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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-14-0008

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700 Denver, Colorado 80202

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

Division of Medicaid & Children's Health Operations

December 29, 2014

Julie F. Schwab, Medicaid Director
North Dakota Department of Human Services
600 E. Boulevard Ave, Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota State Plan Amendment (SPA) Transmittal Number ND-14-0008

Dear Ms. Schwab:

Enclosed for your records is an approved copy of North Dakota's Alternative Benefit Plan (ABP) state plan amendment ND-14-0008. This Alternative Benefits Plan SPA, which was submitted on March 28, 2014, meets all federal statutory and regulatory requirements for establishing an ABP.

All requirements pertaining to ABPs must be met including, but not limited to; benefits, payment rates, reimbursement methodologies, cost-sharing state plan pages, and service delivery requirements. In addition, North Dakota must be mindful of submission timeframes in order to achieve effective date consistency related to the provision of benefits to eligible individuals, and in order to claim Title XIX expenditures via the quarterly CMS-64.

This ABP SPA was approved on December 23, 2014 with an effective date of January 1, 2014, as requested by the state and the approval package is enclosed.

If you have any questions concerning this state plan amendment, please contact me, or have your staff contact Ann Clemens, at 303-844-2125 or ann.clemens@cms.hhs.gov.

Sincerely,

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

cc: Maggie Anderson, ND

Enclosure

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.

14-0008

Proposed Effective Date

01/01/2014 *(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		$
Second Year		$

Subject of Amendment

This Amendment is for the Alternative Benefit Plan for the North Dakota Medicaid Expansion Population

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:	**Maggie Anderson**
Last Revision Date:	**Dec 22, 2014**
Submit Date:	**Mar 28, 2014**

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

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:

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

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

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.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

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):

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.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

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 surveys to the state. The state's medical services staff will evaluate the questionnaire for initial screening. If the responses to the questionnaire meet the initial screening criteria, the recipient will receive a letter asking them to receive additional documentation from a physician, physician assistant, or nurse practitioner of their health status and prescription medication list. Upon receipt of the documentation from the physician, physician assistant or nurse practitioner, the state will review the documentation and 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 would begin the first day of the following month.

☐ 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

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

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

Select one of the following:

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

Name of benefit package: Medicaid Expansion ABP

Selection of the Section 1937 Coverage Option

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

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

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

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ◉ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ○ Secretary-Approved Coverage.

Plan name: 2012 Sanford Health Plan HMO

Selection of Base Benchmark Plan

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

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

Other Information Related to Selection of the Section 1937 Coverage Option and the Base 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

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Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

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.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

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:

2012 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

Alternative Benefit Plan

☑ Essential Health Benefit 1: 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:
Excludes 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:
Excludes: 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

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:
Specialist Visits

Source:
Base Benchmark Commercial HMO

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Alternative Benefit Plan

Amount Limit: none

Duration Limit: none

Remove

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: 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: Excludes vitamins, 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: Prior Authorization only required if provider is out of network.

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

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Remove

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:

Alternative Benefit 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 year.

Duration Limit: none

Scope Limit: Excludes 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:

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: see Other information below

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

Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:
• Allogenic transplants for
− Multiple myeloma
• Nonmyeloablative allogenic transplants for
− Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
− Advanced forms of myelodysplastic syndromes
− Advanced Hodgkin's lymphoma
− Advanced non-Hodgkin's lymphoma
− Chronic myelogenous leukemia
• Autologous transplants for
− Chronic myelogenous leukemia
− National Transplant Program

Benefit Provided: Dental Injury

Source: Base Benchmark Commercial HMO

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
none

Duration Limit:
Care must be received within 6 months of occurence

Scope Limit:
Excludes 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; cont.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Excludes 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 vestivuloplasty; dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD). Exclusions do not apply to 19 and 20 year olds.

Benefit Provided:
Oral and maxillofacial surgery

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No Limit

Duration Limit:
None

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.
None of the exclusions apply to individuals who are 19 or 20 years of age.
Care must be received within 6 months of occurance.

Add

Alternative Benefit Plan

☑ Essential Health Benefit 2: 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: Transfers performed only for the convenience of the enrollee or the enrollee's family, cont.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: or 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. Coverage is to the nearest participating provider equipped to furnish the necessary health care services.

Benefit Provided: Emergency Room - Professional

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Alternative Benefit Plan

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:

Add

Alternative Benefit Plan

☑ Essential Health Benefit 3: 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:

Excludes 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 practitioner/provider,

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

cont. exclusions: custodial care, intermediate level of domiciliary care, residential care (except for the treatment of mental disorders or substance abuse disorders), rest cures, services to assist in the activities of daily living. Excludes: 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

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit:	Duration Limit:
none	none

Scope Limit:

Transplants must meet the United Network for Organ Sharing criteria and/or plan policy requirements and must be performed at Plan Participating Centers of Excellence.

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

Solid organ transplants are limited to: Cornea, Heart, Heart/Lung, Kidney, Kidney/Pancreas, Liver, Intestinal (small, small with the liver, small with multiple organs), Lung (single, double), Pancreas.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description.)
• Allogenic transplants for:
− Acute or chronic lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia
− Burkitt's lymphoma for adolescents and young adults
− Advanced Hodgkin's lymphoma
− Advanced non-Hodgkin's lymphoma
− Chronic myelogenous leukemia
− Severe combined immunodeficiency
− Severe or very severe aplastic anemia
• Autologous transplant for:
− Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia
− Advanced Hodgkin's lymphoma
− Advanced non-Hodgkin's lymphoma
− Advanced neuroblastoma
− Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)
• Blood or marrow stem cell transplants for:
− Allogenic transplants for
− Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)
− Advanced forms of myelodysplastic syndromes
− Sickle cell anemia
• Autologous transplants for:
− Multiple myeloma
Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors
− Breast cancer
− Epithelial ovarian cancer
− Amyloidosis
− Ependymoblastoma
− Ewing's sarcoma
− Medulloblastoma
− Pineoblastoma
Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:
• Allogenic transplants for
− Multiple myeloma
• Nonmyeloablative allogenic transplants for
− Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
− Advanced forms of myelodysplastic syndromes
− Advanced Hodgkin's lymphoma
− Advanced non-Hodgkin's lymphoma

− Chronic myelogenous leukemia
• Autologous transplants for
− Chronic myelogenous leukemia
− National Transplant Program

Remove

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

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit:

Excludes independent nursing, homemaker services.

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 coverage for these services as listed in this Section 3(a), but only where the hospice retains responsibility for the care of the Member.

Remove

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: 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

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Not covered as a result of gastric bypass surgery.

Remove

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: sex transformation/gender reassignment; cosmetic surgeries; removal, revision or re-implementation of saline or silicone implants; surgeries to correct congenital deformities unless treatment was started before age 8; prophylactic surgeries. Excludes: 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 prophylactic (preventive) mastectomy.

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:

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

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

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:

Excludes Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

Benefit Provided: Delivery and maternity services

Source: Base Benchmark Commercial HMO — Remove

Authorization: Prior Authorization

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:

Plan must be notified of expected due date when the pregnancy is confirmed. 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 and newborn.

Add

Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided: Partial Hospitalization Program /Day Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See Other Information below.

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

Coverage includes Alcohol, chemical and gambling treatment. Not Covered: confinement services (detoxification centers); detoxification services related to methadone and cyclazocine therapy; long term care in a mental health facility; convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; Autism spectrum disorder disease; learning disabilities; behavioral problems; services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; conduct disorder; custodial care; or intermediate level of domiciliary care.

Benefit Provided: Mental Health Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

hospitalization and day treatment; *telephonic consultation for an enrollee diagnosed with depression (within 12 weeks of starting antidepressent therapy (limit of 1 per enrollee for depression and 1 per enrollee for Attention Deficit Hyperactive Disorder). Limit of 1 telephone consult per year, in conjunction with other in-person services needed. Not covered: convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; Autism spectrum disorder disease; learning disabilities; behavioral problems; mental disability or mental disorder that, according to generally accepted professional standards, is not amenable to favorable modification; services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; or conduct disorder.

Alternative Benefit Plan

Benefit Provided: Outpatient hospital and physician

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: Inpatient Hospital

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Excludes services received in a Residential Treatment Facility for members ages 21 and older.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This benefit is not provided in an Institution for Mental Disease (IMD).

Benefit Provided: Inpatient Physician

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

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

Remove

Benefit Provided: Intensive Outpatient

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:

Coverage includes Alcohol, chemical and gambling treatment. Not Covered: confinement services (detoxification centers); detoxification services related to methadone and cyclazocine therapy; long term care in a mental health facility; convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; Autism spectrum disorder disease; learning disabilities; behavioral problems; services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; conduct disorder; custodial care; or intermediate level of domiciliary care.

Benefit Provided: Outpatient Professional 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: Individual Therapy

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit 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: Medication Management

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: Diagnostic Tests

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: Electroconvulsive Therapy

Source: Base Benchmark Commercial HMO

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Remove

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:
Partial Hospitalization and Day Treatment

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:

Add

Alternative Benefit Plan

☑ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ 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:

Coverage includes a formulary which contains specifics on which medications require prior authorization.
Not covered:Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature)
• Drugs not listed in the Sanford Health Plan Formulary or without Certification or a formulary exception from The Plan
• Replacement of a prescription drug due to loss, damage, or theft
• Outpatient drugs dispensed in a Provider's office or non-retail pharmacy location
• Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or anti-pigmenting of the skin
• Refills of any prescription older than one(1) year
• Compound medications with no legend (prescription) medications
• Acne medication such as Renova and Retin-A Microgel for Members over age thirty (30)
• B-12 injection (except for pernicious anemia)
• Drug Efficacy Study Implementation ("DESI") drugs
• Experimental or Investigational drugs or drug usage
• Growth hormone, except when medically indicated and approved by The Plan
• Orthomolecular therapy, including nutrients, vitamins (including but not limited to prenatal vitamins),multi-vitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life or amino acid based elemental oral formulas), nutritional and electrolyte substances
• Over-the-counter (OTC) Medications; any medication that is equivalent to an OTC medication; drugs not approved by the FDA for a particular use except as required by law (unless
Provider certifies off-label use with a letter of medical necessity)
• Weight management drugs (except when Medically Necessary to treat morbid obesity and approved by The Plan (e.g. Meridia, Xenical, diethylpropion, and phenteramine)
• Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia
• Medication used to treat infertility
• Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the
Practitioner certifies off-label use with a letter of medical necessity).
• Immunological agents (allergy shot extracts)
For the Prescription Drug Coverage Assurance in ABP7 that states: "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." This assurance only applies to covered outpatient drugs as defined in 42 CFR and subsections 1937 and 1927 of the Social Security Act, respectively.

Alternative Benefit Plan

☑ Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All ☐

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

Duration Limit: none

Scope Limit: Excludes services provided in enrollee's home for convenience, cont.

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

Cont. 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, accupressure, aquatic whirlpool therapy, chelation therapy, massage therapy, fluidotherapy, 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.
This benefit covers both habilitation and rehabilitation. Limits are cumulative for both habilitation and rehabilitation.

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:

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

Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See Other information below.

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

Requires Prior Authorization: respiratory equipment such as ventilators, pleural catheters, hand-held battery operated nebulizers, and suction pumps; gastrointestinal equipment; parenteral nutrition; muscoloskelatal equipment; integumentary supplies, wheelchairs, home IV therapy supplies and medication. Not Covered: Home Traction Units
• DME to aid in the correction of congenital anomalies over the age of five (5) years
• 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
• Communication aids or devices to create, replace or augment communication abilities including, but not limited to,
hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication
• 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

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
1 per lifetime*

Duration Limit:
None

Remove

Scope Limit:
*prosthetic limbs, sockets and supplies, and prosthetic eyes. Externally worn breast prostheses and surgical bras following a mastectomy**

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
** includes 2 external prosthesis per Calendar Year and 2 bras per CY. For double mastectomy, coverage extends to 4 external prostheses per CY and 2 bras per CY. Prior Authorization is required for cochlear implants and devices that are permanently implanted such as artificial joints, pacemakers, and surfically implanted breast implant following mastectomy.
Not covered: experimental or investigational services or devices; revision/replacement of prosthetics; replacement or repair of items (if destroyed by enrollee's misuse, abuse or carelessness, lost or stolen); duplicate or similar items; service call charges, charges for repair estimates; wigs; cranial prosthesis, or hair transplants; cleaning and polishing of prosthetic eye.

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:
Excludes custodial care, convalescent care, intermediate level or domiciliary care, residential 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

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
40 visits per year

Duration Limit:
none

Alternative Benefit Plan

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:

This benefit covers both habilitation and rehabilitation. Limits are cumulative for both habilitation and rehabilitation.

Add

Alternative Benefit Plan

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

Benefit Provided: Lab tests, x-ray services, and pathology

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: Imaging / diagnostics (MRI, CT scan, PET scan)

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: Outpatient diagnostic labs, x-ray and pathology

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Not covered: Thermograms or Thermology

Alternative Benefit Plan

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

Remove

Add

Alternative Benefit Plan

■ Essential Health Benefit 9: 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: Excludes weight loss programs. 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: 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

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
2 attempts per year

Duration Limit:
None

Remove

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 State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Excludes provocative food testing and sublingual allergy desensitization.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes testing and treatment, allergy injections, and allergy serum.

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:
Excludes genetic counseling or testing*, elective abortion services, implanon implantable contraceptive device, sterilization of dependant children, and reversal of voluntary sterilization.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Testing for the diagnosis of infertility is covered. Mirena IUD covered once every 5 years. * Excludes genetic testing except as required by the evidence-based services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

Benefit Provided:
Diabetes equipment and supplies; education

Source:
Base Benchmark Commercial HMO

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
2 comprehensive educ programs per lifetime

Duration Limit:
None

Scope Limit:
Excludes food items for medical nutritional therapy; continuous glucose monitoring system.

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, 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, 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 two (2) additional pairs of inserts, Syringes, Insulin infusion devices, 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, Routine foot care including toe nail trimming
Coverage of diabetes self-management training is limited to (1) persons newly diagnosed with diabetes, (2) persons who require a change in current therapy, (3) persons who have a co-morbid condition such as heart disease or renal failure; (4) persons whose diabetes conditions are unstable. Limit of 8 follow up visits per year.
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:
Excludes 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.

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

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

Alternative Benefit Plan

Benefit Provided:

Dialysis

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

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

Alternative Benefit Plan

☑ Essential Health Benefit 10: 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

☐ Other Covered Benefits from Base Benchmark

Collapse All ☒

Alternative Benefit Plan

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

Alternative Benefit Plan

☒ 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.

Add

Alternative Benefit Plan

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

Other 1937 Benefit Provided:

Vision Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Non-routine vision exams relating to eye disease or injury of the eye. Eyeglasses/contact 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 lens per CY

Other:

Scleral Shells: soft shells limited to 2 per calendar year; 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 treatments for prosthetic eyewear; glasses and/or contacts after cataract surgery; routine cleaning of scleral shells.

Add

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

Collapse All ☐

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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.

☑ 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.

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- ☑ 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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Attachment 3.1-C- ☐

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

Alternative Benefit Plan

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. Section 1115 expenditure authority grants authority to limit choice to one managed care plan.

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.

Additional Information: Fee-For-Service (Optional)

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

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Attachment 3.1-C- [ ]

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.

PRA Disclosure Statement

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