


**Letter of Direction #29**

**Date:** March 2, 2020

**To:** Centennial Care 2.0 Managed Care Organizations

**From:** Nicole Comeaux, Director, Medical Assistance Division 

**Subject:** Corrections to Adult/Alternative Benefit Plan (ABP) in CC 2.0 A1

**Title:** ABP corrections

**Purpose**

The purpose of this Letter of Direction (LOD) is to correct and clarify sections from the Amended and Restated Medicaid Managed Care Services Agreement aka the Centennial Care 2.0 MCO contract (CC 2.0 A1).

**Alternative Benefit Plan incorrectly listed as Adult Benefit Plan**

The Alternative Benefit Plan was incorrectly referenced as the “Adult Benefit Plan” in the A1 version of the Amended and Restated Medicaid Managed Care Services Agreement (CC 2.0 A1).

Additionally, this LOD makes corrections to Attachment #5 (ABP Covered Benefits) which were omitted in the CC 2.0 A1. Please see Attachment #1 of this LOD, which shows the changes made to Attachment #5 of the contract.

**This LOD will sunset upon inclusion in the Medicaid Managed Care Services Agreement.**

LOD Attachment #1- Medicaid Managed Care Services Agreement Attachment #5 (ABP Covered Benefits)

## Attachment 5: Alternative Benefit Plan Covered Services

Alternative Benefit Plan Services Included Under Centennial Care
Allergy testing and injections
Annual physical exam and consultation <sup>1</sup>
Applied Behavioral Analysis
Bariatric surgery <sup>2</sup>
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiovascular rehabilitation <sup>3</sup>
Chemotherapy
Chronic Care Management services
Dental services <sup>4</sup>
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education
Dialysis
Diagnostic imaging
Disease management
Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement <sup>5</sup>
Electroconvulsive therapy
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19-20
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
Family planning and reproductive health services and devices, sterilization, pregnancy termination, contraceptives, and insertion and/or removal of contraceptive devices <sup>6</sup>
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
Genetic evaluation and testing <sup>7</sup>
Habilitative and rehabilitative services, including physical, speech and occupational therapy <sup>8</sup>
Hearing screening as part of a routine health exam <sup>9</sup>

<sup>1</sup> Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.

<sup>2</sup> Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight BMI and health status.

<sup>3</sup> Limited to short-term therapy (two consecutive months) per cardiac event.

<sup>4</sup> The ABP covers dental services for adults in accordance with 8.310.2 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.

<sup>5</sup> Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.

<sup>6</sup> Sterilization reversal is not covered. Infertility treatment is not covered.

<sup>7</sup> Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.

<sup>8</sup> Limited to short-term therapy (two consecutive months) per condition.

<sup>9</sup> Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20. The ABP does not cover audiology services.



## Alternative Benefit Plan Services Included Under Centennial Care

Holter monitors and cardiac event monitors
Home health care, skilled nursing and intravenous services <sup>10</sup>
Hospice care services
Immunizations <sup>11</sup>
Inpatient physical and behavioral health hospital/medical services and surgical care <sup>12</sup>
Inpatient rehabilitative services/facilities <sup>13</sup>
Internal prosthetics
IV infusions
Lab tests, x-ray services and pathology
Maternity care, including delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care
Medication assisted therapy for opioid addiction
Non-emergency transportation when necessary to secure covered medical services
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
Organ and tissue transplants <sup>14</sup>
Osteoporosis diagnosis, treatment and management
Outpatient surgery
Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions <sup>15</sup>
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings <sup>16</sup>
Physician visits
Podiatry and routine foot care <sup>17</sup>
Prescription medicines
Primary Care to treat illness/injury and chronic disease management
Pulmonary therapy <sup>18</sup>
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing <sup>19</sup>

<sup>10</sup> Home health care is limited to 100 visits per-year. A visit cannot exceed four hours.

<sup>11</sup> Includes ACIP-recommended vaccines.

<sup>12</sup> Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.

<sup>13</sup> Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.

<sup>14</sup> Transplants are limited to two per lifetime.

<sup>15</sup> Other over-the-counter items may be considered for coverage only when the items are considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.

<sup>16</sup> Includes US Preventive Services Task Force “A” and “B” recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.

<sup>17</sup> Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

<sup>18</sup> Limited to short-term therapy (two consecutive months) per condition.

<sup>19</sup> Subject to the 100-visit home health limit when provided through a home health agency.

## Alternative Benefit Plan Services Included Under Centennial Care

Sleep studies<sup>20</sup>

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Specialist visits

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Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)<sup>21</sup>

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Telemedicine services

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Tobacco Cessation treatment and services may include diagnosis, counseling, prescription medications and products.

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Transitional Care Management services

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Urgent care services/facilities

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Vision care for eye injury or disease<sup>22</sup>

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Vision hardware (eyeglasses or contact lenses)<sup>23</sup>

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<sup>20</sup> Limited to diagnostic sleep studies performed by certified providers/facilities.

<sup>21</sup> The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and respite Services.

<sup>22</sup> Refraction for visual acuity and routine vision care are not covered, except for recipients age 19-20.

<sup>23</sup> Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware and routine vision care are covered for recipients age 19-20 following a periodicity schedule.