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State/Territory Name: Vermont

State Plan Amendment (SPA) #: 23-0019

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 601 E. 12th St., Room 355 Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

May 11, 2023

Adaline Strumolo, Deputy Commissioner Department of Vermont Health Access (DVHA) NOB 1 South, 280 State Drive Waterbury, VT 05671-1010

Re: Vermont State Plan Amendment (SPA) 23-0019

Dear Deputy Commissioner Strumolo:

For your records, this is an approved copy of Vermont's Alternative Benefit Plan (ABP) State plan amendment (SPA) VT 23-0019. This ABP amendment submitted through the Medicaid Model Data Lab (MMDL No. VT 0626.R00.13) on March 15, 2023 meets all federal statutory and regulatory requirements for establishing an ABP.

The state submitted this SPA to amend prior authorization requirements for chiropractic services, physical therapy, occupational therapy, speech therapy and hearing aids. This SPA was approved on May 11, 2023, with an effective date of January 1, 2023.

Enclosed are copies of the approved Alternative Benefit Plan pages for incorporation into Vermont's State Plan.

If you have any questions, please contact Gilson DaSilva at (617) 565-1227 or via email at Gilson.DaSilva@cms.hhs.gov.

Sincerely,

James G. Scott, Director Division of Program Operations

Enclosures

cc: Dylan Frazer, Deputy Director of Medicaid Policy

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:

Vermont

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.

VT-23-0019

Proposed Effective Date

01/01/2023

(mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR §430.12(c)(ii)

Federal Budget Impact

Federal Fiscal Year

Amount

11

11

First Year

2023

\$ 0.00

Second Year

2024

\$ 0.00

Subject of Amendment

Alternative Benefit Package amending PA requirements for chiropractic services, PT/OT/ST, and hearing aids.

Governor's Office Review

O 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:

Approved by the Secretary of Administration

Signature of State Agency Official

Submitted By:

Dylan Frazer

Last Revision Date:

Apr 14, 2023

Submit Date:

Mar 30, 2023



| State Name: Vermont | Attachment 3.1-L- | OMB Control Number: 0938-1148 |
|--|---|-------------------------------------|
| Transmittal Number: VT - 23 - 0019 | | , |
| Benefits Description | | ABP5 |
| The state/territory proposes a "Benchmark-Equiv | alent" benefit package. No | |
| Benefits Included in Alternative Benefit Plan | | |
| Enter the specific name of the base benchmark pl | an selected: | |
| Blue Care, Vermont Health Plan, LLC, CDHP | | |
| | | |
| Enter the specific name of the section 1937 cover Approved." | age option selected, if other than Secretary-Appr | roved. Otherwise, enter "Secretary- |
| Secretary-Approved | | |
| | | |
| | | |

TN: VT 23-0019 Approval Date: 05/11/2023 Effective Date: 01/01/2023

Supersedes: VT 22-0003



| Benefit Provided: | Source: | Remove |
|---|--|----------|
| Outpatient Hospital | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| None | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| benchmark plan: | | |
| Benefit Provided: | Source: | Remove |
| Rural Health Clinic | State Plan 1905(a) | Kemove |
| Authorization: | Provider Qualifications: | _ |
| Authorization required in excess of limitation | Medicaid State Plan | 7 |
| Amount Limit: | Duration Limit: | <u> </u> |
| 5 visits per month; 1 visit per day | 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 | |
| Benefit Provided: | Source: | Remove |
| Federally Qualified Health Center | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Authorization required in excess of limitation | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | ===0 |
| 5 visits per month; 1 visit per day | None | |
| Scope Limit: | 0.00 | |
| None | | |



| Other information regarding this benefit, including the benchmark plan: | Ţ. | |
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| | | |
| Benefit Provided: | Source: | Remove |
| Physician Services in all Settings | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Authorization required in excess of limitation | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| See other information below | None | |
| Scope Limit: | | |
| See other information below | | |
| Other information regarding this benefit, including the benchmark plan: | he specific name of the source plan if it is not the base | |
| | one visit per day for acute care. Excludes solely | |
| without consent. Prior authorizations apply for certa | es; unnecessary testing; experimental; services provided | |
| without consent. Prior authorizations apply for certa exceeded based on medical necessity. | es; unnecessary testing; experimental; services provided in circumstances and procedures. Limits may be | |
| without consent. Prior authorizations apply for certa exceeded based on medical necessity. Benefit Provided: | es; unnecessary testing; experimental; services provided nin circumstances and procedures. Limits may be | Remove |
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| without consent. Prior authorizations apply for certal exceeded based on medical necessity. Benefit Provided: Family Planning Authorization: None Amount Limit: None Scope Limit: | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
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| without consent. Prior authorizations apply for certal exceeded based on medical necessity. Benefit Provided: Family Planning Authorization: None Amount Limit: None Scope Limit: Reversal of sterilizations not covered | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
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| without consent. Prior authorizations apply for certal exceeded based on medical necessity. Benefit Provided: Family Planning Authorization: None Amount Limit: None Scope Limit: Reversal of sterilizations not covered Other information regarding this benefit, including the benchmark plan: Benefit Provided: | es; unnecessary testing; experimental; services provided ain circumstances and procedures. Limits may be Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None | |
| without consent. Prior authorizations apply for certal exceeded based on medical necessity. Benefit Provided: Family Planning Authorization: None Amount Limit: None Scope Limit: Reversal of sterilizations not covered Other information regarding this benefit, including the | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None Source: Source: Source: Source: Source: Source: Source: None | Remove |

TN: VT 23-0019 Supersedes: VT 22-0003 Approval Date: 05/11/2023 Effective Date: 01/01/2023



| Amount Limit: | Duration Limit: | |
|---|---|------------|
| None | None | |
| Scope Limit: | | |
| Excludes solely cosmetic surgery | | |
| Other information regarding this benefit, including benchmark plan: | the specific name of the source plan if it is not the base | |
| | | 75 |
| Benefit Provided: | Source: | Remove |
| OLP: Chiropractic | State Plan 1905(a) | 152 147 |
| Authorization: | Provider Qualifications: | |
| Authorization required in excess of limitation | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | 2 |
| See Att. 3.1-A Item 6.C. | None | |
| Scope Limit: | | |
| See Att. 3.1-A Item 6.C. | | |
| Other information regarding this benefit, including benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 | the specific name of the source plan if it is not the base | |
| benchmark plan: | | |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 Benefit Provided: | | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 Benefit Provided: | | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: | Source: | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry | Source: State Plan 1905(a) | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry Authorization: | Source: State Plan 1905(a) Provider Qualifications: | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry Authorization: None | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.C enefit Provided: DLP: Podiatry Authorization: None Amount Limit: None | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry Authorization: None Amount Limit: None Scope Limit: | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry Authorization: None Amount Limit: None Scope Limit: Non-routine foot care only. Excludes flat foot; sub nail trimming, and preventative hygiene. | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry Authorization: None Amount Limit: None Scope Limit: Non-routine foot care only. Excludes flat foot; subnail trimming, and preventative hygiene. Other information regarding this benefit, including | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None Dluxations of foot not requiring surgery; corns, calluses, | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 enefit Provided: DLP: Podiatry Authorization: None Amount Limit: None Scope Limit: Non-routine foot care only. Excludes flat foot; subnail trimming, and preventative hygiene. Other information regarding this benefit, including benchmark plan: | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None Dluxations of foot not requiring surgery; corns, calluses, the specific name of the source plan if it is not the base | Remove |
| benchmark plan: Coverage is in accordance with Att. 3.1-A Item 6.0 Benefit Provided: DLP: Podiatry Authorization: None Amount Limit: None Scope Limit: Non-routine foot care only. Excludes flat foot; subnail trimming, and preventative hygiene. Other information regarding this benefit, including | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None Dluxations of foot not requiring surgery; corns, calluses, | Remove |

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| | Provider Qualifications: | |
|--|--|--------|
| Prior Authorization | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| Other information regarding this benefit, includ benchmark plan: | ing the specific name of the source plan if it is not the base | |
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| efit Provided: | Source: | Remove |
| *F | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| benchmark plan: 6 months prior to end of life. | Ĩ | |
| | Source: | Damaya |
| nefit Provided: P: Pediatric or Family Nurse Practitioners | Source: State Plan 1905(a) | Remove |
| nefit Provided: P: Pediatric or Family Nurse Practitioners | State Plan 1905(a) | Remove |
| efit Provided: | | Remove |
| nefit Provided: P: Pediatric or Family Nurse Practitioners Authorization: Other | State Plan 1905(a) Provider Qualifications: Medicaid State Plan | Remove |
| efit Provided: P: Pediatric or Family Nurse Practitioners Authorization: | State Plan 1905(a) Provider Qualifications: | Remove |
| Authorization: Other Amount Limit: See other information below | State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| efit Provided: P: Pediatric or Family Nurse Practitioners Authorization: Other Amount Limit: See other information below Scope Limit: | State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| efit Provided: P: Pediatric or Family Nurse Practitioners Authorization: Other Amount Limit: See other information below Scope Limit: See other information below | State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |

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Add

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| Benefit Provided: | Source: | Remove |
|--|--|----------|
| Outpatient Hospital: Emergency Care | State Plan 1905(a) | Tremo re |
| Authorization: | Provider Qualifications: | |
| None | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| benchmark plan: | | |
| benchmark plan: Benefit Provided: Transportation: Ambulance | Source: State Plan 1905(a) | Remove |
| Benefit Provided: | Source: State Plan 1905(a) Provider Qualifications: | Remove |
| Benefit Provided: Transportation: Ambulance | State Plan 1905(a) | Remove |
| Benefit Provided: Transportation: Ambulance Authorization: | State Plan 1905(a) Provider Qualifications: | Remove |
| Benefit Provided: Transportation: Ambulance Authorization: Other | State Plan 1905(a) Provider Qualifications: Medicaid State Plan | Remove |
| Benefit Provided: Transportation: Ambulance Authorization: Other Amount Limit: None Scope Limit: | State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| Benefit Provided: Transportation: Ambulance Authorization: Other Amount Limit: None | State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| Benefit Provided: Transportation: Ambulance Authorization: Other Amount Limit: None Scope Limit: None | State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |

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Supersedes: VT 22-0003



| Benefit Provided: | Source: | Remove |
|--|--|--------|
| Inpatient Hospital | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Concurrent Authorization | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| | including the specific name of the source plan if it is not the base | |
| henchmark plan: | | |
| benchmark plan: Substance use detox is performed in an in | npatient hospital setting. | |
| Substance use detox is performed in an in Benefit Provided: | Source: State Plan 1905(a) | Remove |
| Substance use detox is performed in an in Benefit Provided: | Source: | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital | Source: State Plan 1905(a) | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital Authorization: | Source: State Plan 1905(a) Provider Qualifications: | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital Authorization: Concurrent Authorization | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital Authorization: Concurrent Authorization Amount Limit: | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital Authorization: Concurrent Authorization Amount Limit: None | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital Authorization: Concurrent Authorization Amount Limit: None Scope Limit: Not Institutions for Mental Disease (IMI | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None | Remove |
| Substance use detox is performed in an in Benefit Provided: Inpatient Psychiatric Hospital Authorization: Concurrent Authorization Amount Limit: None Scope Limit: Not Institutions for Mental Disease (IMI) Other information regarding this benefit, | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None D). | Remove |

TN: VT 23-0019 Approval Date: 05/11/2023 Effective Date: 01/01/2023



| Benefit Provided: | Source: | - |
|---|--|---|
| OLP: Licensed Lay Midwife | State Plan 1905(a) | Remove |
| Authorization: | Provider Qualifications: | _ |
| None | Medicaid State Plan | 1 |
| Amount Limit: | Duration Limit: | |
| None None | None | ٦ |
| Scope Limit: | | _ |
| None | | 7 |
| benchmark plan: | |] |
| Benefit Provided: | Source: | Remove |
| Nurse Midwife | State Plan 1905(a) | 100000000000000000000000000000000000000 |
| Authorization: | Provider Qualifications: | _ |
| None | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | —,: |
| None | None | |
| Scope Limit: | 200 | |
| None | | |
| Other information regarding this benefit, incohenchmark plan: | cluding the specific name of the source plan if it is not the base | |
| Benefit Provided: | Source: | Remove |
| Physician Services: Maternity Care | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| None | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | _ |
| | None | |
| None | None | _ |



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| Yes None None | None Source: | Remove |
| Yes None None | None | Remove |
| None None | None Source: | Remove |



| | garding this benefit, including the specific name of the source plan if it is not the base | |
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| benchmark plan: | | |
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Supersedes: VT 22-0003



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| None | | |
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| Other information regarding this benchmark plan: | efit, including the specific name of the source plan if it is not the base | |
| | ntervention, outpatient treatment services, intensive outpatient tion, clinically managed low-intensity residential services, medically hdrawal management. | |
| enefit Provided: | Source: | Remove |
| Authorization: | Provider Qualifications: | |
| None | | |
| Amount Limit: | Duration Limit: | |
| Scope Limit: | | |
| | efit, including the specific name of the source plan if it is not the base | |
| benchmark plan: | | |
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| fit Provided: | | |
|--|----------------|--------------------------|
| Coverage is at least the greater of one drug in each same number of prescription drugs in each categor | | |
| Prescription Drug Limits (Check all that apply.): | Authorization: | Provider Qualifications: |
| ∠ Limit on days supply | Yes | State licensed |
| Limit on number of prescriptions | <u> </u> | |
| ∠ Limit on brand drugs | | |
| Other coverage limits | | |
| □ Preferred drug list | | |
| Coverage that exceeds the minimum requirements | or other: | |

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| Benefit Provided: | Source: | Remove |
|---|--|--------|
| Outpatient Hospital - Rehabilitative therapies | State Plan 1905(a) | remove |
| Authorization: | Provider Qualifications: | |
| None | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| OT/PT/SLP | | |
| Other information regarding this benefit, including benchmark plan: Both rehabilitative and habilitative | the specific name of the source plan if it is not the base | |
| Benefit Provided: | Source: | Remove |
| OT/PT/SLP (non-hospital based) | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Authorization required in excess of limitation | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| See Att. 3:1-A Item 11 | None | |
| Scope Limit: | | |
| None | | |
| Other information regarding this benefit, including benchmark plan: Coverage is in accordance with Att. 3.1-A Item 11. | the specific name of the source plan if it is not the base | |
| <u> </u> | | |
| Benefit Provided: Prosthetic Devices | Source: | Remove |
| 1 Iosaicae Derices | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Yes | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| | | |

TN: VT 23-0019 Supersedes: VT 22-0003 Approval Date: 05/11/2023 Effective Date: 01/01/2023



| None | | |
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| Mc203up | Source: | |
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| Other | | |
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| benchmark plan | on regarding this benefit, including the specific name of the source plan if it is not the base: | |
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Supersedes: VT 22-0003



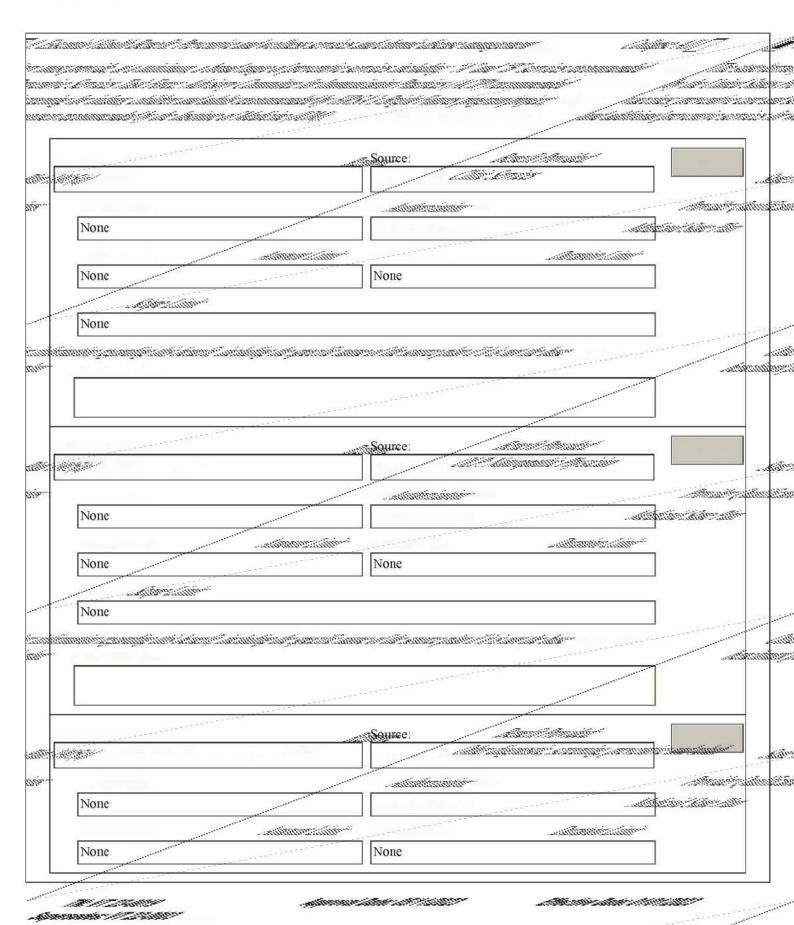
| Benefit Provided: | Source: | Remove |
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| Other Laboratory and X-Ray Services | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | <u></u> |
| Urine drug test limited to 8 per month | None | |
| Scope Limit: | SMA | |
| None | | |
| Other information regarding this benefit, includ benchmark plan: | ling the specific name of the source plan if it is not the base | |
| | st be prior approved. Diagnostic imaging requires prior (RA, PET, PET/CA) unless provided as part of ER or | |

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Supersedes: VT 22-0003





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| Benefit Provided: | Source: | Remo |
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| Medicaid State Plan EPSDT Benefits | State Plan 1905(a) | |
| Authorization: | Provider Qualifications: | |
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | • |
| None | | |
| All federally required services in accor | dance CFR and Statute. | |
| Benefit Provided: | Source: | Remo |
| Benefit Provided: Medicaid State Plan EPSDT Benefits | Source: State Plan 1905(a) | Remo |
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| Benefit Provided: Medicaid State Plan EPSDT Benefits Authorization: Other Amount Limit: None Scope Limit: None | Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: | Remo |

Add



| 11. Other Covered Benefits from Base Benchmark | Collapse All |
|--|--------------|

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Supersedes: VT 22-0003



| Base Benchmark Benefit that was Substituted: | Source: | Remov |
|--|--|--|
| Outpatient Hospital Fee | Base Benchmark | Keinov |
| 1937 benchmark benefit(s) included above under | Hospital service was used in order to ensure identical ram. | |
| | C205 | |
| Base Benchmark Benefit that was Substituted: | Source: | Remov |
| Outpatient Surgery Physician/Surgical Services | Base Benchmark | |
| Duplication - The Medicaid State Plan Outpatient benefits for all beneficiaries in the Medicaid prog | Hospital service was used in order to ensure identical ram. | |
| Dan Danskovak Danset da da da Calendario da | 6 | |
| Base Benchmark Benefit that was Substituted: Urgent Care Centers or Facilities | Source: Base Benchmark | Remov |
| Physician Services in all Settings service was used in the Medicaid program. Certain clinics provide urgent care center providers who are not affiliated | 100 and 100 an | |
| This benefit maps to EHB 1: Ambulatory Patient | Scivices. | 3 |
| Base Benchmark Benefit that was Substituted: | Source: | Remov |
| Primary Care Visit to Treat an Injury or Illness | Base Benchmark | A STATE OF THE STA |
| 1937 benchmark benefit(s) included above under l | Services in all Settings service was used in order to e Medicaid program. | |
| Base Benchmark Benefit that was Substituted: | Source: | P |
| Dental Services (not routine) | Base Benchmark | Remov |
| | indicating the substituted benefit(s) or the duplicate section | |

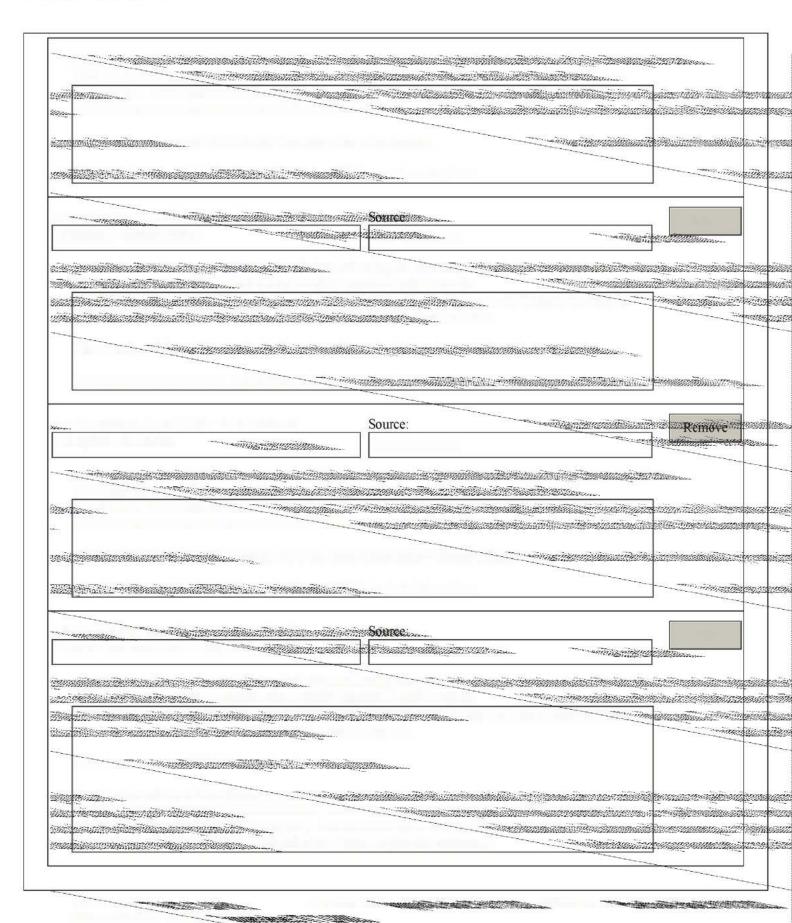


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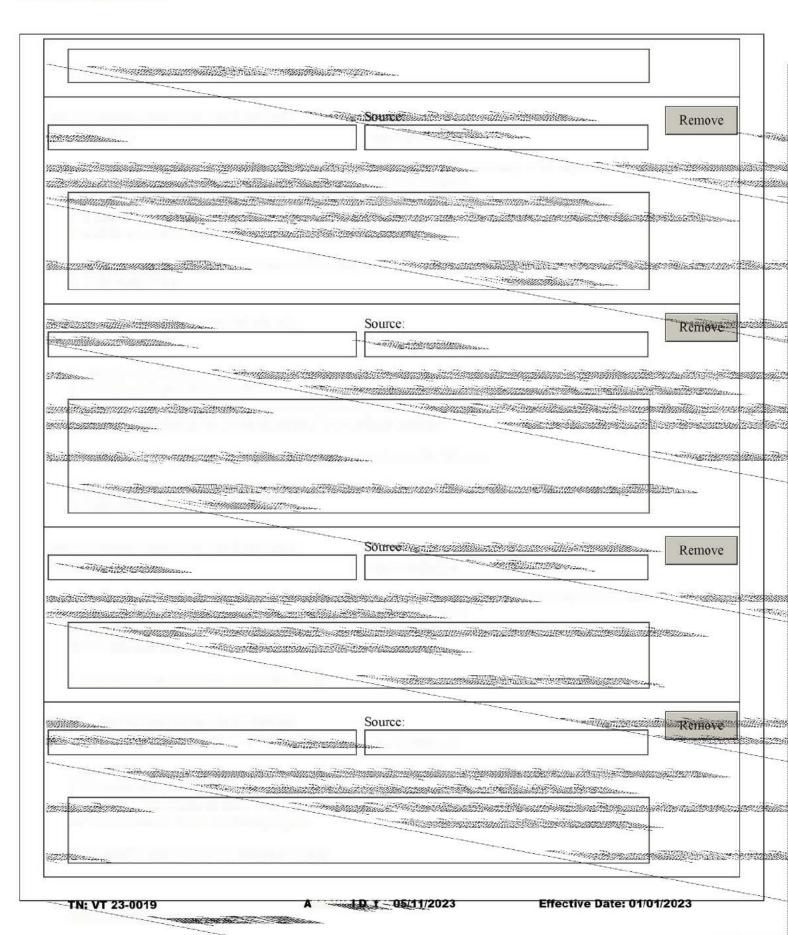




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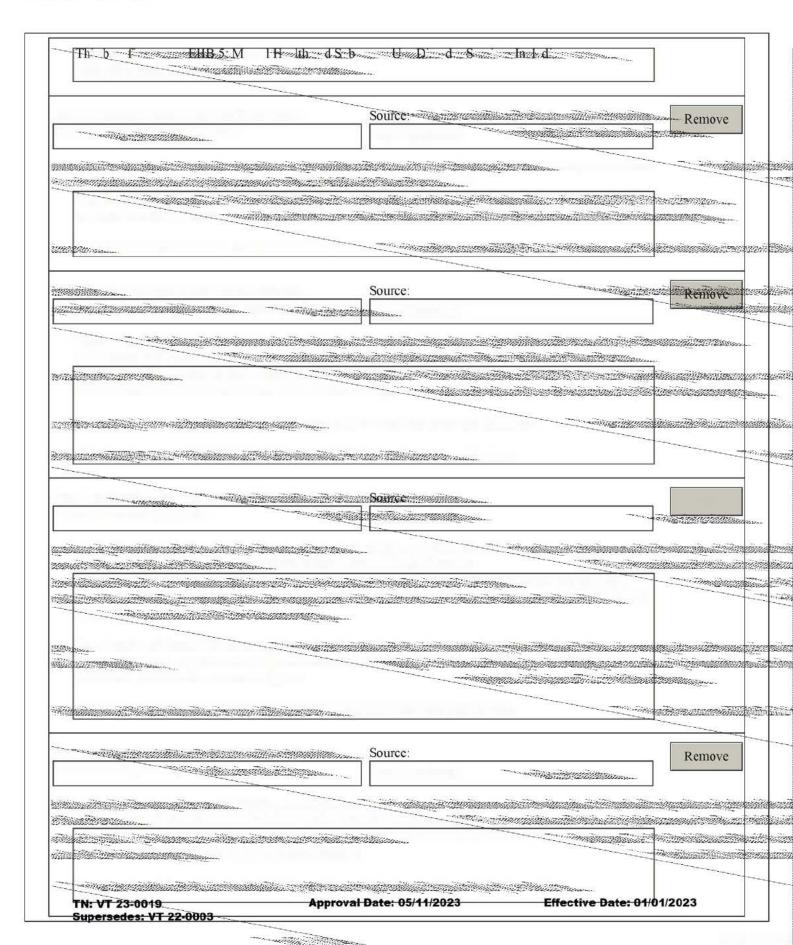




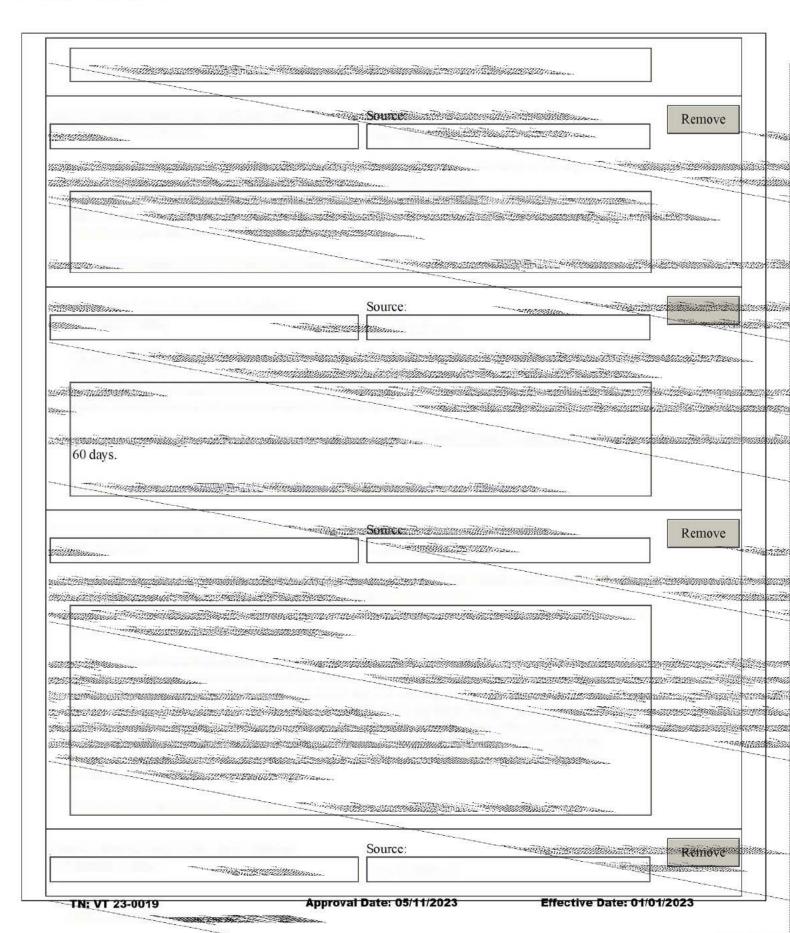
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Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan EPSDT service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Prior authorization required.

VT requires private insurers to cover services to children up to the age of 21 who have an ASD regardless of whether they are gaining a new skill or recovering a lost skill. This is the same coverage that EPSDT provides e.g. to ameliorate, or prevent from worsening or promote healthy development.

| Base Benchmark Benefit that was Substituted: | Source: | Remove |
|--|--|------------|
| Preventive Care/Screening/Immunization | Base Benchmark | remove |
| Explain the substitution or duplication, including in 1937 benchmark benefit(s) included above under E | ndicating the substituted benefit(s) or the duplicate section Essential Health Benefits: | |
| Duplication - The Medicaid State Plan EPSDT and ensure identical benefits for all beneficiaries in the | d Physician Services in All Settings was used in order to e Medicaid program. | |
| This benefit maps to EHB 1: Ambulatory Patient 3 and Vision Care. | Services and EHB 10: Pediatric Services Including Oral | |
| Base Benchmark Benefit that was Substituted: | Source: | Remove |
| Eye Glasses for Children | Base Benchmark | |
| Explain the substitution or duplication, including it 1937 benchmark benefit(s) included above under I | ndicating the substituted benefit(s) or the duplicate section Essential Health Benefits: | |
| Duplication - The Medicaid State Plan EPSDT ser beneficiaries in the Medicaid program. | rvice was used in order to ensure identical benefits for all | |
| Base benchmark benefit limitation(s): One item po | er year. | |
| This benefit maps to EHB 10: Pediatric Services I | ncluding Oral and Vision Care. | |
| Base Benchmark Benefit that was Substituted: | Source: | Remove |
| Dental Check-Up for Children | Base Benchmark | |
| 1937 benchmark benefit(s) included above under I | STREET ST | |
| Duplication - The Medicaid State Plan EPSDT ser beneficiaries in the Medicaid program. | rvice was used in order to ensure identical benefits for all | |
| This benefit maps to EHB 10: Pediatric Services I | ncluding Oral and Vision Care. | |
| Base Benchmark Benefit that was Substituted: | Source: | Remove |
| | | 1 CHILOV C |



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:

Duplication - The Medicaid State Plan Family Planning service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services.

Add

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| 13. Other Base Benchmark Benefits Not Covered | Collapse All |
|---|--------------|

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| Other 1937 Benefit Provided: | Source: | Remove |
|--|--|--------------|
| Dental | Section 1937 Coverage Option Benchmark Benefit | Kemove |
| | Package | |
| Authorization: | Provider Qualifications: | |
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| See Att. 3.1-A Item 10 | None | |
| Scope Limit: | | |
| See Att. 3.1-A Item 10 | | |
| Other: | | |
| Coverage is in accordance with See Att. 3. | 1-A Item 10. | |
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| Other 1937 Benefit Provided: CF/IID | Source: Section 1937 Coverage Option Benchmark Benefit | Remove |
| CIVIID | Package | |
| Authorization: | Provider Qualifications: | |
| Prior Authorization | Medicaid State-Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
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| Other 1937 Benefit Provided: | Source: | |
| Other 1937 Benefit Provided: OLP: High Tech Nursing | Section 1937 Coverage Option Benchmark-Benefit | |
| OLP: High Tech Nursing | Section 1937 Coverage Option Benchmark-Benefit Package | Tellio |
| 경기 ((()) - [| Section 1937 Coverage Option Benchmark-Benefit | |
| OLP: High Tech Nursing Authorization: | Section 1937 Coverage Option Benchmark-Benefit Package Provider Qualifications: Medicaid State Plan | Teller |
| OLP: High Tech Nursing Authorization: Prior Authorization | Section 1937 Coverage Option Benchmark-Benefit Package Provider Qualifications: | Telle (|
| OLP: High Tech Nursing Authorization: Prior Authorization Amount Limit: | Section 1937 Coverage Option Benchmark-Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: | Teller |

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| Other 1937 Benefit Provided: | Saurasi | 120% |
|--|--|--------|
| Extended Services (home visits) for Pregnant Women | Source: Section 1937 Coverage Option Benchmark Benefit Package | Remov |
| Authorization: | Provider Qualifications: | |
| Prior Authorization | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
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| ther 1937 Benefit Provided: | Source: | D |
| DLP: Opticians | Section 1937 Coverage Option Benchmark Benefit | Remov |
| | Package | |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | 908 | |
| Limited to eyeglass dispensing only. | | |
| Other: | | |
| No authorization requirement. | | |
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| ther 1937 Benefit Provided: | Source: | Remov |
| ace-to-Face Tobacco cessation for pregnant women | Section 1937 Coverage Option Benchmark Benefit Package | Kellov |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| grandamin months | | |
| None | None | |

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Effective Date: 01/01/2023



| 16 visits per calendar year. | | |
|---|---|--------|
| Other: | | |
| No authorization requirement. | | |
| Other 1937 Benefit Provided: Case Management for TB related services | Source: Section 1937 Coverage Option Benchmark Benefit | Remove |
| ease Management for 1B related services | Package | |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
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| Other: No authorization requirement. | | |
| No authorization requirement. Other 1937 Benefit Provided: | Source: Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| No authorization requirement. Other 1937 Benefit Provided: | Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| No authorization requirement. Other 1937 Benefit Provided: Outpatient Hospital - Partial Hospitalization | Section 1937 Coverage Option Benchmark Benefit | Remove |
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| No authorization requirement. Other 1937 Benefit Provided: Outpatient Hospital - Partial Hospitalization Authorization: Amount Limit: None Scope Limit: None Other: No authorization requirement. | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None | |
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| No authorization requirement. Other 1937 Benefit Provided: Outpatient Hospital - Partial Hospitalization Authorization: Amount Limit: None Scope Limit: None Other: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None Source: Section 1937 Coverage Option Benchmark Benefit | Remove |

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| With the Part of t | Duration Limit: | |
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| None | None | |
| Scope Limit: | 3 22 | |
| None | | |
| Other: | | |
| No authorization requirement. | | |
| other 1937 Benefit Provided: | Source: | Remove |
| Community Mental Health Center Services | Section 1937 Coverage Option Benchmark Benefit Package | |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
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| rehabilitation services provided by Mental Healt | thotherapy; chemotherapy; group therapy; specialized th Designated Providers authorized by DMH and required State plan is "Other Diagnostic, Screening, Preventive and | |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." | th Designated Providers authorized by DMH and required State plan is "Other Diagnostic, Screening, Preventive and | Damaye |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." | th Designated Providers authorized by DMH and required | Remove |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." | Source: Section 1937 Coverage Option Benchmark Benefit | Remove |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." ther 1937 Benefit Provided: assistive Community Care Services (PNMI) | Source: Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." ther 1937 Benefit Provided: assistive Community Care Services (PNMI) | Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." ther 1937 Benefit Provided: Assistive Community Care Services (PNMI) Authorization: | Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan | Remove |
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| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." ther 1937 Benefit Provided: Assistive Community Care Services (PNMI) Authorization: Amount Limit: None Scope Limit: | Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None | Remove |
| rehabilitation services provided by Mental Healt by state law. The benefit category in Vermont's Rehabilitative Services." Other 1937 Benefit Provided: Assistive Community Care Services (PNMI) Authorization: Amount Limit: None Scope Limit: Persons with functional impairments and/or cog | Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None | Remov |

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| her 1937 Benefit Provided: | Source: | Remove |
|---|---|--------|
| dult Day Health Services | Section 1937 Coverage Option Benchmark Benefit Package | |
| Authorization: | Provider Qualifications: | |
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| Excludes residents of nursing homes or enliper week, 12 hours per day. | nanced residential care facilities. Should not exceed 7 days | |
| Other: | | |
| safety, and psychological needs of adults the medication administration, health monitorin | ive, non-residential program designed to address the health, rough individual plans of care that may include a provision of and oversight, personal care, maintenance therapies, and care d. This benefit has the same effective date as SPA 15-007. | |
| her 1937 Benefit Provided: | Source: | |
| argeted Case Management (4 targeted groups) | | Remove |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
| No authorization requirement. | rs old: (1) Persons with developmental disabilities who are | |
| unable to access needed medical, social, edutheir level of disability, or who lack the actiassist them in accessing needed services; (2) neglect, trauma, behavioral challenges, famiassistance to identify, obtain and monitor nesocial, educational, and other services; (3) P months of age enrolled in the Vermont Depart | cational and other services because of adaptive deficits due to we assistance of a family member or other interested person to Individuals and families who have a history of child abuse or ily dysfunction, and/or family violence who are in need of seded medical (including mental health and substance abuse), Pregnant and postpartum women and infants through twelve artment for Children and Families, Healthy Babies, Kids, and ive special education and related medically necessary Medicaid and Education Plan (IEP). | |
| unable to access needed medical, social, edu their level of disability, or who lack the acti- assist them in accessing needed services; (2) neglect, trauma, behavioral challenges, fami assistance to identify, obtain and monitor ne social, educational, and other services; (3) P months of age enrolled in the Vermont Depa Families Program; (4) Individuals who rece covered services pursuant to an Individualize | ve assistance of a family member or other interested person to Individuals and families who have a history of child abuse or ily dysfunction, and/or family violence who are in need of seded medical (including mental health and substance abuse), Pregnant and postpartum women and infants through twelve artment for Children and Families, Healthy Babies, Kids, and ive special education and related medically necessary Medicaid and Education Plan (IEP). | |
| unable to access needed medical, social, edutheir level of disability, or who lack the activassist them in accessing needed services; (2) neglect, trauma, behavioral challenges, familiassistance to identify, obtain and monitor ne social, educational, and other services; (3) P months of age enrolled in the Vermont Department of the program; (4) Individuals who received | ve assistance of a family member or other interested person to) Individuals and families who have a history of child abuse or ily dysfunction, and/or family violence who are in need of seded medical (including mental health and substance abuse), Pregnant and postpartum women and infants through twelve artment for Children and Families, Healthy Babies, Kids, and ive special education and related medically necessary Medicaid sed Education Plan (IEP). Source: Section 1937 Coverage Option Benchmark Benefit | Remove |
| unable to access needed medical, social, edu their level of disability, or who lack the activassist them in accessing needed services; (2) neglect, trauma, behavioral challenges, familiassistance to identify, obtain and monitor ne social, educational, and other services; (3) P months of age enrolled in the Vermont Department Program; (4) Individuals who received services pursuant to an Individualization of the Provided: | ve assistance of a family member or other interested person to Individuals and families who have a history of child abuse or illy dysfunction, and/or family violence who are in need of seded medical (including mental health and substance abuse), Pregnant and postpartum women and infants through twelve artment for Children and Families, Healthy Babies, Kids, and ive special education and related medically necessary Medicaid sed Education Plan (IEP). Source: | Remove |



| Amount Limit: | Duration Limit: | |
|--|--|------------------|
| None | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
| No authorization requirement. | | |
| Other 1937 Benefit Provided: Personal Care Services | Source: Section 1937 Coverage Option Benchmark Benefit | Remove |
| Personal Care Services | Package | . (11 |
| Authorization: | Provider Qualifications: | |
| Prior Authorization | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None Other: | | |
| None | Source: Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| Other: Other 1937 Benefit Provided: | Section 1937 Coverage Option Benchmark Benefit | Remove |
| Other: Other: Other 1937 Benefit Provided: Nursing Facility 21 and older; custodial care | Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| Other: Other: Other 1937 Benefit Provided: Nursing Facility 21 and older; custodial care Authorization: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| Other: Other 1937 Benefit Provided: Nursing Facility 21 and older; custodial care Authorization: Other | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan | Remove |
| Other: Other: Other 1937 Benefit Provided: Nursing Facility 21 and older; custodial care Authorization: Other Amount Limit: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: | Remove |
| Other: Other: Other 1937 Benefit Provided: Nursing Facility 21 and older; custodial care Authorization: Other Amount Limit: None Scope Limit: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None | Remove |

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| Authorization: | Provider Qualifications: | |
|--|---|--------|
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| Routine exam 1/2 years; diagnostic exam 1/2 years | None None | |
| Scope Limit: | | |
| None | | |
| Other: | , | |
| Contacts and special lenses may require prior authorblind and will improve at least one ADL or IADL. | orization; Other aids to vision approved when legally | |
| ner 1937 Benefit Provided: | Source: | Remo |
| patient Psych. Services for Individuals Under 22 | Section 1937 Coverage Option Benchmark Benefit Package | Kellio |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
| No authorization requirement. | | |
| | | |
| her 1937 Benefit Provided: | Source: | Remo |
| censed Dental Hygienist Services | Section 1937 Coverage Option Benchmark Benefit Package | |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| <u></u> | | |
| Other: Services provided by licensed dental hygienists are | covered when those services are provided by a dental | |
| hygienist who is in a collaborative agreement with | a dentist licensed in Vermont. Cover services are limited iewed and accepted by the State of Vermont, Director of | |

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| Other 1937 Benefit Provided: | Source: | Remove |
|---|--|--------|
| Health Home Services for Opioid Dependence | Section 1937 Coverage Option Benchmark Benefit Package | |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| | e, whole-person care to Medicaid beneficiaries who receive | |
| medication assisted therapy (MAT) for opioi | d dependence. | |
| Other: | | |
| | | |
| Other 1937 Benefit Provided: | Source: | Remove |
| OLP: Licensed Clinical Pharmacist | Section 1937 Coverage Option Benchmark Benefit Package | |
| Authorization: | Provider Qualifications: | |
| Yes | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| See Att. 3.1-A Item 6(D)(9) | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
| Coverage is in accordance with Att. 3.1-A Ite | m 6(D)(9). | |
| Other 1937 Benefit Provided: | Source: | Remove |
| Medical Nutrition Therapy | Section 1937 Coverage Option Benchmark Benefit Package | remove |
| Authorization: | Provider Qualifications: | |
| | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| See Att. 3.1-A Item 13(C)(11) | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
| Coverage is in accordance with Att. 3.1-A Ite | m 13(C)(11). | |
| | | |
| TN: VT 23-0019 | pproval Date: 05/11/2023 Effective Date: 01/0 | 1/2023 |



| other 1937 Benefit Provided: | Source: | Remove |
|--|--|--------|
| Routine Patient Cost in Qualifying Clinical Trials | Section 1937 Coverage Option Benchmark Benefit Package | |
| Authorization: | Provider Qualifications: | |
| Other | Medicaid State Plan | |
| Amount Limit: | Duration Limit: | |
| None | None | |
| Scope Limit: | | |
| None | | |
| Other: | | |
| Coverage in alignment with item 30 in Att. 3.1-A a | nd Att. 3.1-B. | |
| | | |
| 1 | | |
| | | |
| | | |
| ther 1937 Benefit Provided: | Source: | Remove |
| ther 1937 Benefit Provided: | Source: Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| ther 1937 Benefit Provided: Authorization: | Section 1937 Coverage Option Benchmark Benefit | Remove |
| Authorization: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| | Section 1937 Coverage Option Benchmark Benefit Package | Remove |
| Authorization: Amount Limit: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| Authorization: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| Authorization: Amount Limit: Scope Limit: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| Authorization: Amount Limit: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |
| Amount Limit: Scope Limit: | Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: | Remove |

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| 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) | Collapse All |
|--|--------------|
| tilider section 1902(a)(10)(A)(1)(VIII) of the Act.) | |

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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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