State of New Mexico
Medical Assistance Program Manual

Supplement

HUMAN SERVICES DEPARTMENT

DATE: February 18, 2014 **NUMBER: 14-02**

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS: NEW MEXICO ALTERNATIVE BENEFIT PLAN RECIPIENTS
I. BACKGROUND
II. DENTAL, MEDICAL, PROFESSIONAL AND HOSPITAL SERVICES IN THE ABP
III. LONG TERM CARE BENEFITS AND COMMUNITY BENEFITS
IV. DISPOSABLE MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND MEDICAL FOODS
V. PHARMACY ITEMS
VI. PREVENTATIVE SERVICES
VII. COST SHARING - COPAYMENTS
VIII. ABP EXEMPT RECIPIENTS

I. BACKGROUND

Provisions in the federal Patient Protection & Affordable Care Act (PPACA), effective January 1, 2014, created a new group of eligible individuals that are covered for many Medicaid services. These recipients have been referred to as the "Other Adult Group" or the "Expansion Population".

Because their benefits under Medicaid are a little different from the standard Medicaid covered services, to distinguish them from other Medicaid recipients, this particular Medicaid program is known as the ***Alternative Benefit Plan (ABP)*** and the recipients are commonly known as ***"Alternative Benefit Plan recipients" or just "ABP recipients".***

Information Regarding ABP Recipients

1. Each category of Medicaid eligible recipients has a numeric code associated with it. The category for these Alternative Benefit Plan recipients is "100".

   Most ABP recipient will be in managed care programs. A Native American who is an ABP recipient remains in the Medicaid fee-for-service program unless he chooses to be enrolled in managed care or chooses to access services that are available only under the managed care the program.

2. Note that there is also a new group called the ***Alternative Benefit Plan Exempt (ABP-Exempt) Recipients*** whose benefits are the same as standard Medicaid recipients. Their benefits will be discussed later in this notice.

3. In order to qualify for this category, ABP and ABP-Exempt recipients must be aged 19 through 64. Therefore, the benefits presented below are designed for that age group.

   It is very important to note that since recipients aged 19 and 20 can be ABP recipients, ABP recipient at these ages are also entitled to the enhanced benefits for children under the Early, Periodic Screening Diagnosis and Treatment program, known as EPSDT including the EPSDT periodic screenings known as the "Tot-to-Teen health check."

   However, when checking recipient eligibility on the web portal, be certain to pay attention to the Benefit Description. If the Benefit Description says COE 100 and "Full Medicaid Benefits", the recipient is an ABP-Exempt recipient and receives standard Medicaid benefits, not the limited or enhanced services described in this supplement.

ABP Recipient (an ABP - Non-Exempt individual) as it appears on the web portal

COE CODE	BENEFIT DESCRIPTION	BEGIN DATE	END DATE	COE ADD DATE	CO PAY
100	**Alternative Benefit Package Limitations on Some Services**	01/01/2014	12/31/9999	12/09/2013	

ABP Exempt Recipient (Standard Medicaid Services) as it appears on the web portal

COE CODE	BENEFIT DESCRIPTION	BEGIN DATE	END DATE	COE ADD DATE	CO PAY
100	**ABP-Exempt Full Medicaid Benefits** (or just Full Medicaid Benefits)	01/01/2014	12/31/9999	12/09/2013	

4. Also, for the Fee For Service Medicaid program, the prior authorization requirements for services under the ABP are the same as for the standard full benefit Medicaid recipients.

II. DENTAL, MEDICAL, PROFESSIONAL AND HOSPITAL SERVICES IN THE ABP

Most services for ABP recipients are the same as for other full Medicaid recipients including:

- Physician and most practitioner services and visits, including anesthesia, cancer trials, chemotherapy, contraceptives, deliveries, diabetes treatment including diabetic shoes, dialysis family planning, immunizations, maternity services, midwife services, pre- and post-natal care, ob-gyn services, podiatry, pregnancy termination, reproductive health services, surgeries and reconstructive surgeries, and sterilizations; all covered to the same extent as for full standard benefit Medicaid eligible recipients.

- Lab including diagnostic testing, and colorectal cancer screenings, pap smears, PSA tests, and other age appropriate tests, genetic specific molecular lab tests such as BRCA 1 and BRCA 2 and similar tests used to determine appropriate treatment (not including random genetic screening); all covered to the same extent as covered for full standard benefit Medicaid eligible recipients.

- Radiology including diagnostic imaging and radiation therapy, including mammography and other age appropriate imagining; all to the same extent as covered for full standard benefit Medicaid eligible recipients.

- Most behavioral health services for ABP recipients are the same as for other full Medicaid recipients:

  Behavioral health and substance abuse services are available to the same extent as for standard Medicaid recipients, including evaluations, assessments, and therapies including all the various forms of therapy such as comprehensive community support services (CCSS), intensive outpatient (IOP), assertive community treatment (ACT), and psychosocial rehabilitation (PSR); all are covered to the same extent as covered for full standard benefit Medicaid eligible recipients.

  Medication assisted treatment (substance abuse treatment including methadone programs, naloxone, and suboxone) is covered to the same extent as covered for full standard benefit Medicaid eligible recipients.

  Note that the specialized services Family Support, Recovery Services, and Respite Services are not a benefit for an ABP recipient.

  Electroconvulsive therapy is a benefit under ABP even though it is not a benefit for traditional full benefit Medicaid fee for service recipients.

  Autism Spectrum Disorder services are being extended up through age 20 as an EPSDT benefit. However, in order to be comparable to commercial plans, the ABP plan also includes ages 21 and 22 for this benefit.

- Dental services are covered to the same extent as for traditional full benefit Medicaid eligible recipients.

  Note that an ABP recipient age 19 or 20 is entitled to the same services and frequency of services as for an EPSDT recipient including an oral exam every six months and orthodontia when medically necessary.

- Telemedicine is covered for ABP recipients to the same extent as for standard full benefit Medicaid recipients.

Services Limited or Not Covered for APB recipients (these to not apply to ABP exempt recipients, see below)

- Bariatric Surgery is limited to 1 per lifetime.

- Cardiac Rehab is limited to 36 hours per cardiac event. Services are covered under EPSDT if medically necessary without limits on hours.

- Chiropractic services are not covered, except under EPSDT when medically necessary.

- Eye Services, vision exams and glasses:
  Vision exams and glasses are NOT a benefit for an ABP recipient unless the recipient is age 19 or 20 in which case the benefit is covered as per EPSDT rules.

  For adults, vision screening is only covered to the extent that it is part of an overall routine physical exam.

  Eye exams and treatment related to eye diseases (includes testing) are a benefit, but the refraction component is not a benefit.

  Ophthalmologists and optometrists may perform routine eye exams and treat eye conditions but cannot bill for refraction, prescribing glasses, nor, along with opticians, they cannot bill for glasses, contact lenses, or other vision appliances.

  An exception is made for services and appliances following cornea surgeries. Lenses and glasses for aphakia are covered for ABP recipients.

- Hearing testing and hearing aids:
  Hearing testing and hearing aids are NOT a benefit for an ABP recipient unless the recipient is age 19 or 20 in which case the benefit is covered as per EPSDT rules.

  For adults, hearing screening is only covered to the extent that it is part of an overall routine physical health exam and, therefore, is not covered when provided by an audiologist or hearing aid dealer.

- Home health agency services are limited to 100 visits annually and a visit cannot exceed 4 hours. This benefit is covered under EPSDT without limitations on the number or length of visits or services if they are medically necessary.

- Hospice is covered for ABP recipients. If the ABP recipient in hospice requires nursing facility (NF) level of care, the recipient will have to meet the requirements for receiving NF care as described under Long Term Care Benefits, Community Benefits, and *Alternatives to Long Term Care,* below.

- Hospital Services:
  Hospital inpatient, outpatient, urgent care, emergency department, outpatient free-standing psych hospitals, inpatient units in acute care hospitals for rehabilitation or

psychiatric, and rehabilitation specialty hospitals are covered to the same extent as for traditional full Medicaid eligible recipients.

Note that for the Fee-for-Service Medicaid program free-standing psych hospitals are only covered for children up through age 20. Managed care organizations cover free-standing psych hospitals for adults also when medically necessary.

Inpatient drug rehab services are not an ABP benefit. Acute inpatient services for "detox" are an ABP covered benefit.

Extended care hospitals (long term care hospitals certified as acute care hospitals but focus on care for more than 25 days) are not covered.

- Pulmonary rehab is limited to 36 visits per year for adults, but is covered under EPSDT without the limitation on the number of visits.

- Rehabilitation and habilitation for short-term physical, occupational, and speech therapies are covered.

  Short-term therapies are services that produce and demonstrate significant improvement within a two-month period from the initial date of treatment. Short-term therapy beyond the initial 2 months may be extended for one period of up to two additional months dependent on the approval of the medical director or utilization review contractor, and only if such services can be expected to result in continued significant improvement of the member's physical conditions within the extended period.

  Other than the above one-time extension, therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered.

- Sleep studies are not covered; however are covered under EPSDT.

- Tobacco cessation counseling is limited for standard full benefit Medicaid recipients to recipients under age 21 and for pregnant women. However, for ABP recipients additional interventions can be covered. An MCO must cover tobacco cessation counseling beyond the Medicaid fee for service coverage and so does not limit tobacco cessation programs for adults to just pregnant women.

- Transplants are limited to 2-lifetime. This benefit is covered under EPSDT for recipients age 19 or 20 without the lifetime limit.

- Transportation (emergency and non-emergency) including air and ground ambulance, taxi and handivans is covered.

III. LONG TERM CARE BENEFITS AND COMMUNITY BENEFITS

- Community Benefits and nursing facility stays are not covered for an ABP recipient, either in the Medicaid fee-for-service program or the Medicaid managed care programs.

  However, if an ABP recipient becomes an ABP-Exempt recipient, as described below, and is enrolled in a Medicaid managed care organization, the ABP exempt recipient can access these services when all of the requirements to receive these services are met.

  A Medicaid managed care organization can cover a nursing facility as a temporary step down level of care following discharge from a hospital prior to being discharged to home when the alternative would be for the ABP-exempt recipient to remain in the hospital.

IV. DISPOSABLE MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, & MEDICAL FOODS

- Disposable medical supplies for use at home by a recipient such as medically diapers, under pads, gauzes, gloves, dressings, and colostomy supplies are NOT covered.

  Coverage of disposable medical supplies is limited to diabetic supplies (reagents, test strips, needles, test tapes, alcohol swabs, etc.)

  For ABP recipients ages 19 and 20 other disposable medical supplies are covered to the same extent as for an EPSDT recipient aged 19 and 20 year under EPSDT rules.

- Orthotics and prosthetics; all to the same extent as covered for full standard benefit Medicaid eligible recipients. (Note that foot orthotics including shoes and arch supports are only covered in the Medicaid program when they are an integral part of a leg brace, or are diabetic shoes)

- Supplies necessary to utilize oxygen or DME such as administer oxygen, use nebulizer, clean tracheas for ventilator use, or assist in treatments such as casts or splints are covered.

- Supplies used on an inpatient basis, applied as part of a treatment in a practitioner's office, outpatient hospital, residential facilities, as a home health service, etc are covered though often these items are not paid separately in addition to the payment for the overall service. When separate payment is allowed in these settings, the items are considered covered.

- Medical foods for errors of inborn metabolism or as a substitute for other food for weight gain, weight loss, or specialized diets for use at home by a recipient are NOT a benefit for an ABP recipient. However, they are covered for ABP recipients ages 19 and 20 using

the same coverage provisions as for children under EPSDT in the standard Medicaid program.

V. PHARMACY ITEMS

- Prescription drug items are a benefit of the ABP but are subject to all restrictions and limitations such as preferred drug lists and use of generic items.

- Over the counter items (that is, items that don't require a prescription) have limited coverage. Coverage is limited to prenatal drug items (examples are vitamins, folic acid, and iron), low dose aspirin as preventative for cardiac conditions; contraceptive drugs and devices, and items for treating diabetes. When an over the counter item is therapeutically preferred to available at a lower cost than a prescription drug, coverage may also extended to include the over the counter item.

  OTC items are covered for ABP recipients age 19 and 20 to the same extent as for standard full benefit Medicaid recipients.

VI. PREVENTIVE SERVICES

Because the ABP is based on a commercial insurance model, the ABP has preventative services that are not in the standard Medicaid benefit package.

- One of the most significant benefits in the ABP that is not found in the standard Medicaid benefit package is that an adult recipient can have annual physicals including screenings as preventive health care.

  Preventive care services, typical of what is found in a commercial insurance plan, are covered for ABP recipients. Typically, this includes annual exams with all the screening components appropriate for the age, condition, and history of the recipient as recommended by various physician specialty associations and academies.

  In addition to the more routine age appropriate screenings, the following should be considered:

  Alcohol misuse screening and counseling: The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

  Breastfeeding counseling The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. This may occur during the routine prenatal care and postpartum care and possibly assessment for any issues by the pediatrician treating the newborn.

Depression screening: The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.

Falls prevention in older adults - exercise or physical therapy: The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. This may include detection of an issue during routine annual preventive care exams, and referring as necessary. The referrals might be to community programs, home use of TV and DVD programs. The ABP plan does not include payment for the exercise.

Healthy diet counseling: The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists.

Intimate partner violence screening: women of childbearing age: The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

Obesity screening and counseling: The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multi-component behavioral interventions.

VII. COST SHARING - COPAYMENTS

Some ABP eligible recipients will have to pay small co-pays for certain services, depending on their income.

Since copayments for ABP receipts are only applicable for ABP recipients who are at 101% or above the federal poverty level. The eligibility on the web portal indicates if copayments are applicable in the "COPAY" box.

COE CODE	BENEFIT DESCRIPTION	BEGIN DATE	END DATE	COE ADD DATE	CO PAY
100	**Alternative Benefit Package Limitations on Some Services**	01/01/2014	12/31/9999	12/09/2013	(find copayment information in this block)

The amounts and rules for the copayments are as follows:
PHARMACY COPAYMENT: $3 per drug item Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items and for psychotropic drug items.

PRACTITIONER SERVICES COPAYMENTS: $8 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session. This copayment applies in places of service such as offices, outpatient hospitals (other than emergency rooms), clinics, and urgent care centers. It is applied to the professional service, not to any facility charge. These practitioner services copayments do not apply to emergency room facility or emergency room professional charges because of the exemption for emergency services.

HOSPITAL COPAYMENTS: $ 25 inpatient admission - A copayment is not applied when the hospital is receiving the recipient as a transfer from another hospital or when the recipient is admitted through the emergency room.
When the copayment is applied to an inpatient service, the copayment is always applied to the hospital charge, not the professional charge.

EXEMPTIONS for ABP copayments:

1. Native Americans (race code 3).
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code.
3. Emergency services.
4. Family planning services, drugs, procedures, supplies, and devices
5. Hospice patients.
6. Medicare Cross Over claims including claims from Medicare Advantage Plans
7. Pregnant women - all services unless MAD gets approval from CMS to exempt some services as not pregnancy related; so currently all services for pregnant women are exempt.
8. Prenatal & postpartum care and deliveries, and prenatal drug items
9. Mental health (behavioral health) and substance abuse services, including psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.)
10. All preventive services.
11. Provider preventable conditions.
12. When the maximum family out of pocket expense has been reached.

There can also be copayments on unnecessary services:

UNNECESSARY USE OF A BRAND NAME DRUG - COPAYMENT: $8 per brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.
Psychotropic drug items are exempt from the brand name copayment (only the regular copayment applies). Native Americans and claims from IHS and tribal facilities are also exempt from this copayment.

UNNECESSARY USE OF THE ER - COPAYMENT: $8 per visit of non emergent use of the ER Applies to the hospital and not to the professional practitioner services in the ER.
Native Americans and claims from IHS and tribal facilities are also exempt from this copayment.

A complete description of ABP co-payments, as well as all other copayments in the Medicaid program and their application can be found at:
http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/Information%20for%20Recipients/Cost%20Sharing%20Chart/Cost%20Sharing%20Chart.pdf

VII. ABP EXEMPT RECIPIENTS

An ABP Exempt recipient has the standard full Medicaid benefit coverage rather than the ABP coverage.

The ABP-Exempt recipient is an ABP individual who has a physical health or mental health disability or other condition that qualifies the recipient as medically frail. When an ABP recipient's condition is evaluated and it is determined they meet the qualifying conditions, they may choose to become an "ABP Exempt" recipient.

The benefit package of an "ABP Exempt" recipient changes from the standard ABP recipient to that of the "standard" Medicaid full benefit recipient. That is, the ABP benefit package ends, and the ABP Exempt recipient then has access to the same benefits as a full standard Medicaid recipient.

Once the recipient becomes a ABP Exempt recipient, he is NOT subject to any of the service limits associated with ABP. They do not retain any of the additional services that are found only in the ABP (primarily preventive services.). If the ABP Exempt recipient is enrolled in an MCO, the MCO extends the same benefits and managed care services to the ABP Exempt recipient that are provided to the full benefit Medicaid recipient.

The term "ABP recipient" always means an ABP recipient who is NOT ABP exempt. If the recipient is exempt, and therefore eligible for the standard Medicaid full benefit services, the recipient is always referred to as an "ABP Exempt recipient".

Because the benefits of an ABP- Exempt recipient become the same as any other standard full benefit Medicaid recipient, we do not list his benefits in this chart.

ABP or with ABP Exempt eligibility will appear on the recipients eligibility record on the New Mexico Medicaid Web Portal. Providers may also check eligibility through the Automated Voice Response System (AVRS) at 800-820-6901.

If you have questions regarding the above information, you may contact the MAD Program Policy and Integrity Bureau at (505) 827-3129 to be referred to the appropriate individual.

We appreciate your participation in MAD's programs.