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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #:14-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

June 30, 2014

Nicholas A. Toumpas, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire SPA TN 14-0005

Dear Commissioner Toumpas,

Enclosed is an approved copy of New Hampshire's (NH) State Plan Amendment (SPA) 14-0005, which was submitted to CMS on May 23, 2014 and entitled *"NH Alternate Benefit Plan."* SPA 14-0005 transmitted a proposed amendment to New Hampshire's approved Title XIX State Plan to enroll individuals at or below 133% FPL Age 19 through 64 in accordance with section 1902(a)(1)(A)(i)(VIII) eligibility group in an Alternative Benefit Plan. The proposed effective is August 15, 2014.

Transmittal # 14-0005 --NH Alternative Benefit Plan
--Effective August 15, 2014

Enclosed is a copy of the new State Plan pages to be incorporated within a separate section at the back of NH's approved State Plan:

- ABP 1-1
- ABP 2a-1 to 2a-3
- ABP 2c-1 to 2c-3
- ABP 3-1 to 3-2
- ABP 4-1
- ABP 5-1 to 5-26
- ABP 7-1 to 7-2
- ABP 8-1 to 8-3
- ABP 9-1
- ABP 10-1
- ABP 11-1
- ABP 4.19-B Page 1 - Page 6

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Kathleen Dunn, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

OFFICIAL

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: New Hampshire

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.

NH-14-0005

Proposed Effective Date

08/15/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1937 of the SSA

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 48549806.00
Second Year	2015	$ 301954200.00

Subject of Amendment

Alternative Benefit Plan

(Note: FI is based upon Lewin PMPY estimates; NH is in final stages of rate setting and will submit updated FI as soon as rates are finalized.)

Governor's Office Review

- **Governor's office reported no comment**
- **Comments of Governor's office received**
  Describe:
- **No reply received within 45 days of submittal**
- **Other, as specified**
  Describe:
  Comments if any will follow

Signature of State Agency Official

Submitted By:	**Diane Peterson**
Last Revision Date:	**Jun 27, 2014**
Submit Date:	**May 23, 2014**

Date Received: 05/23/2014

Plan Approved - One Copy Attached

Date Approved: 06/30/2014

Effective Date of Approved Material: 08/15/2014

Signature of Regional Official

/s/

Typed Name: Richard R. McGreal

Division of Medicaid and Children's Health Operations
Boston Regional Office

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New Hampshire New Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. — No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Alternative Benefit Plan

Describe:

The State gives beneficiaries the option of receiving all official communications through an online portal, rather than a paper notice. Individuals who elect this option receive an email notifying them that a new notice has been uploaded to the portal. When the individuals log on to the portal, they see a PDF of a notice. The text of the notice is identical to the hard copy notice sent to other individuals.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan and informing them of the differences in the benefits.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan and informing them of the differences in the benefits.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, a Medicaid member can self-identify at any time as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

Alternative Benefit Plan

☐ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is eligible under Section 1902(a)(10)(A)(i)(VIII) and is not in any of the following categories: children; currently eligible parents; blind or disabled; pregnant women; or foster children.

☒ Self-identification

Describe:

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, a Medicaid member can self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information. Member Services staff will have a script for providing choice counseling to people who identify themselves as medically frail.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

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☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☒ Review at the time of eligibility redetermination
- ☐ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ◉ Ad hoc basis
- ○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals who self-identify as medically frail at the time of application will return the notice included with their eligibility determination in order to notify the State that they would like to be disenrolled from the ABP and enrolled in the ABP that is the Medicaid State Plan. Instructions for completing this process are included in their eligibility determination notice.

Individuals seeking exemption from the Alternative Benefit Plan at any time during their period of eligibility will notify the Medicaid agency who will initiate the change process. The appropriate contact information for the agency is included in their eligibility determination notice. Once the applicant makes the request, the same notice delivered as part of the medically frail individuals' eligibility notice will be sent to the member. Individuals that would like to be enrolled in the ABP that is the Medicaid State Plan must complete the form and return it to the Medicaid agency to complete the process. All requests to disenroll from the ABP must be submitted in writing to the Medicaid agency.

The notices provided to individuals who either respond affirmatively to the triggering question on the initial application or who later self-identify as exempt include a description of the differences between the ABP and the ABP that is the Medicaid State Plan. The notices also inform individuals that if they elect to receive the ABP, they may request to be moved to the ABP that is the Medicaid State

Alternative Benefit Plan

Plan at any time by contacting the Medicaid agency.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

New Hampshire has created its Adult Group Alternative Benefit Package based on the Matthew Thornton Blue Health Plan, which is the base benchmark plan selected by the State to define Essential Health Benefits for products in the Marketplace. The State has added the additional benefits required for the Alternative Benefit Package, but not covered by the base benchmark plan, namely, non-emergency medical transportation, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services, routine eye exams, eyeglasses, and dental as described herein. Individuals will also have access to FQHC and RHC services, as well as open access to family planning providers.

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

Alternative Benefit Plan

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Matthew Thornton Blue Health Plan

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The Matthew Thornton Blue Health Plan is the second largest plan by enrollment in the small group insurance market. The Matthew Thornton Blue Health Plan was selected by the State of New Hampshire to be the base benchmark plan to define essential health benefits for the individual and small group markets in New Hampshire.

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☑ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

The State will submit State Plan Amendments eliminating cost-sharing for all individuals with incomes less than or equal to 100% FPL. The State will submit State Plan Amendments to impose targeted cost-sharing on individuals in the new adult group with incomes above 100% FPL. The cost-sharing described in that State Plan Amendment will apply to all individuals in the new adult group with incomes above 100% FPL, regardless of whether they are receiving the Alternative Benefit Plan or the Alternative Benefit Plan that is the Medicaid State Plan.

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
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Attachment 3.1-L- [ ]

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:

The base benchmark plan is the Matthew Thornton Blue Health Plan.

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: Primary Care Visit to Treat an Injury of Illness
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial 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: Specialist Visit
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial 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 Practitioner Office Visit (APRN, PA, etc.)
Source: Base Benchmark Small Group

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial 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:

Includes Advance Practice Registered Nurse, Physician Assistant, Nurse Practitioner, and Certified Midwives, consistent with their scope of practice.

Remove

Benefit Provided:

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

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

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

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

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

Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided:

Hospice Services

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

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: Urgent Care Centers or Facilities
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial 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/Emergency Room 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: Emergency Transportation/Ambulance
Source: Base Benchmark Small Group
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial 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:

Remove

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Hospital Services
Source: Base Benchmark Small Group
Remove

Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization is required only for out-of-state inpatient hospitalization.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial 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:
Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided: Bariatric Surgery
Source: Base Benchmark Small Group

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial 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:

Remove

Benefit Provided:

Transplant

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial 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:

Prior authorization is required for all organ transplants, except kidney transplants.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Minimum stay of 48 hours

Add

Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided: Mental/behavioral Health Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

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

Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; and telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider.

Benefit Provided: Mental/behavioral health inpatient services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

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

Benefits are available for inpatient hospital services or residential treatment center facility for mental health care; inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility; partial hospitalizations; and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase

Alternative Benefit Plan

of a substance abuse condition.
Benefits exclude IMDs.

Remove

Benefit Provided:
Substance Abuse Disorder Outpatient Services

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below.

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

Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; and telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider.

Benefit Provided:
Substance Abuse Disorder Inpatient Services

Source:
Base Benchmark Small Group

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below.

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

Benefits are available for inpatient hospital services or residential treatment center facility for mental health care; inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility; partial hospitalizations; and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase

Alternative Benefit Plan

of a substance abuse condition. Benefit excludes IMDs.	Remove
	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.):	Authorization:	Provider Qualifications:
☐ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

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

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided: Home Health Care Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: No benefits are available for custodial care.

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

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 100 days per year
Duration Limit: None

Scope Limit: No benefits are available for custodial care.

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

Benefit Provided: Outpatient Rehabilitation Services
Source: Base Benchmark Small Group

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 20 visits per year for each therapy type
Duration Limit: None.

Scope Limit: See below.

Alternative Benefit Plan

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

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services.

No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational, or occupational reasons; or therapy for TMJ.

Remove

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial 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: Cardiac Rehabilitation

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial 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: Habilitation Services

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Remove

Amount Limit: 20 visits for each therapy type

Duration Limit: None

Scope Limit: See below.

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

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services.

No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational, or occupational reasons; or therapy for TMJ.

Benefit Provided: Chiropractic Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 12 vistis per year

Duration Limit: None

Scope Limit: Includes spinal manipulation and manual medical intervention services

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

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial 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:

Benefits are available for durable medical equipment, medical supplies, and prosthetic devices. Prior authorization is required for durable medical equipment and adult incontinence supplies.

Remove

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Diagnostic Tests (X-Ray and Lab Work)

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial 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:

No benefits are available for diagnostic x-rays in connection with research or study.

Benefit Provided: Imaging (CT/PET scans/MRIs)

Source: Base Benchmark Small Group — Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial 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:

Prior authorization is required for the following types of imaging: CT, PET, MRI, MRA, and nuclear cardiology.

Add

Alternative Benefit Plan

☑ 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 Care/Screening/Immunization

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial 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 preventive care benefit includes the following: (1) all services listed on the USPSTF A and B lists; (2) Advisory Committee for Immunization Practices (ACIP) recommended vaccines; (3) preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and (4) additional preventive services for women recommended by the Institute of Medicine (IOM) and HRSA. This benefit includes family planning services and contraceptive coverage, consistent with the requirements of the additional preventive services for women recommended by the IOM and HRSA. Specifically, the preventive services benefit includes all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

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:
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:

EPSDT will apply for all 19 and 20 year olds. Prior authorization required for the following dental services: comprehensive and interceptive orthodontics, dental orthotic devices, surgical periodontal treatment, and extractions of asymptomatic teeth.

Add

Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark — Collapse All ☐

Other Base Benefit Provided:
Routine Eye Exam (Adult)

Source:
Base Benchmark

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
1 exam every 2 years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit:
No prior authorization.

Add

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted: Source:

Emergency Room Services | 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 New Hampshire Medicaid state plan as outpatient hospital care/emergency room services under EHB 2.

State plan benefit has no scope limit.

Base benchmark covers emergency room services only for treatment of an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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: Non-Emergency Medical Transportation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.

Other 1937 Benefit Provided: Eyeglasses for individuals 21 and over

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 pair per year single vision or bifocal glasses*

Duration Limit: None

Scope Limit: None

Other: One refraction is covered to determine the need for glasses, no more frequently than every 12 months. One pair single vision lenses with frames is covered, provided that the refractive error is at least plus or minus .50 diopter according to the type of refractive error, in each eye. One pair of glasses with bifocal corrective lenses or one pair of glasses with corrective lenses for close vision and one pair of glasses with corrective lenses for distant vision if there is a refractive error of at least .50 diopter for both close and distant vision Benefit is the same as described in the Medicaid State Plan. No authorization is required.

Other 1937 Benefit Provided: Dental for individuals 21 and over

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Coverage is limited to treatment of acute pain or infection

Remove

Other:

Benefit is the same as described in the Medicaid State Plan. No authorization is required.

Add

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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 ☐

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

All individuals in the new adult group who receive the Alternative Benefit Plan will be enrolled in Medicaid managed care plans. The ABP benefit package administered by the plans will include coverage for EPSDT services for 19 and 20 year olds. Dental benefits for 19 and 20 year olds are not included in the Medicaid managed care plan benefit package, and these benefits will be provided through the fee-for-service Medicaid program.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State will initially leverage its existing Medicaid managed care plans to administer the ABP. The State will update the contracts with the current and any additional plans to reflect the new ABP benefit package, and establish capitation rates for the new adult group. The State will work closely with the plans to inform them about the benefits unique to the ABP. The State will require that plans contract with additional providers, as needed, to ensure adequate access to the full range of services offered in the ABP. The State will also require that the plans notify their participating providers of the unique features of the ABP.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- ◉ Competitive procurement method (RFP, RFA).
- ○ Other procurement/selection method.

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Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	Skilled Nursing Facility	Benefit will be provided through fee-for-service Medicaid.	X
+	Inpatient Hospital Swing Bed, SNF	Benefit will be provided through fee-for-service Medicaid.	X

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

☒ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☒ Individuals in a retroactive period of Medicaid eligibility.

☐ Other:

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be auto-assigned to an MCO. To auto-assign individuals, the state will determine if a household member has selected a plan already, and enroll the non-assigned member into the same plan as their household member. For beneficiaries for whom it is not possible to determine any family member plan selection, the state will randomly assign members to ensure equitable enrollment among plans. All managed care enrolled individuals may disenroll from the plan they selected or were auto-assigned to within 90 days of their plan enrollment, with or without cause. If after 90 days, they have not disenrolled, they will be locked into that plan for a period of 12 months. If the member disenrolls from a plan within the 90 day window and does not disenroll from managed care (if that option applies) they must select a new plan in which to enroll.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

The state will amend its contracts with existing MCOs to include the full scope of ABP benefits. The state will also develop a capitation

Alternative Benefit Plan

rate for the new adult group. MCOs will have the authority to develop utilization management plans, including selecting which categories of benefits are subject to prior authorization. As a result, the authorization requirements may differ from those set forth in ABP5, and they may differ across MCOs. The State will review and approve the MCO's utilization management plans. As part of that review process, the State will ensure that the prior authorization requirements imposed do not violate mental health parity requirements.

Fee-For-Service Options

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

(•) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

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

Some long-term care benefits are not included in the MCO's benefit package currently; instead, the State provides these services through a separate fee-for-service process. To the extent the benefits that are not currently covered by the MCO benefit packages are included in the ABP, the State will cover those benefits through the fee-for-service system.

Additionally, individuals will receive the ABP through fee-for-service while they are awaiting enrollment in an MCO.

All benefits provided through the fee-for-service system will be subject to the authorization requirements set forth in ABP5.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

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Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

All individuals eligible under Section 1902(a)(10)(A)(i)(VIII) with access to cost-effective employer-sponsored insurance will be required to receive coverage through the State's Health Insurance Premium Payment (HIPP) program. The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **Yes**

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

Individuals eligible under Section 1902(a)(10)(A)(i)(VIII) will be permitted to voluntarily enroll in cost-effective individual market coverage consistent with updated State Plan Amendments that the state will submit separately. For a Medicaid beneficiary who receives coverage in a health plan in the individual market through the state's approved Medicaid state plan that provides premium assistance under section 1905(a) and regulations codified at 42 CFR §435.1015, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits around the individual market health plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

V.20131219

Month Day, YYYY

[BENEFICIARY NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [BENEFICIARY NAME],

Welcome to the New Hampshire Health Protection Program.

Why you are getting this letter
You told us that you have a physical or behavioral health condition that limits what you are able to do (like bathing, dressing, daily chores, etc.), or that you live in a medical facility or nursing home. You may also have told us that you have a serious mental illness, a long-term problem with drugs or alcohol, or some other serious health condition. Because of your health care needs, you may choose between two health benefit plans.

Your health benefit choices
You may choose to receive benefits under the Alternative Benefit Plan, or you may choose to receive benefits under New Hampshire's standard Medicaid plan.

The differences between the two health benefit plans
Most of the health care benefits are the same for both plans, but there are some differences. The chart below shows how the two plans are the same and how they are different.

	Standard Medicaid Plan	**Alternative Benefit Plan**
Annual physical and routine doctor visits	Yes	Yes
Prescription Drugs	Yes	Yes
Inpatient hospital care	Yes	Yes
Access to long-term care services, like nursing homes, if you are determined to be medically eligible	Yes	No
Help with everyday tasks, like bathing, getting dressed, and preparing meals	Yes	No
Services to help you stop using drugs or alcohol	No	Yes
Limits on the number of visits for some services, like physical therapy	Yes	Yes

If you need long-term care services such as help with everyday tasks, or you live in a nursing home, you can only get those services in the Standard Medicaid Benefit plan.

If you need help to stop using drugs or alcohol, you can only get those services under the Alternative Benefit Plan.

You may have to pay co-payments for some health care services for either plan. If you do have a co-payment, you will receive a letter that tells you about your responsibility to pay the co-payments for some health care services.

What you need to do

If you want the Alternative Benefit Plan you do not need to do anything. If you want the Standard Medicaid Plan, please mail this form to:

[ADDRESS]

You can ask questions about your benefit choices and get help picking a set of benefits by calling 1-800-xxx-xxxx. If you do not make a choice, you will receive the Alternative Benefit Plan. You can change your mind and ask for the standard Medicaid Plan at any time. If you change your mind, call 1-800-xxx-xxxx.

You can learn more about your benefits by visiting the New Hampshire Medicaid website at http://www.dhhs.nh.gov/ombp/medicaid/.

✂----------

[BENEFICIARY NAME]
[ADDRESS]
[CITY, STATE ZIP]

Check the option below:

____ I would like to have standard Medicaid Plan.

_____
Signature

_____
Date

Mail to: **[Address]**

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

1. Chiropractor Services – Payment for chiropractor services provided under New Hampshire's alternative benefit plan is made on a fee for service basis. Payment is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

2. Services for the Treatment of Substance Use Disorders – New Hampshire's Medicaid state plan specifies the reimbursement methodology in Attachment 4.19-A and Attachment 4.19-B for some services that are rendered for the treatment of substance use disorders. Please refer to the appropriate, existing Attachments for these services as follows:

   Attachment 4.19-A – Inpatient Hospital Reimbursement
   - Inpatient Hospital Acute Care Services for Substance Use Disorders
   - Inpatient Governmental Psychiatric Hospital

   Attachment 4.19-B – Payment for All Types of Care Other Than Inpatient Hospital, Skilled Nursing, or Intermediate Nursing Care Services
   - Outpatient Hospital Services
   - Physician Services
   - Services of Other Licensed Practitioners
   - Clinic Services
   - EPSDT
   - Prescribed Drugs
   - Extended Services to Pregnant Women

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

The reimbursement methodology for other services in the alternative benefit plan, that are not already in the state plan for the current eligibles, for treatment of substance use disorders are as described below:

(a) Services of Other Licensed Practitioners – Payment for master licensed alcohol and drug counselors (MLADC's) is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(b) Outpatient Services Facilities – Payment for services provided by outpatient facilities are as described below.

(1) Intensive Outpatient Services: Payment for intensive outpatient services provided by outpatient facilities shall be made at a per diem rate as established by the department pursuant to NH RSA 161:4, VI. Intensive outpatient services are comprised of a combination of individual and group treatment services for three hours/day, three days/week. The service is similar to the current Medicaid behavioral health service of ½ day of behavioral health partial hospitalization (H0035) and was, therefore, priced at the same rate.

(2) Partial hospitalization: Payment for partial hospitalization provided in an outpatient services facility shall be made at a per diem rate as established by the department pursuant to NH RSA 161:4, VI. Partial hospitalization is comprised of a combination of a range of group and individual outpatient treatment services that are provided at least 20 hours/week. It was determined that this level and intensity of service was similar to the current medicaid covered full day of behavioral health partial hospitalization (S0201) and was, therefore, priced at the same rate.

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(b) Outpatient Services Facilities (continued)

(3) Medically Monitored Outpatient Withdrawal Management: Payment for medically monitored outpatient withdrawal management provided in an outpatient services facility shall be made at a per visit rate as established by the department pursuant to NH RSA 161:4, VI. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's per visit rate or the provider's usual and customary charge. These services must be supervised by a physician and include such things as physician assessment for withdrawal, vitals, and physician management of any elevated levels. This service typically takes place over the course of 3-10 days. Due to the nature of the service, it was compared to a physician visit for ratesetting purposes. It was determined that it was best compared to an established patient office visit, which is defined as requiring 2 of 3 components (detailed history, detailed exam, medical decisions of moderate complexity). It was, therefore, priced equivalent to Medicaid's current rate for the office visit code of 99214.

(4) Individual, Family, or Group Counseling: Individual, family, or group counseling provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(5) Peer Recovery Support: Payment for peer recovery support provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(b) Outpatient Services Facilities (continued)

(6) Crisis Intervention: Payment for crisis intervention provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(7) Non-Peer Recovery Support: Payment for non-peer recovery support provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(8) Continuous Recovery Monitoring: Payment for continuous recovery monitoring provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(9) Assessments: Payment for assessments provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of August 15, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(c) Residential Treatment and Rehabilitation Facilities – Payment for services provided in residential treatment and rehabilitation facilities of fewer than 17 beds is as described below.

(1) Rehabilitative Services: Payment for services in residential treatment and rehabilitation facilities shall be made at a per diem as established by the department pursuant to NH RSA 161:4, VI, and based on the appropriate level of intensity (low, medium, high, or specialty care such as extended services to pregnant women and children) in accordance with the American Society of Addiction Medicine (ASAM) Criteria. The per diem rates were established based on rates paid by medicaid or on a contract basis by various divisions for similar services and based on clinical determinations of similarities of service delivery, practitioner involvement, and intensity. Payment does not include room and board.

A clinical determination was made that the low level intensity service for adults should be priced at the current medicaid rate for therapeutic behavioral health services (H2020) which is a per diem rate of $120.00. By their nature, adolescent services are more involved than adult services at the low level of intensity. These adolescent services were priced at a per diem rate of $128.00.

The high level intensity services for adults was priced based on the current medicaid rate ($162.60) for high level intensity services. The comparable medium level intensity services for adolescents was priced at a per diem rate of $170.00. This rate was based on the current medicaid rate ($170.00) for a similar adolescent facility under the division for children, youth and families, and the fact that adolescent services are more involved than adult services and thus should be priced somewhat higher.

High intensity specialty care, which encompasses the extended services to pregnant women substance use programs, was priced using the current program's price of $162.60 as a basis. This medicaid rate was set about 20 years ago based on cost reporting and contract prices that were then reviewed and substantiated a year after the program was launched. Based on this information, and in comparison to the proposed adult high intensity rate of $162.60, a rate of $230 has been set for the high intensity specialty level of care for pregnant and postpartum women in substance use treatment programs. This rate takes into account that the $162.60 rate has not been increased in over 20 years with such proposed increase being equivalent to less than a 2% inflation factor over each of 18 years. It also takes into consideration the complexities of specialty care for this population such as ensuring access to obstetrical care and active participation in pre-natal care and parenting.

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(c) Residential Treatment and Rehabilitation Facilities (continued)

Once the above rates were calculated, they were compared to the average per diem rate for a rehabilitation hospital stay to ensure that they were reasonable; rates were found to be substantially and acceptably less than the average per diem rate of $847.59.

(2) Medically monitored withdrawal management: Medically monitored withdrawal management provided in a residential treatment and rehabilitation facility includes medical service components such as monitoring of vital signs and managing medications for withdrawal from alcohol and other drug substances. This service is clinically equivalent to a high intensity level of specialty care and thus payment shall be made at the $230 per diem rate as described above for high intensity specialty care.