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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 23-0056

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 30, 2023

Lori A. Weaver
Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire State Plan Amendment (SPA) 23-0056

Dear Commissioner Weaver:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0056 (MMDL: NH.6663.R00.00). This amendment proposes to provide lactation consultation services in New Hampshire's Alternative Benefit Plan.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR §440.230. This letter is to inform you that New Hampshire's Medicaid SPA Transmittal Number 23-0056 was approved on November 29, 2023, with an effective date of July 1, 2023.

If you have any questions, please contact Joyce Butterworth at (857) 357-6375 or via email at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

[redacted]

Division of Program Operations

Enclosures

cc: Henry Lipman, State Medicaid Director
Dawn Tierney, Medicaid Business and Policy

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **New Hampshire**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

NH-23-0056

Proposed Effective Date

07/01/2023 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1905(a)(29) of the SSA

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2023	$ 3750.00
Second Year	2024	$ 15000.00

Subject of Amendment

Mandatory Medicaid State Plan Coverage of Lactation Consultation Services

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  comments if any, will follow

Signature of State Agency Official

Submitted By:	**Jody Farwell**
Last Revision Date:	**Nov 1, 2023**
Submit Date:	**Sep 29, 2023**

Alternative Benefit Plan

State Name: New Hampshire Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: NH - 23 - 0056

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 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)

Effective January 1, 2019, New Hampshire will provide coverage to all members of the adult group through its Medicaid managed care network. In order to be eligible for the ABP, individuals must meet the eligibility requirements of the adult group (1902(a)(10)(A)(i)(VIII)(42 CFR 435.119) and the requirements of the 1115 demonstration. Adults in the Granite Advantage demonstration will receive the 10 Essential Health Benefits through this ABP, which will be aligned with the New Hampshire Medicaid State Plan benefit package for ease of administration.

V 20160722

Alternative Benefit Plan

State Name: New Hampshire Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: NH - 23 - 0056

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.	Yes

Explain how the state 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.

New Hampshire has fully aligned the benefits in its ABP with its approved Medicaid state plan. Services in the EHB base benchmark plan that are not included in the current state plan will be added to the state plan to ensure full alignment.

PRA Disclosure Statement

V 20160722

Alternative Benefit Plan

State Name: New Hampshire Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: NH - 23 - 0056

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: New Hampshire Aligned Medicaid ABP

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.

The state/territory offers the benefits provided in the approved state plan.

Benefits include all those provided in the approved state plan plus additional benefits.

Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.

The state/territory offers only a partial list of benefits provided in the approved state plan.

The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

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

ABP benefits and limitations are commensurate with the State Plan. (1) The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP 5; and (2) The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.

Selection of Base Benchmark Plan

Alternative Benefit 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.

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):

See New Hampshire Aligned Medicaid ABP5.

PRA Disclosure Statement

V 20160722

Alternative Benefit Plan

State Name: New Hampshire Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: NH - 23 - 0056

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. No

Other Information Related to Cost Sharing Requirements (optional):

Cost sharing is described on pages G1-G3 of the cost sharing sections of the state plan. These state plan pages have superseded Attachment 4.18-A.

PRA Disclosure Statement

V 20160722

Alternative Benefit Plan

State Name: New Hampshire Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: NH - 23 - 0056

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, supplemented with FEDVIP pediatric oral and vision benefits.

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

Secretary Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Physician Visits
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State 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.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes physician, primary care, and specialist visits as well as physician/surgical services for outpatient surgery. Specialist visit benefits are available to determine the cause of medically documented infertility and the treatment of that underlying medical condition; does not include artificial insemination, assisted reproductive technologies or diagnostic tests to support AI or AIT. Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided: Other Licensed Practitioner Visits
Source: State Plan 1905(a)
Remove

Authorization: Yes
Provider Qualifications: Medicaid State 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.

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, Certified Midwives, Ophthalmologists/Optometrists, and Podiatrists consistent with their scope of practice. Includes physician, primary care, and specialist visits as well as physician/surgical services for outpatient surgery. Specialist visit benefits are available to determine the cause of medically documented infertility and the treatment of that underlying medical condition; does not include artificial insemination, assisted reproductive technologies or diagnostic tests to support AI or AIT. Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

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

Authorization: None
Provider Qualifications: Medicaid State 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.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Outpatient services for specialist services are available to determine the cause of medically documented infertility and the treatment of that underlying medical condition; does not include artificial insemination, assisted reproductive technologies or diagnostic tests to support AI or AIT. Includes dialysis treatment.

Benefit Provided: Hospice 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: FQHC/RHC 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: Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services include physician, primary care, and specialist visits. Specialist visit benefits are available to determine the cause of medically documented infertility and the treatment of that underlying medical condition; does not include artificial insemination, assisted reproductive technologies or diagnostic tests to support AI or AIT.

Alternative Benefit Plan

Benefit Provided:

Source:

Remove

Authorization:

None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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: Outpatient Hospital/Emergency Hospital Services
Source: State Plan 1905(a)
Remove

Authorization: Yes
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:
Includes emergency room and urgent care

Benefit Provided: Emergency Transportation/Ambulance and Air Amb
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:
Source:
Remove

Authorization: None
Provider Qualifications:
Amount Limit:
Duration Limit:
Scope Limit:

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

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

Benefit Provided: Inpatient Hospital Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State 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, and convenience services.

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.

Remove

Benefit Provided: Physician Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State 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.

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; must meet PA coverage criteria and have lost at least 15% of body weight prior to scheduling bariatric surgery. Service includes reconstructive surgery. Services are available to determine the cause of medically documented infertility and the treatment of that underlying medical condition; does not include artificial insemination, assisted reproductive technologies or diagnostic tests to support AI or AIT. Human organ and tissue transplants are covered, including bone marrow and stem cell transplants.

Remove

Benefit Provided: Other Licensed Practitioner

Source: State Plan 1905(a)

Authorization: Yes

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

As under physician if OLP is providing such services.

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

As under physician if OLP is providing such services.

Benefit Provided:

Source:

Remove

Authorization:

None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

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

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

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Excludes coverage for surrogate parenting or gestational carriers
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inpatient hospital services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Excludes delivery and inpatient coverage for surrogate parenting or gestational carriers
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Minimum stay must allow for coverage for at least 48 hours

---

Benefit Provided: Other licensed practitioner services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Includes APRNs, nurse midwives, certified pediatric and family nurse practitioners, certified midwives. Excludes delivery and inpatient coverage for surrogate parenting or gestational carriers

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

Benefit Provided: FQHC/RHC services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Excludes coverage for surrogate parenting or gestational carriers

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

Benefit Provided: Tobacco Cessation for Pregnant Women

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 8 counseling sessions per each of 2 quit attempts

Duration Limit: None

Scope Limit: Limits can be exceeded via prior authorization based on medical necessity.

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

Benefit Provided: Home health 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:
Extended services to pregnant women

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:
Freestanding birthing centers

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Excludes delivery and inpatient coverage for surrogate parenting or gestational carriers

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

Benefit Provided:
Family Planning Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Add

Alternative Benefit Plan

Collapse All ☐

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

Remove

Benefit Provided: Mental Health Services (dx, screen, prev, rehab)

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State 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:

Provided under "other diagnostic, screening, preventive, and rehabilitative" services and known as "community mental health services." The $1,800 limit per recipient/fiscal year may be exceeded if the recipient is certified to meet the DBH eligibility category criteria. Those who are adults with severe or severe and persistent mental illness with low service utilization are limited to $4,000 which may be exceeded via request to waive. Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits. Benefit does not include services provided in an IMD.

Remove

Benefit Provided: IMD over 65 services

Source: State Plan 1905(a)

Authorization: Yes

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:

Remove

Benefit Provided: SUD - other dx, screening, prev, rehab

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State 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:

Substance Abuse Disorder Services (SUD) are provided under "other diagnostic, screening, preventive, and rehabilitative" services. Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits. 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. SUD includes clinic service of methadone clinics. Benefit does not include services provided in an IMD.

Remove

Benefit Provided:

Inpatient hospital services

Source:

State Plan 1905(a)

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:

Prior authorization required for out of state, inpatient hospitalization. Acute care services only.

Remove

Benefit Provided:

Inpatient psychiatric services, under 22

Source:

State Plan 1905(a)

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:

Remove

Benefit Provided:

Other licensed practitioner services

Source:

State Plan 1905(a)

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:
Physician services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:

Source:

Remove

Authorization:
None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Add

■ 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 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 ☐

Remove

Benefit Provided: Home Health Care Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 20 visit limit/year each therapy type

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:

Includes home health, DME, supplies, and home health-PT/OT/ST services; 20 visit limit applies to therapies and there is a separate 20 visit limit for each type. Therapies provided via home health are combined with therapies provided via independent therapists when counting toward the limit.

Remove

Benefit Provided: Physical, Occupational, Speech Therapy

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 20 visits/year 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, occupational, speech. Benefit limits are shared between outpatient rehabilitation and habilitation services, but the limit can be exceeded based on medical necessity. Prior authorization is required only for services over the limit.

Remove

Benefit Provided: Inpatient hospital

Source: State Plan 1905(a)

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:

Coverage for cardiac rehabilitation and respiratory therapy.

Benefit Provided: Outpatient hospital services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Coverage for cardiac rehabilitation and respiratory therapy

Benefit Provided: Habilitation Services

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 20 visits/year 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, occupational, speech. Benefit limits are shared between outpatient rehabilitation and habilitation services, but the limit can be exceeded based on medical necessity. Prior authorization is required only for services over the limit.

Benefit Provided: Prosthetics

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

Benefits are available for prosthetic devices supported by a letter of medical necessity. Monaural and binaural hearing aids covered as determined medically necessary by the practitioner.

Benefit Provided:

Skilled Nursing Facility Services

Source:

State Plan 1905(a)

Remove

Authorization:

Yes

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Individual must meet functional assessment/level of care criteria

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

Skilled level nursing facility services are covered for care that is not long-term custodial care.

Benefit Provided:

Source:

Remove

Authorization:

None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

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

Benefit Provided: Other Lab and X-Ray Services

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:

No benefits are available for diagnostic x-rays in connection with research or study. Prior authorization is required for the following types of imaging: CT, PET, MRI, MRA, and nuclear cardiology.

Benefit Provided:

Source:

Remove

Authorization: Yes

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Add

■ 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: Physician Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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.

Benefit Provided: Other licensed practitioners

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:

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.

Alternative Benefit Plan

Remove

Benefit Provided: FQHC/RHC

Source: State Plan 1905(a)

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:

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.

Remove

Benefit Provided: EPSDT

Source: State Plan 1905(a)

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:

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.

Remove

Benefit Provided: Nicotine Cessation Counseling

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit:
8 counseling sessions per each of 2 quit attempts

Duration Limit:
None

Scope Limit:
Limits can be exceeded via prior authorization based on medical necessity.

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.

Benefit Provided:
Lactation Consultation 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:
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 ☐

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

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 extraction of asymptomatic teeth. Routine eye exam to determine need for glasses is covered. These benefits may be provided under state plan physician, OLP, FQHC/RHC, EPSDT, and dental services. All medically necessary mandatory and optional Medicaid benefits are provided under EPSDT.

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source:

Authorization: Yes

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source:

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Add

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

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

Base Benchmark Benefit that was Substituted: Emergency Room Services
Source: Base Benchmark
Remove

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

Duplication: Covered under New Hampshire Medicaid state plan as outpatient hospital care/emergency room services under EHB 2.

State plan benefit has no scope limit.

Base Benchmark Benefit that was Substituted: Chiropractic Care
Source: Base Benchmark
Remove

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

Chiropractic services were removed and replaced by substitution with the actuarial value of eye glasses, which are not covered in the base benchmark. Coverage for eyeglasses comes from coverage provided in the State Plan and includes 1 pair bifocals or 1 pair reading and distance vision glasses.
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.

Base Benchmark Benefit that was Substituted: Diabetic Education and Nutritional Therapy
Source: Base Benchmark
Remove

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

Diabetic Education and Nutrition Therapy was removed and replaced by substitution with the actuarial value of adult medical day care which is not covered in the base benchmark.

Base Benchmark Benefit that was Substituted: Primary Care,Specialist,Other Practitioner Visits
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as physician, other licensed practitioner, and FQHC/RHC services and mapped to EHB 1, Ambulatory Patient Services

Base Benchmark Benefit that was Substituted: Outpatient Facility
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as outpatient hospital and mapped to EHB 1, Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as physician and other licensed practitioner services and mapped to EHB 1, Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Hospice Services

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as hospice services and mapped to EHB 1, Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Routine Foot Care

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as other licensed practitioner services and mapped to EHB 1, Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Routine Eye Exam, Adult

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as other licensed practitioner services and mapped to EHB 1, Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Clinic Services-Dialysis Treatment

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as outpatient hospital services (or any other appropriate setting covered under the state plan) and mapped to EHB 1, Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted:	Source:	
Urgent Care Ctrs/Facilities, OP Hospital ER	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 NH Medicaid state plan as outpatient hospital and emergency hospital services and mapped to EHB 2, Emergency Services.

Base Benchmark Benefit that was Substituted:	Source:	
Emergency Transport/Ambulance	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 NH Medicaid state plan as emergency ambulance and air ambulance transportation services and mapped to EHB 2, Emergency Services.

Base Benchmark Benefit that was Substituted:	Source:	
Inpatient Hospital 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 NH Medicaid state plan as inpatient hospital services and mapped to EHB 3, Hospitalization Services.

Base Benchmark Benefit that was Substituted:	Source:	
IP Phys/Surgical/Bariatric/Organ Transplant	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 NH Medicaid state plan as physician and other licensed practitioner and mapped to EHB 3, Hospitalization Services.

Base Benchmark Benefit that was Substituted:	Source:	
Prenatal and Postnatal Care	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 NH Medicaid state plan as physician, other licensed practitioner, FQHC/RHC, tobacco cessation for PW, home health, IP hospital, extended services to PW, freestanding birthing centers, and mapped to EHB 4, Maternity and Newborn Care Services.

Base Benchmark Benefit that was Substituted:	Source:	
Delivery and IP Services for Maternity	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 NH Medicaid state plan as inpatient hospital and freestanding birthing center

services and mapped to EHB 4, Maternity and Newborn Care Services.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health OP Services
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as community mental health center services under other diagnostic, preventive, screening and rehab services; SUD services; physician services; and other licensed practitioner services; and mapped to EHB 5, Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health IP Services
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as IP hospital, IMD over 65, and IP psych under 22, and mapped to EHB 5, Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder (SUD) OP Services
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as SUD under other diagnostic, rehab, preventive and screening services and mapped to EHB 5, Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: SUD IP Services
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as SUD under other diagnostic, rehab, preventive and screening services and IP hospital services, and mapped to EHB 5, Mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Prescription drugs
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as prescribed drugs and mapped to EHB 6, Prescription drugs.

Base Benchmark Benefit that was Substituted: Home Health Care Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under NH Medicaid state plan as home health services and mapped to EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Outpatient rehabilitation and habilitation
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under NH Medicaid state plan as home health-PT/ST/OT services and physical therapy and related services and mapped to EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Respiratory therapy and cardiac rehabilitation
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under NH Medicaid state plan as outpatient and inpatient hospital services and mapped to EHB 7, rehabilitative and habilitative services and devices

Base Benchmark Benefit that was Substituted: DME, supplies, prosthetics, hearing aids
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under NH Medicaid state plan as home health and prosthetics and mapped to EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Skilled nursing facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under NH Medicaid state plan as skilled level nursing facility services and mapped to EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Diagnostic xrays/lab work and Imaging(CT/PET, MRI)
Source: Base Benchmark
Remove

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

Duplication: Covered under NH Medicaid state plan as other lab and x-ray services and mapped to EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: Preventive care/screening/well baby/immunization

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as physician, other licensed practitioner, FQHC/RHC, EPSDT, and mapped to EHB 9, Preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Maternity and Reproductive Health

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as physician, inpatient hospital, other licensed practitioner, FQHC/RHC, and family planning, and mapped to EHB 4, Essential health benefit: maternity and newborn care.

Base Benchmark Benefit that was Substituted: Nicotine Cessation Counseling

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as Nicotine Cessation Counseling - Preventive Service and Mapped to EHB 9, Essential Health Benefit: Preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Lactation Consultation Services

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as Lactation Consultation - Preventive Service and Mapped to EHB 9, Essential Health Benefit: Preventive and wellness services and chronic disease management.

Add

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

☒ 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: Dental for individuals 21 and over
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: $1,500, excluding preventive services
Duration Limit: None
Scope Limit: Diagnostic, preventive, limited periodontics, restorative, and oral surgery services.
Other: Benefit is the same as described in the Medicaid State Plan. No authorization is required. "Authorization - Other" = None

Other 1937 Benefit Provided: Private Duty Nursing
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: Must meet functional assessment

Other 1937 Benefit Provided:
Personal Care Attendant Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Must be chronically wheelchair bound. "Authorization - Other" = None

Other 1937 Benefit Provided:
AMDC (dx, screen, prev, rehab)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
"Authorization - Other" = None. Adult medical day care (AMDC) is provided under "other diagnostic, screening, preventive, and rehabilitative services."

Other 1937 Benefit Provided:
Eyeglasses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
1 pair bifocals or 1 pair reading and distance vision glasses. "Authorization - Other" = None

Other:
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.

Remove

Other 1937 Benefit Provided: Intermediate Level Nursing Facility Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Individual must meet functional assessment/level of care criteria

Other: Must meet level of care, as in scope above. Services are covered for long term custodial care.

Remove

Other 1937 Benefit Provided: Targeted Case Management

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: as per state plan

Scope Limit: None

Other: "Authorization-Other" = None. TCM includes developmentally disabled, behavioral health, chronically ill children, adult and elderly, and EPSDT case management. For those transitioning to a community setting, number of consecutive days varies among the various types of TCM as per the state plan details.

Remove

Other 1937 Benefit Provided: 1915(i) HCBC Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: See other below

Duration Limit: See other below

Scope Limit:
See other below

Other:
HCBC 1915(i) for children age 5 up to 21 years of age with Severe Emotional Disturbance. Based on functional assessment. There are various limits and time frames in the extensive service details of the various components of the 1915(i) as specified in Attachment 3.1(i) of the state plan.

Other 1937 Benefit Provided:
ICF-IDD

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Individual must meet functional assessment/level of care criteria

Other:
Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF-IDD) are covered and based on functional assessment/level of care noted above

Other 1937 Benefit Provided:
Non-Routine Foot Care

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Yes

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
"Authorization-Other" = None. Provided under "other licensed practitioner" (podiatrist).

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Varies

Duration Limit:
Varies

Scope Limit:
Varies

Other:
See Attachment 3.1-A, Page 12, Item 30; and Attachment 3.1-B, Page 12, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials in New Hampshire's Medicaid State Plan.

Other 1937 Benefit Provided:
Medication Assisted Treatment (MAT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
MAT is provided as defined in the approved State Plan 3.1-A, Page 6 pre-a 1-3, Supplement Page 13-25; and Attachment 3.1-B, Page 5-a 1-3, Supplement Page 13-25.
MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

Other 1937 Benefit Provided:

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add

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

PRA Disclosure Statement

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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