Table of Contents

State/Territory Name: ND

State Plan Amendment (SPA) #: 22-0002-A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

December 29, 2022

Krista Flemming, Interim Director
Medical Services Division
North Dakota Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota State Plan Amendment (SPA) 22-0002-A

Dear Interim Director Flemming:

We have reviewed the State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0002-A. This Alternative Benefit Plan (ABP) amendment proposes to amend the State Plan to account for the change in managed care organization for Medicaid Expansion members between ages 21 - 64.

Please be informed that this SPA was approved on December 29, 2022, with an effective date of January 1, 2022. Enclosed are copies of the approved CMS-179 summary page and SPA pages.

If you have any questions, please contact Curtis Volesky at (303) 844-7033 or via email at curtis.volesky@cms.hhs.gov.

Sincerely,

[redacted] Digitally signed by ames G. Scott -S ate: 2022.12.29 12:08:22 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Stacey Koehly, skoehly@nd.gov
LeeAnn Thiel, lthiel@nd.gov
Jodi M. Hulm, jmhulm@nd.gov
Jared D. Ferguson, jadferguson@nd.gov
Robin Dennis, rdennis@nd.gov

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.

22-0002-A

Proposed Effective Date

01/01/2022 *(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	0	$ 0.00
Second Year		$ 0.00

Subject of Amendment

This amendment accounts for the change in managed care organization for Medicaid Expansion members between ages 21-64.

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:
Dec 28, 2022
Submit Date:
Apr 4, 2022

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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 - Ages 21-64

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). No

Targeting Criteria (select all that apply):

- ☐ Income Standard.
- ☐ Disease/Condition/Diagnosis/Disorder.
- ☒ Other.

Other Targeting Criteria (Describe):

ND Medicaid member ages 19-20 are enrolled in separate ABP.

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)

ND Medicaid member ages 19-20 are enrolled in separate ABP.

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.

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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

Alternative Benefit Plan

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):

ND Medicaid member ages 19-20 are enrolled in separate ABP.

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.20160722

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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

Alternative Benefit Plan

- ☐ 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):

ND Medicaid member ages 19-20 are enrolled in separate ABP.

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.20160722

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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: North Dakota Medicaid Expansion - Ages 21-64

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: BlueCare Gold 90 500

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.
  - ( ) 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:

The source of benefits and any limitations utilized include a combination of the North Dakota EHB-Benchmark Plan and the approved North Dakota Medicaid State Plan.

Alternative Benefit Plan

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

The ABP includes and aligns with the following as approved within the North Dakota Medicaid State Plan:
- EHB Prescriptions Drugs effective 01-01-2020 (refer to ABP 5 Benefit Description #6);
- 1915(i) Services effective 10-01-2020 (refer to ABP 5 Benefit Description #14);

ND Medicaid member ages 19-20 are enrolled in separate ABP.

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.20190813

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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):

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.20160722

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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:

BlueCare Gold 90 500

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

Secretary-Approved Coverage with benefits and limitations source from a combination of the North Dakota's EHB Benchmark Plan and the North Dakota Medicaid State Plan.

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Outpatient Hospital Surgical Center
Source: Base Benchmark Commercial HMO
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Exclusions include: surgical procedures that can be done in Practitioner's office (i.e. vasectomy, toe nail removal) 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: Primary Care to Treat Illness/Injury
Source: Base Benchmark Commercial HMO
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
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: Special Visits
Source: Base Benchmark Commercial HMO
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None

Alternative Benefit Plan

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

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits per Benefit Period

Duration Limit:

None

Scope Limit:

Exclusions: Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life.

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

Exclusions Continued: This includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent further problems. No benefits available over the 20 visits per benefit period.

Benefit Provided:

Chemotherapy Service

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

Alternative Benefit Plan

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:
Urgent Care Services

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Exclusion: No out of network coverage.

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

Coverage: medical care provided for a condition that, without timely treatment, could be expected to deteriorate into an emergency, or case prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require Urgent Care include abdominal pain of unknown origin, unremitting new symptoms of

Alternative Benefit Plan

dizziness of unknown cause, and suspected fracture. Urgent Care requires timely face-to-face medical attention within twenty-four (24) hours of Enrollee notification of the existence of an urgent condition.

Remove

Benefit Provided: Home Health Care Non Rehab

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Exclusions include: Dietitian Services, homemaker services, social worker services, maintenance care, custodial care, food or home delivered meals or respite 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

Remove

Benefit Provided: Dental Injury

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Must be received within 6 months of date of injury

Scope Limit:

Exclusions include: routine dental care and treatment; natural teeth replacements including crowns, bridges, braces or 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).

Remove

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Alternative Benefit Plan

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:

Add

Alternative Benefit Plan

☑ 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: None
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: 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:

Alternative Benefit Plan

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

■ 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: Exclusions: Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitaria care.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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: Excludes: donor organs or tissue other than human donor organs or tissue.

Alternative Benefit Plan

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

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Administration of Medically Appropriate and Necessary anesthesia for a covered surgical procedure when ordered by the attending Professional Health Care Provider and provided by or under the direct supervision of an Anesthesiologist or Professional

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

Continued: Health Care Provider other than the operating surgeon or the assistant surgeon.

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:

Benefits are provided only for the treatment of Members diagnosed with a condition where there is a life expectancy of 6 months or less.

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: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

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

Exclusions: Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition. Services or procedures with the primary purpose to improve appearance and not primarily to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes, or which primarily improve or alter body features which are variations of normal development.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care Collapse All ☐

Remove

Benefit Provided:
Delivery and Maternity Services

Source:
Base Benchmark Commercial HMO

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
2 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:
Benefits for Inpatient maternity services allow a minimum stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The Health Care Provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Remove

Benefit Provided:
Pre and Postnatal Care

Source:
Base Benchmark Commercial HMO

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 2 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:

Add

Alternative Benefit Plan

Collapse All ☐

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

☑ 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.

Remove

Benefit Provided: Mental Health Inpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Not Covered: Psychiatric services in an IMD (Institution for Mental Disease).

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

Benefits are available for the Inpatient treatment of psychiatric illness, including management of medical problems related to an eating disorder diagnosis, when provided by an appropriately licensed and credentialed Hospital or Psychiatric Care Facility. Precertification may be required for Inpatient Hospital Admissions.

Remove

Benefit Provided: Substance Use Disorder Inpatient treatment

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefits are available for the Inpatient treatment of substance abuse, including medically managed Inpatient detoxification, medically monitored Inpatient detoxification, medically managed intensive Inpatient treatment or medically monitored intensive Inpatient treatment, when provided at an appropriately licensed and credentialed Substance Abuse Facility.

Remove

Benefit Provided: Mental Health Outpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

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:

Covered: Home and Office Visits: Benefits Including assessment, counseling, Behavioral Modification Intervention for Autism Spectrum Disorder (Including Applied Behavioral Analysis (ABA)), treatment planning, coordination of care, psychotherapy and group therapy provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

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:
None

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

Covered: Home and Office Visits: Benefits Including assessment, counseling, treatment planning, coordination of care, psychotherapy, group therapy and Opioid Treatment Program provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Benefits are available in an Opioid Treatment Program for opioid use disorder when provided by an appropriately licensed and credentialed Opioid Treatment Program.

Add

Alternative Benefit Plan

■ 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:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☐ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Retail outpatient pharmacy benefits are administered by the Department of Human Services and not by BCBSND.

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.

Remove

Benefit Provided: Physical, Speech and Occupational Therapy

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: This benefit covers both habilitation and rehabilitation.

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

Remove

Benefit Provided: Cardiac Rehab

Source: Base Benchmark Commercial HMO

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:

Remove

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

Duration Limit: None

Alternative Benefit Plan

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:

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: fitting and necessary adjustments of Prosthetic Appliances or Limbs and supplies that replace all or part of an absent body part, standard Prosthetic Appliances and Limbs only, repairs when Medically Appropriate and Necessary (precertificaton needed),externally worn breast prostheses and surgical bras, including necessary replacements following mastectomy, subject to a Maximum Benefit Allowance of 2 external prostheses and 2 bras per Member per Benefit Period, double mastectomy, allow a Maximum Benefit Allowance of 4 external prostheses and 2 bras per Member per Benefit Period.
Not Covered: dental appliances, artificial organs or Prosthetic Appliances and Limbs intended only for cosmetic purposes. Orthotic Devices available over the counter or those required for leisure or recreational activity or to allow a Member to participate in a sport activity unless Medically Appropriate and Necessary and approved. Prosthetic Limbs or components intended only for cosmetic purposes or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Member to participate in sport activities.

Benefit Provided:

Skilled Nursing Facility

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 days per Member per Benefit Period

Duration Limit:

None

Scope Limit:

Exclusions: Maintenance Care or 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:

No benefits available over the 30 days per benefit period.

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:

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:

This benefit covers both habilitation and rehabilitation.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided:
Diagnostic Services

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
A Diagnostic Service must be ordered by a Professional Health Care Provider. Diagnostic Services include but are not limited to X-ray and other imaging services, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

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: Colorectal Cancer Screening

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:

Benefit Provided: Nutritional Counseling

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

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:

Hyperlipidemia – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
Gestational Diabetes – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
Diabetes Mellitus – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
Hypertension – Maximum Benefit Allowance of 2 visits per Member per Benefit Period.
PKU – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.

Benefit Provided: Tobacco Cessation Counseling Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Benefit Provided: Allergy Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Includes: Including serum, direct skin testing and patch testing when ordered by a Professional Health Care Provider

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

Exclusions: testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.
The following methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.
This exclusion also includes clinical ecology, orthomolecular therapy, vitamins or dietary nutritional supplements, or related testing provided on an Inpatient or Outpatient basis.

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:

Benefits include contraceptive services, sexually transmitted disease testing, follow up care, reproductive health services and sterilizations.

Alternative Benefit Plan

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

Contraceptive services include Injections for birth control purposes, Diaphragm or cervical cap, Surgical implantation and removal of a contraceptive device, Insertion and removal of an Intrauterine Device (IUD), Outpatient surgical sterilization and related services. See Inpatient and Outpatient Surgical Services, Contraceptive Prescription Medications and Drugs, Including birth control pills, patches and vaginal rings.

Remove

Benefit Provided: Diabetes Equipment, Supplies, Education

Source: Base Benchmark Commercial HMO

Authorization: Other

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:

Coverage includes: Gestational Diabetes – Maximum Benefit Allowance of 4 visits per Member per Benefit Period, Diabetes Mellitus – Maximum Benefit Allowance of 4 visits per Member per Benefit Period, Diabetes care services include Outpatient Home and Office Visits, Diagnostic Services, Outpatient Nutritional Care Services, Diabetes Education Services, Dilated Eye Examinations and Diabetes Supplies, Diabetes Prevention Program services for Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled through a Diabetes Prevention Provider. Palliative or cosmetic foot care, foot support devices (including custom made foot support devices) or subluxations of the foot, care of corns, bunions (except for capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. Benefits are available for custom diabetic shoes and inserts, and the care of corns, calluses and toenails when Medically Appropriate and Necessary for Members with diabetes

Remove

Benefit Provided: Wellness Services

Source: Base Benchmark Commercial HMO

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:

Coverage includes: Preventive Screening Services, Immunizations, Routine Diagnostic Screenings, Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening for Members age 45 and older, Prostate Cancer Screening for Members age 40 and older, Intensive Behavioral

Alternative Benefit Plan

Interventions for Obesity, Nutritional Counseling, Outpatient Nutritional Care Services
(Including Feeding and Eating Disorder, Diabetes Education Services, Diabetes Prevention Program,
Dilated Eye Examination (for diabetes related diagnosis), Tobacco Cessation Counseling Services

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: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Other

Amount Limit: N/A

Duration Limit: N/A

Scope Limit: N/A

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

ND Medicaid member ages 19-20 are enrolled in separate ABP

Add

Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Other Base Benefit Provided: Vision Services

Source: Base Benchmark

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: None

Scope Limit: Exclusions see below:

Other information regarding this benefit:

Coverage is only for Dilated Eye Examination (for diabetes related diagnosis) Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.

Exclusions: Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits are available for routine vision examinations. No benefits are available for refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses or complications resulting from refractive surgery. No benefits are available for eyeglasses or contact lenses following cataract surgery.

Add

Alternative Benefit Plan

☐ 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:

This Benefit Plan does not cover newborns or dependents. Members who become pregnant will have an opportunity to change to North Dakota's 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:

Exclusion:Room and board at a vocational residential rehabilitation center, a community reentry program, Halfway House or Group Home.

Add

Alternative Benefit Plan

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

Remove

Other 1937 Benefit Provided:
1915(i) Behavioral Health HCBS

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:
Included in coverage: Care coordination, Benefit planning services, Training and support for unpaid caregivers, Peer Support, Non-Medical Transportation, Community Transition Services, Supported Education, Pre-Vocation Training, Supported Employment, and Housing Supports

Remove

Other 1937 Benefit Provided:
Access to Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
No Authorization is required for this service.

Other:
Coverage: Routine individual costs include all items and services consistent with the coverage that is typical for a qualified individual who is not enrolled in a clinical trial. Such items include: services of a physician, diagnostic or laboratory tests, other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care. Exclusions: The investigational item, device, or service, itself; the costs of any non-health service that might be required for a person to receive the treatment or intervention (e.g., transportation, hotel, meals, and other travel expenses), costs of managing the research, or items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the individual; or costs which would not be covered under the member's contractual benefits for non-investigational treatments, service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Add

☐ 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

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.20190808

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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. No

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.

☑ 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.

Alternative Benefit Plan

☑ 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

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 - 22 - 0002 - A

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:

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

Managed Care Options

Managed Care Assurance

- [x] 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.

Alternative Benefit Plan

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

Describe program below:

The State has chosen Secretary-Approved Coverage offering an array of benefits through the combination of the North Dakota EHB-Benchmark Plan and the approved North Dakota Medicaid State Plan. In addition, Alternative Benefit Plan incorporates the Essential Health Benefits and ensures 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.

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.20181119

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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:

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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.

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

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

Transmittal Number: ND - 22 - 0002 - A

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.20160722