



Alternative Benefit Plan

DRAFT

State Name: Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NH - 16 - 0001

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations

ABPI

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

Alternative Benefit Plan Population Name:

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

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

Geographic Area

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

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

Under the New Hampshire Health Protection Premium Assistance Section 1115(a) Medicaid Research and Demonstration waiver, # 11-W-00298/1, approved by CMS on March 4, 2015, New Hampshire will use individual premium assistance to support the purchase of commercial coverage for adults eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. This coverage will be provided by certain qualified health plans (QHPs), certified for sale in the individual market in New Hampshire's federally facilitated Marketplace, from January 1, 2016 to December 31, 2016. Adults in the demonstration will receive the 10 Essential Health Benefits through the QHPs and required wrap benefits through Medicaid fee-for-service.

Those adults excluded from the demonstration are those who identify as medically frail, or those who are enrolled in New Hampshire's HIPP program. Those adults who identify as medically frail, or those who elect to opt-out of the demonstration as American Indian/Alaskan Native or due to pregnancy, will receive either the Alternative Benefit Plan or Medicaid state plan services through Medicaid Managed Care organizations. Those adults excluded from the demonstration due to their enrollment in HIPP will receive coverage through cost-effective employer sponsored insurance.

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

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

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

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

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

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

- a) Enrollment in the specified Alternative Benefit Plan is voluntary;
- b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and
- c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

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

- a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and
- b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

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

- Letter
- Email
- Other



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Describe:

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

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

An attachment is submitted.

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

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

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

Information about how to identify as medically frail for demonstration enrollees is also at www.dhhs.state.nh.us/ombp/pap.

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

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

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

Additionally, a Medicaid member can self-identify at any time as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, or contact Member Services at 1-844-275-3447 or go to www.nheasy.nh.gov for additional information.

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

- a) Was informed in accordance with this section prior to enrollment;
- b) Was given ample time to arrive at an informed choice; and
- c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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



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- In the eligibility system.
- In the hard copy of the case record.
- Other

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

- Copy of correspondence sent to the individual.
- Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- Other
- The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

Members can work with Maximus, our enrollment broker; ServiceLink, our Aging and Disability Resource Center (ADRC); and our district office staff to select the appropriate benefit plan available to them.

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State Name:

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Enrollment Assurances - Mandatory Participants

ABP2c

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

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

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

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

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

Describe:

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

- Self-identification

Describe:

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

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

Additionally, a Medicaid member can self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder by contacting Member Services at 844-275-3447 or visiting www.nheasy.nh.gov for additional information.

Member Services staff will have a script for providing choice counseling to people who identify themselves as medically frail.

- Other

Describe:

If a PAP enrollee requests benefits that are not covered in the PAP, but which are covered through other portions of New Hampshire's Medicaid program, the QHP carrier may inform DHHS of the potential need for options counseling for that enrollee.

The QHP Carrier will be able to inform DHHS of these requests by contacting designated staff at DHHS Client Services who have been designated to receive medical frailty referrals from QHP carriers.



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DHHS will contact the identified enrollees by phone or mail and offer benefits options counseling as appropriate.

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

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

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

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

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

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

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

Individuals who self-identify as medically frail at the time of application will return the notice included with their eligibility determination in order to notify the State that they would like to be disenrolled from the ABP administered through the Premium Assistance Program and enrolled in (a) the ABP that is administered through the Medicaid Managed Care Organizations (MCO's) or (b) the Medicaid state plan services administered through the MCO's. Instructions for completing this process are included in their eligibility determination notice.

Individuals seeking exemption from the Alternative Benefit Plan at any time during their period of eligibility will notify the Medicaid



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agency who will initiate the change process. The appropriate contact information for the agency is included in their eligibility determination notice. Once the applicant makes the request, the same notice delivered as part of the medically frail individuals' eligibility notice will be sent to the member. Individuals that would like to be dis-enrolled from the ABP must complete the form and return it to the Medicaid agency to complete the process.

The notices provided to individuals who either respond affirmatively to the triggering question on the initial application or who later self-identify as exempt include a description of the differences between the ABP and the Medicaid State Plan Services administered through the MCO's.

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

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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

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

Name of benefit package:

Selection of the Section 1937 Coverage Option

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

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

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

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

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

New Hampshire has created its Adult Group Alternative Benefit Package based on the Matthew Thornton Blue Health Plan, which is the base benchmark plan selected by the State to define Essential Health Benefits for products in the Marketplace. The State has added the additional benefits required for the Alternative Benefit Package, but not covered by the base benchmark plan, namely, non-emergency medical transportation, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services, routine eye exams, eyeglasses, and dental as described herein. Individuals will also have access to FQHC and RHC services, as well as open access to family planning providers. QHP enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC/RHC. If family planning services are accessed at a Medicaid enrolled provider or facility that the QHP considers an out of network provider, the state's FFS ABP will cover these services.

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

Selection of Base Benchmark Plan

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



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The Base Benchmark Plan is the same as the Section 1937 Coverage option.

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:

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

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

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Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

The base benchmark plan is the Matthew Thornton Blue Health Plan. The additional benefits that New Hampshire will provide through fee-for-service Medicaid to adults in the demonstration waiver who are entitled to receive the ABP are: non-emergent medical transportation, EPSDT services for 19 and 20 year olds, family planning services and supplies from Medicaid-enrolled providers, vision coverage for individuals 21 and over limited to exams and eye glasses as applicable, and dental coverage for individuals 21 and over limited to treatment for acute pain or infection.

For benefits provided by the Qualified Health Plans, the state also authorizes benefit packages substantially equal/actuarially equivalent to the benefit package articulated in this document.

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



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1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:

Primary Care Visit to Treat Illness or Injury

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

Benefit Provided:

Specialist Visit

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

Benefit Provided:

Other Practitioner Office Visit (APRN, PA, etc.)

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none



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

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

Benefit Provided:

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

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

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

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

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

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

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

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

Benefit Provided:

Hospice Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none



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Scope Limit:

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

Add



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2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:

Urgent Care Centers or Facilities

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

Benefit Provided:

Outpatient Hospital/Emergency Room Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Excludes coverage of non-emergent use of the Emergency Department.

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

Benefit Provided:

Emergency Transportation/Ambulance

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



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

Add



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3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

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

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

Prior authorization is required only for out of state inpatient hospitalization.

Benefit Provided:

Inpatient Physician and Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

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

Benefit Provided:

Bariatric Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



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

Benefit Provided:

Transplant

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

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

Add



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4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Prenatal and Postnatal Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Benefit Provided:

Delivery and All Inpatient Services for Maternity

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Minimum stay of 48 hours

Add



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

Collapse All

Benefit Provided:

Mental/behavioral Health Outpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

see below

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

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

Benefit Provided:

Mental/behavioral health inpatient services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See below

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

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



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DRAFT

Benefit Provided:

Substance Abuse Disorder Outpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See below.

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

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

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See below.

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

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

Add



Alternative Benefit Plan

DRAFT

6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
<input type="checkbox"/> Limit on days supply	<input type="text" value="Yes"/>	<input type="text" value="State licensed"/>
<input type="checkbox"/> Limit on number of prescriptions		
<input type="checkbox"/> Limit on brand drugs		
<input type="checkbox"/> Other coverage limits		
<input checked="" type="checkbox"/> Preferred drug list		

Coverage that exceeds the minimum requirements or other:

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



Alternative Benefit Plan **DRAFT**

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:	Source:	Remove
Home Health Care Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:		
no benefits available for custodial care		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Skilled Nursing Facility	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
100 days per year	none	
Scope Limit:		
no benefits available for custodial care		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Outpatient Rehabilitation Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
20 visits per year for each therapy type	none	
Scope Limit:		
see below		



Alternative Benefit Plan

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

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services. No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational or occupational reasons; or therapy for TMJ.

Benefit Provided:

Respiratory Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

Benefit Provided:

Cardiac Rehabilitation

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

Benefit Provided:

Habilitation Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

DRAFT

Amount Limit:

20 visits for each therapy type

Duration Limit:

none

Scope Limit:

see below

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

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services. No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational or occupational reasons; or therapy for TMJ.

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

12 visits per year

Duration Limit:

none

Scope Limit:

Includes spinal manipulation and manual medical intervention services

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

Benefit Provided:

Durable Medical Equipment

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

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



Alternative Benefit Plan DRAFT

Add



Alternative Benefit Plan DRAFT

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Diagnostic Tests (X-Ray and Lab Work)

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

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

Benefit Provided:

Imaging (CT/PET scans/MRIs)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

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

Add



Alternative Benefit Plan DRAFT

9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Preventive Care/Screening/Immunization"/>	<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="none"/>	<input type="text" value="none"/>	
Scope Limit:	<input type="text" value="none"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="The preventive care benefit includes the following: (1) all services listed on the USPSTF A and B lists; (2) Advisory Committee for Immunization Practices (ACIP) recommended vaccines; (3) preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and (4) additional preventive services for women recommended by the Institute of Medicine (IOM) and HRSA. This benefit includes family planning services and contraceptive coverage, consistent with the requirements of the additional preventive services for women recommended by the IOM and HRSA. Specifically, the preventive services benefit includes all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."/>		
<input type="button" value="Add"/>		



Alternative Benefit Plan **DRAFT**

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

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

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

Add



Alternative Benefit Plan DRAFT

11. Other Covered Benefits from Base Benchmark

Collapse All

Other Base Benefit Provided:

Routine Eye Exam (Adult)

Source:

Base Benchmark

Remove

Authorization:

Retroactive Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

1 exam every 2 years

Duration Limit:

none

Scope Limit:

Other information regarding this benefit:

no prior authorization

Add



Alternative Benefit Plan DRAFT

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All



Alternative Benefit Plan DRAFT

13. Other Base Benchmark Benefits Not Covered

Collapse All



Alternative Benefit Plan **DRAFT**

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Non-emergency Medical Transportation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

none

Other:

prior authorization is required for non-emergency medical transportation, including scheduled ambulance.

Other 1937 Benefit Provided:

Eyeglasses for individuals 21 and over

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 pair per year single vision or bifocal glasses*

Duration Limit:

none

Scope Limit:

none

Other:

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

Other 1937 Benefit Provided:

Dental for individuals 21 and over

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

coverage is limited to treatment of acute pain or infection



Alternative Benefit Plan DRAFT

Other:

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

Add



Alternative Benefit Plan **DRAFT**

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

Collapse All

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V.20140415



Alternative Benefit Plan

DRAFT

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NH - 16 - 0001

OMB Expiration date: 10/31/2014

Benefits Assurances

ABP7

EPSDT Assurances

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

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

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

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

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

Through an Alternative Benefit Plan.

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

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

All non-medically frail individuals in the new adult group who participate in the New Hampshire Health Protection Premium Assistance Section 1115 (a) Research and Demonstration Waiver, #11-W-00298/1 will receive the Alternative Benefit Plan through cost-effective Qualified Health Plans certified for sale in the individual market through New Hampshire's Federally Facilitated Marketplace. The benefit package administered by the Qualified Health Plans will include coverage for the 10 Essential Health Benefits:

- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Hospitalization
- Ambulatory patient services
- Maternity and newborn care
- Mental health and substance use disorder services
- Preventive and wellness services and chronic disease management
- Emergency services
- Pediatric services, including oral and vision care.

The remaining services in the ABP will be provided through fee-for-service Medicaid: EPSDT services for 19 and 20 year olds, dental benefits for treating acute pain and infection for individuals over 21, eye glasses for individuals over 21, non-emergency medical transportation, and family planning services from Medicaid-enrolled providers.

Prescription Drug Coverage Assurances

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

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



Alternative Benefit Plan

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- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20140415



Alternative Benefit Plan **DRAFT**

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NH - 16 - 0001

OMB Expiration date: 10/31/2014

Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).
- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

For the delivery system under the authority of the 1932(a) managed care state plan amendment, New Hampshire contracts with two managed care organizations, Well Sense and New Hampshire Healthy Families, to administer Medicaid state plan benefits to the majority of its beneficiaries. The 1932(a) authority was used to provide benefits to the expansion population from September 1, 2015 until December 31, 2015. New Hampshire will continue to use the two managed care organizations to administer Medicaid benefits to the remaining Medicaid beneficiaries who are not subject to the Section 1115(a) Research and Demonstration waiver, #11-W-00298/1, including the expansion adults who identify as medically frail.

Beginning on January 1, 2016, New Hampshire will purchase coverage for the non-medically frail through cost-effective Qualified Health Plans (QHP's) certified for sale on New Hampshire's federally facilitated Marketplace using its Section 1115(a) Research and Demonstration waiver, #11-W-00298/1. The state will deliver the remaining categories of benefits in the ABP not covered through the 10 essential health benefits through fee-for-service Medicaid.

New Hampshire sent heads up notices together with detailed program information to the non-medically frail beneficiaries in the new adult group about their conversion to the Premium Assistance Program beginning in late September of 2015. A Premium Assistance Program specific web page was also published at that time. In early November, New Hampshire sent plan selection and plan confirmation notices to non-medically frail beneficiaries in the newly eligible adult group. Throughout September-November, New Hampshire held multiple overview sessions on the Premium Assistance Program for providers and stakeholders.

MCO: Managed Care Organization



Alternative Benefit Plan **DRAFT**

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1932(a) mandatory managed care state plan amendment.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

For the delivery system under the authority of the 1932(a) state plan amendment, New Hampshire contracts with two managed care organizations, Well Sense and New Hampshire Healthy Families, to administer Medicaid state plan benefits to the vast majority of its beneficiaries. The 1932(a) authority was used to provide ABP benefits to the expansion population from September 1, 2015 until December 31, 2015.

Additional Information: MCO (Optional)

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

Fee-For-Service Options

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

- Traditional state-managed fee-for-service
- Services managed under an administrative services organization (ASO) arrangement

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

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

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

All benefits provided through the fee-for-service system will be subject to the authorization requirements set forth in ABP 5.

Additional Information: Fee-For-Service (Optional)

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

Non-medically frail adults eligible for coverage under Section 1902(a)(10)(A)(i)(VIII) of the Act who are deemed eligible after October 1, 2015 will be in fee-for-service until the coverage date under their Qualified Health Plan begins. For those who select a QHP by the 15th of the month, coverage under the QHP will begin the first of the following month. For those who select a QHP after the 15th of the month, coverage under the QHP will begin the first of the second following month.

Other Service Delivery Model



Alternative Benefit Plan DRAFT

Name of service delivery system:

Premium Assistance Program.

Provide a narrative description of the model:

Beginning on January 1, 2016, New Hampshire will purchase coverage for the non-medically frail newly eligible adults through cost-effective Qualified Health Plans (QHPs) certified for sale on New Hampshire's federally facilitated Marketplace using its Section 1115(a) Research and Demonstration waiver, #11-W-00298/1 approved in March of 2015.

The QHPs will provide the ten Essential Health Benefits within the ABP to the newly eligible adults. The state will deliver the remaining benefits in the ABP through fee-for-service Medicaid to the non-medically frail new adults.

New Hampshire sent heads up notices together with detailed program information to the non-medically frail beneficiaries in the new adult group about their conversion to the Premium Assistance Program beginning in late September of 2015. A Premium Assistance Program specific webpage was also published at that time.

In early November, New Hampshire sent plan selection and plan confirmation notices to non-medically frail beneficiaries in the newly eligible adult group. Eligible adults will shop for their QHP through New Hampshire's eligibility and enrollment system. Those enrollees with income above the federal poverty level will be subject to standard copayments that are consistent with 42 CFR 447 subpart A.

Enrollees are given 30 days from the date of notice to enroll with a Qualified Health Plan. If they do not make an election within that time frame, they are auto-assigned. The enrollees then have an additional 30 days to select a different QHP than the one to which they were auto-assigned, if they so choose.

PRA Disclosure Statement

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V.2014041



Alternative Benefit Plan

DRAFT

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NH - 16 - 0001

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums ABP9

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

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

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

The state/territory otherwise provides for payment of premiums.

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

Non-medically frail, non-pregnant individuals eligible under Section 1902(a)(10)(A)(i)(VIII) are required to enroll in cost-effective individual market coverage consistent with New Hampshire's approved Section 1115a Research and Demonstration waiver #11-W-00298/1. For a Medicaid beneficiary who receives coverage in a cost-effective Qualified Health Plan in the individual market through the state's Waiver, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums. Cost sharing will not exceed nominal levels as established at 42 CFR 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20140415