Table of Contents

State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-15-0002

This file contains the following documents in the order listed:

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

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

Region VIII

December 1, 2015

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

RE: North Dakota #15-0002

Dear Ms. Anderson:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 15-0002. This amendment reflects North Dakota Medicaid Expansion Alternative Benefit Plan changes effective January 1, 2015.

Please be informed that this State Plan Amendment was approved November 23, 2015. We are enclosing the Summary Report (CMS-179) and the amended plan page(s).

If you have any questions concerning this amendment, please contact Kirstin Michel at (303) 844-7036.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Divisions for Medicaid & Children's Health Operations

cc: Maggie Anderson, ND
Kathy Rodin, ND

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **North Dakota**

Transmittal Number:

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

ND-15-0002

Proposed Effective Date

01/01/2015 *(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	2015	$ 1740297.00
Second Year	2016	$ 2320396.00

Subject of Amendment

North Dakota Medicaid Expansion ABP changes effective January 1, 2015

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:	**Mar 30, 2015**
Submit Date:	**Mar 30, 2015**

Alternative Benefit Plan

Attachment 3.1-C- ☐

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

Enrollment Assurances **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

Alternative Benefit Plan

☐ 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):

Alternative Benefit Plan

Attachment 3.1-C: [ ]

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

Selection of Benchmark 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.

Alternative Benefit Plan

PRA Disclosure Statement

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

V 20130917

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-

Benefit Description ABP6

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 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 Calendar 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:
Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lie of Hospital or Skilled Nursing Facility: part-time or intermittent care by a RN or LPN/LVN; part-time or intermittent home health aide services for direct patient care only: physical, occupational, speech, inhalation, and intravenous therapies up to maximum benefit allowable; and/or medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized. One(1) home health visit constitutes four (4) hours of nursing care

Benefit Provided:
Access to Clinical Trials

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
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

Alternative Benefit Plan

Benefit Provided:
Dental Injury

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

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

Scope Limit:
Excludes routine dental care and treatment; natural teeth replacements including crowns, bridges, braces or implants; Osseointegrated 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 vestibuloplasty; 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 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, 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

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

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

Alternative Benefit Plan

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; 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.

Benefit Provided: Infertility Services

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:	Duration Limit:	
Limited to Plan Guidelines	None	Remove

Scope Limit:

Includes testing for the diagnosis of infertility.

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

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

Add

Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided: Mental Inpatient Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

Not covered: convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; Austim spectrum disorder; learning disabilities; behavioral problems; mental disability or mental disorder that, according to generally accepted professional standards, is not amenable to favorable modification services; services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; or conduct disorder. For enrollees ages 21 and older, services rendered in an IMD and room and board at a Residential Treatment Facility are not covered.

Benefit Provided: Substance Use Disorder Inpatient Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

Not covered: confinement services to hold or confine an enrollee under chemical influence when no Medically Necessary services are provided, regardless of where services are received (e.g. detoxification centers); convalescent care; marriage, family, bereavement, pastoral, financial, legal, or custodial care counseling; Austim spectrum disorder; learning disabilities; behavioral problems; mental disability or mental disorder that, according to generally accepted professional standards, is not amenable to favorable modification services; services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; or conduct disorder. For enrollees ages 21 and older, services rendered in an IMD and room and board at a Residential Treatment Facility are not covered.

Alternative Benefit Plan

Benefit Provided:
Mental Outpatient Treatment

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
partial hospitalization, and/or intensive outpatient; *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; Austim spectrum disorder; learning disabilities; behavioral problems; mental disability or mental disorder that, according to generally accepted professional standards, is not amenable to favorable modification services; services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; or conduct disorder.

Benefit Provided:
Substance Abuse Disorder Outpatient Treatment

Source:
Base Benchmark Commercial HMO

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
none

Duration Limit:
none

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
other qualified mental health and substance abuse disorder professionals; partial hospitalization; and intensive outpatient programs.
Not covered: confinement services to hold or confine an enrollee under chemical influence when no Medically Necessary services are provided, regardless of where services are received (e.g. detoxification centers); 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; Austim spectrum disorder; learning disabilities; behavioral problems; mental disability or mental disorder that, according to generally accepted professional standards, is not amenable to favorable

modification services: services related to environmental change; behavioral therapy, modification or training; milieu therapy; sensitivity training; conduct disorder; or custodial, intermediate, or domiciliary care.	Remove
	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, aquatic whirlpool therapy, chelation therapy, massage therapy, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), therapeutic touch, lifestyle improvement services, such as physical fitness programs, or health or weight loss clubs or clinics, educational programs, vocational and job rehabilitation, recreational therapy, traction services, and special education including sign language lessons to instruct a member.
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: None

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

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Commercial HMO

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
- 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 for enrollees 21 and older, 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

Amount Limit:

1 per Lifetime*

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

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

Remove

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, 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

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:

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

Remove

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: None
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

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: once every five (5) years; and/or generic oral contraceptives, other contraceptives including injectable medroxyprogesterone acetate, and emergency contraception with generic Plan B are covered at 100% (no cost). Voluntary sterilizations are covered and include: medical - occlusion of the fallopian tubes by use of permanent implants (e.g. Essure) and/or surgical - tubal ligation or vasectomies. Tubal ligation covered at 100% of allowed only when performed as the primary procedure and if performed as part of a maternity delivery or for any other medical reason it will be covered as a medical benefit with the applicable cost-

Alternative Benefit Plan

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

Remove

Benefit Provided:
Diabetes Equipment and Supplies; Education

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Excludes food items for medical nutritional therapy; 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 - prior authorization required, 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. No more than two (2) comprehensive education programs per lifetime and up to eight (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

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

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.

Remove

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.

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.

Benefit Provided:

Preventive Services

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

The following preventive services, as defined in the Affordable Care Act, received from an in-network provider are covered at no charge: evidenced based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; immunizations for routine use that have in effect a recommendations from the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member involved; with respect to covered persons who are age 19 and 20 - evidence informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and EPSDT; and with respect to covered persons who are women, such additional

preventive care and screening not described above are provided for in comprehensive guidelines supported by the Health Resources and Services Administration .

Remove

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 ☒

Other Base Benefit Provided:	Source:	
Vision Services (Refer to Attachment B)	Base Benchmark	Remove

Add

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.

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

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
For those members 21 and older, coverage at a Residential Treatment Facility does not include room and board.

Add

Alternative Benefit Plan

☐ Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Alternative Benefit Plan

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

PRA Disclosure Statement

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

V.20130917

☒ **Other Covered Benefits from Base Benchmark**

Other Base Benefit Provided:	**Source:**
Vision Services	Base Benchmark

Authorization:	Provider Qualifications:
None	Medicaid State Plan

Amount Limit:	Duration Limit:
None	None

Scope Limit:

Non-routine vision exams relating to eye disease or injury to the eye.
Eyeglasses/contacts lenses with diagnosis of aphakia.
Eyeglasses, including one frame per lifetime up to $200 or clear contact lenses for the aphakia eye for 2 single lenses per CY.
Scleral Shells: soft shells limited to 2 per calendar year; hard shells limited to 1 per lifetime.

Other:

Not covered: routine vision exams, refractive errors of the eye; purchase, examinations, or fitting of eyeglasses or contact lenses; radial keratotomy, myopic keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; replacement of lost, stolen, broken, or damaged lenses or glasses, bifocal contact lenses, special lens coating or lens treatment for prosthetic eyewear; glasses and/or contacts after cataract surgery; routine cleaning of scleral shells.

Alternative Benefit Plan

Attachment 3.1-C- [ ]

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

Service Delivery System **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):

V.20130917