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State/Territory Name North Dakota

State Plan Amendment (SPA) #: 25-0017

This file contains the following documents in the order listed:

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

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

Medicaid and CHIP Operations Group

October 6, 2025

Sarah Aker
Executive Director
Medical Services Division
ND Department of Health and Human Services
600 East Boulevard Avenue, Dept. 325
Bismark, ND 58505

Re: North Dakota State Plan Amendment (SPA) – 25-0017

Dear Director Aker:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0017. This amendment makes changes to the North Dakota Medicaid Expansion Alternative Benefits Plan (ABP) to align with the 19–20-year-old ABP. This SPA is a technical change to add to the Other Licensed Providers section.

We conducted our review of your submittal according to statutory requirements in 1902(a)(10)(A)(i)(VIII) of the Act. This letter informs you that North Dakota Medicaid SPA TN 25-0017 was approved on October 3, 2025, with an effective date of July 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the North Dakota State Plan.

If you have any questions, please contact Tyson Christensen at (816) 426-6440 or via email at Tyson.Christensen@cms.hhs.gov.

Sincerely,

Nicole McKnight
On Behalf of Courtney Miller, MCOG Director

Enclosures

cc: LeeAnn Thiel

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **North Dakota**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

TN-25-0017

Proposed Effective Date

07/01/2025 *(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~~	*2025	$ 1740297.00
Second Year	~~2016~~	*2026	$ 2320396.00

Subject of Amendment

North Dakota Medicaid Expansion ABP changes effective 7/1/2025 to align with the 19-20 YO ABP

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

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

Signature of State Agency Official

Submitted By:	**Krista Fremming**
Last Revision Date:	**Jul 17, 2025**
Submit Date:	**Jul 17, 2025**

*Pen and Ink change approved by state on 10/01/25

Alternative Benefit Plan

State Name: North Dakota

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 25 - 0017

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

BlueCare Gold 90 500

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

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

Alternative Benefit Plan

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

Benefit Provided: Outpatient Hospital Surgical Center
Source: Base Benchmark Commercial HMO
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Exclusions include: surgical procedures that can be done in Practitioner's office (i.e. vasectomy, toe nail removal) and complications from a non-covered procedure or service.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Primary Care to Treat Illness/Injury
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Exclusions Include: Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management; and complications from a non-covered procedure or service.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Special Visits
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None

Scope Limit:

None

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

Benefit Provided:

Chiropractic

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits per Benefit Period

Duration Limit:

None

Scope Limit:

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

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

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

Benefit Provided:

Chemotherapy Service

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Anesthesia by Local Infiltration

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Urgent Care Services

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Exclusion: No out of network coverage.

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

Coverage: medical care provided for a condition that, without timely treatment, could be expected to deteriorate into an emergency, or case prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require Urgent Care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent Care requires timely face-to-face medical attention within twenty-four (24) hours of Enrollee notification of the existence of an urgent condition.

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: None

Duration Limit: None

Scope Limit:

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

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

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

Benefit Provided: Dental Injury

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

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

Scope Limit:

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

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

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

Benefit Provided: Dialysis

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:
Other Licensed Practitioner - OLP

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Yes

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:

Attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d
• Psychologists
• Certified Registered Nurse Anesthetist
• Nurse Practitioners who meet North Dakota's advanced educational and clinic practice requirements and who are certified in specialties in addition to family and pediatric nurse practitioner services.
• Clinical Social worker
• Registered Pharmacist
• Physician Assistants and Clinical Nurse Specialists
• Marriage and Family Therapists and Licensed Professional Clinical Counselors
• Professional Counselor

Benefit Provided:

Source:

Remove

Authorization:
None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Alternative Benefit Plan

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

Add

Alternative Benefit Plan

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

Benefit Provided: Emergency Room - Facility
Source: Base Benchmark Commercial HMO
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Ambulance Transportation Services
Source: Base Benchmark Commercial HMO
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Coverage is to the nearest provider equipped to furnish the necessary health care services.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Not Covered: Services and/or travel expenses relating to a non-emergency medical condition; and complications from a non-covered procedure or service.

Benefit Provided: Emergency Room - Professional
Source: Base Benchmark Commercial HMO
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit:

Alternative Benefit Plan

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

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Medical and Surgical care
Source: Base Benchmark Commercial HMO
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Exclusions: Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitaria care.

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

Benefit Provided: Bariatric Surgery
Source: Base Benchmark Commercial HMO
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: Once per Lifetime
Duration Limit: None
Scope Limit: None

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

Benefit Provided: Organ and Tissue Transplants
Source: Base Benchmark Commercial HMO
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Excludes: donor organs or tissue other than human donor organs or tissue.

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

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Continued: Health Care Provider other than the operating surgeon or the assistant surgeon.

Benefit Provided: Hospice

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

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

Benefit Provided: Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

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

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

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

Add

Alternative Benefit Plan

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

Benefit Provided: Delivery and Maternity Services
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: 2 ultrasounds per pregnancy
Duration Limit: None
Scope Limit: Covers prenatal through postnatal maternity care and delivery and care for complications of pregnancy of the mother.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Benefits for Inpatient maternity services allow a minimum stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The Health Care Provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

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 2 routine ultrasounds per pregnancy to determine fetal age, size and development are allowed.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Source:
Remove

Authorization: Yes
Provider Qualifications:
Amount Limit:
Duration Limit:

Alternative Benefit Plan

Scope Limit:

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

Add

Collapse All ☐

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

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

Remove

Benefit Provided: Mental Health Inpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

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

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

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

Remove

Benefit Provided: Substance Use Disorder Inpatient treatment

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Remove

Benefit Provided: Mental Health Outpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Covered: Home and Office Visits: Benefits Including assessment, counseling, Behavioral Modification Intervention for Autism Spectrum Disorder (Including Applied Behavioral Analysis (ABA)), treatment planning, coordination of care, psychotherapy and group therapy provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

Benefit Provided:
Substance Abuse Disorder Outpatient Treatment

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Covered: Home and Office Visits: Benefits Including assessment, counseling, treatment planning, coordination of care, psychotherapy, group therapy and Opioid Treatment Program provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Benefits are available in an Opioid Treatment Program for opioid use disorder when provided by an appropriately licensed and credentialed Opioid Treatment Program.

Add

■ 6. Essential Health Benefit: Prescription drugs

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

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☐ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

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

Alternative Benefit Plan

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

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

Benefit Provided: Physical, Speech and Occupational Therapy
Source: Base Benchmark Commercial HMO
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: This benefit covers both habilitation and rehabilitation.

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

Benefit Provided: Cardiac Rehab
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: Durable Medical Equipment
Source: Base Benchmark Commercial HMO
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: Limited to Plan Guidelines
Duration Limit: None

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

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

Benefit Provided:
Prosthetics and Orthotics

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limited to Plan Guidelines

Duration Limit:
None

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

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

Benefit Provided:
Skilled Nursing Facility

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Yes

Provider Qualifications:
Medicaid State Plan

Amount Limit:
30 days per Member per Benefit Period

Duration Limit:
None

Scope Limit:
Exclusions: Maintenance Care or Custodial Care

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
No benefits available over the 30 days per benefit period.

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

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This benefit covers both habilitation and rehabilitation.

Benefit Provided:

Source:

Remove

Authorization:
Prior Authorization

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

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

Benefit Provided: Diagnostic Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

Duration Limit: None

Scope Limit: Prior authorization and/or limitations may apply to certain items per the Plan guidelines

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

A Diagnostic Service must be ordered by a Professional Health Care Provider. Diagnostic Services include but are not limited to X-ray and other imaging services, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

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

Benefit Provided: Colorectal Cancer Screening

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Benefit Provided: Nutritional Counseling

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Limited to Plan Guidelines

Duration Limit: None

Scope Limit:

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

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

Benefit Provided: Tobacco Cessation Counseling Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Benefit Provided: Allergy Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

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

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

Benefit Provided: Family Planning

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

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

Contraceptive services include Injections for birth control purposes, Diaphragm or cervical cap, Surgical

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

Remove

Benefit Provided: Diabetes Equipment, Supplies, Education

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

Remove

Benefit Provided: Wellness Services

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Coverage includes: Preventive Screening Services, Immunizations, Routine Diagnostic Screenings, Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening for Members age 45 and older, Prostate Cancer Screening for Members age 40 and older, Intensive Behavioral Interventions for Obesity, Nutritional Counseling, Outpatient Nutritional Care Services (Including Feeding and Eating Disorder, Diabetes Education Services, Diabetes Prevention Program, Dilated Eye Examination (for diabetes related diagnosis), Tobacco Cessation Counseling Services

Alternative Benefit Plan

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Other

Amount Limit: N/A

Duration Limit: N/A

Scope Limit: N/A

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

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

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source:

Remove

Authorization: Yes

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Add

Alternative Benefit Plan

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

Other Base Benefit Provided: Vision Services

Source: Base Benchmark

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: None

Scope Limit: Exclusions see below:

Other information regarding this benefit:

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

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

Add

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

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

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

Source: Base Benchmark

Remove

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

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

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

Source: Base Benchmark

Remove

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

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

Add

Alternative Benefit Plan

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

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Services must be determined medically necessary by the state.
The service are limited to individuals with a behavioral health diagnosis along with a completed WHODAS assessment reviewed and approved by the state.

Other 1937 Benefit Provided:
Access to Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
No Authorization is required for this service.

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

Other 1937 Benefit Provided:
Other Licensed Practioners - OLP

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d
• Licensed Registered Nurse
• Licensed School Psychologist

Add

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

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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