Table of Contents

State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 25-0005

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

June 17, 2025

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

Re: New Hampshire State Plan Amendment (SPA) 25-0005

Dear Commissioner Weaver:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0005. This amendment proposes to include coverage of and the Medicaid reimbursement rate methodology for targeted case management services for eligible juveniles as defined by Section 1902(nn)(2) of the Social Security Act.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR § 440.300. This letter informs you that New Hampshire's Medicaid SPA TN 25-0005 was approved on June 17, 2025, effective January 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the New Hampshire State Plan.

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

Sincerely,

[redacted]

Ruth A. Hughes, Acting Director
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-25-0005

Proposed Effective Date

01/01/2025 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1937 of the Social Security Act, 42 CFR 440.300 et seq

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2025	$ 0.00
Second Year	2026	$ 0.00

Subject of Amendment

Targeted Case Management for Substance Use Disorder

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:	**Apr 10, 2025**
Submit Date:	**Mar 31, 2025**

Alternative Benefit Plan

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

Transmittal Number: NH - 25 - 0005

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

Alternative Benefit 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:

Alternative Benefit Plan

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

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided: Inpatient Hospital Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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.

Benefit Provided: Physician Services

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:

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.

Benefit Provided: Other Licensed Practitioner

Source: State Plan 1905(a)

Remove

Authorization: Yes

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

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

Alternative Benefit Plan

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

Alternative Benefit Plan

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

Alternative Benefit 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

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

Collapse All ☐

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.

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:

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.

Benefit Provided: Inpatient psychiatric services, under 21

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:

Benefit Provided: Other licensed practitioner services

Source: State Plan 1905(a)

Remove

Alternative Benefit Plan

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 ☐

Benefit Provided: Home Health Care Services

Source: State Plan 1905(a)

Remove

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.

Benefit Provided: Physical, Occupational, Speech Therapy

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: Inpatient hospital

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: 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

Alternative Benefit Plan

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

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: 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.

Benefit Provided: FQHC/RHC

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: EPSDT

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: Nicotine Cessation Counseling

Source: State Plan 1905(a)

Remove

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 ☐

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 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.

Benefit Provided: Medicaid State Plan EPSDT Benefits

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:

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source:

Remove

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 ☐

Alternative Benefit Plan

☒ 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: Urgent Care Ctrs/Facilities, OP Hospital ER

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 emergency hospital services and mapped to EHB 2, Emergency Services.

Base Benchmark Benefit that was Substituted: Emergency Transport/Ambulance

Source: Base Benchmark

Remove

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

Duplication: Covered under 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: Inpatient Hospital Services

Source: Base Benchmark

Remove

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

Duplication: Covered under NH Medicaid state plan as inpatient hospital services and mapped to EHB 3, Hospitalization Services.

Base Benchmark Benefit that was Substituted: IP Phys/Surgical/Bariatric/Organ Transplant

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 and mapped to EHB 3, Hospitalization Services.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal 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 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: Delivery and IP Services for Maternity

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 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 21, 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 ☐

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: 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.

Other 1937 Benefit Provided:
Intermediate Level Nursing Facility 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:
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.

Other 1937 Benefit Provided:
Targeted Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
as per state plan

Scope Limit:
None

Other:
"Authorization-Other" = None. TCM includes developmentally disabled, behavioral health, chronically ill children, adult and elderly, substance use disorder, 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.

Other 1937 Benefit Provided:
1915(i) HCBC Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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:
Crisis Stabilization

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below

Other:
Crisis Stabilization is an outpatient service providing up to 30-days of stabilization services per crisis episode. Crisis Stabilization includes services that are designed to ameliorate or minimize an acute crisis episode or to prevent incarceration, emergency department, inpatient psychiatric hospitalization, or medical detoxification. Services are provided to recipients who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods which could threaten the safety of self or others.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Mobile Crisis Response and Stabilization 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:
See below

Other:
Mobile Crisis Response and Stabilization Services (MCRSS) are intended to provide rapid crisis response, individual assessment, and evaluation and treatment of mental health crisis to individuals experiencing a mental health crisis or substance use disorder crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow. MCRSS will be available 24 hours a day, 7 days a week, 365 days per year basis and where the individual is experiencing a mental health crisis and shall not be restricted to select locations within any region on particular days or times and must address substance use disorders, including opioid use disorder, if identified. MCRSS are furnished outside of a hospital or other facility setting. MCRSS are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. MCRSS involve all services, supports, and treatments necessary to provide a timely crisis response, crisis interventions such as de-escalation, and crisis prevention activities specific to the needs of the individual. At a minimum, MCRSS include initial response of conducting immediate crisis screening and assessment, mobile crisis stabilization and de-escalation, and coordination with and referral to health, social and other services as needed to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization. All MCRSS must be provided under the supervision of an independently licensed behavioral health professional who must be available to provide real time clinical assessment in person or via telehealth.

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.

V.20160722