

# OFFICIAL

Revision: HCFA-PM 91-4 (BPD)  
August 1991

Attachment 3.1-A  
Page 1  
OMB No.: 0938-

State/Territory: New Hampshire

## AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY\*\*

1. Inpatient hospital services other than those provided in an institution for mental diseases.
- Provided:  No limitations  With limitations\*
- 2.a. Outpatient hospital services.
- Provided:  No limitations  With limitations\*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).
- Provided:  No limitations  With limitations\*
- Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
- Provided:  No limitations  With limitations\*
3. Other laboratory and x-ray services.
- Provided:  No limitations  With limitations\*

\*\*Limitations in the State Plan may be exceeded with prior approval by the Department based on medical necessity.

\*Description provided on attachment.

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TN No. 12-009  
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TN No. 94-24

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## AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Title XIX – NH  
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Page 1-a

### 1. Inpatient Hospital Services

Payment for inpatient hospital services is limited to medically necessary days only. Medically necessary days are days of stay approved by the State agency responsible for utilization review, or its designee, i.e., the Quality Improvement Organization (QIO), which evaluates the quality, necessity, and appropriateness of care and renders length of stay determinations.

All accommodations and ancillary services are paid for each approved, medically necessary day. The day(s) of discharge does not count toward the limit. No payment is made for days of stay beyond the determination of medical necessity.

Coverage of organ transplantation is limited as per Attachment 3.1-E.

Prior authorization is required for inpatient hospitalizations at out of state hospitals, excluding border facilities and emergency hospitalizations.

### 2. a. Outpatient Hospital

Payment for outpatient hospital services is limited to twelve (12) visits per recipient per state fiscal year. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity. Visits to Urgent Care or the Emergency Department (ED) are not limited. The services associated with the outpatient hospital visit, and that may be performed by various practitioners, are also limited to twelve. This is a combination limit meaning that the services of physicians, ARNP's, clinical psychologists and pastoral counselors count in combination toward a limit of 12 when provided in the outpatient hospital setting. This limit may be exceeded in conjunction with the outpatient hospital limit if prior authorization is granted by the Department based on medical necessity.

b. Rural Health Clinic (RHC) Services – Hospital Based (HB) and Non-Hospital Based (NHB) - are provided as defined in Section 1905(a)(2)(B) of the Social Security Act. RHC services include services provided by physicians (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1), nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, visiting nurses and other ambulatory services included in the NH Title XIX State Plan. RHC services also include services and supplies that are furnished incident to professional services furnished by a physician (to include a physician assistant under the supervision and direction of the physician), nurse practitioner, certified nurse midwife, and for visiting nurse care, medical supplies, other than drugs and biologicals. "Other ambulatory services" that are included in the NH Title XIX State Plan and covered as RHC services are covered according to the applicable descriptions, service limitations, and payment provisions described elsewhere in this Title XIX State Plan. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity

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2. (continued)

c. Federally Qualified Health Center Services (FQHC's) and FQHC Look-A-Like (LAL) Services are provided as defined in Section 1905(a)(2)(C) of the Social Security Act. FQHC and FQHC-LAL services include services provided by physicians (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1), nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, visiting nurses and other ambulatory services included in the NH Title XIX State Plan. FQHC and FQHC-LAL services also include services and supplies that are furnished incident to professional services furnished by a physician (to include a physician assistant under the supervision and direction of the physician), nurse practitioner, certified nurse midwife, and for visiting nurse care, related medical supplies, other than drugs and biologicals. "Other ambulatory services" that are included in the NH Title XIX State Plan and covered as FQHC services are covered according to the applicable descriptions, service limitations, and payment provisions described elsewhere in this Title XIX State Plan. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

3. Other Laboratory and X-Ray Services

Payment is limited to fifteen (15) diagnostic x-ray procedures per recipient per state fiscal year. This limit includes x-ray procedures when performed by a physician or an independent laboratory. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Prior authorization is required for the following diagnostic x-ray services unless they are performed as part of a hospital emergency department visit, as part of an inpatient hospitalization, or performed concurrent with, or on the same day as, an urgent care facility visit:

- computerized tomography (CT)
- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)
- positive emission tomography (PET)
- nuclear cardiology

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AMOUNT, DURATION AND SCOPE OF MEDICAL  
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- 4.a Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
Provided:  No limitations  With limitations\*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*
- 4.c.(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachment 2.2-A, B, if this eligibility option is elected by the State.\*  
Provided:  No limitations  With limitations
- 4.c.(ii) Family planning-related services provided under the above State Eligibility Option.\*  
Provided:  No limitations  With limitations
- 4.d. Tobacco Cessation Counseling Services for Pregnant Women.\*  
Provided:  No limitations  With limitations
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.  
Provided:  No limitations  With limitations\*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).  
Provided:  No limitations  With limitations\*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.  
Provided:  No limitations  With limitations\*

\*Description provided on attachment.

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4a. Nursing Facility Services

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment is made for a non-private room unless a private room is medically necessary. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Bureau of Elderly and Adult Services.

4b. Early and Periodic Screening, Diagnosis, and Treatment

Limited to federal requirements for the categorically needy. Any limits to services provided in Attachment 3.1-A do not apply to individuals under EPSDT as long as medical necessity criteria as determined by the Office of Medicaid Business and Policy have been met.

4c. Family Planning Services

4c. (i) Family planning services include those services described in Section 1905(a)(4)(C).

4c. (ii) Family planning–related services provided under the state eligibility option at Attachment 2.2-A, B, are those medical diagnosis and treatment services provided in a family planning setting as part of, or as follow-up to, a family planning visit pursuant to Section 1902(a)(10)(G)(XVI). Family planning-related services that are covered in NH include: (1) services to treat adverse reactions to, or medical complications of, family planning procedures, services, treatment, or therapies (e.g., treatment of perforated uterus due to intrauterine device insertion, treatment of severe menstrual bleeding caused by Depo-Provera injection); (2) drugs (as well as follow-up visits and re-screens based on CDC guidelines) for the treatment of STD's, except for HIV/AIDS and hepatitis, when the STD is identified or diagnosed during a routine or periodic family planning visit; (3) drugs and other treatment (as well as follow-up visit) for lower genital tract and genital skin infections/disorders, and urinary tract infections, when identified/diagnosed during a routine/periodic family planning visit; and (4) vaccinations to prevent cervical cancer routinely provided pursuant to a family planning service in a family planning setting.

4d. Tobacco Cessation Counseling Services for Pregnant Women

Face-to-Face Tobacco Cessation Counseling Services Provided:

- (a) By or under the supervision of a physician; and
- (b) By any other health care professional who is legally authorized to furnish such services under state law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or\*
- (c) By any other health care professional legally authorized to provide tobacco cessation services under state law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

\*any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

NH allows eight (8) counseling sessions per each of two quit attempts. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

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Page 2-a (cont)

5a. Physician Services

Coverage for physician services is unlimited except for those physician services affiliated with outpatient hospital visits, which are limited (in combination with ARNP, clinical psychologist, and pastoral counselor services – 6d) to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity. Laboratory tests and diagnostic x-rays are not counted against the outpatient physician visit limit.

Except for kidney and tissue transplants, to include corneas, bone grafts, and skin transplants, which are covered without prior authorization, prior authorization is required for the coverage of physician services for organ transplants which include bone marrow, liver, heart, lung, heart-lung, pancreas, and pancreas-kidney. (See Attachment 3.1-E for specific details.) Certain surgical procedures to include bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty and rhinoplasty also require prior authorization.

Non-covered organ transplantation and procurement services include physician services for the surgery, inpatient hospital services for the surgical admission(s), and organ procurement related to the following types of transplants: any type of organ or tissue transplant not specified above (including hairplasty) or more than two transplants of the same type of organ per recipient per lifetime.

In accordance with federal law, coverage for induced abortions is provided when the physician certifies that the pregnancy was the result of rape or incest or the woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

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Physician laboratory and diagnostic radiology services are subject to the limit described under the Other Laboratory and X-ray service heading.

Services provided by licensed psychiatrists and ophthalmologists are included in the physician limits. Payment for refraction is limited to one (1) per recipient per state fiscal year, whether the provider is an optometrist or ophthalmologist.

5b. Medical and Dental Services

Services provided by a doctor of dental surgery or dental medicine which would otherwise be physician services are treated in the same manner as physicians in accordance with 5a.

6a. Podiatrists' Services

Payment for the services of licensed podiatrists is limited to four (4) visits per recipient per state fiscal year.

Podiatrist services shall be covered for medical and surgical treatments of the foot and lower leg for pathological conditions of the foot due to localized illness, injury, or symptoms involving the foot. Prevention and reduction of corns, calluses, and warts are covered if by cutting or surgical means only. Other licensed podiatrist services include routine foot care and trimming and burring of nails, including mycotic nails, performed by a podiatrist provided that:

The recipient's primary health care provider has documented in the recipient's medical record the the recipient's current medical condition justifies the need for such foot care to be performed by a podiatrist; and

The primary health care provider has written a referral to a podiatrist for such care, and the referral is maintained in the recipient's record.

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TN No: 10-008

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State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF MEDICAL  
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b. Optometrists' services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Chiropractors' services

Provided:  No limitations  With limitations\*  
 Not provided.

d. Other practitioners' services

Provided: Identified on attached sheet with description of  
limitations, if any.  
 Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided:  No limitations  With limitations\*

b. Home health aide services provided by a home health agency.

Provided:  No limitations  With limitations\*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL  
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- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided:  No limitations  With limitations\*  
 Not provided.

8. Private duty nursing services.

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

TN No. 91-23

Supersedes

TN No. 86-2b

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11/27/92

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6b. Optometrist Services

Payment to state licensed optometrists or ophthalmologists for refraction is limited to one (1) per recipient per state fiscal year whether the provider is a licensed optometrist or ophthalmologist.

6c. Chiropractor Services

Not covered

6d. Clinical Psychologist

Treatment provided by a licensed clinical psychologist, who is not on the staff of a community mental health center, is unlimited except for psychotherapy treatment affiliated with outpatient hospital services. Clinical psychologist services (in combination with ARNP and pastoral counselor services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Advanced Registered Nurse Practitioners

Section 6405 of P.L. 101-239 (OBRA 1989) is met by ARNP. Treatment provided by advanced registered nurse practitioners (known as advanced practice registered nurses-APRN's-in NH) who meet state licensure requirements is unlimited except for psychotherapy treatment affiliated with outpatient hospital services. ARNP psychotherapy services (in combination with clinical psychologist and pastoral counselor services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Certified Midwives

Midwife services comprised of the necessary supervision, care, and advice provided to women during the pregnancy, labor and postpartum period, and including care of the newborn, shall be provided pursuant to RSA 326-D and by individuals certified to practice midwifery in New Hampshire pursuant to RSA 326-D:6. For purposes of this Title XIX state plan service, certified midwives shall be considered the equivalent of licensed practitioners per CMS.

Pastoral Counselors

Psychotherapy services provided by a licensed pastoral counselor, who is not on the staff of a community mental health center, is unlimited except for psychotherapy treatment affiliated with outpatient hospital services. Pastoral counselor psychotherapy services (in combination with clinical psychologist and ARNP services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Master Licensed Alcohol and Drug Counselors (MLADC) and Licensed Alcohol and Drug Counselors (LADC)

MLADC's who are licensed by the NH Board of Licensing for Alcohol and other Drug Use Professionals and LADC's who are permitted to engage in independent practice in accordance with Chapter Law 189:2, II, Laws of 2008, and Chapter Law 249:24, V, Laws of 2010, shall be permitted to provide only certain Substance Use Disorder (SUD) Treatment and Recovery Support Services as allowed by the Department.

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Home Health Services

Home health services are provided in accordance with 42 CFR 440.70 and include nursing services home health aide services, and the services specified in 7c and 7d. Home health services are provided to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in 42 CFR 440.70(b)(3). A face to face encounter, in accordance with 42 CFR 440.70(f), is required. Medicaid recipients do not have to be homebound in order to receive home health services. Home health services can be provided in any non-institutional setting in which normal life activities take place. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place are provided in accordance with physician review and other requirements as specified in 42 CFR 440.70(b)(3).

Home health agencies must meet the Medicare conditions of participation in 42 CFR Part 484.

Services cannot be provided in a hospital, nursing facility, or ICF-MR, except as allowed at 42 CFR 470.70(c).

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7. Home Health Services (continued)

7c. Medical Supplies, Equipment and Appliances

Prior authorization is required for the purchase of most durable medical equipment as detailed in the department's rules at He-W 571, as well as for modifications to manual or power wheelchairs. Repairs to power wheelchairs require prior authorization if the repairs total \$800 or more.

Prior authorization is required for disposable diapers and related incontinence supplies for recipients 21 years of age and older. Other medical supplies do not require prior authorization.

7d. Physical and Occupational Therapy, Speech Pathology and Audiology Services

When provided by a home health agency, visiting nurse association, or independent therapist, these services are limited to eighty (80), fifteen minute units per recipient per state fiscal year. The 80 units may be used for one type of therapy or in any combination of therapies. Services provided by a rehabilitation center are limited to twelve (12) visits per recipient per state fiscal year for all types of service, except therapies which are subject to the above limits.

8. Private Duty Nursing Services

Private duty nursing services which are covered are those provided by a registered or licensed practical nurse under the order and general direction of the patient's physician to a patient only in his place of residence, not a long term care facility. Prior authorization is required every sixty (60) days from the Office of Medicaid Business and Policy.

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9. Clinic services.

Provided:  No limitations  With limitations\*  
 Not provided.

10. Dental services.

Provided:  No limitations  With limitations\*  
 Not provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Occupational therapy.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Services for individuals with speech, hearing, and language disorders  
(provided by or under the supervision of a speech pathologist or  
audiologist).

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

TN No. 86-2b  
Supersedes  
TN No. PCO-11  
81-12

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## AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

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9. Clinic Services

Out-of-state clinic services require prior authorization from the Department. Such payment authorization may be given only if substantiated by the attending physician's statement of medical necessity.

10. Dental Services

Treatment covered for recipients under 21 includes: (a) prophylaxis every 150 days, (b) restorative treatment, (c) periodic examinations, no more frequently than every one hundred fifty days, unless they are medically necessary to diagnose an illness or condition, (d) vital pulpotomy, (e) extractions of symptomatic teeth associated with diagnosed pathology as documented in the provider's treatment record, (f) extractions of asymptomatic teeth subject to prior authorization, with the exception of third molars for which the prior authorization requirement is suspended through May 31, 2015, (g) extractions of third molars associated with diagnosed pathology as documented in the provider's treatment record, and subject to prior authorization, except that the prior authorization requirement is suspended through May 31, 2015, (h) general anesthesia and nitrous oxide analgesia (i) orthodontic therapy subject to prior authorization, (j) x-rays including complete or panoramic every 5 years, bitewings every 12 months if medically necessary, and all types regardless of limits if required to complete a differential diagnosis, (k) palliative treatment, (l) removable prosthetic replacement of permanent teeth, subject to prior authorization, (m) topical fluoride treatment two times/year, (n) endodontia, including root canal therapy, (o) crowns, (p) periodontic treatment limited to prophylaxis, scaling, and root planing, (q) sealants for permanent and deciduous molars every 5 years, (r) surgical periodontal treatment subject to prior authorization, and (s) any other services that meet EPSDT medical necessity criteria as determined by the Department. Any limits to services do not apply to EPSDT recipients as long as medical necessity criteria as determined by the Department have been met.

Dental services covered for recipients 21 and over for the treatment for relief of acute pain or elimination of acute infection are: (a) palliative treatment, (b) extraction of the causative tooth or teeth, (c) treatment of severe trauma, (d) surgical procedures performed in a hospital, and (e) x-rays for areas described above.

Prior authorization from the Department is also required for (a) orthodontic therapy considered under the EPSDT medical necessity provisions, and (b) services not listed but identified in an EPSDT screening. Prior authorization for all orthodontic therapy is granted based upon substantiation of the meeting of conditions specified by the Department. Orthodontic therapy is covered only until the recipient reaches the age of 21.

11. Physical Therapy and Related Services (Occupational and Speech Therapy)

When provided by a home health agency, visiting nurse association, outpatient hospital (to include rehabilitation center), or independent therapist, these services are limited to eighty (80) 15-minute units per recipient per state fiscal year. The eighty (80) units may be used for one type of therapy or in any combination of therapies in an outpatient setting. The limits may be exceeded if prior authorization is granted from the Department based on medical necessity.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Dentures.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Prosthetic devices.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Eyeglasses.

Provided:  No limitations  With limitations\*  
 Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided:  No limitations  With limitations\*  
 Not provided.

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\*Description provided on attachment.

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TN No. PCO-11  
75-17

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12a. Prescribed Drugs

Co-payments for prescribed drugs are described in Section G, "Medicaid Premiums and Cost Sharing," of the state plan.

Maintenance medication, which is defined as legend or non-legend medication to be used for routine, continuous therapy for at least 120 days, shall be dispensed as follows:

- Solid oral drugs shall be dispensed as a minimum supply of 30 days and a maximum supply of 90 days with the exception of oral contraceptives as described below; and
- Solid oral contraceptive drugs shall be dispensed as a minimum supply of 28 days and a maximum supply of 12 months.

Prior authorization is required for certain drugs appearing on a list maintained by the New Hampshire Department of Health and Human Services and updated as necessary.

Per Section 1927(d)(5) of the Act, the prior authorization program provides a response by telephone or other telecommunication device within 24 hours of a request. In an emergency situation, the prior authorization program provides for the dispensing of at least a 72-hour supply of a covered drug.

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TN No: 04-002

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12a. Prescribed Drugs (continued)

Preferred Drug Lists and Supplemental Rebate Agreements:

In accordance with Section 1927 of the Social Security Act, the state has established a preferred drug list.

Certain covered products, in accordance with Section 1927 of the Social Security Act, may not be among the baseline preferred drugs identified by the Drug Utilization Review (DUR) Board for various therapeutic classes. All Medicaid covered products remain available through the Medicaid program, but may require prior authorization. The state, or the state in consultation with a contractor, may negotiate supplemental rebate agreements that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.

The prior authorization program provides a response by telephone or other telecommunication device within 24 hours of a request. In an emergency situation, the prior authorization program provides for the dispensing of at least a 72-hour supply of a covered drug.

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for the supplemental drug rebate program for the Medicaid population:

- Supplemental rebate agreements between the state and a pharmaceutical manufacturer will be separate from federal rebates and are in excess of those required under the national drug rebate agreement.
- Effective September 1, 2019, the Department will implement a single state-managed PDL for all Medicaid participating managed care organizations (MCO's) and for Medicaid fee for service. The NMPI supplemental rebate agreements will apply to the drug benefit, both fee for service and those paid by contracted MCO's, under prescribed conditions in Attachment A-2 of the NMPI Supplemental Rebate Agreement, effective September 1, 2019.
- CMS has authorized New Hampshire to enter into the Michigan multi-state pooling agreement, also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid recipients. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on April 9, 2004, have been authorized by CMS for pharmaceutical manufacturers' existing agreements through their current expiration dates. An updated NMPI SRA was submitted to CMS on January 25, 2008, and again on June 25, 2013, and has been authorized for any renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid recipients.
- Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.
- All drugs covered by the program, irrespective of any prior authorization requirement, will comply with provisions of the national drug rebate agreement.
- Manufacturers with supplemental rebate agreements are allowed to audit utilization data.
- The unit rebate amount is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act.

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12a. Prescribed Drugs (continued)

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1927(d)(2) and 1935(d)(2) 1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

**No excluded drugs are covered**

**The following excluded drugs are covered:**

- (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
- (b) agents when used to promote fertility (see specific drug categories below)
- (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
- (d) agents when used for the symptomatic relief of cough and colds (see specific drug categories below)
- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (all are covered)
- (f) nonprescription drugs (see specific drug categories below)
- (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

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12a. Prescribed Drugs (continued)

**The Medicaid agency lists specific categories of drugs below:**

(a) All anorexia and weight gain drugs are covered. All weight loss drugs are covered if prior authorization criteria are met.

(f) Some are covered – see below.

(f) (continued)

**Non-Legend Drug List**

Insulins are covered for recipients. NH's Preferred Drug List (PDL) lists insulins available without prior authorization. Items in this list are listed alphabetically by therapeutic class, then by the generic name of the drug or drug ingredients. Only the generic versions, singly or in combination, regardless of strength or dosage form, are covered. Combination products will not be covered if they contain active ingredients that are not covered.

**Analgesics:**

acetaminophen  
aspirin  
aspirin with buffers  
ibuprofen  
ketoprofen  
naproxen

**Antihistamines:**

brompheniramine  
chlorpheniramine  
diphenhydramine  
loratadine

**Antimicrobials/Antifungals, Topical**

bacitracin  
clotrimazole  
miconazole  
neomycin  
polymixin B  
tolnaftate

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12a. Prescribed Drugs (continued)

(f) (Non-Legend Drug List continued)

**Spermicides:**

nonoxynol-9

**Gastrointestinal Products:**

Alginic acid  
aluminum carbonate  
aluminum hydroxide  
bisacodyl  
calcium carbonate  
calcium polycarbophil  
casanthranol  
cellulose  
cimetidine  
docusate calcium  
docusate sodium  
famotidine  
glycerin suppositories  
magaldrate  
magnesium citrate  
magnesium hydroxide  
magnesium trisalicylate  
meclizine  
methylcellulose  
nizatadine  
omeprazole  
psyllium  
ranitidine  
sennosides

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12a. Prescribed Drugs (continued)

(f) (Non-Legend Drug List continued)

**Vitamins and Nutrients:**

calcium carbonate  
calcium carbonate/vit D  
calcium citrate  
calcium glubionate  
calcium gluconate  
calcium phosphate  
ferrous fumarate  
ferrous gluconate  
ferrous sulfate  
magnesium chloride  
magnesium gluconate  
magnesium oxide  
niacin  
niacinamide  
nicotinic acid

**Miscellaneous Products:**

A&D ointment  
ammonium lactate 12%  
hydrocortisone  
instant dextrose/glucose  
lanolin  
nicotine  
permethrin  
salicylic acid  
sodium chloride solution for inhalation  
water for inhalation  
zinc oxide

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AMOUNT, DURATION AND SCOPE OF MEDICAL/REMEDIAL CARE SERVICES PROVIDED

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Page 5-b

12c. Prosthetic Devices

Prior authorization is required for the purchase of hearing aids and ear molds. A written request, supported by a physician's statement of medical necessity, must be submitted to the Medicaid Administration Bureau for hearing aids and ear molds.

12d. Eyeglasses

Payment for eyeglasses is limited to the following:

- one (1) pair of single vision glasses with lenses, provided that the refractive error is at least plus or minus .50 diopter according to the type of refractive error, in each eye.
- one (1) repair of glasses every 12 months, including replacement of the broken component(s) only.
- replacement of lenses or lenses and frames only when refractive error changes .50 diopter or more in both eyes.
- contact lenses, trifocal lenses, and ocular prostheses under certain conditions and with prior authorization.

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AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Preventive services.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Rehabilitative services.

Provided:  No limitations  With limitations\*  
 Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Skilled nursing facility services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Intermediate care facility services.

Provided:  No limitations  With limitations\*  
 Not provided.

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\*Description provided on attachment.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

13 a. b. c. d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

These services are generally covered under other types of services described elsewhere in this plan.

Additional Diagnostic, Screening, Preventive and Rehabilitative Services reimbursed by Medicaid include:

- those provided for eligible adults and children within screening programs such as Head Start, the Public School systems, and medical and dental screening programs conducted as part of approved and organized day care programs.
- those provided by agencies under current Bureau of Maternal and Child Health, Office of Community and Public Health, contract obligation.

Mental Health Services (Division of Behavioral Health) are covered as follows:

The limit for all community mental health services shall be \$1,800 (Medicaid reimbursement) per recipient per state fiscal year. Medicaid recipients shall qualify to exceed the \$1,800 limit if the community mental health program certifies that the recipient meets the criteria for one of the Division of Behavioral Health (DBH) eligibility categories. However, those individuals who meet the eligibility criteria as Adults with Severe or Severe and Persistent Mental Illness with Low Service Utilization shall not be allowed to exceed a \$4,000 state fiscal year cap unless approved through a waiver request submitted to DBH.

Individual community mental health service limits shall also apply.

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Any such services provided by an out-of-state provider require prior authorization for reimbursement.

Other Preventive and Rehabilitative Services covered include:

- those provided in a facility specifically designated for intensive inpatient rehabilitation services such as the Crotched Mountain Rehabilitation Center or one of such facilities in Massachusetts. Prior authorization is required.
- adult medical day care services provided in a licensed facility. Payment for adult medical day care services is made only when the recipient is determined to be medically frail and/or elderly by a physician and is not residing in an institution. Recipients must attend adult medical day care for a minimum of two days per week, five hours per day.
- early intervention services include client centered family training and counseling, developmental training, speech therapy, occupational therapy, and physical therapy. Specifically excluded from coverage are direct child day care, case management, and child transportation--the latter two being Medicaid covered services already.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

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Substance Use Disorder (SUD) Treatment and Recovery Support Services

SUD services covered under the rehabilitative benefit include the following:

- a. Screenings for the purpose of identifying individuals who have an alcohol or drug use problem or who are at risk for developing one. Screenings include evaluating responses to standardized screening instrument questions about the context, frequency, and amount of alcohol and other drug use. The screening must be performed by licensed psychotherapy providers, licensed MLADC's, or LADC's engaged in independent practice in accordance with NH statutes.
- b. Individual, group, or family treatment consistent with Level 1, ASAM Criteria 2013. Treatment consists of services provided by a clinician to assist an individual(s) to achieve treatment objectives through the exploration of substance use disorders and their ramifications, including an examination of attitudes and feelings, and consideration of alternative solutions and decision making with regard to alcohol and other drug related problems. Services must be performed by licensed psychotherapy providers, licensed MLADC's, LADC's engaged in independent practice in accordance with NH statutes, licensed physicians, or licensed APRN's.
- c. Intensive outpatient SUD services consistent with Level 2.1 which means intensive and structured individual and group alcohol and/or other drug treatment services and activities provided at least 3 hours a day and at least 3 days a week for recipients age 21 and over, and at least 2 hours a day and at least 3 days a week for recipients under age 21 and to include a range of outpatient treatment services and other ancillary and/or other drug services. Services must be delivered by licensed psychotherapists or licensed MLADC's.
- d. Partial hospitalization consistent with Level 2.5, ASAM Criteria 2013, involving intensive and structured individual and group treatment of moderate to severe co-occurring mental health disorders that are provided at least 20 hours per week, but which, at this level, does not involve 24-hour care. This level encompasses services that are capable of meeting the complex needs of people with co-occurring substance use and other conditions and is typically an organized, outpatient service that delivers treatment services usually during the day. Services, with the exception of medication management, must be delivered by licensed psychotherapists or licensed MLADC's. Medication management must be delivered by licensed psychiatrists or licensed APRN's with a psychiatric specialty.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services (continued)

e. Medically monitored outpatient withdrawal management, consistent with Level 1-WM, ASAM Criteria 2013. Services shall be provided under an integrated or collaborative service model and, at this level, consist of outpatient withdrawal management without extended on-site monitoring. Services must be delivered by behavioral health personnel and other health care providers who provide a planned regimen of care in the outpatient setting. These providers shall be licensed psychotherapists, licensed MLADC's, licensed physicians, or licensed APRN's.

f. Crisis intervention when a recipient is facing a crisis or emergency situation and the crisis intervention is related to the recipient's SUD. Crisis intervention is a response to a crisis or emergency situation experienced by an individual which is related to a recipient's SUD. Services must be performed by licensed psychotherapy providers, licensed MLADC's, LADC's engaged in independent practice in accordance with NH statutes, licensed physicians, or licensed APRN's.

g. Peer recovery support involving non-clinical services to help recipients and families identify and work toward strategies and goals around stabilizing and sustaining recovery and, as applicable, coordinating care by providing links to professional treatment and community supports. Peer recovery support services are recipient directed and delivered by peers who have lived experience with recovery and who are certified recovery support workers (CRSW) or licensed LADC's or MLADC's, all of whom must have at least 30 contact hours of recovery coach training approved by the NH Training Institute on Addictive Disorders, the NAADAC Association for Addiction Professionals, the New England Institute of Addiction Studies, the Addiction Technology Transfer Center, or the Connecticut Communities of Addiction Recovery Coach Academy. Supervision of the CRSW or LADC is carried out by an MLADC.

h. Non-peer recovery support including non-clinical group or individual services consistent with a recipient's treatment plan that help to prevent relapse and promote recovery. Services must be provided by a CRSW or licensed LADC or MLADC. The CRSW and licensed LADC must be under the supervision of an MLADC.

i. Continuous recovery monitoring including recovery check-ups with recipients on a regular basis, evaluations of the status of the recipient's recovery, consideration of a broad array of recipient needs, and provision of active referral to community resources as applicable. Services must be provided by a CRSW or licensed LADC or MLADC. The CRSW and licensed LADC must be under the supervision of an MLADC.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services (continued)\*\*\*

j. Evaluations to determine the existence and severity of the SUD and appropriate level of care for the recipient. This service must be provided by a licensed psychotherapist, a licensed MLADC, or a LADC engaged in independent practice in accordance with NH statutes.

k. Medically monitored residential withdrawal management consistent with Level 3.7-WM, ASAM Criteria 2013, meaning that such services are organized and delivered by behavioral health personnel and other health care providers who provide a planned regimen of care in a 24-hour live-in setting for the purpose of stabilizing situations of severe withdrawal. This residential setting is not an Institute for Mental Disease (IMD). Services must be delivered by licensed psychotherapists, licensed MLADC’s, licensed physicians, or licensed APRN’s.

l. Rehabilitative services, consistent with Level 3.1 and Level 3.5, ASAM Criteria 2013, as summarized at <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf>, or other services as described in a, h, and i above, in a facility licensed as a residential treatment and rehabilitation facility, or in a state-owned SUD residential treatment and rehabilitation facility which is exempt from licensure in accordance with RSA 151:2, II, i. This residential setting is not an Institute for Mental Diseases (IMD). Recipients being treated at an ASAM 3.5 level of care must be present in the facility at least 22 hours per day. For recipients age 21 and over, this is a clinically managed, high-intensity residential service that includes a planned program of professionally directed evaluation, care and treatment for the restoration of functioning. For recipients under age 21, this service is a clinically managed, medium intensity, residential service that includes a planned program of professionally directed evaluation, care and treatment for the restoration of functioning.

Recipients treated at an ASAM 3.1 level of care receive a level of service that is a clinically managed, low intensity residential service that includes a planned program of professionally directed evaluation, care and treatment for the restoration of functioning. Services must be delivered by licensed psychotherapists, licensed MLADC’s, licensed physicians, or licensed APRN’s.

\*\*\*Note: Additional coverage details regarding services a through l above are contained in the immediately following Supplement to this Page 6 Section related to SUD Treatment and Recovery Support Services

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## 13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1 - pre a 3)

**a. Screenings:** No additional description.

### **b. Individual, group, or family treatment consistent with Level 1, ASAM (Outpatient):**

#### **Support Systems**

In Level 1 services, necessary support systems include:

- Continued treatment planning individualized to the patients' needs
- Medical, psychiatric, psychological, laboratory, and toxicology services, which are available on-site or through consultation or referral. Medical and psychiatric consultation is available within 24 hours by telephone or, if in person, within a time frame appropriate to the severity and urgency of the consultation requested.
- Direct affiliation with (or close coordination through referral to) more intensive levels of care and medication management.
- Emergency services available by telephone 24 hours a day, 7 days a week.

#### **Therapies**

Therapies offered in Level 1 involve skilled treatment services, which may include evaluation, individual and group counseling, motivational enhancement, family therapy with patient present, psychoeducational groups, psychotherapy, addiction pharmacotherapy, or other skilled therapies. Skill restoration therapy which is defined as services intended to reduce or remove barriers to clients who are achieving and maintaining recovery is also included. Such services are provided in an amount, frequency, and intensity appropriate to the objectives of the treatment plan. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. For patients with mental health conditions, the issues of psychotropic medication, mental health treatment, and their relationship to substance use and addictive disorders are addressed as the need arises. Therapies must be recommended by a physician or other licensed practitioner of the healing arts and furnished in accordance with page 6 pre-a 1.

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## 13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

### c. Intensive outpatient SUD services consistent with Level 2.1 ASAM:

#### **Support Systems**

In Level 2.1 programs, necessary support systems include:

- Continued treatment planning individualized to the patients' needs
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral. Psychiatric and other medical consultation is available within 24 hours by telephone and within 72 hours in person.
- Emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session.
- Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.

#### **Therapies**

Therapies offered by Level 2.1 programs include:

- A minimum of 3 hours per day, 3 days per week for adults (age 21 and over) and 2 hours per day, 3 days per week for adolescents (under age 21) of skilled treatment services. Such services may include evaluation, individual and group counseling, medication management, family therapy with patient present, psychoeducational groups, and other skilled therapies. Skill restoration therapy which is defined as services intended to reduce or remove barriers to clients who are achieving and maintaining recovery is also included. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan. In cases in which the patient is not yet fully stable to safely transfer to a Level 1 program that is not associated with the treatment agency, the patient's treatment for Level 1 services may be continued within the current Level 2.1 program. Therapies must be recommended by a physician or other licensed practitioner of the healing arts and furnished in accordance with page 6 pre-a 1.
- Family therapy for the family members, guardians, or significant others and which is for the direct benefit of the patient in accordance with the patient's needs and treatment goals identified in the patient's treatment plan, and for the purpose of assisting in the patient's recovery.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient's developmental stage and comprehension level.
- Motivational interviewing, enhancement, and engagement strategies, which are used in preference to confrontational approaches.

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## 13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

### **d. Partial hospitalization consistent with Level 2.5 ASAM:**

#### **Support Systems**

**In Level 2.5 programs, necessary support systems include:**

- Continued treatment planning individualized to the patients' needs
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral. Psychiatric and other medical consultation is available within 8 hours by telephone and within 48 hours in person.
- Emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session.
- Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.

#### **Therapies**

Therapies offered by Level 2.5 programs include:

- A minimum of 20 hours per week of skilled treatment services. Services may include evaluation, individual and group counseling, medication management, family therapy with patient present, psychoeducational groups, and other skilled therapies. Skill restoration therapy which is defined as services intended to reduce or remove barriers to clients who are achieving and maintaining recovery is also included. These are provided in the amounts, frequencies, and intensities appropriate to the objectives of the treatment plan. Therapies must be recommended by a physician or other licensed practitioner of the healing arts and furnished in accordance with page 6 pre-a 1.
- Family therapy for the family members, guardians, or significant others and which is for the direct benefit of the patient in accordance with the patient's needs and treatment goals identified in the patient's treatment plan, and for the purpose of assisting in the patient's recovery.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient's developmental stage and comprehension level.
- Motivational enhancement and engagement strategies, which are preferred over confrontational approaches.

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## 13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

### e. Medically monitored outpatient withdrawal management consistent with Level 1-WM ASAM:

#### **Support Systems**

**In Level 1-WM withdrawal management, support systems feature the following:**

- Continued treatment planning individualized to the patients' needs
- Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems as indicated.
- Ability to obtain a comprehensive medical history and physical examination of the patient at admission.
- Affiliation with other levels of care, including other levels of specialty addiction treatment, for additional problems identified through a comprehensive biophysical assessment.
- Ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing.
- 24-hour access to emergency medical consultation services should such services become indicated.
- Assist in accessing transportation services for patients who lack safe transportation.
- Coordinating discharge or transfer planning and referrals for counseling and community recovery support groups.

#### **Therapies**

Therapies offered by Level 1-WM withdrawal services, which must be recommended by a physician or other licensed practitioner of the healing arts and furnished in accordance with page 6 pre-a 2, include individual assessment, medication or non-medication methods of withdrawal management, patient education, non-pharmacological clinical support, involvement of family members or significant others in the withdrawal management process with the patient present,. Family involvement in the withdrawal management process is for the direct benefit of the patient in accordance with the patient's needs and treatment goals identified in the patient's treatment plan and for the purpose of assisting in the patient's recovery.

Therapies also include physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

**f. Crisis Intervention:** No additional description

**g. Peer Recovery Support:** Services include:

- Alcohol and/or substance abuse services delivered by a peer with lived experience in recovery
- Preventive services to include individual skills development and restoration to prevent continuation or recurrence of substance misuse
- Psychoeducation interventions to support patients' recovery
- Development (and periodic revision) of a specific recovery plan that is based on the information collected through the assessment that specifies the goals and actions to address the recovery goals and other services needed by the individual
- Ensuring the active participation of the patient, and working with the patient to develop and refine recovery goals
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

**h. Non-peer recovery support:** Services include:

- Alcohol and/or substance abuse services delivered by a licensed or certified practitioner
- Preventive services to include individual skills development and restoration to prevent continuation or recurrence of substance misuse
- Psychoeducational interventions to support patients' recovery
- Development (and periodic revision) of a specific recovery plan that is based on the information collected through the assessment that specifies the goals and actions to address the recovery goals and other services needed by the individual
- Ensuring the active participation of the patient, and working with the patient to develop and refine recovery goals
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments

**i. Continuous recovery monitoring:** No additional description.

**j. Evaluation:** No additional description.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

**k. Medically monitored residential withdrawal management consistent with Level 3.7-WM ASAM:**

**Support Systems**

In Level 3.7-WM residential withdrawal management, support systems feature the following:

- Availability of specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems for the purposes of care and treatment planning for the client
- Available of medical nursing care and observation, based on clinical judgement
- Direct affiliation with other levels of care
- Ability to conduct or arrange for appropriate laboratory or toxicology tests

**Therapies**

Therapies offered by Level 3.7-WM residential withdrawal management programs include daily clinical services to assess and address the needs of each patient. Such clinical services may include appropriate medical services, individual and group therapies, and withdrawal support. Hourly nurse monitoring of the patient's progress and medication administration are available, if needed. The following therapies are provided as clinically necessary, depending on the patient's progress through withdrawal management and the assessed needs in ASAM Dimensions 2 through 6:

- A range of cognitive, behavioral, medical, mental health and other skilled therapies are administered to the patient on an individual or group basis. These are designed to enhance the patient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment.
- Multidisciplinary individualized assessment and treatment.
- Health education services.
- Services to families and significant others with the patient present and which is for the direct benefit of the patient in accordance with the patient's needs and treatment goals identified in the patient's treatment plan and for the purpose of assisting in the patient's recovery.

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

**1. Rehabilitative services in a residential treatment and rehabilitation facility consistent with Level 3.1 and Level 3.5 ASAM:**

**Level 3.1: Clinically Managed Low-Intensity Residential Services**

**Support Systems**

**In Level 3.1 programs, necessary support systems include:**

- Continued treatment planning individualized to the patients' needs.
- Telephone or in-person consultation with a physician and emergency services, available 24 hours a day, 7 days a week.
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

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## 13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

### SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

#### Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

### 1. Rehabilitative services in a residential treatment and rehabilitation facility consistent with Level 3.1 and Level 3.5 ASAM:

#### Level 3.1: Clinically Managed Low-Intensity Residential Services (continued)

##### Therapies

Therapies offered by Level 3.1 programs include:

- Daily clinical services to improve the patient's ability to structure and organize the tasks of daily living and recovery to include preventive services to include individual skills development and restoration to prevent continuation or recurrence of substance misuse.
- Planned clinical program activities (constituting at least 5 hours per week of professionally directed treatment) to stabilize and maintain the stability of the patient's substance use disorder symptoms, and to help him or her develop and apply recovery skills. Activities may include relapse prevention, exploring interpersonal choices, and development of a social network supportive of recovery.
- Addiction pharmacotherapy.
- Random drug screening to monitor and reinforce treatment gains, as appropriate to the patient's individual treatment plan.
- Motivational enhancement and engagement strategies appropriate to the patient's stage of readiness to change, which are used in preference to confrontational approaches.
- Counseling and clinical monitoring to support successful initial involvement or reinvolved in regular, productive daily activity (such as work or school) and, as indicated, successful reintegration into family living. Health education services are also provided.
- Regular monitoring of the patient's medication adherence.
- Recovery support services.
- Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addictive disorder.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

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13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)  
(Continued)

**1. Rehabilitative services in a residential treatment and rehabilitation facility consistent with Level 3.1 and Level 3.5 ASAM (continued):**

**Level 3.5: Clinically Managed High-Intensity Residential Services (Adult Criteria)**

**Support Systems**

In Level 3.5 programs, necessary support systems include:

- Continued treatment planning individualized to the patients' needs
- Telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in states where they are licensed as physician extenders and may perform the duties designated her for a physician; emergency services, available 24 hours a day, 7 days a week.
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.
- Stabilization of imminent risk as defined by ASAM.

**Therapies**

Therapies offered by Level 3.5 programs include:

- Daily clinical services to improve the patient's ability to structure and organize the tasks of daily living and recovery to include preventive services to include individual skills development and restoration to prevent continuation or recurrence of substance misuse.
- Planned clinical program activities to stabilize and maintain stabilization of the patient's addiction symptoms, and to help him or her develop and apply recovery skills. Activities may include relapse prevention, exploring interpersonal choices, and development of a social network supportive of recovery.
- Counseling and clinical monitoring to promote successful initial involvement or reinvolved in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living.

13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

**I. Rehabilitative services in a residential treatment and rehabilitation facility consistent with Level 3.1 and Level 3.5 ASAM (continued):**

**Level 3.5: Clinically Managed High-Intensity Residential Services (Adult Criteria) (continued) Therapies (continued)**

Therapies offered by Level 3.5 programs include:

- Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the patient’s individual treatment plan.
- A range of evidence-based cognitive, behavioral, and other skilled therapies administered on an individual and group basis, medication education and management, addiction pharmacotherapy, psychoeducational groups, and skill development services to prevent continuation and recurrence of substance misuse, adapted to the patient’s developmental stage and level of comprehension, understanding, and physical abilities, as well as skill restoration therapy which is defined as services intended to reduce or remove barriers to clients who are achieving and maintaining recovery.
- Motivational enhancement and engagement strategies appropriate to the patient’s stage of readiness and desire to change. Motivational therapies and other evidence-based practices are used in preference to the confrontational strategies.
- Counseling and clinical interventions to develop or restore the patient’s skills needed for productive daily activities and integration into family living in order to prevent the continuation or recurrence of substance misuse.
- Monitoring of the patient’s adherence in taking any prescribed medications and/or any permitted over-the-counter (OTC) medications or supplements.
- Planned clinical activities to enhance the patient’s understanding of his or her substance use and/or mental disorders.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

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Attachment 3.1-A  
Page 6 pre-a 1-3  
Supplement, page 12

13d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

SUPPLEMENT TO: Substance Use Disorder (SUD) Treatment and Recovery Support Services

Additional Details and Descriptions of ASAM Levels Associated with SUD Services and/or More Detailed Service Descriptions (by service entry as described on pages 6 pre a 1-pre a 3)

(Continued)

**I. Rehabilitative services in a residential treatment and rehabilitation facility consistent with Level 3.1 and Level 3.5 ASAM (continued):**

**Level 3.5: Clinically Managed High-Intensity Residential Services (Adult Criteria) (continued) Therapies (continued)**

Therapies offered by Level 3.5 programs include (continued from page 11):

- Daily scheduled professional services, including interdisciplinary assessments and treatment, designed to develop and apply recovery skills. Such services may include relapse prevention, exploring interpersonal choices, and development of a social network supportive of recovery. Such services may also include medical services, nursing services, individual and group counseling, psychotherapy, family therapy with patient present, psychoeducational groups, and physical therapy as well as skill restoration therapy which is defined as services intended to reduce or remove barriers to clients who are achieving and maintaining recovery.
- Planned community reinforcement designed to foster prosocial values and milieu or community living skills such as attending recovery support groups and engaging in pro-social activities.
- Services for the patient’s family and significant others with the patient present which is for the direct benefit of the patient, in accordance with the patient’s needs and treatment goals identified in the patient’s treatment plan, and for the purpose of assisting in the patient’s recovery.

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## AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

### 13 a, b, c, d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

#### 13c. Preventive Services – ACA Section 4106 Assurances

All of the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and all approved adult vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP) are available to both categorically and medically needy recipients in need of such services. Such services are provided in accordance with Sections 1905(a)(13) and 1905(b) of the Social Security Act (SSA), as amended by Section 4106 of the Affordable Care Act (ACA). As stipulated by these federal regulations, the state does not impose any cost sharing on such services.

The state covers preventive services under the following benefit, as described in Attachment 3.1-A, *Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy*, and 3.1-B, *Amount, Duration, and Scope of Medical and Remedial Care and Services Provided Medically Needy Group*, of the state plan:

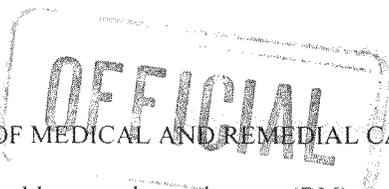
- Outpatient Hospital Services/RHC/FQHC (2)
- Other Laboratory and X-Ray Services (3)
- Physician Services (5a)
- Medical Care and Other Types of Remedial Care (6)
- Home Health (7)
- Physical Therapy and Related Services (11)
- Nurse-midwife Services (17)

The payment methodology for each of the above noted benefits is described in Attachment 4.19-B, *Methods and Standards for Establishing Payment Rates- Other Types of Care*, of the state plan.

The state's utilization review and approval procedures conforms to those specified by the USPSTF and ACIP periodicity or indications where specified.

The state has generated a crosswalk of appropriate codes and/or modifiers that are reflective of the USPSTF and ACIP recommendations. As changes are made to the USPSTF or ACIP recommendations, the state will update its coverage and billing codes to comply with those revisions.

The state has financial monitoring and documentation procedures in place to ensure proper claiming for the one percentage point increase in federal medical assistance percentage (FMAP) that apply to these expenditures, as permitted by Section 4106 of the ACA.



AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Preventive services provided by a registered nurse (RN) to a newborn and his/her mother at their home to include a physical assessment, preventive health education, and assistance with connecting with a primary health care provider and the State EPSDT program.

Medicaid services provided in a licensed supported residential health care facility (private non-medical institution) must have prior authorization by the Office of Medical Services.

A private non-medical institution for children is a residential child care facility. Covered services must be prior authorized by the Division for Children, Youth and Families.

Therapeutic foster care must be prior authorized by the Division for Children, Youth and Families. Covered services are client centered family mental health counseling, individual counseling, crisis intervention and stabilization and medical care coordination. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

Intensive Day Therapy is covered when prior authorized by the Division of Human Services. Intensive Day Therapy is a package of services which can include case management, occupational therapy, physical therapy, speech therapy, and nursing services. Prior authorization is for a two (2) month period with a limit of six (6) months total. Recipient must generally receive a minimum of four (4) hours of service for five (5) days of each week.

Intensive Day Programming is covered when prior authorized by the Division for Children, Youth and Families. Based on a clinical assessment, each child receives an individually designed program of individual, group, and/or family system therapy and counseling. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

Crisis Intervention is covered when pre-approved by the Division for Children, Youth and Families. Covered services include therapeutic and intensive counseling, and are generally limited to a six week period. This service is available 24 hours per day, seven days per week. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

Child Health Support Services are covered when pre-approved by the Division for Children, Youth and Families. Covered services for foster children are provided by RN's and include a brief health screening at the time of the child's placement, referrals for comprehensive health and development assessments, health planning conferences, and follow-up care. Covered services for children in their own homes include an initial health assessment/health education, support counseling, and behavioral health management. Supervision of the services for children in their own homes is provided by a RN or licensed practical nurse (LPN). Supervision of the services for children in their own homes may be provided by a Master's level social worker, mental health worker or counselor when the services are support counseling and/or behavioral health management. Services provided to children in their own homes are usually limited to three (3) months.

Home Based Therapy Services are covered when pre-approved by the Division for Children, Youth and Families. Covered services include psychotherapy and mental health counseling and therapy. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

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OFFICIAL

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED**

Psychotherapy services provided by a clinical social worker, mental health counselor, marriage and family therapist, or other practitioner, who is certified by the NH Board of Examiners of Psychology and Mental Health Practice, and who is not on the staff of a community mental health center, are covered up to twelve (12) psychotherapy visits per recipient per state fiscal year--such visits to be counted toward the twelve (12) visit psychotherapy cap for all non-physician practitioners. The above providers must follow a treatment plan prescribed by a licensed practitioner who is licensed to provide psychotherapy services.

- 14a. Prior authorization is required before any payment is made for such services rendered out-of-state. No payment will be made for out-of-state care in an IMD if it is determined that the same care could have been provided in-state.
- 14c. Payment for intermediate care services in institutions for mental disease is available to categorically and medically needy recipients in need of such care. Payment for intermediate care services in institutions for mental disease must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Determination of need for, and authorization of payment for, intermediate care services in institutions for mental disease is made by the Office of Long Term Care.

TN No: 97-9  
Supersedes  
TN No: 96-17

Approval Date: \_\_\_\_\_

Effective Date: 7/1/97

State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDED

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided:      \_\_\_ No limitations       With limitations\*  
 Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided:      \_\_\_ No limitations       With limitations\*  
 Not provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided:      \_\_\_ No limitations       With limitations\*  
 Not provided

17. Nurse-midwife services.

Provided:      \_\_\_ No limitations       With limitations\*  
 Not provided

18. Hospice care (in accordance with section 1905(o) of the Act and section 2302 of the Affordable Care Act which amends sections 1905(o)(1) and 2110(a)(23) of the Act to allow concurrent, curative care for children).

Provided:       No limitations      \_\_\_ With limitations\*  
 Not provided

\*Description provided on attachment.

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TN No.      10-007  
Supersedes  
TN No.      89-17

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HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED

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Title XIX - NH  
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Page 7-a

15a. and 15b. Intermediate Care Facilities

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment for nursing facility care must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Payment is made for a non-private room. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Office of Long Term Care.

Medicaid-only certified beds in which nursing facility services are provided shall be at or about 5,146 beds statewide. However, the Department of Health and Human Services does not intend to attain this number of beds unless there is a need for the beds to ensure access to services. Furthermore, the Commissioner or his/her designee shall approve certification of additional Medicaid-only nursing facility beds if needed to ensure access to nursing facility services. \*

Nursing facility beds certified for both Medicare and Medicaid will be approved in accordance with He-Hea 904.

16. Inpatient Psychiatric Facility Services

Inpatient psychiatric facility services for individuals under 22 years of age are available to both categorically and medically needy recipients in need of such services. Providers must be designated by the director of the Division of Behavioral Health Services as a Designated Receiving Facility. A Designated Receiving Facility is any community mental health program or treatment facility which serves both voluntary and involuntary emergency hospitalization patients. Designated Receiving Facility services are:

1. In a physically separate area used exclusively for psychiatric patients;
2. Provided by staff with specialized training in mental illness and its treatment;
3. Provided by a facility with a discrete unit budget;
4. Provided by a facility accredited by JCAH under the psychiatric standards; and
5. Generally recognized as a discrete operating unit.

17. Nurse Midwife Services

Nurse midwife services are provided to both the categorically and the medically needy under the categories of nurse midwife services, ARNP services, physician services, rural health clinic services and clinic services. They are subject to the limitations of the individual service categories described elsewhere in this plan. These services are performed by ARNPs (see Other Practitioner Services).

\* The legislature has mandated that funding be made available for appropriate and effective alternatives to nursing facility services. This can be accomplished by providing funding only for the number of nursing facility beds that are necessary to achieve the purpose of providing nursing facility services. The number of beds available to Medicaid eligibles is currently significantly greater than the number of beds occupied.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Title XIX – NH  
Attachment 3.1-A  
Page 7-b

18, Hospice Services

Hospice services are provided in accordance with Section 1905(o) of the Act. The state is following the same election periods established in Section 1812(d)(1). Additionally, the state's hospice program is in accordance with section 2302 of the Affordable Care Act which amends sections 1905(o)(1) and 2110(a)(23) of the Act, i.e., a voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or have payment made under Title XIX for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made. The state elects to define "child," as a recipient under 21 years of age.

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TN No: N/A

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Effective Date: 07/01/2010

Official

Revision: HCFA-PH-94-4  
APRIL 1994

(HB) ATTACHMENT 3.1-A  
Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1913(g) of the Act).

Provided:  With limitations

Not provided.

b. Special tuberculosis (TB) related services under section 1902(2)(2) of the Act. (F) of

Provided:  With limitations\*

Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

No. 94-13 Approval Date 7/13/94 Effective Date 1/1/94 TN  
Supersedes  
TN No. 93-12, p8  
and TN 90-17, p.10 (Note Attachment 3.1-A, p.10-A (TN 92-17) now becomes p.10

*OK*

State/Territory: New Hampshire

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

Provided:  No limitations  With limitations\*  
 Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided:  No limitations  With limitations\*  
 Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided:  No limitations  With limitations\* See ARNP

\*Description provided on attachment.

TN No. 94-22  
Supersedes 91-23 Approval Date 10/20/94 Effective Date 01/01/94

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

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21. Ambulatory Prenatal Care for Pregnant Women

Services are subject to the limitations stated elsewhere under each specific service listed in Attachment 3.1-A and 3.1-B.

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20. Extended Services to Pregnant Women

- a. Major categories of services covered are the same services covered under this state plan for all categorically and medically needy Medicaid recipients. However, pregnant women are exempt from the physician service limit.

Extended services provided by Office of Community and Public Health (OCPH) contracted prenatal programs are exempt from the service limits. OCPH contracted prenatal programs provide services such as coordination with the WIC Program and case management services. Services include sixty (60) days post partum.

- b. Major categories of service covered are the same services covered under this state plan for all categorically and medically needy Medicaid recipients.

Services are subject to the limitations stated elsewhere under each specific service listed in Attachment 3.1-A and 3.1-B, except that pregnant women are exempt from the physician service limit.

- c. Outpatient substance abuse treatment is available to pregnant and post partum women when provided by agencies under contract obligation with the Division of Alcohol and Drug Abuse Prevention and Recovery (DADAPR) to provide substance abuse services to pregnant and post partum women, and with the Office of Community and Public Health to provide prenatal and post partum services.

Substance abuse treatment services are also available to pregnant and post partum women who reside at residential treatment and rehabilitation facilities of fewer than 17 beds that are under contract obligation with the Division of Alcohol and Drug Abuse Prevention and Recovery (DADAPR) to provide substance abuse services to pregnant and post partum women, and that will allow the residents to bring their minor children of the women residents, and that sign a provider agreement addendum that stipulates reporting requirements.

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Supersedes  
TN No: 94-25

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State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

b. Services provided in Religious Non-Medical Health Care Institutions.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

e. Emergency hospital services.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

\* Description provided on attachment

TN No: 02-004  
Supersedes  
TN No: 91-23

Approval Date 5/28/2002      Effective Date: 01/01/2002

State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

b. Services provided in Religious Non-Medical Health Care Institutions.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

e. Emergency hospital services.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

\* Description provided on attachment

TN No: 02-004  
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State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

b. Services provided in Religious Non-Medical Health Care Institutions.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

e. Emergency hospital services.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

- Provided:                       No limitations                       With limitations\*  
 Not provided.

\* Description provided on attachment

TN No: 02-004  
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**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED**

Title XIX-NH  
Attachment 3.1-A  
Page 9-a

**24. Transportation**

Transportation to obtain necessary medical care is provided to both the categorically needy and the medically needy. Emergency medical transportation is described below. Non-emergency medical transportation (NEMT) is provided via a broker and is described at the end of Attachment 3.1-A as Addendum 1.

Payment will not be made to a medical service provider transporting recipients to his/her location of service, unless otherwise noted herein.

Hospital-based ambulance service providers may be reimbursed as providers of ambulance services when the operating costs of the ambulance service are not incorporated into the reimbursement rates for the hospital.

**Emergency Ambulance and Air Ambulance Transportation:**

Emergency ambulance transportation is covered in the case of an emergency medical condition for transportation to the nearest acute care hospital with appropriate treatment facilities. Air ambulance for emergency medical conditions is covered if the recipient's condition is such that s/he cannot be safely transported on a timely basis via an ALS ground transportation with appropriate staff and the recipient is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the recipient to the nearest facility capable of treating the recipient.

Transportation - Non-emergency

This addendum contains the narrative for 24a with the exception of air and emergency ambulance transport which is described following the 24a preprint page.

24. Any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary in accordance with Section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

Non-emergency transportation is provided in accordance with 42 CFR 431.53 as an administrative service.

Without limitations

With limitations (describe limitations in a Supplement to 3.1A or in Attachment 3.1D)

**\*STOP HERE IF ANY OF THE ABOVE BOXES HAVE BEEN CHECKED\***

Non-emergency transportation is provided without a broker in accordance with 42 CFR 440.170 as an optional medical service, excluding “school-based” transportation.

Without limitations

With limitations (describe limitations in a Supplement to 3.1A or in Attachment 3.1D)

(If non-emergency transportation is provided without a broker as an optional medical service or as an administrative service, the state should describe in Attachment 3.1D how the transportation program operates including types of transportation and transportation related service provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other agencies or programs.)

Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost effectively provide transportation and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(i).

24. Transportation - Non-emergency (continued)

X (1) The State will operate the broker program without regard to the requirements of the following paragraphs of Section 1902(a):

     (1) State-wideness (Please indicate the areas of the State that are covered by the broker. If the State chooses to contract with more than one broker, the State must provide a separate preprint for each broker.)

     (10)(B) Comparability

  X   (23) Freedom of Choice

X (2) Transportation services provided will include:

  X   Wheelchair van

  X   Taxi

  X   Stretcher Car

     Bus Passes

     Tickets

  X   Secured Transportation

  X   Other Transportation (if checked, describe below other types of transportation provided)

Transportation is also provided for scheduled and routine non-emergency ambulance; rail (e.g. Amtrak), private auto, and bus (via post-trip reimbursement).

- X (3) The State assures that transportation services will be provided under a contract with a broker who:
- (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
  - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and that transport personnel are licensed, qualified, competent, and courteous;
  - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;
  - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physical referrals under Section 1877 and such other prohibitions and requirements as the Secretary determined to be appropriate.)

X (4) The broker contract will provide transportation to the categorically needy. See the eligibility sections of the NH Title XIX State Plan in order to find descriptions of the eligibility categories.

**OFFICIAL**

24. Transportation - Non-emergency (continued)

X (5) Payment Methodology

(A) Please describe the methodology used by the State to pay the broker:

The broker will be paid a per member per month risk capitated rate to include the cost of transportation and administration.

(B) Please describe how the transportation provider will be paid:

The commercial transportation providers will be paid based on the contracted rate agreed to between the transportation provider and the broker. Friends and family will be paid a mileage rate determined by the broker and/or for receipts submitted for bus and rail travel.

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the state plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

State general funds.

X (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

X (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

     (F) The State has included Federal Medicaid matching funds as State match when drawing down FTA SAFETEA-LU grants. (not applicable; law has expired)

X (6) The broker is a non-governmental entity:

X The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 42 CFR 440.170(4)(ii).

     The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

     Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

24. Transportation - Non-emergency (continued)

\_\_\_\_\_ Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

\_\_\_\_\_ The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

\_\_\_\_\_(7) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

\_\_\_\_\_ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

\_\_\_\_\_ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

\_\_\_\_\_ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the amount charged to other human services agencies for the same service..

\_\_\_\_\_(8) Please provide a complete description of how the NEMT brokerage program operates. Include all services provided by the broker (call center, oversight of providers, etc.). If applicable, describe any transportation services that will not be provided by the broker and how these services will be provided.

Scheduling: Recipients call the broker's call center to request a ride to Medicaid covered services. The call center follows a script to determine the most available, cost-effective, and medically appropriate transportation for the recipient. The medical appointment is confirmed via a call to the Medicaid provider. The recipient is given the approval for "friends and family" transportation or a commercial subcontractor is notified by the transportation broker of a pending appointment and given the opportunity to accept or reject the booking.

Oversight, Management, and Informing: The broker is responsible for following the CFR oversight requirements which will also be monitored by the Department's Program Integrity Unit. The broker is also responsible for maintaining appropriate documentation to support services rendered or denied and for providing timely payment to providers. Broker is also responsible for maintaining a grievance and appeals process and informing recipients of such process.

Coordination with Department: Weekly calls are held between the Department's Client Services Unit, Policy Unit, and the transportation broker to discuss any unresolved issues or questions and to work on policies and forms related to the day to day implementation of the program. Other communications occur as needed.

Services: The broker does not arrange emergency transportation; these are state plan services.

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED**

Title XIX-NH  
Attachment 3.1-A  
Page 9-b

RESERVED

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED**

Title XIX-NH  
Attachment 3.1-A  
Page 9-c

23d. Skilled Nursing Services for Patients Under 21

Payment for such services is covered for both the categorically needy and the medically needy with the prior authorization of Medicaid Administrative Services. A written request, including the medical and nursing care information required to establish medical necessity, is accompanied by a statement of the child's social situation from the district office social worker. Authorization for such payments is issued for a specified period of time with a provision for extending such authorization on request of the facility and the patient's attending physician with accompanying medical substantiation.

23e. Emergency Hospital Services

Emergency hospital services are provided without prior authorization and are subject to the same utilization review and evaluation procedures by the Medicaid fiscal agent as would be true of other inpatient hospital services. Such services, when necessary in an out-of-state hospital, are provided at the request of the patient and/or hospital if the emergency nature of the service can be, in fact, substantiated by the facts of the situation.

Emergency hospital services are subject to the inpatient and outpatient hospital limits described elsewhere in this plan. That is, the limits for hospital services include both routine and emergency services.

23f. Personal Care Services

Personal care services are available to chronically wheelchair mobile categorically and medically needy recipients.

Personal care services prescribed by a physician may be provided in the recipient's home. Additionally, personal care services may be provided in any other location as long as they are services that would otherwise have been provided in the home. However, in accordance with federal regulations at 42 CFR 440.167, personal care services may not be provided to a recipient who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

**OFFICIAL**

TN No. 02-014  
Supersedes  
TN No. 90-20

Approval Date 03/20/03

Effective Date 10/01/02

Revision: HCFA-Region I  
SEPTEMBER 1990

ATTACHMENT 3.1-A  
Page 10

STATE New Hampshire

*already a 24*  
24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89):

Provided:  No Limitations  With Limitations\*

See ARNP

\*Description provided on attachment.

TN No. 90-17  
Supersedes  
TN No. -

Approval Date

7/1/90 *incorrect*

*Bill Mc's error*  
Effective Date 7/01/90

12/12/90

*Official*

State: New Hampshire

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals,  
as defined, described and limited in Supplement 2 to Attachment 3.1-A,  
and Appendices A-G to Supplement 2 to Attachment 3.1-A.

           provided       X       not provided

*\* NH Medicaid  
State Plan already  
has a page 10.  
Thus, we have called  
this page, page 10A.*

# OFFICIAL

Attachment 3.1-A  
Page 11

from 2011 draft template

State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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**28. (i) Licensed or otherwise state-approved freestanding birth centers**

Provided:  No limitations  With limitations\*  None licensed or approved

**28. (ii). Licensed or otherwise state-recognized covered professionals providing services in the freestanding birth center**

Provided:  No limitations  With limitations\*

Not Applicable (there are no licensed or state approved freestanding birth centers)

Please check all that apply:

(a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). \*\*

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).\*\*

\*\*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

(b) See Item 6(d), "Advanced Registered Nurse Practitioners" and "Certified Midwives"

\*Description provided on attachment.

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TN No. 12-002  
Supersedes  
TN No. ~~XXXX~~ NEW

Approval Date 5/30/2012

Effective Date 01/04/2012

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory:           New Hampshire          

**CASE MANAGEMENT SERVICES**

**BEHAVIORAL HEALTH CASE MANAGEMENT**

**A. Target Group:**

- (a) An adult shall be eligible for case management services if he or she has a severe mental illness (SMI) or severe and persistent mental illness (SPMI) as outlined in NH administrative rule He-M 401.
- (b) A child shall be eligible for case management services if he or she has a severe emotional disturbance as outlined in NH administrative rule He-M 401.

  X   Target group includes individuals transitioning to a community setting. Case management services will be made available for up to   180   [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

**B. Areas of State in which services will be provided (§1915(g)(1) of the Act):**

- X   Entire State
- Only in the following geographic areas [Specify areas]

**C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):**

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
- X   Services are not comparable in amount, duration, and scope (§1915(g)(1)).

TN No:   08-009    
Supersedes  
TN No:   87-06  

Approval Date   05/07/2018  

Effective Date:   06/12/2008

**CASE MANAGEMENT SERVICES, BEHAVIORAL HEALTH (continued)**

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual’s needs and completing related documentation;
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual; and
  - assessing the individual’s strengths and determining their preferences.

Comprehensive assessments shall be developed and reviewed with the individual; a hard copy is signed by the individual at least annually and updated as needed.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

**CASE MANAGEMENT SERVICES, BEHAVIORAL HEALTH CASE MANAGEMENT (continued)**

**D. Definition of Services (continued):**

- ❖ **Monitoring and follow-up activities:** Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring includes reviewing the individual's current status and progress, or lack thereof, in achieving the goals and objectives identified in the individual service plan, as documented in the progress notes for the reporting quarter. The individual service plan review includes support needs, goals, objectives, services, timelines, referrals, crisis plan, and employment or education plan, as appropriate. Monitoring takes place on a quarterly basis.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

**CASE MANAGEMENT SERVICES, BEHAVIORAL HEALTH CASE MANAGEMENT (continued)**

**E. Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:**

All participating Behavioral Health Case Management providers shall be employed by an approved community mental health (CMH) program to serve the clients receiving services from the CMH program, and shall have:

1. A baccalaureate degree in social work, rehabilitation, psychology, education, or a related human services field; or
2. An associate's degree in social work, rehabilitation, psychology, education, or a related human services field and the following experience:
  - (a) Two years of experience working with persons who have severe mental disability; or
  - (b) Two years of experience that provides an individual with an understanding of mental illness and that was acquired as an adult in the provision of significant supports to persons with mental illness, including the experience acquired by family members of persons with mental illness or by other persons who have personal knowledge of mental illness.
3. Any staff person who does not meet the criteria above shall be eligible to provide case management services if they were providing case management services for at least 2 years prior to April 2007 and they receive supervision of at least 2 hours per week.

**F. Freedom of Choice (42 CFR 441.18(a)(1)):**

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

**Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):**

- X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

**CASE MANAGEMENT SERVICES, BEHAVIORAL HEALTH CASE MANAGEMENT (continued)**

**G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Supersedes  
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**CASE MANAGEMENT SERVICES, BEHAVIORAL HEALTH CASE MANAGEMENT (continued)**

**I. Case Records (42 CFR 441.18(a)(7)):**

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

**J. Limitations:**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

**[Specify any additional limitations.] (N/A)**

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory:           New Hampshire          

**CASE MANAGEMENT SERVICES**

**DEVELOPMENTAL SERVICES CASE MANAGEMENT**

**A. Target Group:**

Target group is Medicaid eligible individuals who have a “demonstrated developmental disability” as defined under NH’s RSA 171-A:2, V, namely, “a disability: Which is attributable to mental retardation, cerebral palsy, epilepsy, autism or a specific learning disability, or any other condition of an individual found to be closely related to mental retardation as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that required for mentally retarded individuals; and which originates before such individual attains age 22, has continued or can be expected to continue indefinitely, and constitutes a severe disability to such individual’s ability to function normally in society.” Or a child, age 0-3, who has a developmental disability, demonstrates a developmental delay, or who is at risk for developmental delay.

  X   Target group includes individuals transitioning to a community setting. Case management services will be made available for up to   90   [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

**B. Areas of State in which services will be provided (§1915(g)(1) of the Act):**

  X   Entire State

     Only in the following geographic areas [Specify areas]

**C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):**

     Services are provided in accordance with §1902(a)(10)(B) of the Act.

  X   Services are not comparable in amount, duration, and scope (§1915(g)(1)).

**CASE MANAGEMENT SERVICES, DEVELOPMENTAL SERVICES (continued)**

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual’s needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Assessments are done initially upon eligibility and initial service design, some annually, and some as needed, including but not limited to:

- Upon eligibility: Psychological, Functional Assessment, Support Intensity Scale (SIS), Health Risk Screening Tool (HRST)
  - Annually: Health Risk Screening Tool, Level of Care Assessment
  - As Needed or as Needs Change: Health Risk Screening Tool, Support Intensity Scale, Functional Assessment, Psychological Evaluations
- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
    - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
    - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
    - identifies a course of action to respond to the assessed needs of the eligible individual.
  - ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
    - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

**CASE MANAGEMENT SERVICES, DEVELOPMENTAL SERVICES CASE MANAGEMENT (continued)**

**D. Definition of Services (continued):**

- ❖ **Monitoring and follow-up activities:** Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

**Monitoring includes:**

- Monthly contacts;
- Quarterly contacts in the person's residence or site of service;
- Quarterly satisfaction survey; and
- Annual service review.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

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Supersedes  
TN No: 90-24

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CASE MANAGEMENT SERVICES, DEVELOPMENTAL SERVICES CASE MANAGEMENT (continued)

E. **Qualifications of Providers** (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)) [Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:

All participating Developmental Services Case Management providers shall:

1. Be selected by the individual and his or her guardian and designated by the Area Agency in accordance with He-M 503;
2. Have a Bachelor's Degree in psychology, social work, human services, special education, education, or related field, or equivalent experience in the field;
3. Provide documentation to support claims when requested by the Department or its agent.

F. **Freedom of Choice (42 CFR 441.18(a)(1))**:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

**Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b))**:

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

There are no limitations on the providers except that they be eligible under He-M 503 and live in catchment area.

**CASE MANAGEMENT SERVICES, DEVELOPMENTAL SERVICES CASE MANAGEMENT (continued)**

**G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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**CASE MANAGEMENT SERVICES, DEVELOPMENTAL SERVICES CASE MANAGEMENT (continued)**

**I. Case Records (42 CFR 441.18(a)(7)):**

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

**J. Limitations:**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.] None

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory:           New Hampshire          

**CASE MANAGEMENT SERVICES**

**ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT**

**A. Target Group:**

The target population for this service is adults over the age of 18 years who live in a community setting who require assistance due to a chronic medical diagnosis and/or frailty associated with aging, including Alzheimer’s Disease or other types of dementia, meet clinical eligibility requirements established in RSA 151-E:3 I, and are participants in the Home and Community Based Care waiver NH 0060900R4.

  X   Target group includes individuals transitioning to a community setting. Case management services will be made available for up to   30   [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

**B. Areas of State in which services will be provided (§1915(g)(1) of the Act):**

  X   Entire State

     Only in the following geographic areas [Specify areas]

**C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):**

     Services are provided in accordance with §1902(a)(10)(B) of the Act.

  X   Services are not comparable in amount, duration, and scope (§1915(g)(1)).

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Supersedes  
TN No:   87-12  

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**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES  
(continued)**

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual’s needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Upon intake, the case manager shall conduct a comprehensive assessment, which includes, but is not limited to (a) utilization of a formal tool to evaluate the participant’s status based on face to face interview; (b) biopsychosocial history; (c) functional status; (d) living environment, including accessibility; (e) social environment; (f) risk, including the potential for abuse, neglect, and exploitation; (g) ability to participate in the community; and (h) a medical eligibility assessment.

Annually, or as needs change, (a) update the formal comprehensive assessment tool identified above; and (b) medical eligibility assessment.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**D. Definition of Services (continued):**

- ❖ Monitoring and follow-up activities: Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring includes:

- At least one monthly telephone call with the participant to include a review of services;
- At least one face to face contact every sixty days to include a review of services;
- A quarterly review of participant record to ensure the delivery of services; and
- A quarterly review of all reported complaints, incidents, related to the delivery of services.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**E. Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)) [Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:**

1. Case management providers shall be licensed in accordance with requirements of state law including RSA 151.
2. Case management agencies shall employ a full-time administrator responsible for the development and implementation of the policies of the case management agency and for compliance with applicable rules;
3. Case management providers shall establish and maintain agency written policies and procedures regarding the areas required by administrative rule He-E 805, and shall ensure that they are properly followed and enforced.
4. Case managers shall meet the following minimum requirements:
  - (a) Have demonstrated knowledge of the local service delivery system and the resources available to participants;
  - (b) Have demonstrated knowledge of the development and provision of integrated, person-centered services; and
  - (c) Have a degree in a human-service related field and one year of supervised experience, or a similar combination of training and experience.

**F. Freedom of Choice (42 CFR 441.18(a)(1)):**

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

**Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):**

N/A Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No: 08-011  
Supersedes  
TN No: 96-12

Approval Date 05/07/2018

Effective Date: 06/12/2008

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**I. Case Records (42 CFR 441.18(a)(7)):**

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

**J. Limitations:**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

**[Specify any additional limitations.] (N/A)**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory:           New Hampshire          

**CASE MANAGEMENT SERVICES**

**CHRONICALLY ILL CHILDREN CASE MANAGEMENT**

**A. Target Group:**

Target group is Medicaid eligible individuals under age 21 who have a chronic health condition defined as: a physical condition lasting or expected to last for 6 months or longer; affecting the child’s ability to function on a daily basis; in the areas of emotional, social or physical development; or in his or her family, school or community; requiring more frequent medical care from primary care and specialty providers than typically required for well child and acute illness visits; and which is not primarily due to a developmental disability as defined in RSA 171-A or a mental illness as defined in RSA 135-C or other emotional disability.

  X   Target group includes individuals transitioning to a community setting. Case management services will be made available for up to   60   [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

**B. Areas of State in which services will be provided (§1915(g)(1) of the Act):**

- X   Entire State
- Only in the following geographic areas [Specify areas]

**C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):**

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
- X   Services are not comparable in amount, duration, and scope (§1915(g)(1)).

**CASE MANAGEMENT SERVICES, CHRONICALLY ILL CHILDREN (continued)**

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual’s needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Assessments are completed upon intake and eligibility determination;  
At least annually, or more frequently if needed, assessments are updated and reviewed;  
The case manager receives updated medical information as it is completed and reviews this and incorporates it, as applicable.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

TN No: 08-012  
Supersedes  
TN No: 95-03

Approval Date 04/27/2018

Effective Date: 06/12/2008

**CASE MANAGEMENT SERVICES, CHRONICALLY ILL CHILDREN CASE MANAGEMENT  
(continued)**

**D. Definition of Services (continued):**

- ❖ **Monitoring and follow-up activities:** Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring includes (a) annual record reviews; and (b) annual client and family satisfaction surveys.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

TN No: 08-012  
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TN No: 95-03

Approval Date 04/27/2018

Effective Date: 06/12/2008

**CASE MANAGEMENT SERVICES, CHRONICALLY ILL CHILDREN CASE MANAGEMENT  
(continued)**

**E. Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)) [Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:**

All participating Chronically Ill Children Case Management providers (called Partners in Health/PIH coordinators) shall:

1. Provide documentation to support claims when requested by the Department or its agent.
2. Have at least an associate's degree from an accredited program in a field of study related to health or social services with at least one year's corresponding experience.

**F. Freedom of Choice (42 CFR 441.18(a)(1)):**

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

**Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):**

- X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

**CASE MANAGEMENT SERVICES, CHRONICALLY ILL CHILDREN CASE MANAGEMENT  
(continued)**

**G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No: 08-012  
Supersedes  
TN No: 95-03

Approval Date 04/27/2018

Effective Date: 06/12/2008

**CASE MANAGEMENT SERVICES, CHRONICALLY ILL CHILDREN CASE MANAGEMENT  
(continued)**

**I. Case Records (42 CFR 441.18(a)(7):**

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

**J. Limitations:**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

**[Specify any additional limitations.] (N/A)**

# OFFICIAL

Title XIX – NH

Supplement 1 to Attachment 3.1-A  
Page 5A (BEAS-ACPD)  
CMS 2237 IFC

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:           New Hampshire          

### CASE MANAGEMENT SERVICES

#### ADVANCE CARE PLANNING AND DIRECTIVES CASE MANAGEMENT

**Available only through June 30, 2010**

#### A. Target Group:

The target population for this service is Medicaid recipients throughout New Hampshire whose medical providers have diagnosed them as severely ill. This means that the recipient has been diagnosed as having an illness or medical condition that is expected to continually deteriorate and may be expected to result in death within approximately two years.

N/A Target group includes individuals transitioning to a community setting. Case management services will be made available for up to \_\_\_\_\_ [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

#### B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

Entire State

Only in the following geographic areas [Specify areas]

#### C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):

Services are provided in accordance with §1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope (§1915(g)(1)).

TN No: 08-013

Supersedes

TN No: 02-007

Approval Date 04/25/2018

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# OFFICIAL

Title XIX – NH

Supplement 1 to Attachment 3.1-A  
Page 5B (BEAS-ACPD)  
CMS 2237 IFC

## CASE MANAGEMENT SERVICES, ADVANCE CARE PLANNING AND DIRECTIVES (continued)

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, as frequently as the patient's condition requires, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
  
- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
  
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

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Title XIX – NH

Supplement 1 to Attachment 3.1-A  
Page 5C (BEAS-ACPD)  
CMS 2237 IFC

## CASE MANAGEMENT SERVICES, ADVANCE CARE PLANNING AND DIRECTIVES CASE MANAGEMENT (continued)

### D. Definition of Services (continued):

- ❖ Monitoring and follow-up activities: Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

TN No: 08-013  
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TN No: 02-007

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Title XIX – NH

Supplement 1 to Attachment 3.1-A  
Page 5D (BEAS-ACPD)  
CMS 2237 IFC

## **CASE MANAGEMENT SERVICES, ADVANCE CARE PLANNING AND DIRECTIVES CASE MANAGEMENT (continued)**

### **E. Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:**

Case management providers shall:

1. Be agencies licensed in accordance with requirements of state law including RSA 151 or be licensed by the state in which they practice;
2. Be agencies certified as a Medicare Hospice providers;
3. Be the above agencies who employ registered nurses, social workers with at least a bachelor's degree and working under the direction of the physician, physicians, dietary counselors, home health aides, physical, occupational and speech therapists, and other staff as needed.

### **F. Freedom of Choice (42 CFR 441.18(a)(1):**

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

#### **Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b):**

N/A Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

TN No: 08-013  
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# OFFICIAL

Title XIX – NH

Supplement 1 to Attachment 3.1-A  
Page 5E (BEAS-ACPD)  
CMS 2237 IFC

## **CASE MANAGEMENT SERVICES, ADVANCE CARE PLANNING AND DIRECTIVES CASE MANAGEMENT (continued)**

### **G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

### **H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Title XIX – NH

Supplement 1 to Attachment 3.1-A  
Page 5F (BEAS-ACPD)  
CMS 2237 IFC

## CASE MANAGEMENT SERVICES, ADVANCE CARE PLANNING AND DIRECTIVES CASE MANAGEMENT (continued)

### I. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

### J. Limitations:

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.] (N/A)

TN No: 08-013  
Supersedes  
TN No: 02-007

Approval Date 04/25/2018

Effective Date: 06/12/2008

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory:           New Hampshire          

**CASE MANAGEMENT SERVICES**

**EPSDT CASE MANAGEMENT**

**A. Target Group:**

The client must:

1. be Medicaid eligible and under the age of 21 years;
2. be determined, as certified by a physician, psychologist or APRN, to be in need of EPSDT care coordination services as medically necessary;

  N/A   Target group includes individuals transitioning to a community setting. Case management services will be made available for up to \_\_\_\_\_ [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

**B. Areas of State in which services will be provided (§1915(g)(1) of the Act):**

- Entire State
- Only in the following geographic areas [Specify areas]

**C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):**

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope (§1915(g)(1).

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TN No: 93-13, 94-5,  
94-27, 93-13

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Effective Date: 06/12/2008

**CASE MANAGEMENT SERVICES, EPSDT CASE MANAGEMENT (continued)**

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual’s needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

The assessments shall occur at the time of a well-child visit delivered in accordance with the Bright Futures/American Academy of Pediatrics periodicity schedule.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

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94-27, 93-13

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**CASE MANAGEMENT SERVICES, EPSDT CASE MANAGEMENT (continued)**

**D. Definition of Services (continued):**

- ❖ **Monitoring and follow-up activities:** Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring includes face to face discussion with the parent/guardian at the time of a scheduled well-child visit delivered in accordance with the Bright Futures/American Academy of Pediatrics periodicity schedule.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

TN No: 08-014

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TN No: 93-13, 94-5

94-27, 93-13

Approval Date 03/26/2018

Effective Date: 06/12/2008

**CASE MANAGEMENT SERVICES, EPSDT CASE MANAGEMENT (continued)**

**E. Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:**

All participating EPSDT Case Management providers shall:

1. Be employed by, and work under the direction of, NH Medicaid enrolled physicians, physician groups, or APRN's;
2. Be NH licensed clinical social workers, NH licensed registered nurses (RN's), NH licensed practical nurses (LPN's), NH certified medical assistants, or family support workers with a relevant bachelor's degree and 2 years experience in the health care field; and
3. Provide documentation to support claims when requested by the Department or its agent.

**F. Freedom of Choice (42 CFR 441.18(a)(1):**

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

**Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b):**

**n/a** Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

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**CASE MANAGEMENT SERVICES, EPSDT CASE MANAGEMENT (continued)**

**G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are currently paid a one unit rate per eligible child when case management is provided in conjunction with a well-child visit delivered in accordance with the Bright Futures/American Academy of Pediatrics periodicity schedule.

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**CASE MANAGEMENT SERVICES, EPSDT CASE MANAGEMENT (continued)**

**I. Case Records (42 CFR 441.18(a)(7):**

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

**J. Limitations:**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.] (N/A)

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