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State/Territory Name: Michigan

State Plan Amendment (SPA)#: 22-1002

This file contains the following documents in the order listed

1) Approval Letter
2) CMS 179
3) Approved SPA Pages from MMDL
June 22, 2022

Ms. Farah Hanley
Medicaid Director
Medical Services Administration
400 S Pine St 7th Fl
Lansing, MI 48933-2250

RE: State Plan Amendment (SPA) Transmittal Number 22-1002

Dear Ms. Hanley:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-1002. This amendment proposes to provide authority to the state to cover and to reimburse for doula services for eligible Michigan Medicaid beneficiaries under the Alternative Benefit Plan.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 440.130(c). This letter is to inform you that MI Medicaid SPA 22-1002 was approved on June 21, 2022 with an effective date of October 1, 2022.

If you have any questions, please contact Keri Toback at (312) 353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Erin Black, MDHHS
State/Territory name: Michigan

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.

MI-22-1002

Proposed Effective Date

10/01/2022 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Section 1937 of the Social Security Act

Federal Budget Impact

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year 2023</td>
<td>$819400.00</td>
</tr>
<tr>
<td>Second Year 2024</td>
<td>$819400.00</td>
</tr>
</tbody>
</table>

Subject of Amendment

This State Plan Amendment (SPA) is submitted in order to cover and to reimburse for doula services.

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:
  Kate Massey, Director
  Behavioral and Physical Health and Aging Services Administration

Signature of State Agency Official

Submitted By: Erin Black
Last Revision Date: Apr 7, 2022
Submit Date: Apr 7, 2022
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:

**Priority Health HMO**

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

**Secretary-Approved**

For any Home and Community Based Services benefits as permitted in 1915(i) in ABP 5, the state assures that:

1. The service(s) are provided in settings that meet HCB setting requirements;
2. The service(s) meet the person-centered service planning requirements;
3. Individuals receiving these services meet the state-established needs-based criteria that are not related solely to age, disability, or diagnosis, and are less stringent than criteria for entry into institutions. Services can be accessed as needed, even if the individuals have needs that are below institutional level of care.
### Essential Health Benefit 1: Ambulatory patient services

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

- **Authorization:** None  
- **Provider Qualifications:** Medicaid State Plan

- **Amount Limit:** See below  
- **Duration Limit:** None

**Scope Limit:**

Services must be related to a diagnosed mental or physical health condition calling for therapeutic management, an exam to diagnose a mental deficiency, or family planning.

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

Includes Primary Care and Specialist/Referral Physician Services; Other Practitioner Services (e.g. Nurse Practitioner, Physician Assistant). No payments for services of staff in residence (e.g. interns and residents) or for staff functioning in an administrative capacity. Physician services related to a diagnosed mental health condition in an inpatient setting are covered only when rendered by a psychiatrist or physician (MD or DO), or psychological testing by a licensed psychologist under the direction of a psychiatrist or physician (MD or DO). Laboratory services performed in the physician office are limited to those determined to be reasonable and appropriate for that site. Physician visits in a nursing home setting are limited to one visit per month; additional visits must be documented as medically necessary.

### Outpatient Hospital Services

**Benefit Provided:** Outpatient Hospital Services  
**Source:** State Plan 1905(a)

- **Authorization:** Other  
- **Provider Qualifications:** Medicaid State Plan

- **Amount Limit:** None  
- **Duration Limit:** None

**Scope Limit:**

Outpatient hospital services and supplies, including services performed by physicians and other health professionals; received on an outpatient basis. Certain services require prior authorization.

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

Benefit also includes ambulatory surgery center facility services.

### Home Health Care

**Benefit Provided:** Home Health Care  
**Source:** State Plan 1905(a)

- **Authorization:** Authorization required in excess of limitation  
- **Provider Qualifications:** Medicaid State Plan

- **Amount Limit:** None  
- **Duration Limit:** None

Supersedes TN: 21-1001

Approval Date: 06/21/2022  
Effective Date: 10/01/2022

TN 22-1002
### Alternative Benefit Plan

#### Hospice

**Benefit Provided:** Hospice  
**Source:** State Plan 1905(a)  
**Authorization:** Other  
**Provider Qualifications:** Medicaid State Plan  
**Amount Limit:** None  
**Duration Limit:** See below  
**Scope Limit:** Hospice is a program of care and support for beneficiaries who are terminally ill.  

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:  
Benefits are subject to an enrollment determination process. Terminally ill beneficiaries have the option to enroll in a hospice program if their life expectancy is 6 months or less, as determined by a physician and the Hospice Medical Director. For beneficiaries under age 21, in accordance with Section 2302 of the Affordable Care Act, hospice care for children concurrent with curative treatment of the child’s terminal illness is covered.

#### Podiatry - Other Licensed Practitioners

**Benefit Provided:** Podiatry - Other Licensed Practitioners  
**Source:** State Plan 1905(a)  
**Authorization:** None  
**Provider Qualifications:** Medicaid State Plan  
**Amount Limit:** None  
**Duration Limit:** None  
**Scope Limit:** Services are limited to those necessary to diagnose and/or treat illness, injury, the prevention of disability, or services provided to patients suffering from specific systemic diseases for which self-treatment would be hazardous.

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

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Approval Date: 06/21/2022  
Effective Date: 10/01/2022

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**TN: 22-1002**  
Supersedes TN: 21-1001
<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Cessation Treatment</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

**Authorization:** None

**Provider Qualifications:** Medicaid State Plan

**Amount Limit:** None

**Duration Limit:** None

**Scope Limit:**
Face-to-face tobacco cessation counseling services must be performed by or under the supervision of a physician or other health care professional licensed under state law.

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cert. Nurse Anesthes - Other Licensed Practitioners</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

**Authorization:** None

**Provider Qualifications:** Medicaid State Plan

**Amount Limit:** None

**Duration Limit:** None

**Scope Limit:**
Services are limited to those provided on an inpatient or outpatient basis and reimbursement is directed through to the provider or the provider’s employer.

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Services &amp; Supplies</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

**Authorization:** None

**Provider Qualifications:** Medicaid State Plan

**Amount Limit:** None

**Duration Limit:** None

**Scope Limit:**
Family planning services include any medically approved means of voluntarily preventing or delaying pregnancy, including diagnostic evaluation, drugs, and supplies. Infertility treatment is not a covered benefit.
Alternative Benefit Plan

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Services-Other Licensed Practitioners</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: Authorization required in excess of limitation</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: 18 visits per calendar year</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Chiropractic services are limited to spinal manipulation. Benefit includes one set of spinal x-rays per beneficiary, per year.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists - Other Licensed Providers</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: None</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: None</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Services are limited to those necessary to diagnosis and/or treat behavioral health disorders within the Psychologist’s scope of practice as defined by State law.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Workers - Other Licensed Providers</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: None</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: None</td>
<td>Duration Limit: None</td>
</tr>
</tbody>
</table>
## Alternative Benefit Plan

### Professional Counselors - Other Licensed Providers

**Source:** State Plan 1905(a)

**Provider Qualifications:** Medicaid State Plan

**Authorization:** None

**Amount Limit:** None

**Duration Limit:** None

**Scope Limit:**

Services are limited to those necessary to diagnosis and/or treat behavioral health disorders within the Professional Counselor's scope of practice as defined by State law.

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

### Marriage & Family Therapist - Other Licensed Providers

**Source:** State Plan 1905(a)

**Provider Qualifications:** Medicaid State Plan

**Authorization:** None

**Amount Limit:** None

**Duration Limit:** None

**Scope Limit:**

Services are limited to those necessary to diagnosis and/or treat behavioral health disorders within the Marriage and Family Therapist's scope of practice as defined by State law.

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

### Clinical Nurse Specialist - Other Licensed Providers

**Source:** State Plan 1905(a)

**Provider Qualifications:** Medicaid State Plan

**Authorization:** None

**Amount Limit:** None

**Duration Limit:** None

**Scope Limit:**

Services are limited to those necessary to diagnosis and/or treat behavioral health disorders within the Clinical Nurse Specialist's scope of practice as defined by State law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
<table>
<thead>
<tr>
<th>Amount Limit</th>
<th>Duration Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Scope Limit:
None

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

Essential Health Benefit 2: Emergency services

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services - Other Medical Care</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: None</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: None</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Benefit is limited to services that are necessary to evaluate or stabilize an emergency medical condition.</td>
<td></td>
</tr>
</tbody>
</table>

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

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<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Transp./ Ambulance - Other Medical Care</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: None</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: None</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Benefit is limited to services that are necessary to evaluate or stabilize an emergency medical condition.</td>
<td></td>
</tr>
</tbody>
</table>

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

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<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Services - Clinics</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: None</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: None</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Benefit is limited to unscheduled diagnosis and treatment of illnesses for ambulatory beneficiaries requiring immediate medical attention for non-life-threatening conditions.</td>
<td></td>
</tr>
</tbody>
</table>

TN: 22-1002
Supersedes TN: 21-1001
Approval Date: 06/21/2022
Effective Date: 10/01/2022
Alternative Benefit Plan

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

[Blank field for input]
### Essential Health Benefit 3: Hospitalization

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- Prior Authorization

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- None

**Scope Limit:**

Services are covered when furnished by a certified hospital under the direction of a physician. Laboratory and radiology services performed as routine procedures or physician standing orders are excluded.

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

- Medical, surgical, and rehabilitation inpatient services: elective admissions, readmissions, and transfers for inpatient hospital services must be authorized through the Admissions and Certification Review Contractor. Transplant Services are covered and certain transplant procedures require prior authorization. Admissions and continued stays for rehabilitation units and freestanding rehabilitation hospitals require prior authorization.

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Approval Date: 06/21/2022

Effective Date: 10/01/2022

TN: 22-1002

Supersedes TN: 21-1001
## Alternative Benefit Plan

### Essential Health Benefit 4: Maternity and newborn care

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care - Physician Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**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:**  
Benefit includes physician services related to maternity care, including prenatal care, delivery related services, and postpartum care.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care - Inpatient Hospital Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:** None  
**Provider Qualifications:** Medicaid State Plan  
**Amount Limit:** None  
**Duration Limit:** None  
**Scope Limit:** Services are covered when furnished by a certified hospital under the direction of a physician.

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**  
Benefit includes inpatient hospital services related to maternity care, including prenatal care, delivery related services, and postpartum care.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care - Outpatient Hospital Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:** None  
**Provider Qualifications:** Medicaid State Plan  
**Amount Limit:** None  
**Duration Limit:** None  
**Scope Limit:** Benefit includes outpatient hospital services related to maternity care, including prenatal care, delivery related services, and postpartum care.
### Alternative Benefit Plan

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Midwife Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**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:

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

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral Health - Inpatient Hospital Serv.</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**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:

See Supplement to Attachment 3.1-A, Item 1.a. Inpatient Hospital Services in Michigan’s Medicaid State plan.

### Mental/Behavioral Health - Rehabilitation Services

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral Health - Rehabilitation Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**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:


### Substance Use Disorder - Inpatient Hospital Service

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder - Inpatient Hospital Service</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- None

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- None

**Scope Limit:**
- None

Approval Date: 06/21/2022
Effective Date: 10/01/2022

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Supersedes TN: 21-1001
## Alternative Benefit Plan

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

See Supplement to Attachment 3.1-A, Item 1.a. Inpatient Hospital Services in Michigan’s Medicaid State plan.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder - Rehabilitation Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
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</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

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

**Essential Health Benefit 6: Prescription drugs**

**Benefit Provided:**
Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

**Prescription Drug Limits (Check all that apply):**
- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

**Authorization:**

**Provider Qualifications:**
- State licensed

**Coverage that exceeds the minimum requirements or other:**

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

**Essential Health Benefit 7: Rehabilitative and habilitative services and devices**

- **Benefit Provided:** Rehabilitation Services: Outpatient Services
  - **Source:** State Plan 1905(a)

  - **Authorization:** Authorization required in excess of limitation
  - **Provider Qualifications:** Medicaid State Plan
  - **Amount Limit:** See below
  - **Duration Limit:** See below

  **Scope Limit:**
  Rehabilitative therapy services must be either restorative or specialized maintenance programs to be covered. Therapy must be ordered, in writing, by a physician or other Medicaid approved licensed practitioner within the scope of their practice.

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

  Rehabilitative physical therapy and occupational therapy are each limited to 144 units (15 minute increments) per 12 month consecutive period. Speech therapy services in the outpatient setting are limited to 36 visits in a 12 month consecutive period. Outpatient rehabilitative services also includes medically necessary diabetic patient education and services for persons with neurological damage per program criteria. Enrollment of Speech-Language Pathologists as Medicaid Providers is effective 7/1/17.

  Additional approved state plan sources for outpatient rehabilitation services include 1905(a)(5); 1905(a)(7); and 1905(a)(13) respectively.

- **Benefit Provided:** Habilitative Services - Outpatient Services
  - **Source:** Other state-defined

  - **Authorization:** Authorization required in excess of limitation
  - **Provider Qualifications:** Medicaid State Plan
  - **Amount Limit:** See below
  - **Duration Limit:** See below

  **Scope Limit:**
  Habilitative therapy services include those that help a person keep, learn or improve skills and functioning for daily living.

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

  Habilitative physical therapy and occupational therapy are each limited to 144 units (15 minute increments) per 12 month consecutive period. Speech therapy services in the outpatient setting are limited to 36 visits in a 12 month consecutive period. Enrollment of Speech-Language Pathologists as Medicaid Providers is effective 7/1/17.

- **Benefit Provided:** Home Health Svcs.- Med Supplies, Equip, Appliances
  - **Source:** State Plan 1905(a)
## Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics and Orthotics; Eyeglasses, Hearing Aid</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Nursing Facility Services – Other Medical Service</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

### Prosthetics and Orthotics; Eyeglasses, Hearing Aid

- **Authorization:** Prior Authorization
- **Provider Qualifications:** Medicaid State Plan
- **Amount Limit:** None
- **Duration Limit:** None
- **Scope Limit:**
  - Described below

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

- Certain medical supplies may require prior authorization. Eye glasses and contact lenses are covered benefits based upon specified medical necessity criteria; replacement lens coverage limits vary based on age and type of lens. Services also include hearing aids and auditory osseointegrated devices.

### Nursing Facility Services – Other Medical Service

- **Authorization:** Prior Authorization
- **Provider Qualifications:** Medicaid State Plan
- **Amount Limit:** None
- **Duration Limit:** None
- **Scope Limit:**
  - This is intended to be a short-term rehabilitation benefit.

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

- Eligibility determination based upon a Level I Preadmission Screening/annual Resident Review (PASARR); and a determination of medical/functional assessment using the Medicaid Nursing Facility...
Level of Care Determination (LOCD). Benefit includes bed and board; nursing care; routine PT/OT/SLT consisting of repetitive services to maintain function.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health -Rehab</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

Authorization:

<table>
<thead>
<tr>
<th>Authorization required in excess of limitation</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization required in excess of limitation</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

Amount Limit:

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<tr>
<th>Amount Limit:</th>
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</thead>
<tbody>
<tr>
<td>See below</td>
</tr>
</tbody>
</table>

Duration Limit:

<table>
<thead>
<tr>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>See below</td>
</tr>
</tbody>
</table>

Scope Limit:

<table>
<thead>
<tr>
<th>Scope Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Described below</td>
</tr>
</tbody>
</table>

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

Physical therapy and occupational therapy as provided by a home health agency are each limited to 24 visits per 60 days; additional services require prior authorization.

Add
### Essential Health Benefit 8: Laboratory services

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- Other

**Provider Qualifications:**
- Medicaid State Plan

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Scope Limit:**

Covered services include laboratory tests which are medically necessary for diagnosis and treatment of illness or injury when ordered by a physician or other licensed practitioner.

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

Screening or routine laboratory testing, except as specified for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program or Preventive Medicine services, or by Medicaid policy, is not a benefit. A limited number of laboratory services require prior authorization.
Alternative Benefit Plan

Essential Health Benefit 9: Preventive and wellness services and chronic disease management

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: Preventive Services
Source: Base Benchmark Small Group

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: See below
Duration Limit: See below

Scope Limit:
One preventive medicine visit per year; other preventive services as per recommended guidelines of the referenced authorities.

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

“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).

The base-benchmark provides for the full range of preventive benefits as required under current federal requirements.
Alternative Benefit Plan

**Essential Health Benefit 10: Pediatric services including oral and vision care**

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid State Plan EPSDT Benefits</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

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

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐
## Alternative Benefit Plan

### Base Benchmark Benefits Not Covered due to Substitution or Duplication

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider Services - Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

Primary Care Provider Services were bundled with Specialist/Referral Care and mapped to the "ambulatory patient services" EHB category. The bundled services are a duplication of physician services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Care Services - Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

Referral Care Services were bundled with Primary Care Provider services and mapped to the "ambulatory patient services" EHB category. The bundled services are a duplication of physician services and other licensed practitioner services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital Services - Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

Outpatient hospital services are mapped to the "ambulatory patient services" EHB category. The services are a duplication of outpatient hospital services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care - Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

Home health care services are mapped to the "ambulatory patient services" EHB category. The services are a duplication of Home health care services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice - Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

Hospice services are mapped to the "ambulatory patient services" EHB category. The services are a duplication of hospice services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services by Other Health Professional - Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

Supersedes TN: 21-1001

TN: 22-1002

Approval Date: 06/21/2022

Effective Date: 10/01/2022
### 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:

**Services by Other Health Professional (Podiatry) are mapped to the "ambulatory patient services" EHB category. The services are a duplication of podiatry services -other licensed practitioner- from the existing state Medicaid plan.**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Emergency Care -Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

**Medical emergency care is mapped to the "emergency services" EHB category. The services are a duplication of emergency services -other medical care- from the existing state Medicaid plan.**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Ambulance Services -Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

**Emergency ambulance care is mapped to the "emergency services" EHB category. The services are a duplication of emergency transportation services -other medical care- from the existing state Medicaid plan.**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Services -Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

**Urgent care services are mapped to the "emergency services" EHB category. The services are a duplication of clinic services from the existing state Medicaid plan.**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient Care -Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

**Inpatient hospital care is mapped to the "hospitalization" EHB category. The services are a duplication of inpatient hospital services from the existing state Medicaid plan.**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity and Newborn Care -Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

**Maternity and newborn care is mapped to the "maternity and newborn care" EHB category. The services are a duplication of physician, outpatient, and inpatient hospital services from the existing state Medicaid plan.**

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**TN: 22-1002**

**Supersedes TN: 21-1001**

**Approval Date:** 06/21/2022

**Effective Date:** 10/01/2022
<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Acute Inpt. Hospitalization. -Dupl.</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

Mental Health acute inpatient hospitalization is mapped to the "mental health and substance use disorder services" EHB category. The services are a duplication of psychiatric inpatient hospital services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Rehabilitation - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

Outpatient Rehabilitation services are mapped to the "rehabilitative and habilitative services and devices" EHB category. The services are a duplication of Rehabilitation Services: Outpt. Hospital Services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment and Supplies- Dupl.</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

Durable Medical Equipment and Supplies are are mapped to the "rehabilitative and habilitative services and devices" EHB category. The services are a duplication of Home Health Services.-Med Supplies, Equip, Appliances from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics and Orthotics - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

Prosthetics and Orthotics are mapped to the "rehabilitative and habilitative services and devices" EHB category. The services are a duplication of Prosthetics and Orthotics from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Services - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

Chiropractic Services are mapped to the "ambulatory patient service" EHB category. The services are a duplication of Chiropractic Services-Other Licensed Practitioners from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nsg. Facility - Facility Rehab. Care-Dupl.</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:
**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:

**Skilled Nursing Facility - Facility Rehabilitation services** are mapped to the "rehabilitative and habilitative services and devices" EHB category. The services are a duplication of nursing facility services - other medical services - from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Services - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

**Laboratory services** are mapped to the "laboratory services" EHB category. The services are a duplication of laboratory services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Cessation Treatment - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

**Tobacco Cessation Treatment** is mapped to the "ambulatory patient services" EHB category. The services are a duplication of Tobacco Cessation Treatment from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other services provided by health professionals - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

**Other services provided by health professionals** (e.g. allergy testing, diabetic services, pain management, etc.) is mapped to the "ambulatory patient services" EHB category. These services are a duplication of physician services, outpatient hospital services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

**Home Health services** are mapped to the "ambulatory patient services" EHB category. The services are a duplication of home health services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning/Reproductive Services - Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

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:

**Family Planning/Reproductive Services** is mapped to the "ambulatory patient services" EHB category. The services are a duplication of Family Planning Services and supplies from the existing state Medicaid plan.
<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral Care Services - Duplication</strong></td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

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:

Referral Care Services is mapped to the "ambulatory patient services" EHB category. The services are a duplication of Certified Nurse Anesthetists - Other Licensed Practitioner services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nurse Midwife Services - Duplication</strong></td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

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:

Nurse Midwife Services is mapped to the "maternity and newborn care" EHB category. The services are a duplication of Nurse Midwife services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Outpatient Treatment - Duplication</strong></td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

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:

Mental Health Outpatient Treatment services are mapped to the "mental health and substance use disorder services" EHB category. The services are a duplication of mental/behavioral health outpatient - rehabilitation services from the existing state Medicaid plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Abuse Services - Duplication</strong></td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

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:

Substance Abuse Services covering inpatient hospital services are mapped to the "mental health and substance use disorder services" EHB category. Substance Abuse Services covering outpatient treatment is also mapped to the "mental health and substance use disorder services" EHB category. These services are a duplication of Substance use disorder - Inpatient Hospital Service & Outpatient Services - Rehabilitation from the existing state Medicaid plan.

Add
| Other Base Benchmark Benefits Not Covered | Collapse All |
### Other 1937 Covered Benefits that are not Essential Health Benefits

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
<td></td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
<td></td>
</tr>
<tr>
<td>Varies</td>
<td>Varies</td>
<td></td>
</tr>
</tbody>
</table>

**Scope Limit:**
Preventive dental services are covered every six months. Radiograph limits vary based on type of view (e.g., bitewing, panorex, etc.).

**Other:**
Dental treatment for adults, including diagnostic, therapeutic, and restorative care, are covered for conditions relating to a specific medical problem. All prosthodontics (dentures) require prior authorization.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision/Optometrist Services</strong></td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
<td></td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
<td></td>
</tr>
<tr>
<td>Authorization required in excess of limitation</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
<td></td>
</tr>
<tr>
<td>Varies</td>
<td>Varies</td>
<td></td>
</tr>
</tbody>
</table>

**Scope Limit:**
Routine eye exam once every two years; non-routine exams limited to those services relating to eye trauma and eye disease and low vision evaluations, services and aids (which must be prior authorized).

**Other:**
Vision/Optometrist Services are covered for adults. Certain services and supplies may be subject to meeting stipulated criteria and/or prior authorization.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care Services</strong></td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
<td></td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
<td></td>
</tr>
<tr>
<td>Varies</td>
<td>Varies</td>
<td></td>
</tr>
</tbody>
</table>

**Approval Date:** 06/21/2022  
**Effective Date:** 10/01/2022  
**TN:** 22-1002  
**Supersedes TN:** 21-1001  
**Page 29 of 35**
**Alternative Benefit Plan**

**Scope Limit:**
Requires certification by a licensed health care professional and a plan of care to determine medical necessity for services.

**Other:**
Personal Care Services, under the Home Help Program, include assistance with eating, toileting, bathing, grooming, dressing, transferring, self-administered medication, meal preparation, shopping/errands, laundry and light housekeeping for beneficiaries requiring physical help to perform activities of daily living. Program eligibility criteria applies. This benefit is included for individuals in accordance with 42 CFR 440.315(f).

**Other 1937 Benefit Provided:**
Extended Services to Pregnant Women

**Authorization:**

**Provider Qualifications:**

**Amount Limit:**
1 assessment visit; up to 9 professional visits

**Duration Limit:**
Varies

**Scope Limit:**
Services must be related to or associated with maternal and infant health conditions that may complicate pregnancy.

**Other:**
Maternal Infant Health Plan (MIHP) services are preventive health services that include social work, nutrition counseling, nursing services (including health education and nutrition education) and beneficiary advocacy services as provided by program criteria. Prior authorization is generally not required.

**Other 1937 Benefit Provided:**
Nursing Facility Services - Long Term Care

**Authorization:**
Prior Authorization

**Provider Qualifications:**

**Amount Limit:**
None

**Duration Limit:**
None

**Scope Limit:**
Period of covered services is the minimum period necessary in this type of facility for proper care and treatment of the patient; benefit includes bed and board; nursing care; routine PT/OT/SLT consisting of repetitive services to maintain function.

**Other:**
Eligibility determination based upon a Level I Preadmission Screening/Annual Resident Review (PASARR); and a determination of medical functional assessment using the Medicaid Nursing Facility Level of Care Determination (LOCD). This benefit is included for individuals in accordance with 42 CFR 440.315(f).
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Services</td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Authorization:**
- Other

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- None

**Scope Limit:**
- See scope limit below.

**Other:**

Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services are covered with the same limitations as services provided in the practitioner's office, when furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Prior authorization is generally not required.

Mental Health Clinic Services are covered benefits when provided under the auspices of an approved mental health clinic.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reg./Lic. Dental Hygienists - Other Licensed Pract.</td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Authorization:**
- Other

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- None

**Scope Limit:**
- Limited to services rendered on behalf of an organization, clinic or group practice.

**Other:**

Covered services are limited to those allowed under the RDH's scope of practice as defined by State law. Prior authorization is generally not required. However, authorization required in excess of limitation.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Targeted Case Mgmt Services</td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Authorization:**
- Other

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- None

---

**TN: 22-1002**
**Supersedes TN: 21-1001**
**Approval Date: 06/21/2022**
**Effective Date: 10/01/2022**

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Alternative Benefit Plan

Scope Limit:
None

Other:

Other 1937 Benefit Provided:
Pharmacists - Other Licensed Practitioners

Authorization:
Other
Amount Limit:
None

Scope Limit:
Limited to administration of vaccines and toxoids and the provision of medication therapy management services as allowed by applicable state authority. The provision of medication therapy management services is effective 4/1/17.

Other:
Prior authorization is generally not required.

Other 1937 Benefit Provided:
ICF/IID Services

Authorization:
Concurrent Authorization
Amount Limit:
None

Scope Limit:
Service is provided for individuals who are developmentally disabled (or for persons with related conditions) in properly certified and/or licensed public or private institutions (or distinct part thereof) for the developmentally disabled.

Other:
Intermediate care services are provided based on the level of care appropriate to the patient’s medical needs. Admission to an intermediate care facility must be upon the written direction of a physician, who must periodically recertify the need for care. Admission must also be prior authorized by the Michigan Department of Community Health or its designee. The period of covered services is the minimum period necessary for the proper care and treatment of the patient.

Services regularly provided in these settings are in compliance with the provisions of 42 CFR 440.150 and include health related and programmatic care, supervised personal care, as well as room and board.
### Other 1937 Benefit Provided

**Program of All-Inclusive Care for Elderly (PACE)**

**Source:**
Section 1937 Coverage Option Benchmark Benefit Package

**Authorization:**
Other

**Provider Qualifications:**
Medicaid State Plan

**Amount Limit:**
See below

**Duration Limit:**
See below

**Scope Limit:**
PACE services are provided to beneficiaries age 55 or older meeting program criteria.

**Other:**
The State of Michigan's ABP PACE Program benefit is the same as under the approved Medicaid state plan for this benefit. This benefit is included for individuals in accordance with 42 CFR 440.315(f).

### Other 1937 Benefit Provided

**Rehabilitation - Mental Health Crisis Residential**

**Source:**
Section 1937 Coverage Option Benchmark Benefit Package

**Authorization:**
Other

**Provider Qualifications:**
Medicaid State Plan

**Amount Limit:**
None

**Duration Limit:**
None

**Scope Limit:**
None

**Other:**

### Other 1937 Benefit Provided

**Mental Health Outpatient Community Support**

**Source:**
Section 1937 Coverage Option Benchmark Benefit Package

**Authorization:**
Other

**Provider Qualifications:**
Medicaid State Plan

**Amount Limit:**
Varies

**Duration Limit:**
Varies

**Scope Limit:**
None

**Other:**
### Alternative Benefit Plan

Other 1937 Benefit Provided:
- **Substance Use Disorder Residential Services**
  - **Source:** Section 1937 Coverage Option Benchmark Benefit Package
  - **Authorization:** Other
  - **Amount Limit:** None
  - **Scope Limit:** None
  - **Other:** See Supplement to Attachment 3.1-A, Item 13d. Rehabilitative Services in Michigan's Medicaid State plan.

- **Subst Use Disorder Sub-Acute Detox Services**
  - **Source:** Section 1937 Coverage Option Benchmark Benefit Package
  - **Authorization:** Other
  - **Amount Limit:** None
  - **Scope Limit:** None
  - **Other:** See Supplement to Attachment 3.1-A, Item 13d. Rehabilitative Services in Michigan's Medicaid State plan.

- **Behavioral Health Community Based Services 1915(i)**
  - **Source:** Section 1937 Coverage Option Benchmark Benefit Package
  - **Authorization:** Other
  - **Amount Limit:** None
  - **Scope Limit:** None
  - **Other:**
**Alternative Benefit Plan**

### Other

Effective 10/1/19 Services are authorized via Section 1115 expenditure authority and are provided as described in Attachment 3.1-2. 1915(i) Home and Community-Based Services in Michigan's Medicaid State plan. Effective 10/1/22 expenditure authority for 1915(i) services will no longer be provided under the 1115 and will be provided under state plan authority.

### Other 1937 Benefit Provided:

#### Health Home Services for Chronic Conditions

- **Authorization:** Other
- **Amount Limit:** None
- **Duration Limit:** Varies
- **Scope Limit:** Health Home services are limited to chronic conditions identified in the approved Medicaid state plan.

### Other:

Health Home services include a comprehensive system of care coordination utilizing an interdisciplinary care team approach to person and family-centered integrated primary medical care, behavioral health care, and community-based social services and supports for beneficiaries with specified chronic conditions or for beneficiaries with opioid use disorder and risk of developing another chronic condition.

### Other 1937 Benefit Provided:

#### Targeted Case Management - Flint Water Group

- **Authorization:** Authorization required in excess of limitation
- **Amount Limit:** See below
- **Duration Limit:** See below
- **Scope Limit:** Targeted Group F populations as defined in the state plan specify services and provider qualifications.

### Other:

Services include comprehensive client assessment; care/services plan development; linking/coordinating of services; reassessment/follow-up; monitoring of services as defined by program.

Services by designated providers are limited to 1 face to face comprehensive assessment/reassessment visit per year and 5 face to face monitoring visits per year. Additional services require prior authorization.

This coverage is to further the Flint, Michigan demonstration project authorized under section 1115 of the Act (Project No. 11W00302/5). Freedom of choice has been waived pursuant to the authority approved under the Flint Michigan Section 1115 Demonstration (Project No. 11W00302/5). This benefit is effective 5/9/16.
### Other 1937 Benefit Provided: Audiology/Hearing Services

**Source:** Section 1937 Coverage Option Benchmark Benefit Package

**Authorization:**
- Other

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- Varies

**Duration Limit:**
- Varies

**Scope Limit:**
Limited to those that are medically necessary and allowed under the Audiologist scope of practice as defined by State law. Prior authorization is generally not required. However, authorization is required for services in excess of limitations.

**Other:**
Covered services are provided in the same manner as the approved Medicaid State plan.

### Other 1937 Benefit Provided: Pediatric Outpatient Intensive Feeding Services

**Source:** Section 1937 Coverage Option Benchmark Benefit Package

**Authorization:**
- Prior Authorization

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- Varies

**Scope Limit:**
Limited to medically necessary services provided to pediatric beneficiaries who experience significant feeding difficulties due to anatomical, congenital, cognitive conditions, or complications of severe illness.

**Other:**
Pediatric intensive feeding program services consist of an initial comprehensive evaluation, individualized plan of care, treatment, monitoring and education to address complex feeding and swallowing difficulties. Services are provided by a multi-disciplinary team of medical and behavioral health professionals. Program services are effective 05/01/2018.

### Other 1937 Benefit Provided: NF Transition Community Based Services 1915(i)

**Source:** Section 1937 Coverage Option Benchmark Benefit Package

**Authorization:**
- Other

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- Varies

**Duration Limit:**
- Varies

**Scope Limit:**
None
Alternative Benefit Plan

Other:
See Attachment 3.1-i.1. 1915(i) Home and Community-Based Services in Michigan's Medicaid State plan. Program services are effective 10/01/2018.

Other 1937 Benefit Provided:
Peer-Delivered or Peer-Operated Support Services

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Other 1937 Benefit Provided:
Medication-Assisted Treatment (MAT)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Varies

Duration Limit:
None

Scope Limit:
None

Other:

MAT is provided as defined in the approved state plan 3.1-A (and if applicable, 3.1B pages).

MAT is exclusively provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

Other 1937 Benefit Provided:
Genetic Counselors • Other Licensed Practitioners

Source:
Section 1937 Coverage Option Benchmark Benefit Package
### Alternative Benefit Plan

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**Scope Limit:**
- Limited to providing genetic counseling services as defined by state law under the genetic counselor’s scope of practice.

**Other:**

### Other 1937 Benefit Provided: Routine Patient Cost in Qualifying Clinical Trials

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**Scope Limit:**
- Varies

**Other:**

### Other 1937 Benefit Provided: Doula Services

<table>
<thead>
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**Scope Limit:**
- Services are limited to pregnant and postpartum beneficiaries.

**Other:**
Alternative Benefit Plan

☐ 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.)

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