



Alternative Benefit Plan

State Name: Ohio

Attachment 3.1-L- ☐

OMB Control Number: 0938-1148

Transmittal Number: OH - 19 - 0005

Benefits Description

ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Anthem Blue Access PPO

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

Secretary-Approved



Alternative Benefit Plan

☒ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Physician services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Physician Services covered in the office, patient's home, hospital, or skilled nursing facility, or elsewhere. Services provided by Optometrists (diagnosis and treatment of condition of the eye including the ordering and dispensing of materials such as contact lenses, and low vision aids) are also included under physician services.

Benefit Provided:

Outpatient hospital services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services included under this benefit also include urgent care services provided in outpatient settings such as outpatient clinics, physicians offices. Pre certification is required on outpatient hysterectomies.

Benefit Provided:

Private duty nursing services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



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

Level of care is required by the treating physician. Medicaid beneficiaries have three avenues from which to access PDN: post hospitalization services up to 60 days duration and 56 hours per week upon discharge from a 3 day or more covered inpatient stay; for those up to the age of 21 who have a medically necessary PDN authorization; and for those age 21 and over can access PDN with authorization.

Benefit Provided:

Home health services

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

14 hours per week

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:

No more than a total of eight hours per day with a visit constituting no more than four hours in length.

Benefit Provided:

Other licensed practitioner services:Chiropractor

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

15 dates of services (adults) annual

Duration Limit:

None

Scope Limit:

None

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

For recipients under age 21 limits include 30 dates of service per 12 month period and services beyond the limit may be provided if medically necessary; for recipients age 21 and over 15 dates of service per 12 month period.

Benefit Provided:

Other laboratory & x-ray: x-ray services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



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Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Hospice care

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

The attending physician and Hospice physician are required to certify that the beneficiary has six months or less in which to live if the illness runs its normal course.

Benefit Provided:

Other licensed practitioner services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services included under this benefit include those provided by other practitioners such as Pharmacists, Physician Assistants, Mechanotherapists, Anesthesiologist Assistants, Dietitians, and Advanced Practice Nurses not otherwise described.

Benefit Provided:

Clinic: Ambulatory Surgery Center Services

Source:

State Plan 1905(a)

Remove



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Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Add



Alternative Benefit Plan

☒ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided:

Other Medical Services:Emergency Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Other Medical Services: Transportation/Ambulance

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Add



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☒ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient hospital services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Certain specific items and services are covered with prior authorization. For example, services such as the treatment of obesity, and plastic or cosmetic surgery must be proven to meet a medical need prior to services being rendered.

Add



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☒ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Physician services: maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Inpatient hospital services: maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Outpatient hospital: maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

Add



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

Collapse All ☐

Benefit Provided:

Other licensed practitioner services: NP-LBHP

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Psychological testing is limited to a maximum of 12 hours per 12-month period per recipient, per provider in a non-hospital setting; neuropsychological testing is limited to a maximum of eight hours per 12-month period per recipient, per provider in a non-hospital setting; diagnostic interview examinations are limited to one code per recipient, per provider per 12-month period; structured screening and brief intervention is limited to one code per recipient, per provider, per 12-month period. Additional services beyond the established limits may be allowed when medically necessary and approved through the prior authorization process. Evidence-based practices (EBPs) require prior authorization to document medical necessity.

Benefit Provided:

Rehabilitation Services: AOD outpatient services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Treatment plans are subject to prior authorization. Rehabilitation services for substance use disorders are covered as outpatient services in a certified treatment program and may also include ambulatory detoxification.

Benefit Provided:

Inpatient Hospital Services: Mental Health Inpat.

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan



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Amount Limit:

None

Duration Limit:

None

Scope Limit:

Inpatient services related to mental health disorders.

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

Certification for a hospital stay is conducted by an independent clinical utilization review vendor and occurs at the time of admission. The intent of the pre-certification process is to obtain clinical documentation of the admission and provide information that will facilitate the provision of services during the hospital stay. Covered mental health services do not include services provided to individuals aged 21-64 inclusive who reside in facilities that meet the Federal definition of an institution for the treatment of mental disease.

Benefit Provided:

Inpatient Hospital Services: AOD IP Detoxification

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Yes, see description below.

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

Coverage of inpatient hospital days for treatment of chemical dependency is limited to coverage of services for detoxification. Rehabilitation services related to chemical dependencies are not covered in an inpatient setting, but are covered as outpatient and residential services in a certified treatment program, See Rehabilitation Services: AOD outpatient services, above. Federal Financial Participation is not permitted for services of residents aged 22 – 64 in facilities that meet the Federal definition of an institution for the treatment of mental disease for covered alcohol and other drug treatment other than capitated coverage in an IMD permitted at 42 CFR 438.6(e).

Benefit Provided:

Physician services:MH/SUD services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



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

Benefit Provided:

Outpatient Hospital Services: MH/SUD outpatient

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Add



Alternative Benefit Plan

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☐ Limit on number of prescriptions
- ☐ Limit on brand drugs
- ☐ Other coverage limits
- ☒ Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

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



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☒ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided:

Physical therapy and related services: PT

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 shared Rehab/Hab visits annually

Duration Limit:

None

Scope Limit:

None

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

The following services are subject to limits under this benefit: Physical, Occupational, Speech Therapy- 30 dates of services per 12 month period for each service. Additional visits are available through the prior authorization process.

Benefit Provided:

Physical therapy and related services: OT

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 shared Rehab/Hab visits annually

Duration Limit:

None

Scope Limit:

None

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

The following services are subject to limits under this benefit: Physical, Occupational, Speech Therapy- 30 dates of services per 12 month period for each service. Additional visits are available through the prior authorization process.

Benefit Provided:

Physical therapy and related services: ST

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 shared Rehab/Hab visits annually

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

The following services are subject to limits under this benefit: Physical, Occupational, Speech Therapy- 30 dates of services per 12 month period for each service. Additional visits are available through the prior authorization process. Audiology services are included under the State Plan speech therapy services benefit.

Benefit Provided:

Home health services: Medical supplies, equipment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Home health services: Medical supplies, equipment, and appliances suitable for use in the home. Includes hearing aids.

Benefit Provided:

Nursing Facility

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Rehabilitative

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

Beneficiary must meet level of care to be admitted to a skilled nursing facility.

Add



Alternative Benefit Plan

☒ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided:

Other laboratory & and x-ray: Diagnostic Lab

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Yes, see description below.

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

The following lab services are not covered: lab services performed in conjunction with non-covered services, lab services performed for forensic reasons, paternity testing, and lab services performed in conjunction with an autopsy.

Add



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

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Preventive services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Add



Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Authorization may be required for services in excess of limits and for Medicaid services not available to adults.

Add



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☐ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐



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☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Base Benchmark Benefit that was Substituted:

Primary care visit treatment of illness or injury

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physician services and Other licensed practitioner services under EHB 1: Ambulatory patient services.

Base Benchmark Plan: no limitations

Base Benchmark Benefit that was Substituted:

Specialist visit

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physician services under EHB 1: Ambulatory patient services.

Base Benchmark Plan: no limitations

Base Benchmark Benefit that was Substituted:

Other practitioner office visit (RN, PA)

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physician services and Other licensed practitioner services under EHB 1: Ambulatory patient services.

Base benchmark Plan: no limitations

Base Benchmark Benefit that was Substituted:

Outpatient Facility (e.g. Amb. Surgery Ctr.)

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Outpatient hospital services and Ambulatory Surgery Centers under EHB 1: Ambulatory patient services.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Outpatient Surgery Physician Surgical Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physician services under EHB 1: Ambulatory patient services.

Base Benchmark Plan: no limitations.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Chiropractic care

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Other licensed practitioner services: Chiropractor under EHB 1: Ambulatory patient services.
Base Benchmark Plan: 12 visits per 12 month period.

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physical therapy and related services for PT, OT and ST under EHB 7: Rehabilitative and habilitative services and devices.
Base Benchmark Plan: In a 12 month period, 20 PT visits, 20 OT visits, 36 Cardiac Rehabilitation visits, 20 Pulmonary Rehab visits, and 20 Speech Therapy visits.

Base Benchmark Benefit that was Substituted:

Hospice services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Hospice care under EHB 1: Ambulatory patient services
Base Benchmark coverage: Patient must have a life expectancy of six months or less, as confirmed by the attending physician. Covered services will continue if the patient lives longer than six months. Services include skilled nursing; diagnostic; PT, speech and inhalation therapies, if part of a treatment plan; medical supplies; counseling services; prescription drugs given by the Hospice; and home health aide.

Base Benchmark Benefit that was Substituted:

Urgent Care Centers or Facilities

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physician services and Outpatient hospital services under EHB 1. Ambulatory patient services.
Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Home Care Services: Private Duty Nursing

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Private duty nursing services under EHB 1. Ambulatory patient services. Translation of state plan maximum of 24 hours per day for 365 days to annual spending for comparison purposes to the Base Benchmark Plan limitations resulted in estimated



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maximum of more than \$230,000 per year with no lifetime maximum. This was calculated assuming that two four hour base rate payments of \$52.20 plus 96 unit rates per 15 minutes over the base rate of 4 hours at \$5.69 per 15 minute unit could be paid per day over a year.
Base Benchmark Plan: covered under the Home Health Services benefit. Limitation on annual spending of \$50,000 and lifetime maximum of \$100,000.

Base Benchmark Benefit that was Substituted:

Home Care Services: Home Health

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Home Health under EHB 1. Ambulatory patient services.

Base Benchmark Plan: 100 visits, Network and Non-Network combined. Services must be authorized and approved by the attending physician.

Base Benchmark Benefit that was Substituted:

Emergency Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Other Medical Services:Emergency Hospital Services under EHB 2. Emergency Services.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Other Medical Services: Transportation/Ambulance under EHB 2. Emergency Services.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Inpatient Hospital Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Inpatient hospital services under EHB 3. Hospitalization.

Base Benchmark Plan: no limitations. Coverage of Inpatient treatment of biologically based mental illness is provided to the same extent and degree as for the treatment of physical illness.

Base Benchmark Benefit that was Substituted:

Inpatient Physician and Surgical services

Source:

Base Benchmark

Remove



Alternative Benefit Plan

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

Duplication: covered under the Ohio Medicaid state plan as Physician services under EHB 1: Ambulatory patient services.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Nursing Facility services under EHB 7: Rehabilitative and habilitative services and devices.

Base Benchmark Plan: 90 days per benefit period.

Base Benchmark Benefit that was Substituted:

Pre-natal and Post Natal Care

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physician services: maternity and Outpatient hospital: maternity under EHB 4: Maternity and newborn care

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Delivery/ Inpatient Services for Maternity Care

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Inpatient hospital services: maternity under EHB 4: Maternity and newborn care

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Generic Drugs

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan under EHB 6: Prescription drugs.

Base Benchmark Plan: Covered services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan. Certain limitations within the Generic, Preferred, and Non-preferred drug categories include, but are not limited to, contraceptive devices, human growth hormone, compound drugs unless one component requires a prescription, drugs to reduce or eliminate the dependency on, or addiction to tobacco and tobacco products, over the counter drugs and drugs used in fertility treatment. Prior authorization using Step Therapy is a utilization control device for certain drugs within the Generic, Preferred, and Non-preferred drug categories.



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Base Benchmark Benefit that was Substituted:

Preferred Brand Drugs

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan under EHB 6: Prescription drugs.
Base Benchmark Plan: see limits detailed in Generic drug category above.

Base Benchmark Benefit that was Substituted:

Non-Preferred Brand Drugs

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan under EHB 6: Prescription drugs.
Base Benchmark Plan: see limits detailed in Generic drug category above.

Base Benchmark Benefit that was Substituted:

Habilitation services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Physical therapy and related services: PT, OT and ST under EHB 7: Rehabilitative and habilitative services and devices.
Base Benchmark Plan: In a 12 month period, 20 PT visits, 20 OT visits, 36 Cardiac Rehabilitation visits, 20 Pulmonary Rehab visits, and 20 Speech Therapy visits.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Home health services: Medical supplies, equipment, and appliances suitable for use in the home under EHB 7: Rehabilitative and habilitative services and devices.
Base Benchmark Plan: Authorization required. Non-covered services include, but are not limited to: dentures, dental appliances, orthopedics shoes.

Base Benchmark Benefit that was Substituted:

Diagnostic Test (x-ray and lab work)

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Other laboratory & x-ray: x-ray services under EHB 1: Ambulatory patient services, and as Other laboratory & and x-ray: Diagnostic Lab under EHB 8: Laboratory services.
Base Benchmark Plan: The only service not covered is diagnostic tests for infertility.



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Base Benchmark Benefit that was Substituted:

Imaging (CT/PET Scans, MRIs)

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Other laboratory and x-ray: x-ray services under EHB 1: Ambulatory patient services.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Preventive Care/screening/immunization

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Preventive services under EHB 9: Preventive and wellness services and chronic disease management.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Outpatient Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid State Plan as OLP: NP-LBHP, Physician Services: MH/SUD services, and Outpatient Hospital Services: MH/SUD outpatient under EHB 5: Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Inpatient Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Inpatient Hospital Services: Mental Health Inpatient under EHB 5: Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Plan: no limitations.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Outpatient Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Rehabilitation Services: AOD outpatient services under EHB 5: Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Plan: no limitations.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark

Remove

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

Duplication: covered under the Ohio Medicaid state plan as Inpatient Hospital Services: AOD IP Detoxification under EHB 5: Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Plan: no limitations.

Add



Alternative Benefit Plan

☐ 13. Other Base Benchmark Benefits Not Covered

Collapse All ☐



Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided:

Dental Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Yes

Duration Limit:

None

Scope Limit:

None

Other:

Effective for dates of service on and after July 1, 2018, the dental benefit for beneficiaries 21 years of age and older includes services in the following categories: clinical oral examination; diagnostic imaging and interpretation; tests and laboratory examinations; preventive services; restorative services; endodontic services; periodontic services; prosthodontic services; oral surgery; orthodontic services; other services, and anesthesia.

Prior authorization is required for the following dental services: ceramic crowns, post and core, gingivectomy, gingivoplasty, scaling and root planing, dentures, surgical extractions, comprehensive orthodonture, temporomandibular joint therapy, maxillofacial prosthetics and unspecified procedures not adequately described by a procedure code.

Dental services may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

Individuals up to age 21 can access dental benefits without limitation when medically necessary.

Other 1937 Benefit Provided:

Nursing Facility

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Long term custodial care

Other:

Must meet institutional level of care.

Other 1937 Benefit Provided:

Other licensed practitioner: Podiatry

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove



Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Yes, see description below.

Other:

The following podiatric services are not covered by the program: coverage of debridement of nails is limited to a maximum of one treatment within a 60-day period; General anesthesia services provided by a podiatrist are not covered; Coverage of physical medicine services provided by a podiatrist is limited to acute conditions or periods or acute exacerbation of chronic disease. Beneficiaries younger than age twenty-one can access other podiatrists' services without limitation when such services are medically necessary. No other authorization process.

Other 1937 Benefit Provided:

Eyeglasses

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Yes, see description below.

Duration Limit:

None

Scope Limit:

Yes, see description below.

Other:

Adults one pair (lenses and frames) every 24 months. May get additional pair with prior authorization to determine medical necessity for additional service. No spare eyeglasses or replacements due to personal preference. No trimmed frames.

Other 1937 Benefit Provided:

Targeted Case Management

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Target groups are described in Supplement 1 to Attachment 3.1-A of Ohio's Medicaid state plan.



Alternative Benefit Plan

Other 1937 Benefit Provided: Rehabilitation Services: Comm. Psych. Sup. Treat.	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Authorization required in excess of limitation	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other: CPST is limited to 104 hours per twelve month period, but additional CPST services beyond the established limit may be allowed when medically necessary and approved through the prior authorization process. CPST is an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals intended to identify and address the individualized mental health needs of clients of all ages, including the client's family and care givers. The purpose of CPST is to provide specific, measurable individualized services focused on the client's ability to succeed in the community.		
Other 1937 Benefit Provided: ICF/IID	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Yes, see description below.		
Other: Must meet institutional level of care.		
Other 1937 Benefit Provided: Federally Qualified Health Centers	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	



Alternative Benefit Plan

Scope Limit:

None

Other:

No other authorization process.

Other 1937 Benefit Provided:

Rural Health Clinic services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No other authorization process.

Other 1937 Benefit Provided:

Clinic services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No other authorization process.

Other 1937 Benefit Provided:

Physician services: Routine eye exam non-pediatric

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

one exam

Duration Limit:

annually

Scope Limit:

None

Other:

No other authorization process.

Other 1937 Benefit Provided:

Free standing birthing centers

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No other authorization process.

Other 1937 Benefit Provided:

Family planning services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No other authorization process.

Other 1937 Benefit Provided:

Ext Svcs to Preg Women: Targeted Case Mgt

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove



Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medicaid eligible pregnant women who have been identified by a physician to be at risk of pre-term birth or poor pregnancy outcome.

Other:

Care coordination that facilitates patient access to services and minimizes fragmentation of care. No other authorization process.

Other 1937 Benefit Provided:

Tobacco cessation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Tobacco cessation is covered for pregnant women and all other beneficiaries. No other authorization process.

Other 1937 Benefit Provided:

Rehab Services-Therapeutic Behavioral Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Goal-directed supports and solution-focused interventions. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's treatment plan. The individualized treatment plan is subject to prior authorization. Evidence-based practices (EBPs) require prior authorization to document medical necessity.



Alternative Benefit Plan

Other 1937 Benefit Provided:

Rehab Services-Psychosocial Rehabilitation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Assists individuals with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with an individual's behavioral health diagnosis. The individualized treatment plan is subject to prior authorization. Evidence-based practices (EBPs) require prior authorization to document medical necessity.

Other 1937 Benefit Provided:

Rehab Services-Residential AOD services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Requires prior approval and reviews on an on-going basis as determined necessary by the State or its designee to document compliance with the placement standards.

Other 1937 Benefit Provided:

Other Licensed Practitioner: Nurse Midwives

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No other authorization process.



Alternative Benefit Plan

<input type="text"/>			
Other 1937 Benefit Provided:		Source:	Remove
<input type="text" value="Other Licensed Practitioner: Acupuncturist"/>		<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization:		Provider Qualifications:	
<input type="text" value="Authorization required in excess of limitation"/>		<input type="text" value="Medicaid State Plan"/>	
Amount Limit:		Duration Limit:	
<input type="text" value="None"/>		<input type="text" value="None"/>	
Scope Limit:			
<input type="text" value="None"/>			
Other:			
<input type="text" value="Payment for more than thirty acupuncture visits per benefit year requires prior authorization."/>			
			Add



Alternative Benefit Plan

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

Collapse All ☐

PRA Disclosure Statement

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