None	Medicaid State Plan Duration Limit:	
Amount Limit: None Scope Limit: See Attachment 3.1-A. Other: As described in Attachment 3.1-A, the Person-Cen model within the Other Medical Care benefit categ includes the provision of primary care case manage Security Act.	Medicaid State Plan Duration Limit:	



Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See Attachment 3.1-A		
Scope Limit:		
See Attachment 3.1-A		
Other:		
October 1, 2020 through September 30, 2025. All of previously covered under other applicable benefit cat	bioid Recovery and Treatment (SUPPORT) for That federal law provision is currently in effect from the services covered under this benefit category were egories.	
See Attachment 3.1-A for details regarding this benef provider qualifications, service components, and limi	fit (initially created through SPA 21-0014), including its.	
The state makes the following assurances:		
MAT is provided as defined in the approved state pla 3 pages.	n Attachment 3.1-A and if applicable, Attachment 3.1-	
MAT is provided in accordance with 1905(a)(29) for September 30, 2025.	the period beginning October 1, 2020, and ending	
		Add



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.



	Г			OMB Control Number: 09381148			
Att	tachment 3.1-C-			OMB Expiration date: 10/31/2014			
Benefits Assurances ABP7							
EPS	EPSDT Assurances						
	If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.						
The	The alternative benefit plan includes beneficiaries under 21 years of age.						
Pre	Prescription Drug Coverage Assurances						
V	The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.						
V	The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.						
V	The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.						
1			ssures that when conducting prior authorization of prescription drugs under an authorization program requirements in section $1927(d)(5)$ of the Act.	Alternative Benefit Plan, it			
Other Benefit Assurances							
1		-	assures that substituted benefits are actuarially equivalent to the benefits they repative the territory has actuarial certification for substituted benefits available for CM	-			
V		-	assures that individuals will have access to services in Rural Health Clinics (RH defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Secur				
V			assures that payment for RHC and FQHC services is made in accordance with the cial Security Act.	e requirements of section			
✓		rna	assures that it will comply with the requirement of section 1937(b)(5) of the Act tive Benefit Plan participants at least Essential Health Benefits as described in s ordable Care Act.				
✓	1937(b)(6) of the use disorder bene	e A lefit	assures that it will comply with the mental health and substance use disorder part of by ensuring that the financial requirements and treatment limitations applical to comply with the requirements of section 2705(a) of the Public Health Service to a group health plan.	ble to mental health or substance			
V	Benefit Plan part	tici	assures that it will comply with section $1937(b)(7)$ of the Act by ensuring that be pants include, for any individual described in section $1905(a)(4)(C)$, medical as es in accordance with such section.	-			

✓ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.



The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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

Attachment 3.1-C-	OMB Expiration date: 10/31/2	2014		
Service Delivery Systems ABP8				
Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.				
Type of service deliver	ry system(s) the state/territory will use for this Alternative Benefit Plan(s).			
Select one or more serv	vice delivery systems:			
Managed care.				

Fee-for-service.

Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

C Traditional state-managed fee-for-service

Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-forservice care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The Department contracts with three Administrative Services Organizations to provide a managed fee-for-service delivery system. The ASOs manage medical, dental and behavioral health services. The Medical ASO supports a person-centered medical home program and also provides intensive case management. All services are provided by the Department's provider network. All Medicaid beneficiaries are served by this delivery system.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (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.

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OMB Control Number: 09381148



	OMB Control Number: 09381148			
Attachment 3.1-C-	OMB Expiration date: 10/31/2014			
General Assurances	ABP10			
Economy and Efficiency of Plans				
The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.				
Economy and efficiency will be achieved using the same approach as used for Medicaid state plan	services. Yes			
Compliance with the Law				
✓ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.				
The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).				
The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the prover the Base Benchmark Plan and/or the Medicaid state plan.	ider qualification requirements of			

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.



OMB Control Number: 09381148 OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

PRA Disclosure Statement

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