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M E M O R A N D U M

TO: House Committee on Appropriations, House Committee on Ways and Means, House Committee on Health Care, Senate Committee on Appropriations, Senate Committee on Health and Welfare, Senate Committee on Finance, Health Reform Oversight Committee

CC: Hal Cohen, Secretary, Agency of Human Services
Steven Costantino, Commissioner, Department of Vermont Health Access

FROM: Robin Lunge, Director of Health Care Reform

DATE: December 1, 2015

RE: Review of Vermont Medicaid Benefits per Act 58 of 2015 Legislative Session

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Per Act 58 of the 2015 Legislative Session, this memorandum serves as a report comparing services covered by Vermont Medicaid to the essential health benefits (EHB) benchmark plan required by the Affordable Care Act (ACA).

The following table compares covered services available under the Global Commitment for Health Section 1115 Medicaid Waiver and the Medicaid State Plan under Title XIX of the Social Security Act (SSA), with the EHB benchmark plan available in plan years 2014 to 2016, known as Blue Care, Vermont Health Plan, LLC, CDHP.

The 10 EHBs, as described in section 1302(b) of the ACA, are:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative services and devices (includes habilitative services)
8. Laboratory services
9. Preventive services, wellness services, and chronic disease treatment
10. Pediatric services

Key Findings:

- The population covered through private insurance in the individual and small group market is substantially different than the population covered by Medicaid, which is a health care safety net program for low-income Vermonters and populations with special health needs. For example, Medicaid provides home and community health services to low-income seniors and individuals with disabilities which are not typically covered in private insurance. In addition, some services, like transportation, address access to care issues for a low-income population. In addition, because income is a social determinant of health, services should reflect the needs of the population covered.
- Ambulatory services and emergency services covered by Medicaid are overall comparable to services covered by the benchmark plan. Medicaid covers non-emergency medical transportation, a federally mandated service for Medicaid programs, which is not covered by the benchmark plan.
- Medicaid and the benchmark plan offer similar coverage of inpatient hospital services, including inpatient physician and surgical services.
- Coverage of maternity and newborn care is comparable across Medicaid and the benchmark plan.
- Coverage of mental health and substance use disorder services is comparable across Medicaid and the benchmark plan.
- Prescription drug coverage by Medicaid is similar to that of the benchmark plan, with the exception of infertility drugs. Infertility drugs are covered by the benchmark plan but not Medicaid.
- Coverage of rehabilitative services is comparable across plans; however, unlike the benchmark plan, Medicaid does not have limitations or exclusions on home health aides or outpatient hospital rehabilitative therapies (i.e., occupational therapy, physical therapy, speech language therapy).
- Laboratory services covered by Medicaid and the benchmark plan are generally comparable, with the exception of diagnostic tests. For urine drug tests, Medicaid limits coverage to eight tests per month and the benchmark plan has no limits or exclusions.
- Preventive services and pediatric services covered by Medicaid are generally comparable to the benchmark plan. For preventive services, Medicaid offers more nutritional counseling visits per year than the benchmark plan, in the home, outpatient office and nursing facilities.
- Both Medicaid and the benchmark plan cover routine eye exams. The benchmark plan allows for routine eye exams yearly, while Medicaid limits exams to once every two years.
- Vermont Medicaid covers several services beyond the required EHBs, under 1937 of the SSA and the 1115 Waiver. Some examples of these services include home and community based care under the Choices for Care program, community mental health center services, and services for individuals with functional impairments or cognitive disabilities.

Covered Health Care Services: Essential Health Benefit Benchmark Plan vs. Vermont Medicaid

EHB Category	EHB Benchmark Plan Benefit	EHB Limitations and Exclusions	Corresponding Medicaid Benefit (State Plan & 1115 Waiver)	Medicaid Benefit Limitations and Exclusions
Ambulatory Patient Services	Bariatric Surgery	Covered up to $10,000 per lifetime.	Inpatient Hospital, Physician Services in all Settings	
	Chiropractic Care	Prior Approval is required after the 12th visit.	Chiropractic	10 visits per year before PA required.
	Cosmetic Surgery (if reconstructive)	Cosmetic Surgery is an excluded benefit except for prior approval for reconstruction as detailed in certificate of coverage.	Inpatient Hospital, Physician Services in all Settings	Cosmetic surgery is not covered except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member, or for surgery for therapeutic purposes that coincidentally serves some cosmetic purpose.
	Other: Dental Services (not Routine)		Medical & Surgical Furnished by Dentist	
	Hospice Bereavement visits	2 visits per lifetime	Hospice	6 months prior to end of life. 1115 Wavier allows state to provide coverage for hospice services concurrently with palliative and curative services.
	Hospice Continuous Care Services in Home	5 days per admission or 120 hours of continuous care	Hospice	6 months prior to end of life. 1115 Wavier allows state to provide coverage for hospice services concurrently with palliative and curative services.
	Hospice Respite Care	72 hours/month	Hospice	6 months prior to end of life. 1115 Wavier allows state to provide coverage for hospice services concurrently with palliative and curative services.
	Hospice Services	100 hours per month.	Hospice	6 months prior to end of life. 1115 Wavier allows state to provide coverage for hospice services concurrently with palliative and curative services.
	Hospice Services Homemaker Services	100 hours per month.	Hospice	6 months prior to end of life. 1115 Wavier allows state to provide coverage for hospice services concurrently with palliative and curative services.

	Hospice Social Services Visits	6 visits per lifetime	Hospice	6 months prior to end of life. 1115 Wavier allows state to provide coverage for hospice services concurrently with palliative and curative services.
	Other Practitioner Office Visit (Nurse, Physician Assistant)		Pediatric or Family Nurse Practitioners' Services	Home & Office - 5 visits per month; Nursing Facility - up to 1 visit per week; Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care. Limits may be exceeded based on medical necessity.
	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Outpatient Hospital Services	
	Outpatient Surgery Physician/Surgical Services		Outpatient Hospital Services	
	Primary Care Visit to Treat an Injury or Illness		Physician Services In all Settings	Home & Office - 5 visits per month.
	Routine Foot Care	Covered for Diabetics only; excluded for all other members.	Podiatry	Non-routine foot care only; Excludes flat foot; subluxations of foot not requiring surgery; corns, calluses, nail trimming preventative hygiene
	Acupuncture	Not Covered	Not Covered	
	Infertility Treatment	Not Covered	Not Covered	
	Weight Loss Programs	Not Covered	Not Covered	
			Non-Emergency Transportation (mandatory service under federal law)	Transportation is not otherwise available to the Medicaid recipient; Transportation is to and from medical services which are necessary and covered by the recipient's Medicaid plan.
			Family Planning	
	Specialist Visit		Physician Services In all settings	Home & Office - 5 visits per month; Nursing Facility - up to 1 visit per week; Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care.
	Urgent Care Centers or Facilities		Rural Health Clinic; Federally Qualified Health Center; Physician Services in all Settings	5 visits per month; 1 visit per day

	Other: Preventive Care		Physician Services in all settings; EPSDT	Home & Office - 5 visits per month.
Emergency Services	Emergency Room Services	Insured's condition must meet the criteria for an emergency medical condition.	Physician Services in all settings	Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care.
	Emergency Room Services	Excludes benefits for an emergency room services that does not meet definition of Emergency Service.	Outpatient Hospital Emergency Care	
	Emergency Transportation/ Ambulance	Insured's condition must meet the criteria for an emergency medical condition. Insured must get approval within 48 hours after emergency air or water transport.	Transportation: Ambulance	For emergency services only.
	Emergency Room Services	Insured's condition must meet the criteria for an emergency medical condition.	Outpatient Hospital Emergency Care; Physician Services in all Settings	Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care.
Hospitalization	Inpatient Hospital Services (e.g., Hospital Stay)		Inpatient Hospital Services	
	Inpatient Physician and Surgical Services	May limit the number of visits covered by one Provider in a given day.	Physician Services In all Settings	Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care.
	Mental/Behavioral Health Inpatient Services	Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Inpatient Psychiatric Hospital Services; Inpatient Psych. Services for Individuals Under 22	Does not cover Institutions for Mental Disease (IMD) for individuals between 21 and 65 years old.
	Other: Ambulatory Care	Limited to $35,000 per solid organ transplant for search, removal, storage, and transportation of the organ.	Organ and Tissue Transplant Services	

	Other: Ambulatory Care	For transplants using a live donor, benefits are limited to $65,000 for the live donor's surgical expenses and storage and transportation of the organ for each covered organ transplant procedure completed. Costs for a donor must be incurred within 120 days from the date of the donor's surgery.	Organ and Tissue Transplant Services	
	Other: Substance Abuse Disorder Inpatient Services	Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Substance Abuse Services Residential Treatment; Substance Abuse Services, Residential Detoxification; Substance Abuse Services, Residential Post Detox Services; Substance Abuse Services, Residential Extended post detox.	Residential detoxification is limited to 7 days/acute episode. Residential post-detoxification is limited to 30 days/calendar year. Residential extended post-detoxification is limited to 183 days/calendar year.
Maternity and Newborn Care	Delivery and All Inpatient Services for Maternity Care		Nurse Mid Wife; Physician Services: Maternity Care; Inpatient Hospital: Maternity Care	
	Prenatal and Postnatal Care: Maternity Office Visits		Nurse Mid Wife; Licensed Lay Midwife; Physician Services: Maternity Care Services	
	Prenatal and Postnatal Care		Nurse Mid Wife; Licensed Lay Midwife; Physician Services: Maternity Care services	
Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment	Mental/Behavioral Health Outpatient Services		Clinic Services - Mental Health Clinic (group therapy; individual psychotherapy; day hospital; diagnosis and evaluation; emergency care; chemotherapy); Other Licensed Providers: Behavioral Health services	Behavioral Health: Not covered if resident of inpatient hospital or mental health hospital, or concurrently receiving mental health clinic services.

	Mental/Behavioral Health Outpatient Services		Clinic Services - Mental Health Clinic (group therapy; individual psychotherapy; day hospital; diagnosis and evaluation; emergency care; chemotherapy); Other Licensed Providers: Behavioral Health services	
	Outpatient Surgery Physician/ Surgical Services: Neuropsychological Testing	8 hours per year.	Clinic Services - Mental Health Clinic (group therapy; individual psychotherapy; day hospital; diagnosis and evaluation; emergency care; chemotherapy)	
	Substance Abuse Disorder Outpatient Services		Substance Abuse Services, Non-residential professional services	90 hours of counseling/episode
	Substance Abuse Disorder Outpatient Services: Office Visits		Substance Abuse Services, Non-residential professional services	90 hours of counseling/episode
Prescription Drugs	Drugs (Generic/Preferred Brand/Non-Preferred Brand/Specialty): Antibiotics and Narcotic Day Supply Limitation	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).	Brand Name Drugs; Generic Drugs; OTC Drugs	Limit on days supply; limit on brand drugs; preferred drug list; other coverage limits.
	Generic Drugs	Limited to a 90-day supply for retail and home delivery (mail order) per fill.	Generic Drugs	Limit on days supply; limit on brand drugs; preferred drug list; other coverage limits.
	Drugs (Generic/Preferred Brand/Non-Preferred Brand): Infertility medications	Infertility Drugs up to 4 months per year for natural conception.	Not Covered	
	Non-Preferred Brand Drugs	Limited to a 90-day supply for retail and home delivery (mail order) per fill.	Brand Name Drugs	Limit on days supply; limit on brand drugs; preferred drug list; other coverage limits.
	Other: Nutritional Formulae or supplements	Up to $2,500 per year for medical foods prescribed for the medically necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.	Brand Name Drugs; OTC Drugs	Limit on days supply; limit on brand drugs; preferred drug list; other coverage limits.

	Preferred Brand Drugs	Limited to a 90-day supply for retail and home delivery (mail order) per fill.	Brand Name Drugs	Limit on days supply; limit on brand drugs; preferred drug list; other coverage limits.
	Specialty Drugs	Limited to a 30-day supply. ONLY Participating Specialty pharmacies may be utilized for Specialty drugs.	Brand Name Drugs	Limit on days supply; limit on brand drugs; preferred drug list; other coverage limits.
Rehabilitative Services and Devices (Includes Habilitative Services)	Hospice Services: Home Health Aide	100 hours per month.	Home Health Aide	
	Outpatient Rehabilitation Services: Cardiac Rehabilitation Services	36 visits per cardiac event; three supervised exercise sessions per week up to total of 36 sessions for cardiac and pulmonary rehab programs.	Outpatient Hospital - Rehabilitative therapies (OT/PT/SLP)	
	Durable Medical Equipment	Some durable medical equipment and supplies require prior approval. Includes supplies and equipment necessary for administration, orthotics (if approved), prosthetics, and devices. Threshold applies.	Communication Devices, Wheelchair, Prosthetic Devices; Home Health: Medical Supplies, Equipment and Appliances	Payment will be made for one primary piece of equipment except if a beneficiary with an electric wheelchair needs a manual wheelchair to meet a therapeutic objective, a manual chair may also be approved with prior authorization. Durable medical equipment must be suitable for use in the home
	Home Health Care Services		Home Health Aide; Home Health PT/OT/SLP Services; Home Health Intermittent Part Time Nursing	4 months of PT/OT/SLP then prior authorization required.
	Outpatient Rehabilitation Services: Physical, Speech and Occupational Therapy	Covered up to 30 visits combined per plan year.	OT/PT/SLP (non-hospital based) Services	Under 21, prior authorization after 8 visits; over 21, prior authorization for over 30 visits per year of any type.
	Outpatient Rehabilitation Services	Up to 30 outpatient sessions combined per plan year.	OT/PT/SLP (non-hospital based) Services	Under 21, prior authorization after 8 visits; over 21, prior authorization for over 30 visits per year of any type.
	Durable Medical Equipment: Pre-Fabricated Knee Braces	Excludes custom-fabricated or custom-molded knee braces.	Prosthetic Devices	
	Private-Duty Nursing	Covered up to $2,000 per plan year	Home Health: Private Duty Nursing	
	Hearing Aids		Hearing Aids	Hearing loss has to meet certain conditions; 1 hearing aid per ear every 3 years

	Skilled Nursing Facility	Covered by participating facility only for Acute Care.	Nursing Facility 21 and older	
Laboratory Services	Diagnostic Test (X-Ray and Lab Work)		Other Laboratory and X-Ray Services	Urine drug test limited to 8 per month
	Imaging (CT/PET Scans, MRIs)		Other Laboratory and X-Ray Services	
Preventive and Wellness Services and Chronic Disease Management/ Ambulatory/Pediatric Services including Oral and Vision Care	Other: Nutritional Counseling	3 visits per plan year. Visits for treatment of diabetes do not count toward this visit limit.	Naturopathic Physician; Physician Services in all Settings	Home & Office - 5 visits per month; Nursing Facility - up to 1 visit per week. Limits may be exceeded based on medical necessity.
	Preventive Care/ Screening/ Immunization		Physician Services in all Settings; Clinic Services; Other Diagnostic, Screening, Preventative and Rehab Services; Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Home & Office - 5 visits per month.
Pediatric Services (Including Oral and Vision Care)	Dental Check-Up for Children	2 treatments per year	EPSDT - Dental Services	
	Durable Medical Equipment: Dental Prosthetics	Exclusion: Repair or replacement of dental appliances or dental prosthetics.	EPSDT - Dentures	
	Eye Glasses for Children		EPSDT - Eyeglasses and Other Aids to Vision	
	Habilitation Services		EPSDT	
	Routine Eye Exam for Children	1 routine eye exam per member per calendar year. Does not cover the evaluation and fitting of contact lenses or other supplemental tests.	EPSDT	
Other 1937 (Optional) Covered Benefits that are <u>not Essential Health Benefits</u>	Routine Eye Exam (Adult)	1 routine eye exam per calendar year; Does not cover the evaluation and fitting of contact lenses or other supplemental tests, routine eye care, eye exercises or visual training.	Optometry Services	Routine exam once every 2 years; diagnostic exam once every 2 years. Contact Lens prior authorization; Aids to vision approved when legally blind and will improve at least one ADL or IADL.

	Non-Emergency Care When Traveling Outside the U.S.	Excluded UNLESS member qualifies for coverage due to sabbatical or attending college in a foreign country.	Not Covered. Federal regulations prohibit Medicaid coverage outside of the U.S.	
	Inpatient Physician and Surgical Services: Sterilization Reversal	One attempt at reversal of sterilization covered.	Not Covered	For New Adult Group, non-emergency medical transportation was substituted for this benefit.
			Intermediate Care Facilities for Individuals with Intellectual Diseases (ICF/IID)	
			High Tech Nursing	
			Nursing Facility 21 and older; custodial care	
			Dental- Prophylaxis	1 visit every 6 months; $510 per year
			Extended Services (home visits) for Pregnant Women	
			Opticians	Limited to eye glass dispensing only.
			Face-to-Face Tobacco Cessation Counseling	16 visits per calendar year.
			Case Management for TB related services	
			Outpatient Hospital - Partial Hospitalization	
			Therapeutic Substance Abuse Services - Private Non Medical Institutions (PNMI)	
			Community Mental Health Center Services	Diagnosis and evaluation; emergency care; psychotherapy; chemotherapy; group therapy; specialized rehabilitation services provided by Mental Health Designated Providers authorized by DMH and required by state law. The benefit category in Vermont's State plan is "Other Diagnostic, Screening, Preventive and Rehabilitative Services."
			Assertive Community Care Services - Private Non Medical Institutions (PNMI)	Only for persons with functional impairments and/or cognitive disabilities.

			Day Health Rehabilitation - Center based	Excludes residents of nursing home or enhanced residential care facilities.
			Targeted Case Management	3 target groups for persons over 18 years old: (1) Persons with developmental disabilities who are unable to access needed medical, social, educational and other services because of adaptive deficits due to their level of disability, or who lack the active assistance of a family member or other interested person to assist them in accessing needed services; (2) Families whose children are abused or neglected or suspected of being at imminent risk thereof and Families of children receiving post adoption assistance; (3) Pregnant and postpartum women and infants through twelve months of age enrolled in the Vermont Department for Children and Families, Healthy Babies, Kids, and Families Program.
			Respiratory Care Services	
			Personal Care Services	
			Health Home Services for Medication Assisted Therapy for Opioid Dependence	
Covered Benefits under the Global Commitment for Health Section 1115 Medicaid Waiver that are <u>not Essential Health Benefits</u>			Community Rehabilitation and Treatment	Any limitation on this service defined by Vermont rules and policies
			Traumatic Brain Injury	Any limitation on this service defined by Vermont rules and policies
			Developmental Disability Services	Any limitation on this service defined by Vermont rules and policies
			Mental Illness Under Age 22	Any limitation on this service defined by Vermont rules and policies
			Choices for Care (Long-term Care)	Any limitation on this service defined by Vermont rules and policies. Participants are eligible under any of three categories: Highest Need Group, High Need Group, Moderate Need Group. Covered services (amount, duration, scope) are defined by group.

			Palliative Care Program	For children under the age of 21 years who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood. The program will allow for children to receive palliative and curative services.