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State/Territory Name: New Mexico

State Plan Amendment (SPA) #: 22-0010

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

June 13, 2022

Ms. Nicole Comeaux
Director
Medical Assistance Division
New Mexico Human Services Department
2025 South Pacheco Drive
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Re: New Mexico State Plan Amendment (SPA) 22-0010

Dear Ms. Comeaux:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0010. This SPA adds coverage of routine patient costs associated with participation in qualifying clinical trials to the state's Alternative Benefit Plan (ABP).

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 1905(a)(30) and 1905(gg) of the Social Security Act (SSA). This letter is to inform you that New Mexico Medicaid SPA 22-0010 was approved on June 13, 2022, with an effective date of January 1, 2022.

If you have any questions, please contact Peter Banks at (415) 744-3782 or via email at Peter.Banks@cms.hhs.gov.

Sincerely,

Digitally signed by
James G. Scott -S
Date: 2022.06.13
15:40:11 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Valerie Tapia
Julie Lovato
Donna Lopez

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **New Mexico**

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.

NM-22-0010

Proposed Effective Date

01/01/2022 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1905(a)(30) and 1905(gg) of the Social Security Act (SSA)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2022	$ 0.00
Second Year	2023	$ 0.00

Subject of Amendment

Qualifying Clinical Trials for 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:

  Authority Delegated to the Medicaid Director

Signature of State Agency Official

Submitted By:	**Donna Lopez**
Last Revision Date:	**Jun 6, 2022**
Submit Date:	**Jun 3, 2022**

Alternative Benefit Plan

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

Attachment 3.1- I-

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New Mexico Expansion Alternative Benefit Plan

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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

V.20130724

Alternative Benefit Plan

State Name: New Mexico | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: NM - 22 - 0010

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Notices of eligibility for the Adult Group will describe Alternative Benefit Plan (ABP) exemption criteria, processes for self identification, and procedures for choosing to enroll in the Medicaid State Plan benefit package. Individuals who are enrolled in managed care will also receive information about the ABP, the exemption criteria and related processes from their managed care organization (MCO); this information is also contained in each MCO member handbook.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Individuals in the Adult Group will be automatically enrolled in the ABP when they are determined eligible. Their eligibility notice, referenced and attached above, will describe how they can self-identify as being potentially exempt from the ABP. For managed care recipients, the self-identification process will be facilitated by the member's MCO, which will receive the request for an exemption, evaluate the member based on criteria set forth at 42 CFR 440.315 and further defined by the State, provide benefits counseling to the member (including a description of cost differences between the ABP and the Medicaid State Plan), and facilitate the member's voluntary selection of the ABP that is the Medicaid State Plan, if applicable. The MCO may also identify members who may be Medically Frail and qualify for an ABP exemption through a mandatory Health Risk Assessment (HRA). The HRA is the first step of care coordination during which the MCO makes contact with their members, asks a series of general health questions, and explains care coordination. The HRA is designed to help the MCO identify members who may be candidates for care coordination due to their medical needs or health status, and is required within the first 30 days of a member's enrollment with the MCO. Members who are identified through the HRA as potentially Medically Frail will receive a Comprehensive Needs Assessment (CNA) to assess the member's physical and behavioral health needs, long-term care needs and disease management needs. The member will also receive a notice from the MCO about the ABP exemption criteria and process. Upon receipt of this notice, the member must initiate the request to be considered for a potential exemption from the ABP through self-identification. For Native American Medicaid recipients who are exempt from managed care, the state's third-party assessor (TPA) contractor will receive and process the recipient's self-identification and request for an ABP exemption based on criteria set forth at 42 CFR 440.315 and further defined by the State. The TPA contractor will provide benefits counseling and facilitate the recipient's voluntary transition to the ABP that is the Medicaid State Plan, if applicable.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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

V.20160722

Alternative Benefit Plan

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

Attachment 3.1-L- ☐

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Only individuals eligible for the Adult Group will be enrolled in the Alternative Benefit Plan (ABP). Individuals eligible for other Medicaid categories on the basis of their eligibility criteria (including age, disability and pregnancy) will be correctly identified at enrollment and placed in the correct category of eligibility. Adult Group members who become pregnant must report their pregnancy to a State eligibility office to facilitate their transition to the pregnancy category, or they will remain in the Adult Group.

☒ Self-identification

Describe:

Individuals in the Adult Group will be automatically enrolled in the ABP when they are determined eligible. Their eligibility notice will describe how they can self-identify as exempt from the ABP. For managed care recipients, the self-identification process will be facilitated by the member's MCO, which will receive the request for an exemption, evaluate the member based on criteria set forth at 42 CFR 440.315 and further defined by the State, provide benefits counseling to the member (including a description of cost differences between the ABP and Medicaid State Plan), and facilitate the member's voluntary selection of the ABP that is the Medicaid State Plan, if applicable.

For Native American Medicaid recipients who are exempt from managed care, the state's third-party assessor (TPA) contractor will receive and process the recipient's self-identification and request for an ABP exemption based on criteria set forth at 42 CFR 440.315 and further defined by the State. The TPA contractor will provide benefits counseling and facilitate the recipient's voluntary transition to the ABP that is the Medicaid State Plan, if applicable. Because Native American Medicaid recipients are exempt from cost-sharing under both the ABP and the Medicaid State Plan, the TPA contractor is not required to describe the cost differences between the two benefit plans, since the recipient will be exempt from cost-sharing in either instance.

☒ Other

Describe:

For managed care recipients, their managed care organization (MCO) may identify members who may be Medically Frail and qualify for an ABP exemption through a mandatory Health Risk Assessment (HRA). The HRA is the first step of care coordination during which the MCO makes contact with their members, asks a series of general health questions, and explains care coordination. The HRA is designed to help the MCO identify members who may be candidates for care coordination due to their medical needs or health status, and is required within the first 30 days of a member's enrollment with the MCO. Members who are identified through the HRA as potentially Medically Frail will receive a Comprehensive Needs Assessment (CNA) to assess the member's physical and behavioral health needs, long-term care needs and disease management needs. The

member will also receive a notice from the MCO about the ABP exemption criteria and process. Upon receipt of this notice, the member must initiate the request to be considered for a potential exemption from the ABP through self-identification.

Native American Medicaid recipients who opt-in to managed care will have access to the MCO processes described above, including the HRA, CNA and related care coordination; however, these services are not available to the Native American fee-for-service population.

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☒ Review at the time of eligibility redetermination
- ☐ Provider identification
- ☒ Change in eligibility group
- ☒ Other

Describe:

Managed care members who may be considered Medically Frail may also be identified through the MCO HRA process, described above.

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

☑ 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.

Alternative Benefit Plan

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

For managed care recipients, the self-identification process will be facilitated by the member's MCO, which will receive the request for an exemption, evaluate the member based on criteria set forth at 42 CFR 440.315 and further defined by the State, provide benefits counseling to the member (including a description of cost differences between the ABP and Medicaid State Plan), and facilitate the member's voluntary selection of the ABP that is the Medicaid State Plan, if applicable.

For Native American Medicaid recipients who are exempt from managed care, the state's third-party assessor (TPA) contractor will receive and process the recipient's self-identification and request for an ABP exemption based on criteria set forth at 42 CFR 440.315 and further defined by the State. The TPA contractor will provide benefits counseling and facilitate the recipient's voluntary transition to the ABP that is the Medicaid State Plan, if applicable. Because Native American Medicaid recipients are exempt from cost-sharing under both the ABP and the Medicaid State Plan, the TPA contractor is not required to describe the cost differences between the two benefit plans, since the recipient will be exempt from cost-sharing in either instance.

The MCOs and TPA contractor will conduct the evaluation of ABP exemption criteria, benefits counseling and voluntary transition to the ABP that is the Medicaid State Plan, if applicable, within 10 working days of receipt of the request from the Medicaid recipient. The recipient will remain enrolled in the ABP until a decision has been made about their exemption and the recipient has made a proactive choice to switch to the Medicaid State Plan benefit package. The recipient will receive a notice informing them of the MCO's or TPA contractor's decision. If the recipient qualifies for an exemption from the ABP, they may then choose whether to remain in the ABP or select the Medicaid State Plan as their benefit package. The MCO or TPA contractor will make an indication of this choice using identifiers that are available in the Medicaid Management Information System (MMIS), which will in turn trigger the recipient's appropriate benefit package. Recipients who are determined by the MCO or TPA contractor as not meeting the criteria set forth at 42 CFR 440.315 and as further defined by the State may request a reconsideration or file a fair hearing in accordance with State regulations.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

PRA Disclosure Statement

Alternative Benefit Plan

State Name: New Mexico Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: NM - 22 - 0010

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3.1

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: New Mexico Expansion Alternative Benefit Plan

Selection of EHB-Benchmark Plan

The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: Presbyterian Health Plan - Individual Silver C HMO

The EHB-benchmark plan is the same as the Section 1937 Coverage option: Yes

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.
  - ( ) The state/territory offers benefits based on the approved state plan.
  - (●) The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

New Mexico's Section 1937 coverage option is Secretary-Approved Coverage.

New Mexico will use benefits from the selected base benchmark plan, which is Presbyterian Health Plan - Individual Silver C HMO, as the basis of the Alternative Benefit Plan (ABP). The selected base benchmark complies with the regulations set forth for ABPs under 42 CFR 440.347 as related to essential health benefits (EHBs).

Alternative Benefit Plan

Other Information Related to Selection of the Section 1937 Coverage Option and the EHB-Benchmark Plan (optional):

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.

V.20190813

Alternative Benefit Plan

State Name: New Mexico Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: NM - 22 - 0010

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.20160722

Alternative Benefit Plan

State Name: New Mexico Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: NM - 22 - 0010

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:

Presbyterian Health Plan - Individual Silver C HMO

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

Secretary-Approved

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services — Collapse All

Benefit Provided: Dental Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: Annual limits on some services
Duration Limit: None
Scope Limit: Refer to State Plan 1905(a)
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Refer to State Plan 1905(a)

Benefit Provided: Dialysis
Source: Base Benchmark Small Group
Remove
Authorization: Other
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: Home Health Care & Intravenous Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: Limited to 100 four-hour 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:

The recipient must require skilled care and be unable to receive medical care on an ambulatory outpatient basis.

Remove

Benefit Provided: Hospice Care Services

Source: Base Benchmark Small Group

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:

To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Certification statements must include information that is based on the recipient's medical prognosis, and that the life expectancy is six months or less if the terminal illness runs its typical course. Recipients must elect to receive hospice care for the duration of the election period. If the recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement. For the duration of the recipient's election of hospice care, the recipient waives their right to Medicaid payment of concurrent services related to the treatment of the terminal condition or a related condition; or for services equivalent to hospice care.

Remove

Benefit Provided: Outpatient Diagnostic Labs, X-Ray & Pathology

Source: Base Benchmark Small Group

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:

Remove

Benefit Provided: Outpatient Diagnostic Labs, X-Ray & Pathology

Source: Base Benchmark Small Group

Alternative Benefit Plan

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 Surgery

Source:
Base Benchmark Small Group

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:
Primary Care to Treat Illness/Injury

Source:
Base Benchmark Small Group

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

Remove

Benefit Provided: Radiation Therapy and Chemotherapy

Source: Base Benchmark Small Group

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:

Remove

Benefit Provided: Specialist Visits

Source: Base Benchmark Small Group

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:

Remove

Benefit Provided: Treatment of Diabetes

Source: Base Benchmark Small Group

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:

This benefit includes medical supplies for the treatment of diabetes.

Alternative Benefit Plan

Benefit Provided: Vision Care for Eye Injury or Disease

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Refraction for visual acuity is not covered. Routine vision care is not covered.

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

Benefit Provided: Vision Hardware

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: One complete set of contact lenses or eyeglasses

Duration Limit: None

Scope Limit: Covered only following surgery for the removal of cataracts from one or both eyes. Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery. Materials obtained more than 90 days following surgery are not covered.

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

Benefit Provided: Podiatry and Routine Foot Care

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered when medically necessary due to malformations, injury, acute trauma or diabetes. Orthopedic shoes, arch supports and foot orthotics are not covered unless they are medically necessary for the treatment of diabetes.

Alternative Benefit Plan

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/Facilities

Source: Base Benchmark Small Group

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: Observation Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Observation Services

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

Defined as outpatient services furnished by a hospital and practitioner/provider on the hospital's premises. Observation services may include the use of a bed and periodic monitoring to evaluate an outpatient's condition.

Benefit Provided:

Source:

Remove

Authorization: Authorization required in excess of limitation

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

Alternative Benefit Plan

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

Benefit Provided: Emergency Ground or Air Ambulance Services
Source: Base Benchmark Small Group
Remove
Authorization: Other
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:
Prior authorization required when taking a recipient to a facility over 100 miles from the New Mexico border.

Benefit Provided: Emergency Department Services/Facilities
Source: Base Benchmark Small Group
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: Emergency Dental Care
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Covers emergency dental care that is needed because of accidental injury from an outside force to a sound, natural tooth. To be considered sound, the tooth must not have significant decay or prior trauma.

Alternative Benefit Plan

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

Emergency treatment of jawbones or surrounding tissues is also covered.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Bariatric Surgery
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: Limited to one per lifetime
Duration Limit: None
Scope Limit: Covered for morbid obesity; or for individuals who have a BMI greater than 35 with at least one comorbidity related to obesity and who have been previously unsuccessful with medical treatment for obesity.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inpatient Medical and Surgical Care
Source: Base Benchmark Small Group
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Surgeries for cosmetic purposes are not covered.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization required for use of a hospital over 100 miles from the New Mexico border, except in an emergency.

Benefit Provided: Organ and Tissue Transplants
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs.

Alternative Benefit Plan

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 Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Covers reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders that result from accidental injury, congenital defects or disease.

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

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

Benefit Provided: Delivery and Inpatient Maternity Services

Source: Base Benchmark Small Group

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:

Includes lactation support, supplies and counseling.

Benefit Provided: Pre- and Post-Natal Care

Source: Base Benchmark Small Group

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:

Amniocentesis, ultrasound or any other procedures requested solely to determine the sex of the fetus are not covered. An exception is made if it is medically necessary to determine the existence of a sex-linked genetic disorder. Determination of the sex of the fetus is covered as part of a medically necessary procedure, but is not covered as an additional visit when the sex of the fetus cannot be determined during the medically necessary procedure.

Add

Alternative Benefit Plan

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: Inpatient Hospital Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Refer to State Plan 1905(a)

Remove

Benefit Provided: Medication-Assisted Therapy for Opioid Addiction

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Refer to State Plan 1905(a)

Remove

Benefit Provided: Outpatient Behavioral Health Professional Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Includes screening, evaluation, testing, assessment, medication management, therapy, and Intensive Outpatient Program (IOP) services.

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

Benefit Provided:

Benefit Provided: Drug/Alcohol Dependency Treatmen

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Refer to State Plan 1905(a)

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

Refer to State Plan 1905(a)

Benefit Provided:

Electroconvulsive Therapy (ECT)

Source:

Base Benchmark Small Group

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:

Benefit Provided:

Assertive Community Treatment (ACT)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Refer to State Plan 1905(a)

Benefit Provided:
Psychosocial Rehabilitation (PSR)

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Refer to State Plan 1905(a)

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	No	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:

New Mexico's ABP prescription drug benefit plan is the same as the prescription drug coverage under the Medicaid State 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.

Remove

Benefit Provided: Autism Spectrum Disorder
Source: Base Benchmark Small Group
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Covers speech, occupational and physical therapy, and applied behavioral analysis for recipients age 21-22 who are enrolled in high school.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization required after initial evaluation. This is a state-mandated service.

Remove

Benefit Provided: Cardiovascular Rehabilitation
Source: Base Benchmark Small Group
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: Short-term therapy (two consecutive months)
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Duration limit is per cardiac event. Exceptions made based on medical necessity. Long-term therapy is not covered.

Remove

Benefit Provided: Durable Medical Equipment & Supplies
Source: Base Benchmark Small Group
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Coverage of medical supplies is limited to diabetic supplies, contraceptive supplies, lactation supplies, cardiac event monitors, and holter monitors.

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

Requires a physician's prescription and prior authorization.

Benefit Provided: Inpatient Rehabilitative Facilities

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Covers inpatient services at a skilled nursing or acute rehabilitation facility when provided as a step-down level of care following discharge from the hospital prior to discharge to home. Extended care or long-term care not covered.

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

Benefit Provided: Orthotic Appliances

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace, or are diabetic shoes.

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

Requires a provider's prescription and prior authorization.

Benefit Provided: Prosthetic Devices, Repair and Replacement

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

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:
Prior authorization required unless the prosthetic device is surgically implanted.

Benefit Provided:
Rehabilitative Services - PT/OT/SLP

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Short-term therapy (two consecutive months)

Scope Limit:
Includes physical and occupational therapy and speech-language pathology.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Physical and occupational therapy require prior authorization, but the initial evaluation does not. Speech language pathology requires prior authorization (including evaluations). Duration limit is per condition; concurrent treatment for separate conditions is covered. Exceptions made based on medical necessity. Long-term therapy is not covered.

Benefit Provided:
Habilitative Services - PT/OT/SLP

Source:
Other state-defined

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Short-term therapy (two consecutive months)

Scope Limit:
Includes physical and occupational therapy and speech-language pathology.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Physical and occupational therapy require prior authorization, but the initial evaluation does not. Speech language pathology requires prior authorization (including evaluations). Duration limit is per condition;

concurrent treatment for separate conditions is covered. Exceptions made based on medical necessity. Long-term therapy is not covered.

Benefit Provided:
Pulmonary Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Short-term therapy (two consecutive months)

Scope Limit:
None

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

Duration limit is per condition; concurrent treatment for separate conditions is covered. Exceptions made based on medical necessity. Long-term therapy is not covered.

Add

Alternative Benefit Plan

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

Benefit Provided: Diagnostic Imaging
Source: Base Benchmark Small Group
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: Lab Tests, X-Ray Services and Pathology
Source: Base Benchmark Small Group
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

☑ 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: Allergy Testing and Injections

Source: Base Benchmark Small Group

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: Annual Physical Exam & Consultation

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Includes a health appraisal exam; laboratory and radiological tests; and early detection procedures. Does not include eye refractions, vision hardware or routine vision services; or hearing aids or hearing aid testing.

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

Benefit Provided: Chronic Disease Management

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

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:

Diabetes Equipment, Supplies & Education

Source:

Base Benchmark Small Group

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:

Genetic Evaluation & Testing

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness.

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

Benefit Provided:

Immunizations

Source:

Base Benchmark Small Group

Remove

Authorization:

None

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: This benefit includes ACIP-recommended vaccines.

Benefit Provided: Insertion/Removal of Contraceptive Devices

Source: Base Benchmark Small Group

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: Osteoporosis Treatment & Management

Source: Base Benchmark Small Group

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: Periodic Glaucoma Test (Age 35 or older)

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Coverage includes testing every one to two years.

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

Benefit Provided:
Preventive Care and Screenings

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Refer to State Plan 1905(a)

Benefit Provided:
Voluntary Family Planning Services

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Sterilization reversal is not covered.

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

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

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

Remove

Authorization: Other

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:

The source plan for this benefit is the New Mexico Medicaid State Plan. Prior authorization required for certain services. Some services subject to a periodicity schedule.

Add

Alternative Benefit Plan

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

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted: Acupuncture (20 visits per year)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted: Chiropractic Care (20 visits per year)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted: CMJ and TMJ Conditions
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted: Special Medical Foods
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted: Infertility (Diagnosis, Treatment & Correction)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with dental services within the Ambulatory Patient Services category. The base benchmark infertility coverage does not include in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or variations of these procedures; surrogate parenting; reversal of sterilization; or any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees, donor egg or sperm retrieval; or infertility medications, including oral infertility drugs.

Add

Alternative Benefit Plan

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

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Child Care

Source: Base Benchmark

Remove

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

Newborns who are born to Medicaid-enrolled mothers are automatically deemed eligible for Medicaid or CHIP, and all newborn services are covered under the Medicaid State Plan.

Add

Alternative Benefit Plan

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

Other 1937 Benefit Provided:
Non-Emergency Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Covers expenses for transportation, meals and lodging that are determined necessary to secure medical or behavioral health services for an Alternative Benefit Plan recipient.

Other:
There is no authorization requirement for this benefit.

Other 1937 Benefit Provided:
Qualifying 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:
Covers routine patient costs associated with participation in qualifying clinical trials.

Other:
Refer to Supplement A to Attachment 3.1-A in New Mexico's Medicaid State plan as approved in NM SPA 22-0009. Effective 1/1/2022.

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.

V.20190808

Alternative Benefit Plan

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

Attachment 3.1-L- [ ]

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

State Name: New Mexico Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: NM - 22 - 0010

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
  - ☒ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☐ Prepaid Ambulatory Health Plans (PAHP).
  - ☐ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

As part of New Mexico's efforts to roll-out its new Section 1115 waiver for Centennial Care on January 1 (which includes both the Other Adult Group and the ABP), the state held more than 200 public education events in every region of the state, including 52 events that were held in Native American communities. The state began running radio, print and online advertisements about Centennial Care in August 2013.

A tribal consultation was held in August 2013, during which the state discussed the ABP services package, as well as the intended selection of New Mexico's Section 1937 option and base benchmark plan. These topics were also discussed at every quarterly Medicaid Advisory Committee (MAC) meeting throughout 2013 and early 2014 to ensure communication with stakeholders. A meeting with tribal providers was held in November 2013 and a second provider meeting took place in March 2014.

In addition, New Mexico began a year-long comprehensive readiness review of its four Centennial Care managed care organizations (MCOs) in early 2013 to ensure that the MCOs are fully operational and compliant with the standards and conditions outlined in the Centennial Care waiver. Ten workgroups were created to focus on certain areas of implementation, such as reporting, care coordination, IT systems, and other issues pertinent to implementing the waiver and, more specifically, the ABP.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

Alternative Benefit Plan

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: July 12, 2013

Describe program below:

New Mexico Centennial Care provides managed physical, behavioral health and long-term care services through four managed care organizations (MCOs). New Mexico's vision for Centennial Care is to build a health care system that delivers the right amount of care at the right time and in the right setting. This vision includes educating recipients to become savvy health care consumers, promoting integrated care, delivering proper care coordination for the most at-risk recipients, involving recipients in their own wellness, and paying providers for good health outcomes. More detailed information about New Mexico Centennial Care can be found online at www.state.nm.us/centennialcare.

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- ◉ Competitive procurement method (RFP, RFA).
- ○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: No

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- ◉ Mandatory participation.
- ○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

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.

In New Mexico, most Native American Medicaid recipients maintain a choice to opt-in to the Centennial Care (managed care) program, or to access care through a traditional state-managed fee-for-service delivery system; however, Native American recipients who are dually eligible for Medicare and Medicaid or who have a nursing facility level of care, are required to enroll in Centennial Care. Native American recipients who access care through fee-for-service may opt-in to Centennial Care at any time during their eligibility.

The base services offered in the ABP are the same for both fee-for-service and Centennial Care recipients, and are detailed in Section 5 of this State Plan Amendment; however, Centennial Care recipients may receive additional "value-added services" from their MCOs that are not available to fee-for-service recipients.

Additional Information: Fee-For-Service (Optional)

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

Alternative Benefit Plan

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

Attachment 3.1-L- [ ]

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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.

Alternative Benefit Plan

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

Attachment 3.1-L- ☐

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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.20130807

Alternative Benefit Plan

State Name: New Mexico Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: NM - 22 - 0010

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20160722