### **Table of Contents**

**State/Territory Name: New Hampshire** 

State Plan Amendment (SPA) #: 23-0056

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

### DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 601 E. 12th St., Room 355 Kansas City, Missouri 64106



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.



**Division of Program Operations** 

### Enclosures

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

State/Territory name:		New Hampshire	
Transmittal Number		T FALL CONTRACTOR OF THE STATE	es na agree y e
		shes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being option of gits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = 0	
alpha/numeric suff		,,	
NH-23-0056			
D 1 E00 E	NO.		
Proposed Effective I	ate		
07/01/2023	(mm/dd/yyyy)		
Federal Statute/Regi	ılation Citation		
Section 1905(a)			
Federal Budget Imp			
	Federal Fiscal Yea	ar Amount	
First Year	2023	\$ 3750.00	
		3 37 30.00	
Second Year	2024	£ 45000.00	
		\$ 15000.00	
Subject of Amendme			
Mandatory Med	icaid State Plan Coverage o	of Lactation Consultation Services	
			le
Governor's Office R	eview		
	r's office reported no com	iment	
The second second	its of Governor's office red		
Describe:			
			//
O No reply	received within 45 days o	of submittal	
Other, as			
Describe:			
commen	ts if any, will follow		
			/.
Signature of State A	gency Official		
Submitted By:		Jody Farwell	
Last Revision I	Date:	Nov 1, 2023	
Submit Date:		Sep 29, 2023	



State Name: New Hampshire	Attachment 3.1-L- OME	3 Control Number: 09381148
Transmittal Number: NH - 23 - 0056		
Alternative Benefit Plan Populations		ABP1
Identify and define the population that will participate in the Altern	native Benefit Plan.	
Alternative Benefit Plan Population Name: New Hampshire Adu	lt Group	
Identify eligibility groups that are included in the Alternative Bene targeting criteria used to further define the population.	efit Plan's population, and which may conta	in individuals that meet any
Eligibility Groups Included in the Alternative Benefit Plan Populat	ion:	
Eligibility Grou	ıp:	Enrollment is mandatory or voluntary?
+ Adult Group		Mandatory X
Enrollment is available for all individuals in these eligibility group	yes Yes	
Geographic Area		
The Alternative Benefit Plan population will include individuals fro	om the entire state/territory.	
Any other information the state/territory wishes to provide about the	ne population (optional)	
Effective January 1, 2019, New Hampshire will provide coverage network. In order to be eligible for the ABP, individuals must me (1902(a)(10)(A)(i)(VIII)(42 CFR 435.119) and the requirements o demonstration will receive the 10 Essential Health Benefits throug State Plan benefit package for ease of administration.	et the eligibility requirements of the adult and the first the 1115 demonstration. Adults in the G	group Granite Advantage

### 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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State Name: New Hampshire	Attachment 3.1-L-	OMB Control Number: 09381148
Transmittal Number: NH - 23 - 0056	· —	
<b>Voluntary Benefit Package Selection Assurances - El</b>	ligibility Group under	ABP2a
Section 1902(a)(10)(A)(i)(VIII) of the Act		ADI Za
The state/territory has fully aligned its benefits in the Alternative E requirements with its Alternative Benefit Plan that is the state's apprequirements. Therefore the state/territory is deemed to have met individuals exempt from mandatory participation in a section 1937	proved Medicaid state plan that is n the requirements for voluntary choice	not subject to 1937
Explain how the state has fully aligned its benefits in the Alternative requirements with its Alternative Benefit Plan that is the state's applications.	C	3
New Hampshire has fully aligned the benefits in its ABP with its a plan that are not included in the current state plan will be added to		

### PRA Disclosure Statement

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State Name: New Hampshire	Attachment 3.1-L- OMB Control	l Number: 09381148
Transmittal Number: NH - 23 - 0056	Attachment 3.1-L-	
Selection of Benchmark Benefit Package	or Benchmark-Equivalent Benefit Package	ABP3
Select one of the following:		
The state/territory is amending one existing	benefit package for the population defined in Section 1.	
The state/territory is creating a single new be	penefit package for the population defined in Section 1.	
Name of benefit package: New Hampshire	e Aligned Medicaid ABP	
Selection of the Section 1937 Coverage Option		
The state/territory selects as its Section 1937 Covera Equivalent Benefit Package under this Alternative B	age option the following type of Benchmark Benefit Package or Benefit Plan (check one):	enchmark-
Benchmark Benefit Package.		
Benchmark-Equivalent Benefit Package.		
The state/territory will provide the following	g Benchmark Benefit Package (check one that applies):	
The Standard Blue Cross/Blue Shie Program (FEHBP).	eld Preferred Provider Option offered through the Federal Employ	ee Health Benefit
State employee coverage that is off	fered and generally available to state employees (State Employee	Coverage):
A commercial HMO with the larger HMO):	est insured commercial, non-Medicaid enrollment in the state/territ	cory (Commercial
Secretary-Approved Coverage.		
The state/territory offers benefit	fits based on the approved state plan.	
	ray of benefits from the section 1937 coverage option and/or base ved state plan, or from a combination of these benefit packages.	benchmark plan
The state/territory offers the	he 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 pr	provided in the approved state plan but in a different amount, durate	ion and/or scope.
The state/territory offers o	only a partial list of benefits provided in the approved state plan.	
The state/territory offers a	a partial list of benefits provided in the approved state plan plus ad	ditional benefits.
Please briefly identify the benefits.	s, the source of benefits and any limitations:	
base benchmark have been accour	commensurate with the State Plan. (1) The state assures that all sented for throughout the benefit chart found in ABP 5; and (2) The ABP5 depicting amount, duration and scope parameters of service id State Plan.	state assures

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Selection of Base Benchmark Plan



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

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## **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	e Alternative Benefit Plan.	
Attachment 4.18-A may be revised to include cost sharing for ABP cost sharing must comply with Section 1916 of the Social Security	Act.	
The Alternative Benefit Plan for individuals with income over 100 Attachment 4.18-A.	% FPL includes cost-sharing oth	ner than that described in No
Other Information Related to Cost Sharing Requirements (optional	l):	
Cost sharing is described on pages G1-G3 of the cost sharing section Attachment 4.18-A.	ons of the state plan. These state	e plan pages have superseded

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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 pac	kage. 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 Pl	an, supplemented with FEDVIP pe	diatric oral and vision benefits.
Enter the specific name of the section 1937 coverage option selected Approved."	ed, if other than Secretary-Approve	d. Otherwise, enter "Secretary-
Secretary Approved		

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Benefit Provided:	Source:	Remove
Physician Visits	State Plan 1905(a)	remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
	sterilization, schlerotherapy for varicose veins and treatment	
Other information regarding this benefit, incl benchmark plan:	uding the specific name of the source plan if it is not the base	
surgery. Specialist visit benefits are available and the treatment of that underlying medical reproductive technologies or diagnostic tests	list visits as well as physician/surgical services for outpatient le to determine the cause of medically documented infertility condition; does not include artificial insemination, assisted to support AI or AIT. Prior authorization required for the y, breast reduction, blepharoplasty, panniculectomy,	
Benefit Provided:	Source:	Remove
Other Licensed Practitioner Visits	State Plan 1905(a)	remove
Authorization:	Provider Qualifications:	
Yes	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
	sterilization, schlerotherapy for varicose veins and treatment	
of spider veins.		
of spider veins.  Other information regarding this benefit, incl benchmark plan:	uding the specific name of the source plan if it is not the base	
of spider veins.  Other information regarding this benefit, includenchmark plan:  Includes Advance Practice Registered Nurse Ophthalmologists/Optometrists, and Podiatri primary care, and specialist visits as well as visit benefits are available to determine the contact that underlying medical condition; does not intechnologies or diagnostic tests to support Allerence.	duding the specific name of the source plan if it is not the base specific name of the source plan if it is not the base specifically specifically specifically specifically specifically specifically documented infertility and the treatment of include artificial insemination, assisted reproductive or AIT. Prior authorization required for the following surgical blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.	
of spider veins.  Other information regarding this benefit, incl benchmark plan:  Includes Advance Practice Registered Nurse Ophthalmologists/Optometrists, and Podiatri primary care, and specialist visits as well as visit benefits are available to determine the contact that underlying medical condition; does not intechnologies or diagnostic tests to support Adservices: bariatric surgery, breast reduction,	s, Physician Assistant, Nurse Practitioner, Certified Midwives, ists consistent with their scope of practice. Includes physician, physician/surgical services for outpatient surgery. Specialist cause of medically documented infertility and the treatment of include artificial insemination, assisted reproductive I or AIT. Prior authorization required for the following surgical	Remove
of spider veins.  Other information regarding this benefit, incl benchmark plan:  Includes Advance Practice Registered Nurse Ophthalmologists/Optometrists, and Podiatri primary care, and specialist visits as well as visit benefits are available to determine the c that underlying medical condition; does not it technologies or diagnostic tests to support Asservices: bariatric surgery, breast reduction,  Benefit Provided:	s, Physician Assistant, Nurse Practitioner, Certified Midwives, ists consistent with their scope of practice. Includes physician, physician/surgical services for outpatient surgery. Specialist cause of medically documented infertility and the treatment of include artificial insemination, assisted reproductive I or AIT. Prior authorization required for the following surgical blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.	Remove
of spider veins.  Other information regarding this benefit, includenchmark plan:  Includes Advance Practice Registered Nurse Ophthalmologists/Optometrists, and Podiatri primary care, and specialist visits as well as visit benefits are available to determine the contact that underlying medical condition; does not intechnologies or diagnostic tests to support Allerence of the contact of the cont	s, Physician Assistant, Nurse Practitioner, Certified Midwives, ists consistent with their scope of practice. Includes physician, physician/surgical services for outpatient surgery. Specialist cause of medically documented infertility and the treatment of include artificial insemination, assisted reproductive I or AIT. Prior authorization required for the following surgical blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.  Source:	Remove

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	Duration Limit:	
None	None	
Scope Limit:  Excludes coverage for reversal of v of spider veins.	voluntary sterilization; schlerotherapy for varicose veins and treatment	
Other information regarding this ben benchmark plan:	nefit, including the specific name of the source plan if it is not the base	
infertility and the treatment of that u	rvices are available to determine the cause of medically documented underlying medical condition; does not include artificial insemination, or diagnostic tests to support AI or AIT. Includes dialysis treatment.	
nefit Provided:	Source:	Remove
spice Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this ben	nefit, including the specific name of the source plan if it is not the base	
benchmark plan:	nefit, including the specific name of the source plan if it is not the base	
benchmark plan:	Source:	Remove
benchmark plan:	Source: State Plan 1905(a)	Remove
benchmark plan:  nefit Provided: HC/RHC Services  Authorization:	Source: State Plan 1905(a) Provider Qualifications:	Remove
hefit Provided: HC/RHC Services	Source: State Plan 1905(a)	Remove
benchmark plan:  nefit Provided: HC/RHC Services  Authorization:	Source: State Plan 1905(a) Provider Qualifications:	Remove
benchmark plan:  nefit Provided: HC/RHC Services  Authorization: None	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan	Remove
benchmark plan:  nefit Provided: HC/RHC Services  Authorization: None  Amount Limit:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
benchmark plan:  nefit Provided: HC/RHC Services  Authorization: None  Amount Limit: None	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
benchmark plan:  nefit Provided: HC/RHC Services  Authorization: None  Amount Limit: None  Scope Limit: None Other information regarding this benchmark plan:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove

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nefit Provided:	Source:	Remov
Authorization:	Provider Qualifications:	
None		
Amount Limit:	Duration Limit:	
Scope Limit:		
	fit, including the specific name of the source plan if it is not the base	
benchmark plan:		

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. Essential Health Benefit: Emergency services		Collapse All
Benefit Provided:	Source:	Remove
Outpatient Hospital/Emergency Hospital Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Yes	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	]
Scope Limit:		_
None		
benchmark plan:  Includes emergency room and urgent care	the specific name of the source plan if it is not the base	
Benefit Provided:	Source:	Remove
Emergency Transportation/Ambulance and Air Amb	State Plan 1905(a)	
Authorization:	Provider Qualifications:	_
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	_
None	None	
Scope Limit:		_
None		
Other information regarding this benefit, including benchmark plan:  Benefit Provided:	the specific name of the source plan if it is not the base  Source:	Remove
Authorization:	Provider Qualifications:	_
None		
Amount Limit:	Duration Limit:	7
Scope Limit:		_
		7

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

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Benefit Provided:	Source:	Remove
Inpatient Hospital Services	State Plan 1905(a)	Kemove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Excludes coverage for reversal of voluntary of spider veins, and convenience services.	v sterilization; schlerotherapy for varicose veins and treatment luding the specific name of the source plan if it is not the base	
benchmark plan: Prior authorization is required only for out-out-out-out-out-out-out-out-out-out-	of-state inpatient hospitalization.	
Benefit Provided:	Source:	Remove
Physician Services	State Plan 1905(a)	remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
	sterilization, schlerotherapy for varicose veins and treatment	
Other information regarding this benefit, inc benchmark plan:	luding the specific name of the source plan if it is not the base	
blepharoplasty, panniculectomy, septoplasty at least 15% of body weight prior to schedul Services are available to determine the caus underlying medical condition; does not include	g surgical services: bariatric surgery, breast reduction, y, and rhinoplasty; must meet PA coverage criteria and have lost ling bariatric surgery. Service includes reconstructive surgery. e of medically documented infertility and the treatment of that ade artificial insemination, assisted reproductive technologies or an organ and tissue transplants are covered, including bone	
Benefit Provided:	Source:	Remove
Other Licensed Practitioner	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Yes	Medicaid State Plan	
Amount Limit:	Duration Limit:	
	None	

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	fit, including the specific name of the source plan if it is not the base	
benchmark plan: As under physician if OLP is providing	ng such services.	
nefit Provided:	Source:	Remove
Authorization:	Provider Qualifications:	
None Amount Limit:	Duration Limit:	
Scope Limit:		
Other information regarding this bene benchmark plan:	fit, including the specific name of the source plan if it is not the base	

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Benefit Provided:	Source:	Remove
Physician Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Excludes coverage for surrogate parenting	g or gestational carriers	
Other information regarding this benefit, ir benchmark plan:	acluding the specific name of the source plan if it is not the	base
Benefit Provided:	Source:	Remove
npatient hospital services	State Plan 1905(a)	Temove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Excludes delivery and inpatient coverage	for surrogate parenting or gestational carriers	
Other information regarding this benefit, ir benchmark plan:  Minimum stay must allow for coverage fo	r at least 48 hours	base
Benefit Provided:	Source:	Remove
Other licensed practitioner services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Amount Limit:		
None None	None	

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benchmark plan:		
enefit Provided:	Source:	D
FQHC/RHC services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None None	
Scope Limit:		
Excludes coverage for surrogate parenting or gestati	ional carriers	
Other information regarding this benefit, including the benchmark plan:	ne specific name of the source plan if it is not the base	
enefit Provided: Cobacco Cessation for Pregnant Women	Source: State Plan 1905(a)	Remove
Cobacco Cessation for Pregnant Women	State Plan 1905(a)	Remove
Obacco Cessation for Pregnant Women  Authorization:	State Plan 1905(a) Provider Qualifications:	Remove
Cobacco Cessation for Pregnant Women  Authorization:  Prior Authorization	State Plan 1905(a) Provider Qualifications:  Medicaid State Plan	Remove
Authorization: Prior Authorization Amount Limit:	State Plan 1905(a) Provider Qualifications:  Medicaid State Plan  Duration Limit:	Remove
Authorization: Prior Authorization  Amount Limit: 8 counseling sessions per each of 2 quit attempts	State Plan 1905(a) Provider Qualifications:  Medicaid State Plan	Remove
Authorization: Prior Authorization Amount Limit:	State Plan 1905(a) Provider Qualifications:  Medicaid State Plan Duration Limit: None	Remove
Authorization: Prior Authorization  Amount Limit: 8 counseling sessions per each of 2 quit attempts Scope Limit: Limits can be exceeded via prior authorization based	State Plan 1905(a) Provider Qualifications:  Medicaid State Plan Duration Limit: None	Remove
Authorization: Prior Authorization  Amount Limit: 8 counseling sessions per each of 2 quit attempts Scope Limit: Limits can be exceeded via prior authorization based Other information regarding this benefit, including the benchmark plan:  enefit Provided:	State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  d on medical necessity.  ne specific name of the source plan if it is not the base  Source:	Remove
Authorization: Prior Authorization  Amount Limit: 8 counseling sessions per each of 2 quit attempts  Scope Limit: Limits can be exceeded via prior authorization based  Other information regarding this benefit, including the benchmark plan:	State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  d on medical necessity.  se specific name of the source plan if it is not the base	
Authorization: Prior Authorization Amount Limit: 8 counseling sessions per each of 2 quit attempts Scope Limit: Limits can be exceeded via prior authorization based Other information regarding this benefit, including the benchmark plan:  enefit Provided: Home health services  Authorization:	State Plan 1905(a) Provider Qualifications:  Medicaid State Plan  Duration Limit: None  d on medical necessity.  se specific name of the source plan if it is not the base  Source: State Plan 1905(a) Provider Qualifications:	
Authorization: Prior Authorization  Amount Limit: 8 counseling sessions per each of 2 quit attempts  Scope Limit: Limits can be exceeded via prior authorization based  Other information regarding this benefit, including the benchmark plan:  enefit Provided: Home health services	State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  d on medical necessity.  se specific name of the source plan if it is not the base  Source:  State Plan 1905(a)	

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None		
	including the specific name of the source plan if it is not the base	e
benchmark plan:		_
enefit Provided:	Source:	Remove
Extended services to pregnant women	State Plan 1905(a)	Temove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
benchmark plan:	including the specific name of the source plan if it is not the base	
benchmark plan:  Benefit Provided:	Source:	Remove
benchmark plan:  Benefit Provided:		
benchmark plan:  senefit Provided:	Source:	
enefit Provided:  Greestanding birthing centers	Source: State Plan 1905(a)	
enefit Provided: Freestanding birthing centers  Authorization:	Source: State Plan 1905(a) Provider Qualifications:	
benchmark plan:  enefit Provided: Freestanding birthing centers  Authorization:  None	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan	
enefit Provided: Treestanding birthing centers  Authorization: None  Amount Limit: None  Scope Limit:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None	
benchmark plan:  Genefit Provided: Greestanding birthing centers  Authorization:  None  Amount Limit:  None  Scope Limit:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	
benchmark plan:  Genefit Provided: Greestanding birthing centers  Authorization: None  Amount Limit: None  Scope Limit: Excludes delivery and inpatient coverage	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
benchmark plan:  Genefit Provided:  Greestanding birthing centers  Authorization:  None  Amount Limit:  None  Scope Limit:  Excludes delivery and inpatient coverage	Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  e for surrogate parenting or gestational carriers	Remove
benchmark plan:  Genefit Provided: Freestanding birthing centers  Authorization: None  Amount Limit: None  Scope Limit:  Excludes delivery and inpatient coverage  Other information regarding this benefit,	Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  e for surrogate parenting or gestational carriers	Remove
benchmark plan:  Genefit Provided: Freestanding birthing centers  Authorization: None  Amount Limit: None  Scope Limit:  Excludes delivery and inpatient coverage  Other information regarding this benefit,	Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  e for surrogate parenting or gestational carriers	Remove
enefit Provided: Freestanding birthing centers  Authorization: None  Amount Limit: None  Scope Limit: Excludes delivery and inpatient coverag Other information regarding this benefit, benchmark plan: enefit Provided:	Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  e for surrogate parenting or gestational carriers	Remove
benchmark plan:  Benefit Provided:  Freestanding birthing centers  Authorization:  None  Amount Limit:  None  Scope Limit:  Excludes delivery and inpatient coverag  Other information regarding this benefit, benchmark plan:  Benefit Provided:	Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  e for surrogate parenting or gestational carriers  including the specific name of the source plan if it is not the base	Remove
benchmark plan:  Benefit Provided: Freestanding birthing centers  Authorization: None  Amount Limit: None  Scope Limit:  Excludes delivery and inpatient coverage  Other information regarding this benefit,	Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:  None  e for surrogate parenting or gestational carriers  including the specific name of the source plan if it is not the base  Source:	Remove

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Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
	enefit, including the specific name of the source plan if it is not the bas	se
Uther information regarding this be	enefit, including the specific name of the source plan if it is not the bas	se
Uther information regarding this be	enefit, including the specific name of the source plan if it is not the bas	se

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Benefit Provided:	Source:	Remove
Mental Health Services (dx, screen, prev, rehab)	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	_
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	_
None	None	
Scope Limit:		_
See below.		
recipient is certified to meet the DBH eligibility c severe and persistent mental illness with low serv exceeded via request to waive. Benefits are availa-	limit per recipient/fiscal year may be exceeded if the rategory criteria. Those who are adults with severe or ice utilization are limited to \$4,000 which may be	
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan	Remove
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit: None  Scope Limit:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit: None  Scope Limit: None	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other information regarding this benefit, including benchmark plan:  Benefit Provided:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None g the specific name of the source plan if it is not the base  Source: Source:	Remove
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other information regarding this benefit, including benchmark plan:  Benefit Provided: SUD - other dx, screening, prev, rehab	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None  Source: State Plan 1905(a)  Provider Qualifications: Medicaid State Plan  Source: State Plan 1905(a)	
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other information regarding this benefit, including benchmark plan:  Benefit Provided: SUD - other dx, screening, prev, rehab  Authorization:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None  Source: State Plan 1905(a) Provider Qualifications:	
provided in an IMD.  Benefit Provided: IMD over 65 services  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other information regarding this benefit, including benchmark plan:  Benefit Provided: SUD - other dx, screening, prev, rehab	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None  Source: State Plan 1905(a)  Provider Qualifications: Medicaid State Plan  Source: State Plan 1905(a)	

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Scope Limit: See below.		
	uding the specific name of the source plan if it is not the base	
Substance Abuse Disorder Services (SUD) a rehabilitative" services. Benefits are availab abuse care, partial hospitalizations, and day/r services or residential treatment center facilit substance abuse care in a hospital or substance	re provided under "other diagnostic, screening, preventive, and le for outpatient treatment for mental health care and substance night visits. Benefits are available for inpatient hospital ty for mental health care; inpatient rehabilitation treatment for ce abuse treatment facility; partial hospitalizations; and to f methadone clinics. Benefit does not include services	
Benefit Provided:	Source:	Remove
Inpatient hospital services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
	rone	
Scope Limit:		
Other information regarding this benefit, includenchmark plan:	uding the specific name of the source plan if it is not the base	
benchmark plan:	uding the specific name of the source plan if it is not the base inpatient hospitalization. Acute care services only.	
benchmark plan:  Prior authorization required for out of state, i  Benefit Provided:		Remove
benchmark plan:  Prior authorization required for out of state, i	inpatient hospitalization. Acute care services only.	Remove
benchmark plan:  Prior authorization required for out of state, i  Benefit Provided:	Inpatient hospitalization. Acute care services only.  Source:	Remove
benchmark plan:  Prior authorization required for out of state, i  Benefit Provided:  Inpatient psychiatric services, under 22	Source:  State Plan 1905(a)	Remove
benchmark plan: Prior authorization required for out of state, i  Benefit Provided: Inpatient psychiatric services, under 22  Authorization:	Source: State Plan 1905(a) Provider Qualifications:	Remove
benchmark plan: Prior authorization required for out of state, i  Benefit Provided: Inpatient psychiatric services, under 22  Authorization: Prior Authorization	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan	Remove
benchmark plan: Prior authorization required for out of state, i  Benefit Provided: Inpatient psychiatric services, under 22  Authorization: Prior Authorization  Amount Limit:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
benchmark plan: Prior authorization required for out of state, i  Benefit Provided: Inpatient psychiatric services, under 22  Authorization: Prior Authorization  Amount Limit: None	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
benchmark plan: Prior authorization required for out of state, i  Benefit Provided: Inpatient psychiatric services, under 22  Authorization: Prior Authorization  Amount Limit: None  Scope Limit: None	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
benchmark plan:  Prior authorization required for out of state, i  Benefit Provided:  Inpatient psychiatric services, under 22  Authorization:  Prior Authorization  Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, incl-benchmark plan:	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
benchmark plan:  Prior authorization required for out of state, i  Benefit Provided:  Inpatient psychiatric services, under 22  Authorization:  Prior Authorization  Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, incl-	Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove

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Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this be benchmark plan:	nefit, including the specific name of the source plan if it is not th	ne base
enefit Provided:	Source:	Remove
Physician services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
	nefit, including the specific name of the source plan if it is not th	ne base
None	nefit, including the specific name of the source plan if it is not the	
None Other information regarding this be benchmark plan: enefit Provided:	Source:	
None Other information regarding this be benchmark plan: enefit Provided:  Authorization:		
None Other information regarding this be benchmark plan: enefit Provided:	Source:	
None Other information regarding this be benchmark plan: enefit Provided:  Authorization: None	Source: Provider Qualifications:	
None Other information regarding this be benchmark plan: enefit Provided:  Authorization: None Amount Limit:  Scope Limit:	Source: Provider Qualifications:	Remove

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# Alternative Benefit Plan

Essential Health Benefit: Prescription drugs		
nefit Provided:		
Coverage is at least the greater of one drug in each same number of prescription drugs in each categor	1 \	, ,
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		
Coverage that exceeds the minimum requirements	or other:	
The ABP prescription drug benefit plan is the same prescribed drugs.	e as under the approved M	ledicaid state plan for

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Benefit Provided:	Source:	Remove
Home Health Care Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	_
Prior Authorization	Medicaid State Plan	]
Amount Limit:	Duration Limit:	_
20 visit limit/year each therapy type	None	]
Scope Limit:		
No benefits are available for custodial care.		]
benchmark plan:	ading the specific name of the source plan if it is not the base	-
therapies and there is a separate 20 visit limit	ome health-PT/OT/ST services; 20 visit limit applies to for each type. Therapies provided via home health are indent therapists when counting toward the limit.	
Benefit Provided:	Source:	Remove
Physical, Occupational, Speech Therapy	State Plan 1905(a)	
Authorization:	Provider Qualifications:	_
Prior Authorization	Medicaid State Plan	]
Amount Limit:	Duration Limit:	_
20 visits/year for each therapy type	None	
Scope Limit:		_
See below.		]
benchmark plan:  There is a separate 20 visit limit for each of the speech. Benefit limits are shared between out	nding the specific name of the source plan if it is not the base me following types of therapies physical, occupational, tpatient rehabilitation and habilitation services, but the limit Prior authorization is required only for services over the limit.	
Benefit Provided:	Source:	Remove
Inpatient hospital	State Plan 1905(a)	Remove
	Provider Qualifications:	_
Authorization:	1 10 vider Quantifications.	7
	Medicaid State Plan	
Authorization:		
Authorization: None	Medicaid State Plan	]

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Coverage for cardiac rehabilitation and respin	ratory therapy.	
Benefit Provided:	Source:	Remove
Outpatient hospital services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, includenchmark plan:  Coverage for cardiac rehabilitation and respin	uding the specific name of the source plan if it is not the base ratory therapy	
enefit Provided: [abilitation Services	Source: State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
20 visits/year for each therapy type	None	
Scope Limit:		
See below.		
	uding 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 t	the following types of therapies physical occupational speech l	
There is a separate 20 visit limit for each of the Benefit limits are shared between outpatient	rehabilitation and habilitation services, but the limit can be authorization is required only for services over the limit.	
There is a separate 20 visit limit for each of the Benefit limits are shared between outpatient and exceeded based on medical necessity. Prior and exceeded based on medical necessity.	rehabilitation and habilitation services, but the limit can be	Remove
There is a separate 20 visit limit for each of the Benefit limits are shared between outpatient exceeded based on medical necessity. Prior at enefit Provided:	rehabilitation and habilitation services, but the limit can be authorization is required only for services over the limit.	Remove
There is a separate 20 visit limit for each of the Benefit limits are shared between outpatient exceeded based on medical necessity. Prior at enefit Provided:	rehabilitation and habilitation services, but the limit can be authorization is required only for services over the limit.  Source:  State Plan 1905(a)	Remove
There is a separate 20 visit limit for each of the Benefit limits are shared between outpatient exceeded based on medical necessity. Prior and enefit Provided:	rehabilitation and habilitation services, but the limit can be authorization is required only for services over the limit.  Source:	Remove
There is a separate 20 visit limit for each of the Benefit limits are shared between outpatient exceeded based on medical necessity. Prior and Benefit Provided:  Prosthetics  Authorization:	rehabilitation and habilitation services, but the limit can be authorization is required only for services over the limit.  Source:  State Plan 1905(a)  Provider Qualifications:	Remove

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Other information regarding this benefit, benchmark plan:	including the specific name of the source plan if it is not the base	
	ces supported by a letter of medical necessity. Monaural and	1
	ned medically necessary by the practitioner.	
nefit Provided:	Source:	Remove
illed Nursing Facility Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	_
Yes	Medicaid State Plan	
Amount Limit:	Duration Limit:	_
None	None	
Scope Limit:		
Individual must meet functional assessn  Other information regarding this benefit, benchmark plan:	nent/level of care criteria including the specific name of the source plan if it is not the base covered for care that is not long-term custodial care.	]
Individual must meet functional assessn  Other information regarding this benefit, benchmark plan:	including the specific name of the source plan if it is not the base covered for care that is not long-term custodial care.	Pamous
Individual must meet functional assessment of their information regarding this benefit, benchmark plan:  Skilled level nursing facility services are	including the specific name of the source plan if it is not the base	Remove
Individual must meet functional assessment of their information regarding this benefit, benchmark plan:  Skilled level nursing facility services are	including the specific name of the source plan if it is not the base covered for care that is not long-term custodial care.  Source:	Remove
Individual must meet functional assessment of the information regarding this benefit, benchmark plan:  Skilled level nursing facility services are mefit Provided:	including the specific name of the source plan if it is not the base covered for care that is not long-term custodial care.	Remove
Individual must meet functional assessn Other information regarding this benefit, benchmark plan: Skilled level nursing facility services are nefit Provided:  Authorization:	including the specific name of the source plan if it is not the base covered for care that is not long-term custodial care.  Source:	Remove
Individual must meet functional assessment of the information regarding this benefit, benchmark plan:  Skilled level nursing facility services are mefit Provided:  Authorization:  None	including the specific name of the source plan if it is not the base covered for care that is not long-term custodial care.  Source:  Provider Qualifications:	Remove

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Benefit Provided:	Source:	Remove
Other Lab and X-Ray Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	J
Prior Authorization	Medicaid State Plan	]
Amount Limit:	Duration Limit:	_
None	None	
Scope Limit:		٦
None		
Other information regarding this benefit, benchmark plan:	including the specific name of the source plan if it is not the base	
	rays in connection with research or study. Prior authorization is ng: CT, PET, MRI, MRA, and nuclear cardiology.  Source:	Remove
Authorization:	Provider Qualifications:	_
Yes		
Amount Limit:	Duration Limit:	٦
Scope Limit:		]
Other information regarding this benefit, benchmark plan:	including the specific name of the source plan if it is not the base	_

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Benefit Provided:	Source:	Remove
Physician Services	State Plan 1905(a)	Kemove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, benchmark plan:	including the specific name of the source plan if it is not the base	
additional preventive services for women	recommended by HRSA's Bright Futures program/project; and (4) in recommended by the Institute of Medicine (IOM) and HRSA. rvices and contraceptive coverage, consistent with the requirements	
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educ	n recommended by the Institute of Medicine (IOM) and HRSA. rvices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, eation and counseling for all women with reproductive capacity.	
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educ	n recommended by the Institute of Medicine (IOM) and HRSA. rvices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the food and Drug Administration approved contraceptive methods, eation and counseling for all women with reproductive capacity.  Source:	Remove
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educ	recommended by the Institute of Medicine (IOM) and HRSA. rvices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, reation and counseling for all women with reproductive capacity.  Source:  State Plan 1905(a)	Remove
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educe  Benefit Provided: Other licensed practitioners  Authorization:	recommended by the Institute of Medicine (IOM) and HRSA. revices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, reation and counseling for all women with reproductive capacity.  Source:  State Plan 1905(a)  Provider Qualifications:	Remove
additional preventive services for womer This benefit includes family planning ser of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educe  Benefit Provided:  Other licensed practitioners	recommended by the Institute of Medicine (IOM) and HRSA. rvices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, reation and counseling for all women with reproductive capacity.  Source:  State Plan 1905(a)	Remove
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educe  Benefit Provided: Other licensed practitioners  Authorization: None  Amount Limit:	recommended by the Institute of Medicine (IOM) and HRSA. revices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, reation and counseling for all women with reproductive capacity.  Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:	Remove
additional preventive services for womer This benefit includes family planning services for the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educe  Benefit Provided:  Other licensed practitioners  Authorization:  None	recommended by the Institute of Medicine (IOM) and HRSA. revices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the food and Drug Administration approved contraceptive methods, cation and counseling for all women with reproductive capacity.    Source:   State Plan 1905(a)     Provider Qualifications:   Medicaid State Plan	Remove
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educe  Benefit Provided: Other licensed practitioners  Authorization: None  Amount Limit: None  Scope Limit:	recommended by the Institute of Medicine (IOM) and HRSA. revices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, reation and counseling for all women with reproductive capacity.  Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:	Remove
additional preventive services for womer This benefit includes family planning set of the additional preventive services for preventive services benefit includes all F sterilization procedures, and patient educe  Benefit Provided: Other licensed practitioners  Authorization: None  Amount Limit: None  Scope Limit: None	recommended by the Institute of Medicine (IOM) and HRSA. revices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the rood and Drug Administration approved contraceptive methods, reation and counseling for all women with reproductive capacity.  Source:  State Plan 1905(a)  Provider Qualifications:  Medicaid State Plan  Duration Limit:	Remove

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enefit Provided:	Source:	Remove
QHC/RHC	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, i benchmark plan:	ncluding the specific name of the source plan if it is not the base	
Advisory Committee for Immunization Poscreening for infants, children and adults additional preventive services for women This benefit includes family planning services for the additional preventive services for women preventive services benefit includes all Fo	following: (1) all services listed on the USPSTF A and B lists; (2) ractices (ACIP) recommended vaccines; (3) preventive care and recommended by HRSA's Bright Futures program/project; and (4) recommended by the Institute of Medicine (IOM) and HRSA. vices and contraceptive coverage, consistent with the requirements women recommended by the IOM and HRSA. Specifically, the bod and Drug Administration approved contraceptive methods, ation and counseling for all women with reproductive capacity.	
enefit Provided:	Source:	Remove
PSDT	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	M. 1 1 Co. c. Dl	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Amount Limit:	Duration Limit:	
Amount Limit: None	Duration Limit:	
Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, i benchmark plan:	Duration Limit:    None	
Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, i benchmark plan:  The preventive care benefit includes the f Advisory Committee for Immunization Proceedings for infants, children and adults additional preventive services for women This benefit includes family planning services for women the additional preventive services for women preventive services for women the additional preventive services benefit includes all Formation the additional preventive services benefit includes all Formation the additional preventive services for women the additional preventive serv	Duration Limit:    None	
Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, i benchmark plan:  The preventive care benefit includes the f Advisory Committee for Immunization Prescreening for infants, children and adults additional preventive services for women This benefit includes family planning services for the additional preventive services for work preventive services benefit includes all Forsterilization procedures, and patient educations.	Duration Limit:    None	Remove
Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, i benchmark plan:  The preventive care benefit includes the f Advisory Committee for Immunization Proceedings for infants, children and adults additional preventive services for women This benefit includes family planning services for women the additional preventive services for women preventive services for women the additional preventive services benefit includes all Formation the additional preventive services benefit includes all Formation the additional preventive services for women the additional preventive serv	Duration Limit:    None	Remove
Amount Limit:  None  Scope Limit:  None  Other information regarding this benefit, i benchmark plan:  The preventive care benefit includes the f Advisory Committee for Immunization Proceedings for infants, children and adults additional preventive services for women This benefit includes family planning services for the additional preventive services for work preventive services benefit includes all Forsterilization procedures, and patient educations.	Duration Limit:    None	Remove

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None d on medical necessity. e specific name of the source plan if it is not the base 1) all services listed on the USPSTF A and B lists; (2) CIP) recommended vaccines; (3) preventive care and led by HRSA's Bright Futures program/project; and (4) ded by the Institute of Medicine (IOM) and HRSA.	
e specific name of the source plan if it is not the base  1) all services listed on the USPSTF A and B lists; (2) CIP) recommended vaccines; (3) preventive care and led by HRSA's Bright Futures program/project; and (4)	
e specific name of the source plan if it is not the base  1) all services listed on the USPSTF A and B lists; (2) CIP) recommended vaccines; (3) preventive care and led by HRSA's Bright Futures program/project; and (4)	
1) all services listed on the USPSTF A and B lists; (2) CIP) recommended vaccines; (3) preventive care and led by HRSA's Bright Futures program/project; and (4)	
CIP) recommended vaccines; (3) preventive care and led by HRSA's Bright Futures program/project; and (4)	
ontraceptive coverage, consistent with the requirements mmended by the IOM and HRSA. Specifically, the 11g Administration approved contraceptive methods,	
Source:	Remove
J [	
1	
] [10.10	
e specific name of the source plan if it is not the base	
CIP) recommended vaccines; (3) preventive care and led by HRSA's Bright Futures program/project; and (4) ded by the Institute of Medicine (IOM) and HRSA. ontraceptive coverage, consistent with the requirements mmended by the IOM and HRSA. Specifically, the ag Administration approved contraceptive methods,	
	mmended by the IOM and HRSA. Specifically, the ag Administration approved contraceptive methods, bunseling for all women with reproductive capacity.

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Danafit Dravidad	C	
Benefit Provided:  Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	Remove
A sale animations		
Authorization: Prior Authorization	Provider Qualifications:  Medicaid State Plan	$\neg$
Amount Limit:	Duration Limit:	$\neg$
None	None	
Scope Limit:		_
None		
benchmark plan:  EPSDT will apply for all 19 and 20 year old	sluding the specific name of the source plan if it is not the baseds. Prior authorization required for the following dental rthodontics, dental orthotic devices, surgical periodontal	;
treatment, and extraction of asymptomatic t covered. These benefits may be provided u	eeth. Routine eye exam to determine need for glasses is nder state plan physician, OLP, FQHC/RHC, EPSDT, and andatory and optional Medicaid benefits are provided under	
Benefit Provided:	Source:	Remove
Medicaid State Plan EPSDT Benefits		
Authorization:	Provider Qualifications:	
Yes		
Amount Limit:	Duration Limit:	<u> </u>
Scope Limit:		_
Other information regarding this benefit, inc benchmark plan:	cluding the specific name of the source plan if it is not the base	, 
Benefit Provided:	Source:	Remove
Medicaid State Plan EPSDT Benefits		
Authorization:	Provider Qualifications:	
Amount Limit:	Duration Limit:	
Amount Emilt.		

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benchmark plan:		¬

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11. Other Covered Benefits from Base Benchmark	Collapse All

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	ution or Duplication	Collapse All
Base Benchmark Benefit that was Substituted:	Source:	Remove
Emergency Room Services	Base Benchmark	
1937 benchmark benefit(s) included above under Esse		n
Duplication: Covered under New Hampshire Medica room services under EHB 2.	id state plan as outpatient hospital care/emergency	
State plan benefit has no scope limit.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Chiropractic Care	Base Benchmark	
Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse	icating the substituted benefit(s) or the duplicate section ential Health Benefits:	n
the State Plan and includes 1 pair bifocals or 1 pair re One pair single vision lenses with frames is covered, minus .50 diopter according to the type of refractive	provided that the refractive error is at least plus or error, in each eye. One pair of glasses with bifocal ive lenses for close vision and one pair of glasses with	n
Base Benchmark Benefit that was Substituted:	Carrage	
Dase Denemiark Denem mat was Substituted.	Source:	Remove
Diabetic Education and Nutritional Therapy	Base Benchmark	Remove
Diabetic Education and Nutritional Therapy	Base Benchmark cating the substituted benefit(s) or the duplicate sectio ential Health Benefits: wed and replaced by substitution with the actuarial	
Diabetic Education and Nutritional Therapy  Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse  Diabetic Education and Nutrition Therapy was removalue of adult medical day care which is not covered	Base Benchmark cating the substituted benefit(s) or the duplicate sectio ential Health Benefits: wed and replaced by substitution with the actuarial	n
Diabetic Education and Nutritional Therapy  Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse  Diabetic Education and Nutrition Therapy was removely value of adult medical day care which is not covered  Base Benchmark Benefit that was Substituted:	Base Benchmark  cating the substituted benefit(s) or the duplicate section ential Health Benefits:  wed and replaced by substitution with the actuarial in the base benchmark.	
Diabetic Education and Nutritional Therapy  Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse Diabetic Education and Nutrition Therapy was removalue of adult medical day care which is not covered  Base Benchmark Benefit that was Substituted:  Primary Care, Specialist, Other Practitioner Visits	Base Benchmark  cating the substituted benefit(s) or the duplicate section ential Health Benefits:  wed and replaced by substitution with the actuarial in the base benchmark.  Source:  Base Benchmark  cating the substituted benefit(s) or the duplicate section	Remove
Diabetic Education and Nutritional Therapy  Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse Diabetic Education and Nutrition Therapy was removalue of adult medical day care which is not covered  Base Benchmark Benefit that was Substituted:  Primary Care, Specialist, Other Practitioner Visits  Explain the substitution or duplication, including indi	Base Benchmark  Icating the substituted benefit(s) or the duplicate section ential Health Benefits:  Ived and replaced by substitution with the actuarial in the base benchmark.  Source:  Base Benchmark  Icating the substituted benefit(s) or the duplicate section ential Health Benefits:  It as physician, other licensed practitioner, and	Remove
Diabetic Education and Nutritional Therapy  Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse Diabetic Education and Nutrition Therapy was removalue of adult medical day care which is not covered  Base Benchmark Benefit that was Substituted:  Primary Care, Specialist, Other Practitioner Visits  Explain the substitution or duplication, including indi 1937 benchmark benefit(s) included above under Esse Duplication: Covered under NH Medicaid state plan	Base Benchmark  Icating the substituted benefit(s) or the duplicate section ential Health Benefits:  Ived and replaced by substitution with the actuarial in the base benchmark.  Source:  Base Benchmark  Icating the substituted benefit(s) or the duplicate section ential Health Benefits:  It as physician, other licensed practitioner, and	Remove

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Duplication: Covered under NH Medicaid state pl Ambulatory Patient Services.	lan as outpatient hospital and mapped to EHB 1,	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Outpatient Surgery Physician/Surgical Services	Base Benchmark	
1937 benchmark benefit(s) included above under E	lan as physician and other licensed practitioner services	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Hospice Services	Base Benchmark	Kemove
1937 benchmark benefit(s) included above under E Duplication: Covered under NH Medicaid state plants Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Routine Foot Care	Base Benchmark	
1937 benchmark benefit(s) included above under E	ndicating the substituted benefit(s) or the duplicate section Essential Health Benefits: lan as other licensed practitioner services and mapped to	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Routine Eye Exam, Adult	Base Benchmark	Remove
1937 benchmark benefit(s) included above under E	ndicating the substituted benefit(s) or the duplicate section Essential Health Benefits: lan as other licensed practitioner services and mapped to	
Base Benchmark Benefit that was Substituted:	Source:	D
Clinic Services-Dialysis Treatment	Base Benchmark	Remove
Explain the substitution or duplication, including in 1937 benchmark benefit(s) included above under E Duplication: Covered under NH Medicaid state pl		

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Base Benchmark Benefit that was Substituted:	Source:	Remove
Urgent Care Ctrs/Facilities, OP Hospital ER	Base Benchmark	
1937 benchmark benefit(s) included above under l	indicating the substituted benefit(s) or the duplicate section Essential Health Benefits: blan as outpatient hospital and emergency hospital services	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Emergency Transport/Ambulance	Base Benchmark	
Explain the substitution or duplication, including it 1937 benchmark benefit(s) included above under l	indicating the substituted benefit(s) or the duplicate section Essential Health Benefits:	
Duplication: Covered under NH Medicaid state p transportation services and mapped to EHB 2, Em		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Inpatient Hospital Services	Base Benchmark	
1937 benchmark benefit(s) included above under l Duplication: Covered under NH Medicaid state p Hospitalization Services.	plan as inpatient hospital services and mapped to EHB 3,	
Base Benchmark Benefit that was Substituted:	Source:	Remove
IP Phys/Surgical/Bariatric/Organ Transplant	Base Benchmark	
Explain the substitution or duplication, including it 1937 benchmark benefit(s) included above under l	indicating the substituted benefit(s) or the duplicate section Essential Health Benefits:	
Duplication: Covered under NH Medicaid state p mapped to EHB 3, Hospitalization Services.	plan as physician and other licensed practitioner and	
Base Benchmark Benefit that was Substituted:	Source:	Remove
	Source: Base Benchmark	Remove
Prenatal and Postnatal Care  Explain the substitution or duplication, including i 1937 benchmark benefit(s) included above under l	Base Benchmark indicating the substituted benefit(s) or the duplicate section Essential Health Benefits:	Remove
Prenatal and Postnatal Care  Explain the substitution or duplication, including i 1937 benchmark benefit(s) included above under I Duplication: Covered under NH Medicaid state p	Base Benchmark indicating the substituted benefit(s) or the duplicate section Essential Health Benefits: blan as physician, other licensed practitioner, FQHC/RHC, al, extended services to PW, freestanding birthing centers,	Remove
1937 benchmark benefit(s) included above under I Duplication: Covered under NH Medicaid state p tobacco cessation for PW, home health, IP hospita and mapped to EHB 4, Maternity and Newborn C Base Benchmark Benefit that was Substituted:	Base Benchmark indicating the substituted benefit(s) or the duplicate section Essential Health Benefits: blan as physician, other licensed practitioner, FQHC/RHC, al, extended services to PW, freestanding birthing centers, Care Services.	Remove
Prenatal and Postnatal Care  Explain the substitution or duplication, including i 1937 benchmark benefit(s) included above under I Duplication: Covered under NH Medicaid state p tobacco cessation for PW, home health, IP hospita and mapped to EHB 4, Maternity and Newborn C	Base Benchmark indicating the substituted benefit(s) or the duplicate section Essential Health Benefits: blan as physician, other licensed practitioner, FQHC/RHC, al, extended services to PW, freestanding birthing centers, care Services.	
Explain the substitution or duplication, including i 1937 benchmark benefit(s) included above under I Duplication: Covered under NH Medicaid state p tobacco cessation for PW, home health, IP hospita and mapped to EHB 4, Maternity and Newborn C Base Benchmark Benefit that was Substituted: Delivery and IP Services for Maternity	Base Benchmark indicating the substituted benefit(s) or the duplicate section Essential Health Benefits: blan as physician, other licensed practitioner, FQHC/RHC, al, extended services to PW, freestanding birthing centers, care Services.  Source:  Base Benchmark indicating the substituted benefit(s) or the duplicate section	

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services and mapped to EHB 4, Maternity and Newbo	orn Care Services.	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Mental/Behavioral Health OP Services	Base Benchmark	
Explain the substitution or duplication, including indices 1937 benchmark benefit(s) included above under Essen Duplication: Covered under NH Medicaid state plan other diagnostic, preventive, screening and rehab serval licensed practitioner services; and mapped to EHB 5, including behavioral health treatment.	as community mental health center services under vices; SUD services; physician services; and other	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Mental/Behavioral Health IP Services	Base Benchmark	Remove
1937 benchmark benefit(s) included above under Esse Duplication: Covered under NH Medicaid state plan and mapped to EHB 5, Mental health and substance utreatment.	as IP hospital, IMD over 65, and IP psych under 22,	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Substance Abuse Disorder (SUD) OP Services	Base Benchmark	
1937 benchmark benefit(s) included above under Esse	as SUD under other diagnostic, rehab, preventive and	
Base Benchmark Benefit that was Substituted:	Source:	Remove
SUD IP Services	Base Benchmark	Kemove
1937 benchmark benefit(s) included above under Esse	as SUD under other diagnostic, rehab, preventive and bed to EHB 5, Mental health and substance use	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Prescription drugs	Base Benchmark	Remove
Explain the substitution or duplication, including indices 1937 benchmark benefit(s) included above under Essen Duplication: Covered under NH Medicaid state plan Prescription drugs.		

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Base Benchmark Benefit that was Substituted:	Source:	Remove
Home Health Care Services	Base Benchmark	
Explain the substitution or duplication, including 1937 benchmark benefit(s) included above under	g indicating the substituted benefit(s) or the duplicate section r Essential Health Benefits:	
	e plan as home health services and mapped to EHB 7,	
rehabilitative and habilitative services and device		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Outpatient rehabilitation and habilitation	Base Benchmark	
Explain the substitution or duplication, including 1937 benchmark benefit(s) included above under	g indicating the substituted benefit(s) or the duplicate section r Essential Health Benefits:	
	plan as home health-PT/ST/OT services and physical 3 7, rehabilitative and habilitative services and devices.	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Respiratory therapy and cardiac rehabilitation	Base Benchmark	
1937 benchmark benefit(s) included above under Duplication: Covered under NH Medicaid state	plan as outpatient and inpatient hospital services and	
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative	r Essential Health Benefits: e plan as outpatient and inpatient hospital services and e services and devices	
1937 benchmark benefit(s) included above under Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative Base Benchmark Benefit that was Substituted:	r Essential Health Benefits: e plan as outpatient and inpatient hospital services and	Remove
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative Base Benchmark Benefit that was Substituted:  DME, supplies, prosthetics, hearing aids  Explain the substitution or duplication, including	r Essential Health Benefits: plan as outpatient and inpatient hospital services and e services and devices  Source: Base Benchmark g indicating the substituted benefit(s) or the duplicate section	Remove
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative and habilitati	Source: Base Benchmark g indicating the substituted benefit(s) or the duplicate section r Essential Health Benefits: e plan as home health and prosthetics and mapped to EHB 7,	Remove
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative and habilitati	Source: Base Benchmark g indicating the substituted benefit(s) or the duplicate section r Essential Health Benefits: e plan as home health and prosthetics and mapped to EHB 7,	Remove
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative services and device and habil	Source: Base Benchmark g indicating the substituted benefit(s) or the duplicate section r Essential Health Benefits: plan as home health and prosthetics and mapped to EHB 7, bes.	
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative services and device as Base Benchmark Benefit (s) included above under and habilitative services and device as Base Benchmark Benefit that was Substituted:  Explain the substitution or duplication, including skilled nursing facility  Explain the substitution or duplication, including 1937 benchmark benefit (s) included above under	Source: Base Benchmark g indicating the substituted benefits: plan as home health and prosthetics and mapped to EHB 7, pess.  Source: Base Benchmark g indicating the substituted benefit(s) or the duplicate section ressential Health Benefits: plan as home health and prosthetics and mapped to EHB 7, pess.  Source: Base Benchmark g indicating the substituted benefit(s) or the duplicate section ressential Health Benefits:	
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative services and device as Base Benchmark Benefit (s) included above under and habilitative services and device as Base Benchmark Benefit that was Substituted:  Explain the substitution or duplication, including skilled nursing facility  Explain the substitution or duplication, including 1937 benchmark benefit (s) included above under	Source: Base Benchmark glindicating the substituted benefit(s) or the duplicate section resential Health Benefits: plan as home health and prosthetics and mapped to EHB 7, sees.  Source: Base Benchmark glindicating the substituted benefit(s) or the duplicate section resential Health Benefits: plan as home health and prosthetics and mapped to EHB 7, sees.  Source: Base Benchmark glindicating the substituted benefit(s) or the duplicate section resential Health Benefits: plan as skilled level nursing facility services and mapped	
Duplication: Covered under NH Medicaid state mapped to EHB 7, rehabilitative and habilitative services and device and habilitative services a	Source:  Base Benchmark  plan as home health and prosthetics and mapped to EHB 7, ess.  Source:  Base Benchmark  plan as home health and prosthetics and mapped to EHB 7, ess.  Source:  Source:  Base Benchmark  g indicating the substituted benefit(s) or the duplicate section are Essential Health Benefits:  plan as home health and prosthetics and mapped to EHB 7, ess.  Source:  Base Benchmark  g indicating the substituted benefit(s) or the duplicate section are Essential Health Benefits:  plan as skilled level nursing facility services and mapped as and devices.  Source:  Source:	

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Duplication: Covered under NH Medicaid state pl laboratory services.	an as other lab and x-ray services and mapped to EHB 8,	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Preventive care/screening/well baby/immunization	Base Benchmark	
1937 benchmark benefit(s) included above under E	an as physician, other licensed practitioner, FQHC/RHC,	
Ersb1, and mapped to Enb 9, Preventive and we	simess services and chronic disease management.	
Base Benchmark Benefit that was Substituted:	Source:	Remove
Maternity and Reproductive Health	Base Benchmark	,,,,,
1937 benchmark benefit(s) included above under E Duplication: Covered under NH Medicaid state pl practitioner, FQHC/RHC, and family planning, and		
and newborn care.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Base Benchmark Benefit that was Substituted:	Source: Base Benchmark	Remove
Base Benchmark Benefit that was Substituted: Nicotine Cessation Counseling	Base Benchmark  Indicating the substituted benefit(s) or the duplicate section	Remove
Base Benchmark Benefit that was Substituted: Nicotine Cessation Counseling  Explain the substitution or duplication, including ir 1937 benchmark benefit(s) included above under E  Duplication: Covered under NH Medicaid state pla	Base Benchmark  Indicating the substituted benefit(s) or the duplicate section	Remove
Base Benchmark Benefit that was Substituted: Nicotine Cessation Counseling  Explain the substitution or duplication, including ir 1937 benchmark benefit(s) included above under E  Duplication: Covered under NH Medicaid state pla and Mapped to EHB 9, Essential Health Benefit: P management.  Base Benchmark Benefit that was Substituted:	Base Benchmark  Indicating the substituted benefit(s) or the duplicate section assential Health Benefits:  In as Nicotine Cessation Counseling - Preventive Service	Remove
Base Benchmark Benefit that was Substituted: Nicotine Cessation Counseling  Explain the substitution or duplication, including ir 1937 benchmark benefit(s) included above under E  Duplication: Covered under NH Medicaid state pla and Mapped to EHB 9, Essential Health Benefit: P management.	Base Benchmark  Indicating the substituted benefit(s) or the duplicate section descential Health Benefits:  In as Nicotine Cessation Counseling - Preventive Service Preventive and wellness services and chronic disease	
Base Benchmark Benefit that was Substituted: Nicotine Cessation Counseling  Explain the substitution or duplication, including in 1937 benchmark benefit(s) included above under E  Duplication: Covered under NH Medicaid state pla and Mapped to EHB 9, Essential Health Benefit: P management.  Base Benchmark Benefit that was Substituted: Lactation Consultation Services	Base Benchmark  Indicating the substituted benefit(s) or the duplicate section desential Health Benefits:  In as Nicotine Cessation Counseling - Preventive Service Preventive and wellness services and chronic disease  Source:  Base Benchmark  Indicating the substituted benefit(s) or the duplicate section	

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13. Other Base Benchmark Benefit	ts Not Covered	Collapse All

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Supersedes TN No: NEW



Non-Emergency Medical Transportation   Source:   Source:   Provider Qualifications:   Medicaid State Plan   Medicaid State Plan   Medicaid State Plan	Other 1937 Benefit Provided:	Source:	
Authorization: Prior Authorization  Amount Limit: None  Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.  Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.  Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.  Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.  Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.  Source: Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Other Medicaid State Plan  Duration Limit: None Scope Limit: Diagnostic, preventive, limited periodontics, restorative, and oral surgery services.  Other: Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Prior Authorization Provider Qualifications: Prior Authorization Provider Qualifications: None None Other:		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Remove
Prior Authorization   Medicaid State Plan   Amount Limit:   Duration Limit:   None   None   Scope Limit:   None   Other:   Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.    Dental for individuals 21 and over			
Amount Limit:   None	Authorization:	Provider Qualifications:	
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  Authorization: Other  Authorization: Other  Amount Limit: S1,500, excluding preventive services  None Scope Limit: Diagnostic, preventive, limited periodontics, restorative, and oral surgery services.  Other: Other' = None  Other 1937 Benefit Provided: Scope Limit: Diagnostic, preventive, limited periodontics, restorative, and oral surgery services.  Other: Prior authorization is required. "Authorization - Other" = None  Other 1937 Benefit Provided: Private Duty Nursing  Source: Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Provider Qualifications: Prior Authorization Medicaid State Plan  Amount Limit: Duration Limit: None None  Other:	Prior Authorization	Medicaid State Plan	]
None   None   None   Scope Limit:   None   Scope Limit:   None   Other:   Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.   Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.   Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.   Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.   Prior definition is section 1937 Coverage Option Benchmark Benefit Package   Prior authorization:   Provider Qualifications:   Prior authorization is required.   Prior authorization   Provider Qualifications:   Prior authorization   Prior authorization   Provider Qualifications:   Prior authorization   Prior au	Amount Limit:	Duration 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  Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Other  Amount Limit: S1,500, excluding preventive services 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: Source: Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Prior Authorization  Provider Qualifications: Prior Authorization  Medicaid State Plan  Amount Limit: None  Other: None  Other:	None		]
None Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.  Other 1937 Benefit Provided: Dental for individuals 21 and over  Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Other  Amount Limit: S1,500, excluding preventive services 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: Source: Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Prior Authorization  Provider Qualifications: Prior Authorization  Medicaid State Plan  Amount Limit: None  Other: None  Other:	Scope Limit:		_
Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.    Description   Provided:   Source:   Section 1937 Coverage Option Benchmark Benefit   Package   Package			]
Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.    Description   Provided:   Source:   Section 1937 Coverage Option Benchmark Benefit   Package   Package	Other:		J
Other 1937 Benefit Provided: Dental for individuals 21 and over  Authorization: Other  Authorization: Other  Amount 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  Authorization: Provider Qualifications:  Other 1937 Coverage Option Benchmark Benefit Package  Authorization: Provider Qualifications: Medicaid State Plan  Amount Limit: None  Other: None  Other:		ncv medical transportation, including scheduled ambulance.	1
Authorization: Other Amount 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 Section 1937 Coverage Option Benchmark Benefit Plackage  Private Duty Nursing  Remove  Remove  Remove  Remove  Other: 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  Remove  Remove  Remove  Other: None  Other:  Other:	4	,	
Section 1937 Coverage Option Benchmark Benefit   Package			
Authorization: Other Amount 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 Section 1937 Coverage Option Benchmark Benefit Plackage  Private Duty Nursing  Remove  Remove  Remove  Remove  Other: 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  Remove  Remove  Remove  Other: None  Other:  Other:			
Dental for individuals 21 and over    Section 1937 Coverage Option Benchmark Benefit   Package	Other 1937 Benefit Provided:	Source:	Remove
Authorization:  Other  Other  Amount Limit:  \$1,500, excluding preventive services  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:  Source:  Private Duty Nursing  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Other:  Other:	Dental for individuals 21 and over		Remove
Other  Amount Limit: \$1,500, excluding preventive services  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  Scotion 1937 Coverage Option Benchmark Benefit Package  Authorization:  Provider Qualifications:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:		Package	
Amount Limit:  \$1,500, excluding preventive services  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  Authorization:  Provider Qualifications:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:	Authorization:	Provider Qualifications:	_
\$1,500, excluding preventive services  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:  Source:  Private Duty Nursing  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Provider Qualifications:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:	Other	Medicaid State Plan	
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  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Provider Qualifications:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:	Amount Limit:	Duration 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  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Provider Qualifications:  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:	\$1,500, excluding preventive services	None	]
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  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Provider Qualifications:  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:	Scope Limit:		_
Benefit is the same as described in the Medicaid State Plan. No authorization is required. "Authorization - Other" = None    Other		restorative, and oral surgery services.	]
Benefit is the same as described in the Medicaid State Plan. No authorization is required. "Authorization - Other" = None    Other	Other:		
Other" = None  Other 1937 Benefit Provided:  Private Duty Nursing  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Provider Qualifications:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:		id State Plan. No authorization is required. "Authorization -	1
Private Duty Nursing  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:			
Private Duty Nursing  Section 1937 Coverage Option Benchmark Benefit Package  Authorization:  Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:			
Private Duty Nursing  Section 1937 Coverage Option Benchmark Benefit Package  Authorization: Prior Authorization  Medicaid State Plan  Amount Limit: None  Scope Limit: None  Other:			
Authorization: Provider Qualifications: Prior Authorization  Medicaid State Plan  Amount Limit: Duration Limit: None  Scope Limit: None Other:	Other 1937 Benefit Provided:		Remove
Authorization: Provider Qualifications: Prior Authorization  Medicaid State Plan  Amount Limit:  None  Scope Limit:  None  Other:	Private Duty Nursing		
Prior Authorization  Medicaid State Plan  Amount Limit:  None  None  Scope Limit:  None  Other:		Package	
Amount Limit:  None  Scope Limit:  None  Other:	Authorization:	Provider Qualifications:	_
None  Scope Limit:  None  Other:	Prior Authorization	Medicaid State Plan	
Scope Limit: None Other:	Amount Limit:	Duration Limit:	_
None Other:	None	None	]
None Other:	Scone Limit:		_
Other:			]
			Л
	Orner:		

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Other 1937 Benefit Provided:	Source:	Remove
Personal Care Attendant Services	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other: Must be chronically wheelchair bound.	"Authorization - Other" = None	
Other 1937 Benefit Provided:	Source:	Remove
AMDC (dx, screen, prev, rehab)	Section 1937 Coverage Option Benchmark Benefit Package	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		
"Authorization - Other" = None. Adult r screening, preventive, and rehabilitative	medical day care (AMDC) is provided under "other diagnostic, services."	
Other 1937 Benefit Provided:	Source:	Remove
Eyeglasses	Section 1937 Coverage Option Benchmark Benefit Package	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
	Duration Limit:	
Amount Limit:	None	
Amount Limit: None		

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	etive error, in each eye. One pair of glasses with bifocal rrective lenses for close vision and one pair of glasses with effractive error of at least .50 diopter for both close and	
ther 1937 Benefit Provided: ntermediate Level Nursing Facility Services	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Individual must meet functional assessment/lev	rel of care criteria	
Other:		
Must meet level of care, as in scope above. Serv	vices are covered for long term custodial care.	
ther 1937 Benefit Provided: Cargeted Case Management Authorization:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
Authorization.	Tiovidei Quantications.	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Amount Limit: None		
Amount Limit:  None  Scope Limit:	Duration Limit:	
Amount Limit:  None  Scope Limit:  None	Duration Limit:	
Amount Limit:  None  Scope Limit:  None  Other:  "Authorization-Other" = None. TCM includes of children, adult and elderly, and EPSDT case ma	Duration Limit:	
Amount Limit:  None  Scope Limit:  None  Other:  "Authorization-Other" = None. TCM includes of children, adult and elderly, and EPSDT case manumber of consecutive days varies among the varies."	Duration Limit:  as per state plan  developmentally disabled, behavioral health, chronically ill nagement. For those transitioning to a community setting, arious types of TCM as per the state plan details.	
Amount Limit:  None  Scope Limit:  None  Other:  "Authorization-Other" = None. TCM includes of children, adult and elderly, and EPSDT case ma	Duration Limit:  as per state plan  developmentally disabled, behavioral health, chronically ill nagement. For those transitioning to a community setting,	Remove
Amount Limit:  None  Scope Limit:  None  Other:  "Authorization-Other" = None. TCM includes of children, adult and elderly, and EPSDT case manumber of consecutive days varies among the variety there 1937 Benefit Provided:	Duration Limit: as per state plan  developmentally disabled, behavioral health, chronically ill nagement. For those transitioning to a community setting, arious types of TCM as per the state plan details.  Source: Section 1937 Coverage Option Benchmark Benefit	Remove
Amount Limit:  None  Scope Limit:  None  Other:  "Authorization-Other" = None. TCM includes of children, adult and elderly, and EPSDT case manumber of consecutive days varies among the variety ther 1937 Benefit Provided:  915(i) HCBC Services	Duration Limit: as per state plan  developmentally disabled, behavioral health, chronically ill nagement. For those transitioning to a community setting, arious types of TCM as per the state plan details.  Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Amount Limit:  None  Scope Limit: None  Other:  "Authorization-Other" = None. TCM includes of children, adult and elderly, and EPSDT case manumber of consecutive days varies among the variety of the consecutive days variety of the consecutive days variety among the variety of the consecutive days variety days among the variety of the consecutive days variety days among the variety of the consecutive days among the consecutive days among the variety of the consecutive days among the consecutive days among the consecutive days among the con	Duration Limit: as per state plan  developmentally disabled, behavioral health, chronically ill nagement. For those transitioning to a community setting, arious types of TCM as per the state plan details.  Source: Section 1937 Coverage Option Benchmark Benefit Package  Provider Qualifications:	Remove

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See other below		
Other:		
	f age with Severe Emotional Disturbance. Based on	
functional assessment. There are various limits ar	nd 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:	Source:	Remove
CF-IDD	Section 1937 Coverage Option Benchmark Benefit Package	Troinio (C
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Individual must meet functional assessment/level	of care criteria	
based on functional assessment/level of care noted		
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted.  Other 1937 Benefit Provided:	Source: Section 1937 Coverage Option Benchmark Benefit	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the 1937 Benefit Provided:  Non-Routine Foot Care	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted other 1937 Benefit Provided:	Source: Section 1937 Coverage Option Benchmark Benefit	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of ther 1937 Benefit Provided: Non-Routine Foot Care  Authorization:  Yes	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the 1937 Benefit Provided: Non-Routine Foot Care  Authorization:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of ther 1937 Benefit Provided:  Non-Routine Foot Care  Authorization:  Yes  Amount Limit:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the services.  Other 1937 Benefit Provided:  Non-Routine Foot Care  Authorization:  Yes  Amount Limit:  None	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the services.  Other 1937 Benefit Provided: Non-Routine Foot Care  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted.  Other 1937 Benefit Provided:  Non-Routine Foot Care  Authorization:  Yes  Amount Limit:  None  Scope Limit:  None	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of ther 1937 Benefit Provided: Non-Routine Foot Care  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the services.  Other 1937 Benefit Provided: Non-Routine Foot Care  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the services of the services for Individual based on functional assessment/level of care noted of the services of the services of the services of the services for Individual based on functional assessment/level of care noted of the services of the services for Individual based on functional assessment/level of care noted of the services of the services for Individual based on functional assessment/level of care noted of the services of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment/level of care noted of the services for Individual based on functional assessment for Indi	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None  other licensed practitioner" (podiatrist).  Source:	
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of ther 1937 Benefit Provided:  Non-Routine Foot Care  Authorization: Yes  Amount Limit: None  Scope Limit: None  Other: "Authorization-Other" = None. Provided under "of the state of the st	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None  other licensed practitioner" (podiatrist).	Remove
Intermediate Care Facility Services for Individual based on functional assessment/level of care noted of the services of the s	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None  Source: Section 1937 Coverage Option Benchmark Benefit	

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Amount Limit:	Duration Limit:	
Varies	Varies	
Scope Limit:		
Varies		
Other:  See Attachment 3.1-A, Page 12, Item 30; a Patient Cost in Qualifying Clinical Trials i	and Attachment 3.1-B, Page 12, Item 30. Coverage of Routine n New Hampshire's Medicaid State Plan.	
Other 1937 Benefit Provided:	Source:	Damaya
Medication Assisted Treatment (MAT)	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
and Attachment 3.1-B, Page 5-a 1-3, Supp MAT is provided in accordance with 1905 September 30, 2025.	(a)(29) for the period beginning October 1, 2020, and ending	
Other 1937 Benefit Provided:	Source:	-
Outer 1937 Benefit Flovided.	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	-
Other		
Amount Limit:	Duration Limit:	
Scope Limit:		
Other:		
Outer.		
		Add

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Supersedes TN No: NEW

## **Alternative Benefit Plan**

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

### 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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TN No: 23-0056 Approval Date: November 29, 2023 Effective Date: July 1, 2023