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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 20-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

June 16, 2020

Caprice Knapp, Medicaid Director
Division of Medical Services
North Dakota Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

Dear Ms. Knapp:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 20-0004. This amendment updates the state's Alternative Benefits Plan (ABP) for the adult group.

Please be informed that this State Plan Amendment was approved June 16, 2020, with an effective date of January 1, 2020. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Krista Fremming, North Dakota
Stacey Koehly, North Dakota

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **North Dakota**

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.

ND-20-0004

Proposed Effective Date

01/01/2020 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1902(a)(10)(A)(i)(VIII) of the Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2020	$-660000.00
Second Year	2021	$-880000.00

Subject of Amendment

Updated North Dakota Medicaid Expansion ABP - Effective January 1, 2020. ABP5 Prescription Drug Benefits changed to follow ND Medicaid (FFS) State Plan and ABP8 changed Prescription Drug Benefit as pharmacy claims deliverable through FFS Medicaid and medical claims deliverable through Managed Care.

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:
  The Department of Human Services, the Single State Medicaid Agency, is designated to file state plan amendments on behalf of the state Medicaid program.

Signature of State Agency Official

Submitted By: **Krista Fremming**

Last Revision Date: **May 28, 2020**

Submit Date: **Mar 24, 2020**

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name: North Dakota Medicaid Expansion

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:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

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

Geographic Area

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

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

PRA Disclosure Statement

Alternative Benefit Plan

State Name: North Dakota | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. No

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

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

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

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

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

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

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

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

☒ Letter

☐ Email

☐ Other

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

An attachment is submitted.

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

The state will notify individuals of their option in the notice received when they are approved as eligible in the new adult group.

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

Enrollees will be notified of the ability to seek designation as medically frail. Interested enrollees will complete a questionnaire and submit the questionnaire to the state office. The state's medical staff will review the questionnaire; and if the enrollee meets the minimum thresholds, the enrollee will seek additional documentation from a physician, nurse practitioner, or physician assistant regarding their health status and prescription medication list. The documentation will be submitted to the state office and a final determination will be made regarding the enrollee being designated as medically frail. Once an individual has been designated medically frail, they will be given the option of remaining in the managed care plan or choosing to receive services through the Medicaid State Plan.

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

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

☐ In the eligibility system.

☒ In the hard copy of the case record.

☐ Other

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

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

Alternative Benefit Plan

<u>PRA Disclosure Statement</u>

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

V.20160722

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

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:

Individuals will use a questionnaire for self-identification if they believe they are medically frail. Enrollees will submit the completed questionnaire to the state. The state's medical services staff will evaluate the questionnaire and if the minimum threshold is met, any supporting documentation from a physician, physician assistant, or nurse practitioner submitted with the questionnaire will be reviewed by a medical professional to validate the diagnoses or medical condition(s) as indicated on the completed questionnaire. If no documentation was submitted with the questionnaire and the minimum threshold was met, the recipient will receive a letter asking them to submit the supporting documentation from a physician, physician assistant, or nurse practitioner. The state’s medical services staff will notify the recipient of the decision. If deemed medically frail, the recipient will have a choice of remaining with the Alternative Benefit Plan or switching to the Medicaid state plan. If enrollee elects to switch to the Medicaid state plan, the status as medically frail may begin no earlier than the first day of the month in which the questionnaire was received by the state.

☐ 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.

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:

The state is using self-identification as the primary method for identifying if an individual is exempt from mandatory enrollment or meet the exemption criteria. At re-enrollment, the renewal notice will provide notification to the enrollees about the option to seek designation as medically frail. In cases where the self-identification is questionable, the state may review claims data to make a final determination.

☑ 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:

The eligibility record for individuals deemed medically frail, who choose to disenroll from the Alternative Benefit Plan, will be updated to ensure that managed care premiums are not paid and to ensure that claims can process, fee-for-service, through the state's Medicaid Management Information System.

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

PRA Disclosure Statement

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3.1

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: Medicaid Expansion ABP

Selection of EHB-Benchmark Plan

The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: Sanford Health Plan HMO

The EHB-benchmark plan is the same as the Section 1937 Coverage option: Yes

Assurances

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.

Plan name: Sanford Health Plan

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

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

PRA Disclosure Statement

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

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. No

Other Information Related to Cost Sharing Requirements (optional):

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Sanford Health Plan HMO.

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

Largest Commercial Non-Medicaid HMO

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided: Outpatient Hospital Surgical Center	Source: Base Benchmark Commercial HMO
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan
Amount Limit: None	Duration Limit: None

Remove

Scope Limit:

Exclusions include: surgical procedures that can be done in Practitioner's office (i.e. vasectomy, toe nail removal), blood and blood derivatives replaced by the member, and take-home drugs.

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

Continued exclusions: Panniculectomy or sequela (i.e. anemia, breast reduction, hernia repair, gallbladder removal) as result of gastric bypass surgery; cosmetic services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services; removal of skin tags; and complications from a non-covered procedure or service.

Benefit Provided: Primary Care to Treat Illness/Injury	Source: Base Benchmark Commercial HMO
Authorization: None	Provider Qualifications: Medicaid State Plan
Amount Limit: None	Duration Limit: None

Remove

Scope Limit:

Exclusions include: Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management; and complications from a non-covered procedure or service.

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

Benefit Provided: Specialist Visits	Source: Base Benchmark Commercial HMO
Authorization: None	Provider Qualifications: Medicaid State Plan
Amount Limit: None	Duration Limit: None

Remove

Scope Limit:

None

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

Benefit Provided: Chiropractic (Therapeutic/Adjustive/Manipulative)

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 20 Visits per Calendar Year

Duration Limit: None

Scope Limit:

Exclusion include: vitamins except for folic acid and prenatal vitamins for women per plan guidelines, minerals, therabands, cervical pillows, traction services and hot/cold pack therapy including polar ice therapy and water circulating devices.

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

Benefit Provided: Chemotherapy Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

Benefit Provided: Radiation Therapy

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Anesthesia by Local Infiltration

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Walk-in Center Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Home Health Care-Non Rehab

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 40 Visits per Calendar Year

Duration Limit: None

Scope Limit:

Exclusions include: nursing care requested by, or for the convenience of the patient or the patient's family (rest cures), custodial or convalescent care.

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

Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lie of Hospital or Skilled Nursing Facility: part-time or intermittent care by a RN or LPN/LVN; part-time or intermittent home health aide services for direct patient care only; physical, occupational, speech, inhalation, and intravenous therapies up to maximum benefit allowable; and/or medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized. One(1) home health visit constitutes four (4) hours of nursing care.

Benefit Provided: Access to Clinical Trials

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Covered as routine patient costs when provided as part of an Approved Clinical Trial if services are otherwise Covered Service.

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

Approve Clinical Trial means a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:
- federally funded or approved trial;
- clinical trail conducted under FDA investigational new drug application; or
- drug trial that is exempt from the requirement of an FDA investigational new drug application.

Not covered: extra costs related to taking part in Approved Clinical Trial (i.e. additional test which are not part of the member's routine care) or research costs related to conducting the Approved Clinical Trial (i.e. research provider time, analysis of results, and clinical tests performed only for research purposes.

Benefit Provided: Dental Injury

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Must be received within 6 months of occurence

Scope Limit:

Exclusions include: routine dental care and treatment; natural teeth replacements including crowns, bridges, braces or implants; Ossenointegrated implant surgery (dental implants); extraction of wisdom teeth; hospitalization for extraction of teeth;

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

Continued exclusions: dental x-rays or dental appliances; shortening of the mandible or maxillae for cosmetic purposes; services and supplies related to ridge augmentation, implantology, and preventative vestibuloplasty; dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD).

Benefit Provided: Oral and Maxillofacial Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Must be received within 6 months of occurance

Scope Limit:

Procedures limited to services required because of injury, accident or cancer that damages natural teeth. Associated radiology services are included. Covered services include those provided in Hospital or dental office.

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

Diagnosis and treatment of Temporomandibular Joint (TMJ) dysfunction and/or Temporomandibular Disorder (TMD). TMJ splints are covered if the primary diagnosis is TMJ/TMD.
Not covered: Routine dental care and treatment; natural teeth replacements including crowns, bridges, braces or implants; osseointergrated implant surgery; extraction of wisdom teeth; hospitalization for extraction of teeth except for NDCC 26.1-36-09.9; dental x-rays and dental appliances; shortening of the mandible for cosmetic purposes; services and supplies related to ridge augmentation, implantology; and preventative vestivuloplasty; dental appliances of any sort.

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Covered until the enrollee qualifies for the federally funded dialysis services under ESRD.

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

Services include equipment, training, and medical supplies required for effective dialysis care.

Add

■ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Emergency Room - Facility
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Not covered: emergency care provided outside the service area if need for care could have been foreseen before leaving the service area; medical or hospital costs resulting from a normal full-term delivery of a baby outside of the service area.

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

Benefit Provided: Ambulance Transportation Services
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Coverage is to the nearest provider equipped to furnish the necessary health care services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Not covered: Transfers performed only for the convenience of the enrollee or the enrollee's family; the enrollee's practitioner and/or provider; services and/or travel expenses relating to a non-emergency medical condition; and complications from a non-covered procedure or service.

Benefit Provided: Emergency Room - Professional
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:

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

Add

■ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided: Inpatient Medical and Surgical care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Exclusion include: take home drugs; personal comfort items, private nursing care, costs associated with private rooms, admissions to hospitals performed only for the convenience of the enrollee, the enrollee's family or the enrollee's

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

Continued exclusions: practitioner/provider,custodial care, rest cures, services to assist in the activities of daily living. Panniculectomy or sequela (i.e. anemia, breast reduction, hernia repair, gallbladder removal) as result of gastric bypass surgery; cosmetic services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services; removal of skin tags; and complications from a non-covered procedure or service.

Benefit Provided: Bariatric Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Once per Lifetime

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Organ and Tissue Transplants

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Covers transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan policy requirements and are performed at Plan Participating Providers or contracted Centers of Excellence.

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 transplants according to the Plan's medical coverage guidelines (available upon request) for the following services: pre-operative care; transplant procedure, facility, and professional fees; organ acquisition costs; bone marrow or stem cell acquisition and short term storage therapy for a member's with a covered illness; short-term storage of umbilical cord blood for a member with a malignancy undergoing treatment when there is a donor match; post-transplant care and treatment; drugs (including immunosuppressive drugs); supplies; psychological testing; and living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan, or other coverage arrangements.
Not covered: transplant evaluations with no end organ complications; storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use; artificial organs, any transplant or transplant services not listed above; expenses incurred by a member as a donor, unless the recipient is also a member; costs related to locating organ donors; donor expenses for complications that occur after sixty (60) days from the date the organ is removed, when the donor is not covered as a member under this Plan; services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies drugs and aftercare for or related to artificial or non-human organ transplants; services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee; services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating center of excellence facilities; and transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria.

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Services of an anesthesiologist or other certified anesthesia provider in conjunction with a certified inpatient or outpatient procedure or treatment.

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

Benefit Provided: Hospice

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Exclusions include: independent nursing, homemaker services, respite care.

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

The following circumstances apply: (1) the enrollee has been diagnosed with a terminal disease and a life expectancy of six months or less, (2) the enrollee has chosen a palliative treatment focus; and (3) the enrollee continues to meet the terminally ill prognosis.
The following Hospice Services are Covered Services:
a. Admission to a hospice Facility, Hospital, or skilled nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
b. In-home hospice care per Plan guidelines (available upon request)
c. Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aid for patient care up to eight (8) hours per day
d. Social services under the direction of a Participating Provider
e. Psychological and dietary counseling
f. Physical or occupational therapy, as described under Section 3(a)
g. Consultation and Case Management services by a Participating Provider
h. Medical supplies, DME and drugs prescribed by a Participating Provider
i. Expenses for Participating Providers for consultant or Case Management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of available coverage for these services, but only where the hospice retains responsibility for the care of the Member.

Benefit Provided: Blood Transfusions

Source: Base Benchmark Commercial HMO

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:

Pheresis Therapy is a covered service.

Benefit Provided: Breast Reduction

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Not covered as a result of gastric bypass surgery.

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

Benefit Provided: Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Surgery to restore bodily function or correct a deformity caused by illness or injury; mastectomy; and related benefits.

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

Not covered: surgical placement of non-covered prosthetics; panniculectomy or sequela (i.e. anemia, breast reduction, hernia repair, gallbladder removal) as result of gastric bypass surgery that do not meet medical necessity; cosmetic surgeries, services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem and not medically necessary, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, or cosmetic dental services; removal of skin tags, prophylactic (preventive) surgeries (i.e. mastectomy, oopherectomy); and removal, revision, or re-implementation of saline or silicone implants that do not meet medical necessity criteria.

Benefit Provided: Inhalation Therapy

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Add

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided: Delivery and Maternity Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Up to 4 Ultrasounds per Pregnancy

Duration Limit: None

Scope Limit:

Covers prenatal through postnatal maternity care and delivery and care for complications of pregnancy of the mother.

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

The minimum inpatient stay, when complications are not present, ranges from 48 hours for a vaginal delivery to a minimum of 96 hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating practitioner and/or provider, after consulting with the mother, determines that they mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother.

Benefit Provided: Pre and Postnatal Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Includes prenatal through postnatal maternity care and delivery and care for complications of pregnancy of the mother. Up to 4 routine ultrasounds per pregnancy to determine fetal age, size and development are allowed.

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

Exclusion include: Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

Benefit Provided: Infertility Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

Duration Limit: None

Scope Limit:

Includes testing for the diagnosis of infertility. Limited to the Plan Guidelines which are available upon request.

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

Not covered: treatment of infertility including artificial means of conception such as artificial insemination, in-vetro fertilization, ovum/embryo placement or transfer, or gamete intra-fallopian tube transfer;cryogenic or other preservation techniques used in such or similar procedures; infertility medication; any other service or supplies related to artificial means of conception; reversals of prior sterilization procedures; and/or any expenses related to surrogate parenting.

Add

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

Collapse All ☐

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Benefit Provided: Mental Inpatient Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

As with other medical/surgical benefits, failure to get prior authorization for inpatient services, including those provided by a hospital or residential treatment facility, may result in a reduction or denial of benefits.

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

Not covered: convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; educational or non-medical services related to learning disabilities; services related to environmental change; educational or non-medical services related to behavioral therapy, modification or training; milieu therapy; or sensitivity training. For enrollees ages 21 and older, services rendered in an IMD, room and board at a Residential Treatment Facility and Applied Behavioral Analysis (ABA) services are not covered.

Benefit Provided: Substance Use Disorder Inpatient Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

As with other medical/surgical benefits, failure to get prior authorization for inpatient services, including those provided by a hospital or residential treatment facility, may result in a reduction or denial of benefits.

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

Not covered: confinement services to hold or confine an enrollee under chemical influence when no Medically Necessary services are provided, regardless of where services are received (e.g. detoxification centers); domiciliary or maintenance care; convalescent or custodial care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; educational or non-medical services related to learning disabilities; services related to environmental change; educational or non-medical services related to behavioral therapy, modification or training; milieu therapy; or sensitivity training. For enrollees ages 21 and older, services rendered in an IMD and room and board at a Residential Treatment Facility are not covered.

Alternative Benefit Plan

Benefit Provided: Mental Outpatient Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage includes outpatient professional services, including individual/group therapy by providers such as psychiatrists, psychologists, or clinical social workers; medication management; diagnostic tests, electroconvulsive therapy (ECT);

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

partial hospitalization, and/or intensive outpatient; and telephonic consultation for an enrollee diagnosed with depression and is within 12 weeks of starting anti-depressant therapy. Telephonic consultation coverage limit of 1 per enrollee for depression and 1 per enrollee for Attention Deficit Hyperactive Disorder.
Not covered: convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; educational or non-medical services related to learning disabilities; services related to environmental change; educational or non-medical services related to behavioral therapy, modification or training; milieu therapy; or sensitivity training. For enrollees ages 21 and older, Applied Behavioral Analysis (ABA) services are not covered.

Benefit Provided: Substance Abuse Disorder Outpatient Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage includes alcohol, chemical and gambling treatment; outpatient professional services, including individual/group therapy by providers such as psychiatrists, psychologists, clinical social workers, licensed chemical dependency counselors, or

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

other qualified mental health and substance abuse disorder professionals; partial hospitalization; and intensive outpatient programs.
Not covered: confinement services to hold or confine an enrollee under chemical influence when no Medically Necessary services are provided, regardless of where services are received (e.g. detoxification centers); long term care in a mental health facility; convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; educational or non-medical services related to learning disabilities; services related to environmental change; educational or non-medical services related to behavioral therapy, modification or training; milieu therapy; sensitivity training; convalescent or custodial care; or domiciliary or maintenance care.

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

Authorization: Yes

Provider Qualifications: State licensed

☒ Limit on days supply

☐ Limit on number of prescriptions

☐ Limit on brand drugs

☒ Other coverage limits

☐ Preferred drug list

Coverage that exceeds the minimum requirements or other:

Any coverage as described in Attachment 3.1-A page 5 #12 and Attachment to Page 5 of Attachment 3.1-A of the North Dakota Medicaid State Plan applies to the Alternative Benefit Plan.

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

Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Physical, Speech and Occupational Therapy

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 Visits per Year per Therapy per Service

Duration Limit: None

Scope Limit: This benefit covers both habilitation and rehabilitation. Limits are not cumulative for both habilitation and rehabilitation services.

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

Exclusions include: services provided in enrollee's home for convenience, hot/cold pack therapy and water circulating devices; speech therapy for the purpose of correcting speech impediments (stuttering or lisps), or assisting in the initial development of verbal facility or clarity; voice training or voice therapy.
Exclusions include: Alternative treatment therapies including, but not limited to: acupuncture, aquatic whirlpool therapy, chelation therapy, massage therapy, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), therapeutic touch, lifestyle improvement services, such as physical fitness programs, or health or weight loss clubs or clinics, educational programs, vocational and job rehabilitation, recreational therapy, traction services, and special education including sign language lessons to instruct a member.

Benefit Provided: Cardiac Rehabilitation

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 Days per Calendar Year

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

Duration Limit:

Scope Limit:
Prior authorization and/or limitations may apply to certain items per the Plan guidelines (available upon request).

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

Not Covered:
• Home Traction Units
• Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances
• Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
• Revision of durable medical equipment, except when made necessary by normal wear or use
• Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness, lost, or stolen
• Duplicate or similar items
• Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
• Items which are primarily educational in nature or for vocation, comfort, convenience or recreation
• Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
• Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
• Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
• Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
• Remote control devices as optional accessories

Benefit Provided: Prosthetics and Orthotics

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

Duration Limit: None

Scope Limit:
Prior authorization and/or limitations may apply to certain items per the Plan guidelines (available upon request).

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

Covers prosthetic limbs, sockets and supplies, and prosthetic eyes; externally worn breast prostheses and

surgical bras including necessary replacements following a mastectomy (single mastectomy includes 2 external prosthesis and 4 bras per Calendar and double mastectomy coverage extends to 4 external prostheses and 4 bras per Calendar Year; and adjustments, modifications, and/or repairs to prosthesis required by wear/tear or due to a change in member's condition or to improve the function as long as repairs do not exceed the estimated expense of purchasing another prosthesis.
Not covered: experimental and/or investigational services or devices except as part of an approved clinical trial; replacement or repair of items (if destroyed by enrollee's misuse, abuse or carelessness, lost or stolen); duplicate or similar items; service call charges, labor charges or charges for repair estimates; wigs, cranial prosthesis, or hair transplants; cleaning and polishing of prosthetic eye; or genital prosthetics, including penile prosthesis and related services.

Benefit Provided: Skilled Nursing Facility

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 Days in a Consecutive 12 Month Period

Duration Limit: None

Scope Limit:

Exclusions include: ustodial care, convalescent care, rest cures, services to assist in activities of daily living. Services in lieu of continued or anticipated hospitalization.

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

Skilled nursing care in a hospital is covered if the level of care needed by the enrollee has been classified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the hospital or in another hospital within a 30 mile radius of the hospital.

Benefit Provided: Home Health Care-Rehab (PT, OT, Speech Therapy)

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 40 Visits per Year

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:

This benefit covers both habilitation and rehabilitation.

Add

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:	Source:
Lab Tests, X-ray Services, and Pathology	Base Benchmark Commercial HMO
Authorization:	**Provider Qualifications:**
None	Medicaid State Plan
Amount Limit:	**Duration Limit:**
None	None
Scope Limit:	
None	

Remove

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

Benefit Provided:	Source:
Imaging / Diagnostics (MRI, CT Scan, PET Scan)	Base Benchmark Commercial HMO
Authorization:	**Provider Qualifications:**
None	Medicaid State Plan
Amount Limit:	**Duration Limit:**
None	None
Scope Limit:	
None	

Remove

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

Benefit Provided:	Source:
Outpatient Diagnostic Labs, X-Ray and Pathology	Base Benchmark Commercial HMO
Authorization:	**Provider Qualifications:**
None	Medicaid State Plan
Amount Limit:	**Duration Limit:**
None	None
Scope Limit:	
Not covered: Thermograms or Thermology	

Remove

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

Add

☒ 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: Colorectal Cancer Screening

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Excludes virtual colonoscopies

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

Benefit Provided: Nutritional Counseling

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Coverage includes foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

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

Excludes weight loss programs.
Not covered: dietary desserts and snack items. For Phenylketonuria (PKU); coverage includes testing, diagnosis, and treatment of PKU including dietary management, formulas, case management, intake and screening, assessment, comprehensive care planning and service referral. Not covered for PKU: dietary desserts and snack items.

Benefit Provided: Smoking Cessation Program

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 2 attempts per year

Duration Limit: None

Scope Limit: Not covered: hypnotism and acupuncture

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

Benefit Provided: Allergy Testing and Injections

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Includes testing and treatment, allergy injections, and allergy serum.

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

Exclusions include: provocative food testing and sublingual allergy desensitization.

Benefit Provided: Family Planning

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Includes consultations and pre-pregnancy planning. The following drugs, services, and devices are covered: barrier methods - diaphragm and cervical cap fitting/purchase; mirena and paragard intrauterine devices only with placement/removal covered

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

once every five (5) years; and/or generic oral contraceptives, other contraceptives including injectable medroxyprogesterone acetate, and emergency contraception with generic Plan B are covered at 100% (no cost). Voluntary sterilizations are covered and include: medical - occlusion of the fallopian tubes by use of permanent implants (e.g. Essure) and/or surgical - tubal ligation or vasectomies. Tubal ligation covered at 100% of allowed only when performed as the primary procedure and if performed as part of a maternity delivery or for any other medical reason it will be covered as a medical benefit with the applicable cost-

share applied.
Not covered: genetic counseling or testing except for services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force - prior authorization required; Reproductive Health Care Services which are prohibited by the laws of North Dakota; elective abortions; and/or reversal of voluntary sterilization.

Benefit Provided: Diabetes Equipment and Supplies; Education

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Excludes food items for medical nutritional therapy.

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

Coverage includes: Blood glucose monitors including continuous glucose monitoring systems (this DME requires certification); Blood glucose monitors for the legally blind; Test strips for glucose monitors; Urine testing strips; Insulin injection aids; Lancets and lancet devices; Insulin pumps and all supplies for the pump (this DME requires certification), Custom diabetic shoes and inserts limited to one (1) pair of depth-inlay shoes and three (3) pairs of inserts or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts; Syringes; Insulin infusion devices (this DME requires certification; Prescribed oral agents for controlling blood sugars; Glucose agents; Glucagon kits; Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes; and Routine foot care including toe nail trimming.
Diabetes self management training and education shall be covered if the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner and/or Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator and; the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the North Dakota Department on Health.

Benefit Provided: Foot Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Include routine foot care for diabetes; non-routine diagnostic testing and treatment of the foot due to illness or injury.

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

Exclusions include: cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery; diagnosis and treatment of weak, strained, or flat feet.

Benefit Provided: Preventive Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Exclusions include: sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to physicals and eye exams for driver's licenses).

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

The following preventive services, as defined in the Affordable Care Act, received from an in-network provider are covered at no charge: evidenced based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; immunizations for routine use that have in effect a recommendations from the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member involved; with respect to covered persons who are age 19 and 20 - evidence informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and EPSDT; and with respect to covered persons who are women, such additional preventive care and screening not described above are provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Add

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

Collapse All ☐

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Services noted as not covered in all other benefit areas must be provided when medically necessary for enrollees under 21 years of age. Some services may require prior authorization.

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

Add

Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐

Other Base Benefit Provided: Vision Services	Source: Base Benchmark
Authorization: Other	Provider Qualifications: Medicaid State Plan
Amount Limit: Other	Duration Limit: None
Scope Limit:	

Remove

Other information regarding this benefit:

Includes: Non-routine vision exams relating to eye disease or injury to the eye; eyeglasses/contacts lenses with diagnosis of aphakia; eyeglasses, including one frame per lifetime up to $200 or clear contact lenses for the aphakia eye for 2 single lenses per CY; and scleral Shells with soft shells limited to 2 per calendar year and hard shells limited to 1 per lifetime.
Not covered: Routine vision exams, refractive errors of the eye; purchase, examinations, or fitting of eyeglasses or contact lenses; radial keratotomy, myopic keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; replacement of lost, stolen, broken, or damaged lenses or glasses, bifocal contact lenses, special lens coating or lens treatment for prosthetic eyewear; glasses and/or contacts after cataract surgery; routine cleaning of scleral shells.

Add

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

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Coverage

Source: Base Benchmark

Remove

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

Newborn Coverage will be provided under the newborn's eligibility under the traditional Medicaid program.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Residential Treatment Room and Board Coverage

Source: Base Benchmark

Remove

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

For those members 21 and older, coverage at a Residential Treatment Facility does not include room and board.

Add

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

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

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 20 - 0004

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

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).

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Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

The Department of Human Services has conducted outreach through: providing testimony to various legislative committees, presenting to provider and advocacy groups, presenting to county social service board and commissioners, developing a dedicated web page, meeting with tribal health and Indian Health Services representatives, and developing public service announcements.

MCO: Managed Care Organization

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

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

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

Identify the date the managed care program was approved by CMS: December 20, 2013

Describe program below:

The State has chosen the section 1937 benchmark option of the commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state. In addition, Alternative Benefit Plan will incorporate the Essential Health Benefits and will ensure compliance with Mental Health and Substance Abuse parity. This group enrolled in the MCO will be solely limited to those individuals eligible in the new adult group under the Medicaid expansion. Medicaid Expansion beneficiaries, including American Indians, will be mandatorily enrolled in one managed care plan offered statewide. The Medicaid Expansion will include individuals who meet the qualifications of the exempt populations as outlined in Section 1937(a)(2)of the Act. Individuals who meet the qualifications of the exempt population can choose to receive the ABP that is the Medicaid State Plan benefit or the ABP that includes Essential Health Benefits. The Medicaid State Plan benefit will be provided through a fee-for-service delivery system. The Alternative Benefit Plan will be provided through a managed care delivery system as outlined in the approved section 1915(b) waiver.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

Add	Benefit/service	Description of how the benefit/service will be provided	Remove
Add	Pharmacy Benefits-Services	Outpatient Pharmacy Benefit-Services submitted as medical claims shall be through the Managed Care Delivery System as administered and managed by the MCO; however, Outpatient Pharmacy Benefit-Services submitted as pharmacy claims shall be through the Fee-For-Service Delivery System as administered and managed by the Department.	**Remove**

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

☐ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☐ Individuals in a retroactive period of Medicaid eligibility.

☒ Other:

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Medicaid Expansion beneficiaries, including American Indians, will be mandatorily enrolled in the one managed care plan offered statewide. The Medicaid Expansion will include individuals who meet the qualifications of the exempt populations as outlined in Section 1937(a)(2)of the Act. Individuals who meet the qualifications of the exempt population can choose to receive the ABP that is the Medicaid State Plan benefit or the ABP that includes Essential Health Benefits. The Medicaid State Plan benefit will be provided through a fee-for-service delivery system.

Additional Information: MCO (Optional)

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

Fee-For-Service Options

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

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

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

For those individuals determined medically frail who elect ABP that is the Medicaid State Plan benefit; for those individuals who are incarcerated who receive only qualifying inpatient care; and for those non-citizen individuals who receive treatment for an emergency medical condition as required under 42 CFR §435.139; and for those individuals who have Hospital Presumptive Eligibility until a full determination can be made.

Additional Information: Fee-For-Service (Optional)

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

As noted under the Other MCO-Based Service Delivery System Characteristics section above -
Outpatient Pharmacy Benefit-Services submitted as medical claims shall be through the Managed Care Delivery System as administered and managed by the MCO; however, Outpatient Pharmacy Benefit-Services submitted as pharmacy claims shall be through the Fee-For-Service Delivery System as administered and managed by the Department

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PRA Disclosure Statement

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

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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.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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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. No

Please describe your approach below:

The premiums paid will more closely reflect commercial insurance rates, adjusted for managed care savings, acuity and other applicable adjustments. Medicaid rate setting does not typically consider cost shifting, acuity and other adjustments.

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.