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## **Table of Contents**

**State/Territory Name:** Montana

**State Plan Amendment (SPA) #:** MT-15-0027

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1961 Stout Street, Room 08-148  
Denver, CO 80294



**Region VIII**

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March 28, 2016

Ms. Mary E. Dalton  
State Medicaid and CHIP Director  
PO Box 4210  
Helena, MT 59601-4210

RE: SPA 15-0027

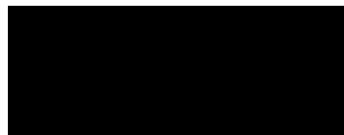
Dear Ms. Dalton:

We reviewed Montana's proposed State Plan Amendment (SPA) submitted under transmittal number MT -15- 0027. This amendment implements Montana's Health and Economic Livelihood Partnership (HELP) Plan and provides ABP Essential Health Benefits, arranged by a Third Party Administrator (TPA), to individuals in the new adult group with income between 51%-138% of the Federal Poverty Level (FPL).

Please be informed that this State Plan Amendment was approved today with an effective date of January 1, 2016. We are enclosing the CMS 179 Form and the approved State Plan pages.

If you have any questions regarding this SPA please contact Michelle Baldi at (312) 353-0909.

Sincerely,



Richard C. Allen  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Cc: Richard Opper, Department Director  
Duane Preshinger  
Jo Thompson  
Mary Eve Kulawik

## Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory  
name:

Montana

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MT 15-0027

Proposed Effective Date

01/01/2016

(mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	\$ 0.00
Second Year	2017	\$ 0.00

Subject of Amendment

This state plan amendment implements Montana's Medicaid expansion, effective 1/1/16. Its estimated federal fiscal impact is reported on the MT 15-0025 Summary Page (CMS 179).

Governor's Office Review

- ☒ Governor's office reported no comment  
☐ Comments of Governor's office received

Describe:

- ☐ No reply received within 45 days of submittal  
☐ Other, as specified

Describe:

Signature of State Agency Official

Submitted By:

Mary Eve

Last Revision Date:

Mar 24, 2016

Submit Date:

Dec 31, 2015



# Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Alternative Benefit Plan Populations

**ABP1**

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

Alternative Benefit Plan Population Name:

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
<input checked="" type="checkbox"/>	Adult Group	<input type="text" value="Mandatory"/>	<input checked="" type="checkbox"/>

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

**Targeting Criteria** (select all that apply):

☒ Income Standard.

Income Standard:

☒ Income standard is used to target households with income at or below the standard.

☐ Income standard is used to target households with income above the standard.

The income standard is as follows:

☒ A percentage:

☐ A specific amount

☐ Federal Poverty Level.

☐ SSI Federal Benefit Amount.

☒ Other.

Enter the Other percentage

Describe:

Individuals must be: (1) a childless adult between 19 and 64 years of age, with an income between 51-138 percent of the FPL; or a parent between 19 and 64 years of age, with an income between 51-138 percent of the FPL.

☒ Disease/Condition/Diagnosis/Disorder.

Disease/Condition/Diagnosis/Disorder

☐ Physical Disability



## Alternative Benefit Plan

- ☐ Brain Injury
- ☐ HIV/AIDS
- ☒ Medically Frail
- ☐ Technology Dependent
- ☐ Autism
- ☐ Developmental Disability
- ☐ Intellectual Disability
- ☐ Mental Illness
- ☐ Substance Use Disorder
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Obesity
- ☒ Other Disease/Condition/Diagnosis/Disorder

Describe:

Have exceptional health care needs, including, but not limited to, a medical, mental health or developmental condition.

☐ Other.

### Geographic Area

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

No

Select a method of geographic variation:

- ☐ By county.
- ☐ By region.
- ☐ By city or town.
- ☒ Other geographic area.

Specify other geographic area:

Live in a region, including an Indian reservation, where the HELP Program TPA is unable to contract with sufficient providers.

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

Individuals must be: (1) a childless adult between 19 and 64 year of age, with an income between 51-138 percent of the FPL; or a parent



## Alternative Benefit Plan

between 19 and 64 years of age, with an income between 51 - 138 percent of the FPL; (2) not eligible for or enrolled in Medicare; (3) a United States citizen or a documented, qualified alien; and (4) a resident of Montana. The following individuals are excluded from the HELP Program TPA ABP: Individuals who are medically frail; have exceptional health care needs, including but not limited to, a medical, mental health or developmental condition; live in a region, including an Indian reservation, where the HELP Program TPA is unable to contract with sufficient providers; or require continuity of coverage, including American Indian/Alaskan Natives, that is not available or could not be effectively delivered through the HELP Program TPA; or otherwise exempt under federal law. Individuals with access to ESI are not included in the TPA model.

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415



# Alternative Benefit Plan

State Name: Montana

Attachment 3.1-L- T

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Enrollment Assurances - Mandatory Participants

**ABP2c**

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

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

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

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

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

Describe:

During the application process, if a Medicaid eligible individual answers yes to the application question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" (this question is from the approved CMS single streamlined application) it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice information them that they will receive benefits through the Aligned Medicaid ABP.

Medicaid beneficiaries can also self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual or developmental disorder that makes them medically frail.

Every Medicaid beneficiary receives a copy of the beneficiary Rights and Responsibilities, including information about medical frailty and how to get more information about being determined medically frail. A copy of this document is also provided to every beneficiary at the time of the eligibility redetermination. The State Medicaid website also provides information on the medical frailty determination process.

Additionally, the TPA's Member Services department is trained to refer individuals seeking to self-identify as medically frail to the State Medicaid Agency.

☐ Other

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



## Alternative Benefit Plan

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

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

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

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

Describe:

Montana will review when a change is reported, at annual review, and when a change in eligibility (e.g., adding a new household member.)

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

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

Individuals seeking exemption from the HELP Program TPA ABP at any time during their period of eligibility will notify the Medicaid agency who will initiate the change process. The appropriate contact information for the agency is included in their eligibility determination notice. Once the applicant makes the request, a Medical Frailty notice will be sent to the individual and the individual will be transferred to the Aligned Medicaid ABP.

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





# Alternative Benefit Plan

## PRA Disclosure Statement

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V.20140415



# Alternative Benefit Plan

State Name: Montana

Attachment 3.1-L- T

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

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

Name of benefit package: Montana HELP Program TPA ABP

## Selection of the Section 1937 Coverage Option

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

- ☒ Benchmark Benefit Package.
- ☐ Benchmark-Equivalent Benefit Package.

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

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

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

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

## Selection of Base Benchmark Plan

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

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ☒ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ☐ Any of the largest three state employee health benefit plans by enrollment.



## Alternative Benefit Plan

- ☐ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ☐ Largest insured commercial non-Medicaid HMO.

Plan name:

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

See MT TPA ABP5.

### PRA Disclosure Statement

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V.20140415



# Alternative Benefit Plan

State Name: Montana

Attachment 3.1-L- T

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Alternative Benefit Plan Cost-Sharing

**ABP4**

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

**An attachment is submitted.**

Other Information Related to Cost Sharing Requirements (optional):

Cost sharing is described on pages G1-G3 of the cost sharing sections of the state plan.

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

## ATTACHMENT A

### Copayment Schedule and Exempt Services

<b>Service Description</b>	<b>Copayments for Individuals With Incomes At or Below 100 Percent FPL</b>	<b>Copayments for Individuals with Incomes Above 100 Percent FPL</b>
Behavioral Health – Inpatient	\$75/stay	10 percent of the payment the State makes for the service
Behavioral Health – Outpatient	\$4	10 percent of the payment the State makes for the service
Behavioral Health – Professional	\$4	10 percent of the payment the State makes for the service
Durable Medical Equipment	\$4	10 percent of the payment the State makes for the item
Emergency Room Services	-	-
Non-Emergency Room Services	\$8	\$8
Lab and radiology	\$4	10 percent of the payment the State makes for the service
Inpatient	\$75/stay	10 percent of the payment the State makes for the service
Other	\$4	10 percent of the payment the State makes for the service
Other Medical Professionals	\$4	10 percent of the payment the State makes for the service
Outpatient Facility	\$4	10 percent of the payment the State makes for the service
Primary Care Physician	\$4	10 percent of the payment the State makes for the service
Specialty Physician	\$4	10 percent of the payment the

<b>Service Description</b>	<b>Copayments for Individuals With Incomes At or Below 100 Percent FPL</b>	<b>Copayments for Individuals with Incomes Above 100 Percent FPL</b>
		State makes for the service
Pharmacy - Generics	-	-
Pharmacy – Preferred Brand Drugs	\$4	\$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	\$8	\$8

Premiums and copayments combined may not exceed 5 percent of family household income.

Certain services, including the following, are exempt from co-pays under federal or state law:

- Emergency services
- Preventive health care services including primary, secondary or tertiary preventive health care services
- Family planning services
- Pregnancy related services
- Generic drugs
- Immunizations
- Medically necessary health screenings ordered by a health care provider



# Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Benefits Description

**ABPS**

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

### Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Base Benchmark Small Group - MT Blue Preferred PPO Blue Dimensions  
HELP Program TPA ABP

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

Secretary-Approved



# Alternative Benefit Plan

☒ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Primary Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Benefit Provided:

Hospice

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

In accordance with section 2302 of the ACA, individuals under the age of 21 will receive hospice care concurrently with curative care. Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Urgent Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None





## Alternative Benefit Plan

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

None

Benefit Provided:

Home Health Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Home Health services not covered: maintenance or custodial care, domestic/housekeeping, food service, meals on wheels.

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

Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Dialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Benefit Provided:

Outpatient Surgery Facility

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None



# Alternative Benefit Plan

Scope Limit:

Not covered for cosmetic surgeries and procedures.

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

None

Benefit Provided:

Outpatient Hospital

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services include: Use of the hospital's facilities and equipment for surgery, respiratory therapy, chemotherapy, radiation therapy, and dialysis therapy.

Benefit Provided:

Specialists

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Benefit Provided:

Other Practitioner

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other



## Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Practitioners include: advance practice registered nurse and physician assistant.

Benefit Provided:

Accident Related Dental Surgery/Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Typically performed as outpatient services, but can be done inpatient if inpatient criteria are met.

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

Covers dental services resulting from an accident. Medically necessary services for the initial repair or replacement of sound natural teeth, which are damaged as the result of an accident. Exclusions include: orthodontics, dentofacial orthopedics or related appliances even if related to the accident. Services for the repair of teeth, which are damaged as the result of biting and chewing. Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Other Individualized Education Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

Annual

Scope Limit:

None

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

Other than diabetic education, that are related to a medical condition.



## Alternative Benefit Plan

Benefit Provided:

Dental Preventive/Diagnostic Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services Include: Dental Services and Dental Hygienist Services.

Add



# Alternative Benefit Plan

☒ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided:

ER Department Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Benefit Provided:

Air & Ground Ambulance

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Add



# Alternative Benefit Plan

## ☒ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services exclude: nursing home, rest home, hospice, rehab facility, SNF, convalescent home, long-term, chronic-care institution, or the facilities providing the care listed.

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

Services include: Room and board, which includes special diets and nursing services; intensive care and cardiac care units, miscellaneous hospital services (lab, operating room, delivery room, recovery room), anesthetic supplies, surgical supplies, x-ray, IV injections, PT, OT, ST, drugs); nonsurgical services, concurrent care and consultation services by a professional provider; observation beds/rooms, use of equipment for surgery, respiratory therapy, chemotherapy, radiation therapy and dialysis therapy. Based on criteria developed by the state these services will be prior authorized.

Benefit Provided:

Cosmetic Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Cosmetic Surgery is covered to correct a condition as a result from an accident, injury, or to treat a congenital anomaly.

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

None

Benefit Provided:

Transplant and Donor Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None



## Alternative Benefit Plan

Scope Limit:

Covers heart, heart/lung, single lung, double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel, cornea and renal transplants. No experimental/investigational procedures or transplants of nonhuman organs or donor.

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

None

Benefit Provided:

Blood Transfusions

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Benefit Provided:

Reconstructive Breast Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services include: All stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to establish a symmetrical appearance; chemotherapy; and prostheses and physical complications of all stages of a mastectomy and breast reconstruction including lymphedemas.

Add



## Alternative Benefit Plan

☒ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Prenatal and Postnatal Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

None

Benefit Provided:

Delivery and All Inpatient Services for Maternity

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services include: delivery of one or more newborns, the initial care of the newborn at birth provided by a physician, standby care provided by a pediatrician at a cesarean section and nursery care (hospital nursery care of newborn infants).

Add





## Alternative Benefit Plan

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

Collapse All ☐

**Benefit Provided:**

Mental/Behavioral Health Outpatient Services

**Source:**

Base Benchmark Small Group

Remove

**Authorization:**

Prior Authorization

**Provider Qualifications:**

Other

**Amount Limit:**

None

**Duration Limit:**

None

**Scope Limit:**

Services exclude: marriage counseling, hypnotherapy, and services provided by a staff member of a school or halfway house.

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

These services are not provided in an institution for mental disease (IMD). The care and treatment of a mental illness provided by a hospital; a physician or prescribed by a physician; a mental health treatment center; a chemical dependency treatment center; a psychologist; a licensed social worker; a licensed clinical professional counselor; a licensed professional addiction counselor; or a licensed psychiatrist. Outpatient benefits must be provided to diagnose and treat a recognized mental illness and treatment must be reasonably expected to improve and restore the level of functioning that has been affected by the mental illness. Prior authorization required for partial hospitalization program, intensive outpatient program, psychological, neuropsychological testing. Based on criteria developed by the state, this service will be prior authorized.

**Benefit Provided:**

Mental/Behavioral Health Inpatient Services

**Source:**

Base Benchmark Small Group

Remove

**Authorization:**

Prior Authorization

**Provider Qualifications:**

Other

**Amount Limit:**

None

**Duration Limit:**

None

**Scope Limit:**

None

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

These services are not provided in an institution for mental disease (IMD). Care must be provided in or by a hospital, a freestanding inpatient facility, or a physician. Medically monitored and medically managed intensive inpatient care and clinically managed high-intensity residential services are covered. Partial hospitalization services must be provided by a hospital, a freestanding inpatient facility, or a physician. Based on criteria developed by the state, this service will be prior authorized.



## Alternative Benefit Plan

Benefit Provided:

Substance Abuse Disorder Outpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services Exclude: marriage counseling, hypnotherapy, and services provided by a staff member of a school or halfway house.

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

These services are not provided in an institution for mental disease (IMD). Chemical Dependency: the care and treatment for chemical dependency provided by a hospital; a mental health treatment center; a chemical dependency treatment center; a physician or prescribed by a physician; a licensed clinical professional counselor; a licensed professional addiction counselor; or an addiction counselor licensed by the State or a licensed psychiatrist. Outpatient services must be provided to diagnose and treat a recognized chemical dependency and treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the chemical dependency. Prior authorization required for partial hospitalization program and intensive outpatient program. Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

These services are not provided in an institution for mental disease (IMD). Chemical Dependency. Care must be provided in or by a hospital; a freestanding inpatient facility or a physician. Medically monitored and medically managed intensive inpatient care services and clinically managed high-intensity residential services are covered. Based on criteria developed by the state, this service will be prior authorized.

Add



## Alternative Benefit Plan

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☐ Limit on number of prescriptions
- ☐ Limit on brand drugs
- ☐ Other coverage limits
- ☒ Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

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



## Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided:

Outpatient Rehabilitative

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Coverage is provided for rehabilitative care services when the individual needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt or disabled. Rehabilitative services include, but are not limited to: (1) physical therapy (2) occupational therapy; (3) speech-language pathology; and (4) behavioral health professional treatment. Applied behavior analysis for adults is excluded. Rehabilitative services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician or mid-level practitioner. Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Habilitative Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services exclude: custodial care, diagnostic admission, maintenance, nonmedical self-help, vocational educational therapy, social or cultural rehabilitation, learning and developmental disabilities and visual, speech or auditory disorders.

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

Coverage is provided for habilitative care services when the individual requires help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. These services include, but are not limited to: (1) physical therapy (2) occupational therapy; (3) speech-language pathology; and (4) behavioral health professional treatment. Applied behavior analysis for adults is excluded. Habilitative services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician or mid-level practitioner. Based on criteria developed by the state, this service will be prior authorized.



## Alternative Benefit Plan

Benefit Provided:

Prostheses

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

>\$2,500

Duration Limit:

None

Scope Limit:

Services exclude: computer-assisted communication devices; or replacement of lost or stolen prosthesis.

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

Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

DME

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

>\$2,500

Duration Limit:

None

Scope Limit:

Services exclude: exercise equipment, lifts, hot tubs, computerized equipment, athletic equipment, replacement of lost or stolen items, repair or rental equipment, or convenience items.

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

Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Skilled Nursing Facility Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

60 days

Duration Limit:

Annual

Scope Limit:

Services exclude: custodial care.



## Alternative Benefit Plan

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

Based on criteria developed by the state, this service will be prior authorized.

Benefit Provided:

Cochlear Implants

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered for all ages if medically necessary.

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

Based on criteria developed by the state, this service will be prior authorized.

Add



## Alternative Benefit Plan

☒ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided:

Diagnostic Test (X-Ray and Lab)

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Diagnostic X-Ray examinations, laboratory and tissue diagnostic examinations, and medical diagnostic procedures.

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

None

Benefit Provided:

Imaging (CT/PET Scans and MRI)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Diagnostic X-Ray and imaging. Tests included computerized tomography scan (CT scan), MRI's, and ultrasound.

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

Based on criteria developed by the state, this service will be prior authorized.

Add



## Alternative Benefit Plan

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

Collapse All ☐

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

Benefit Provided:	Source:	Remove
Asthma Program	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Other	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
See Other		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
The Program goal of asthma care is to achieve asthma control, enabling an enrollee to live without functional limitations, impairment in quality of life, or risk of adverse events. Review of symptoms, treatment options, prevention of triggers, use of short-acting medications, self-management education and controlling exposure to irritants. Management steps to reduce impairment and risk.		

Benefit Provided:	Source:	Remove
Maternity Program	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Other	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
See Other		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
This program is designed to support an enrollee from early pregnancy until six weeks post-delivery to provide all the education and information that enrollees require to ensure a healthy mother and baby. Assistance is also provided to work with an enrollee and their doctor for any high risk situations such as gestational diabetes and the effects of high blood pressure –preeclampsia.		

Add





## Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

New adults 19 & 20 years of age

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

None

Add



# Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐

Other Base Benefit Provided:

Source:

Base Benchmark

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit:

Add



# Alternative Benefit Plan

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

Collapse All ☐

Base Benchmark Benefit that was Substituted:

Infertility Treatment: substitution

Source:

Base Benchmark

Remove

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

Infertility Treatment was removed and replaced in EHB1 by substitution with the actuarial value of Dental Preventive/Diagnostic Services, which are not covered in the base benchmark. Coverage for Dental Preventive/Diagnostic Services comes from the preventive coverage provided in the State Plan.

Base Benchmark Benefit that was Substituted:

Chiropractic Services: substitution

Source:

Base Benchmark

Remove

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

Chiropractic Services was removed and replaced in EHB1 with the actuarial value of Dental Preventive/Diagnostic Services, which are not covered in the base benchmark. Coverage for Dental Preventive/Diagnostic Services comes from the coverage provided in the State Plan.

Base Benchmark Benefit that was Substituted:

Alternative Medicine: substitution

Source:

Base Benchmark

Remove

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

Alternative Medicine was removed and replaced in EHB1 with the actuarial value of Dental Preventive/Diagnostic Services, which are not covered in the base benchmark. Coverage for Dental Preventive/Diagnostic Services comes from the coverage provided in the State Plan.

Add



# Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Source:

Remove

ABA Therapy (Autism)

Base Benchmark

Explain why the state/territory chose not to include this benefit:

The benchmark benefit is for under age 19 only. Montana will be serving age 19-64 in this state plan.

Add



# Alternative Benefit Plan

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

Collapse All ☐

Other 1937 Benefit Provided:

Hearing Aids

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Based on criteria developed by the state, this service will be prior authorized.

Other 1937 Benefit Provided:

Adult Eye Glasses

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 pair

Duration Limit:

annual

Scope Limit:

None

Other:

Provided through the Medicaid Wallman Contract, which is a bulk eyeglass-purchasing contract that was awarded through a competitive bid RFP process. It is the sole source eyeglass provider for Medicaid. Some additional features require prior authorization.

Services include: Frames and lenses. Based on criteria developed by the state, this service will be prior authorized. The services are provided in the same manner as described on pages 3.1A & 3.1B of the approved state plan.

Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



## Alternative Benefit Plan

Scope Limit:

None

Other:

No prior authorization is required. The services are provided in the same manner as described on pages 3.1A & 3.1B of the approved state plan.

Other 1937 Benefit Provided:

Diabetes Prevention Program

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Providers (licensed dietitians, licensed nurses, licensed physical therapists, certified diabetes educators, and exercise physiologists) must contract with Montana's Public Health and Safety Division.

Other:

Services to prevent diabetes provided to people at risk for diabetes as described on pages 3.1A and 3.1B of the approved State Plan. No prior authorization is required.

Other 1937 Benefit Provided:

Dental Treatment Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

\$1,125

Duration Limit:

Annual

Scope Limit:

None

Other:

Services Include: Dental Services (limit excludes preventive/diagnostic, anesthesia, and dentures). No prior authorization is required.

Other 1937 Benefit Provided:

Denture Dental Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan



## Alternative Benefit Plan

Amount Limit:

1 partial set/5 years; 1 full set/10 years.

Duration Limit:

None

Scope Limit:

None

Other:

Services Include: Dentures Services; Other Practitioner: Denturist Services; Other Practitioner Services: Denture Services; Other Practitioner: Denturist Denture Services. Service limits of one partial set of dentures every five years and one full set every ten years. The services are provided in the same manner as described on pages 3.1A & 3.1B of the approved state plan.

Other 1937 Benefit Provided:

Routine Eye Exams for Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

One exam

Duration Limit:

Every 12 months

Scope Limit:

One exam every 12 months unless significant changes in vision or for treatment of eye disease.

Other:

Services Include:  
EYE EXAM NEW PATIENT  
EYE EXAM ESTABLISH PATIENT  
EYE EXAM&TX ESTAB PT 1/>VST  
DETERMINE REFRACTIVE STATE

Add



# Alternative Benefit Plan

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

Collapse All ☐

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415





# Alternative Benefit Plan

State Name: Montana

Attachment 3.1-L- ☐ T

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Benefits Assurances

ABP7

### EPSDT Assurances

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

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

☐ Yes

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

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

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

☒ Through an Alternative Benefit Plan.

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

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

We have fully aligned our HELP Program TPA ABP with the Essential Health Benefits subject to 1937 requirements and the Benchmark Benefit Plan in Montana. EPSDT services are included.

### Prescription Drug Coverage Assurances

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

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

☒ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☒ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

### Other Benefit Assurances

☒ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☒ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.



## Alternative Benefit Plan

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

### PRA Disclosure Statement

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V.20140415



# Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Service Delivery Systems

**ABP8**

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

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

Select one or more service delivery systems:

- ☐ Managed care.
- ☐ Fee-for-service.
- ☒ Other service delivery system.

## Other Service Delivery Model

Name of service delivery system:

Provide a narrative description of the model:

## PRA Disclosure Statement

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V.20140417



# Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Employer Sponsored Insurance and Payment of Premiums

**ABP9**

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

The state/territory otherwise provides for payment of premiums.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

Individuals with access to ESI are not included in the TPA model. Such individuals are associated with alignment ABP. Such individuals are associated with alignment ABP.

### PRA Disclosure Statement

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V.20140415



# Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## General Assurances

ABP10

### Economy and Efficiency of Plans

- ☒ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

### Compliance with the Law

- ☒ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- ☒ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- ☒ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

### PRA Disclosure Statement

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V.20140415



# Alternative Benefit Plan

State Name: Montana

Attachment 3.1-L- T

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0027

OMB Expiration date: 10/31/2014

## Payment Methodology

ABP11

### Alternative Benefit Plans - Payment Methodologies

- ☒ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

### PRA Disclosure Statement

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V.20140415