Alternative Benefit Plan (ABP)
ABP Cost-Sharing & Comparison to Standard Medicaid Services

Most adults who qualify for the Medicaid category known as the “Other Adult Group” receive services under the New Mexico Alternative Benefit Plan (ABP). The ABP covers doctor visits, preventive care, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more. Some recipients will have to pay small co-pays for certain services, depending on their income.

Medicaid recipients in the Other Adult Group who have special health care needs may qualify to receive Standard Medicaid services without any co-payments, except for unnecessary use of brand name drugs or the emergency department. Individuals who have a serious or complex medical condition, a terminal illness, a chronic substance use disorder, a serious mental illness, or a disability that significantly impairs their ability to perform one or more activities of daily living, may choose to receive services under the ABP or under Standard Medicaid.

Individuals who think they have special health care needs should contact their Centennial Care managed care organization (MCO). Native American individuals who are not enrolled with a Centennial Care MCO should call the Molina Third-Party Assessor (TPA) toll-free at (866) 916-3250. They will help to determine if the individual has special health care needs and is eligible to receive Standard Medicaid services. Individuals with special health care needs may choose whether they want to receive services under the ABP or under the Standard Medicaid program.

The table below offers a comparison of the ABP services package to the services that are covered under Standard Medicaid. Since individuals who have ABP coverage will always be ages 19-64, the comparison to Standard Medicaid coverage is for the same age range (ages 19 and above).

<table>
<thead>
<tr>
<th>Benefit Category &amp; Service</th>
<th>ABP Coverage (Recipients ages 19-64)</th>
<th>Standard Medicaid Coverage (For ages 19 and above)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not covered The MCOs have the option to cover this service; check with the MCO.</td>
<td>Not covered The MCOs have the option to cover this service; check with the MCO.</td>
</tr>
<tr>
<td>Cancer clinical trials</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Not covered The MCOs have the option to cover this service; check with the MCO.</td>
<td>Not covered The MCOs have the option to cover this service; check with the MCO.</td>
</tr>
<tr>
<td>Service</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Dental services (8.310.7 NMAC)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restorative dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prosthodontics (removable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Endodontic services for anterior teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive dental services are covered based on a periodicity schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dialysis</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Hearing aids and hearing aid testing</strong></td>
<td>Not covered, except for recipients age 19-20</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Holter monitors and cardiac event monitors</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Home health care and intravenous services</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Home health care is limited to 100 four-hour visits per year</td>
<td></td>
<td>No limitation on number of visits</td>
</tr>
<tr>
<td><strong>Hospice care services</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Infertility treatment</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Naprapathy</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>The MCOs have the option to cover this service; check with the MCO.</td>
<td></td>
<td>The MCOs have the option to cover this service; check with the MCO.</td>
</tr>
<tr>
<td><strong>Non-emergency transportation</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Outpatient diagnostic labs, x-ray and pathology</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Primary care to treat illness/injury</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Radiation and chemotherapy</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Special medical foods for inborn errors of metabolism</strong></td>
<td>Not covered, except for recipients age 19-20</td>
<td>Coverage is the same as ABP (covered for recipients age 19-20 only)</td>
</tr>
<tr>
<td><strong>Specialist visits</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Telemedicine services</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>TMJ or CMJ treatment</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Treatment of diabetes</strong></td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td><strong>Vision care for eye injury or disease</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Does not include vision refraction, except for</td>
<td></td>
<td>Standard Medicaid covers vision refraction</td>
</tr>
<tr>
<td>Recipients age 19-20 and routine vision services</td>
<td>Covered only following the removal of cataracts from one or both eyes. Vision hardware covered for recipients age 19-20 following a periodicity schedule.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Services**

<table>
<thead>
<tr>
<th>Emergency ground or air ambulance services</th>
<th>Covered</th>
<th>Covered (Same as ABP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department services/facilities</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Urgent care services/facilities</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
</tbody>
</table>

**Hospitalization**

| Bariatric surgery | Covered (Limited to one per lifetime) | Covered (No limitation on number of surgeries, as long as medical necessity is met) |
| Inpatient medical and surgical care | Covered | Covered (Same as ABP) |
| Organ and tissue transplants | Covered (Limited to two per lifetime) | Covered (No limitation on number of transplants, as long as medical necessity is met) |
| Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease | Covered | Covered (Same as ABP) |

**Maternity Care**

| Delivery and inpatient maternity services | Covered | Covered (Same as ABP) |
| Non-hospital births | Covered | Covered (Same as ABP) |
| Pre- and post-natal care | Covered | Covered (Same as ABP) |

**Mental/Behavioral Health & Substance Use Disorder Services**

<p>| Inpatient hospital services in a psychiatric unit of a general hospital, including inpatient substance abuse detoxification | Covered | Covered (Same as ABP) |
| Medication-assisted therapy for opioid addiction | Covered | Covered (Same as ABP) |
| Outpatient behavioral health professional services (includes evaluation, testing, assessment, medication management and | Covered | Covered (Same as ABP) |</p>
<table>
<thead>
<tr>
<th>Therapy</th>
<th>Covered</th>
<th>Covered (Same as ABP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services for alcoholism and drug dependency, including Intensive Outpatient Program (IOP)</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>The MCOs have the option to cover this service; check with the MCO.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health supportive services (family support, recovery services, respite services)</td>
<td>Not covered</td>
<td>Covered when provided through a MCO</td>
</tr>
</tbody>
</table>

**Medications**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Covered</th>
<th>Covered (Same as ABP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription medicines</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Over-the-counter medicines</td>
<td>Coverage limited to prenatal drug items, and low-dose aspirin as preventive for cardiac conditions. Other OTC items may be considered for coverage only when the item is considered more medically or economically appropriate than the prescription drugs, contraceptive drugs and devices and items for treating diabetes.</td>
<td>Coverage limitations same as ABP</td>
</tr>
</tbody>
</table>

**Rehabilitative & Habilitative Services and Devices**

<table>
<thead>
<tr>
<th>Services and Devices</th>
<th>Covered</th>
<th>Covered (Same as ABP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism spectrum disorder</td>
<td>Covered</td>
<td>Coverage ends at age 21</td>
</tr>
<tr>
<td>Includes physical, occupational and speech therapy and applied behavioral analysis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular rehabilitation</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Limited to 36 visits per cardiac event</td>
<td></td>
<td>No limitation on visits as long as medical necessity is met</td>
</tr>
<tr>
<td>Durable medical equipment (DME), medical supplies, orthotic appliances and prosthetic</td>
<td>Covered</td>
<td>Coverage is the same as ABP, except that most medically necessary disposable medical</td>
</tr>
<tr>
<td>Requires a provider’s prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devices, including repair or replacement</td>
<td>DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes.</td>
<td>Supplies are also covered when prescribed by a practitioner.</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient rehabilitative facilities</td>
<td>Covered Skilled nursing or acute rehabilitation facility</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Internal prosthetics</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Physical, speech and occupational therapy (rehabilitative and habilitative services)</td>
<td>Covered Short-term therapy limited to two consecutive months per condition. Long-term therapies are not covered</td>
<td>Rehabilitative services covered. No limitation on duration of therapy as long as medical necessity is met. Habilitative services are not covered.</td>
</tr>
<tr>
<td>Pulmonary therapy</td>
<td>Covered Limited to 36 visits per year</td>
<td>Covered No limitation on duration of therapy as long as medical necessity is met.</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>Covered primarily through home health agencies; subject to home health benefit limitations (100 four-hour visits per year).</td>
<td>Covered through home health agencies. No limitation on number of visits as long as medical necessity is met.</td>
</tr>
</tbody>
</table>

**Laboratory and Radiology Services**

| Diagnostic imaging                     | Covered                                                                                      | Covered (Same as ABP) |
| Lab tests, x-ray services and pathology | Covered                                                                                      | Covered (Same as ABP) |

**Preventive & Wellness Services and Chronic Disease Management**

| Allergy testing and injections          | Covered                                                                                      | Covered (Same as ABP) |
| Annual consultation to discuss lifestyle and behavior that promote health and well-being | Covered                                                                                      | Covered for age 19-20. |
| Annual physical exam                   | Covered Eye refractions, eyeglasses and contact lenses, are not covered, except for age 19-20. Hearing aids and hearing aid testing are not covered, except for age 19-20. | Periodic physical exams are only covered for age 19-20. Additional annual physical exams may be provided through a MCO. Vision services, including refractions, eyeglasses and contact lenses, are covered but are limited to |


<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Details</th>
<th>Additional Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic disease management</td>
<td>Covered through primary care provider services. Additional benefits may be available when provided through a MCO.</td>
<td>Covered through primary care provider services. Additional benefits may be available when provided through a MCO.</td>
</tr>
<tr>
<td>Diabetes equipment, supplies and education</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Genetic evaluation and testing</td>
<td>Covered</td>
<td>Covered (same as ABP)</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Insertion and/or removal of contraceptive devices</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Nutritional evaluations and counseling</td>
<td>Covered</td>
<td>Not covered, except for age 19-20 and during pregnancy. Additional benefits may be available when provided through a MCO.</td>
</tr>
<tr>
<td>Osteoporosis diagnosis, treatment and management</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Periodic glaucoma eye test (age 35 or older)</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Periodic colorectal examination (age 35 or older)</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Periodic mammograms (age 35 or older)</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Periodic stool examination (age 40 or older)</td>
<td>Covered</td>
<td>Covered only when medically indicated</td>
</tr>
<tr>
<td>Periodic test to determine blood hemoglobin,</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>blood pressure, blood glucose level and blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cholesterol level or a fractionated cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry and routine foot care</td>
<td>Covered when medically necessary</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Covered</td>
<td>Coverage is limited. Many screening services are covered when appropriate based on age or family history. Additional benefits may be available when provided through a MCO.</td>
</tr>
<tr>
<td>Service</td>
<td>Institutes of Medicine</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Screening pap tests</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>Not covered, except for age 19-20</td>
<td>Covered</td>
</tr>
<tr>
<td>Smoking cessation treatment</td>
<td>Covered Diagnosis, counseling and prescription medicines</td>
<td>Covered only for recipients age 21 and under, and for pregnant women. Additional benefits may be available when provided through a MCO.</td>
</tr>
<tr>
<td>Voluntary family planning services</td>
<td>Covered</td>
<td>Covered (Same as ABP)</td>
</tr>
<tr>
<td>Weight loss programs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>The MCOs have the option to cover this service; check with the MCO.</td>
<td>Not covered The MCOs have the option to cover this service; check with the MCO.</td>
</tr>
</tbody>
</table>

**Long-Term Services & Supports**

<table>
<thead>
<tr>
<th>Service</th>
<th>Not covered</th>
<th>Covered when the requirements to access these services are met, including nursing facility level of care (NF LOC) criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing facility care</td>
<td>Not covered, except as a step down level of care from a hospital prior to being discharged to home when skilled nursing services on a short-term basis are medically necessary.</td>
<td></td>
</tr>
<tr>
<td>Mi Via</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

**ABP Co-Pays**

Co-pays will be charged based on the recipient’s income level. There are some exceptions to co-pays, including:

- Services provided to Native American recipients;
- Services provided by an Indian Health Service (IHS), tribal 638 or urban Indian facility;
- Emergency services;
- Family planning services, drugs, procedures, supplies and devices;
- Hospice services;
- Services provided to pregnant women;
- Prenatal and postpartum care and deliveries, and prenatal drug items;
- Mental health/behavioral health and substance abuse services, including psychotropic drug items;
- Preventive services; and
- Provider preventable conditions.

When an individual has reached the co-pay maximum of five percent of family income, co-pays will not be charged.

<table>
<thead>
<tr>
<th></th>
<th>Income 100% of Federal Poverty Level (FPL) or Below</th>
<th>Income 101-138% of Federal Poverty Level (FPL)</th>
<th>Individual with Special Health Care Needs Regardless of Income Level (Same as Standard Medicaid Coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription medicines</td>
<td>$0</td>
<td>$3</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• Does not apply when the co-pay for a brand-name medicine is charged.</td>
<td>• Some medicines are exempt, including family planning drugs (contraceptives), prenatal drug items and some behavioral health medicines.</td>
<td></td>
</tr>
<tr>
<td>Brand-name prescriptions (when there is a less expensive generic equivalent medicine)</td>
<td>$3</td>
<td>$8</td>
<td>$3</td>
</tr>
<tr>
<td></td>
<td>• Psychotropic drug items are exempt from the brand-name drug co-pay.</td>
<td>• Psychotropic drug items are exempt from the brand-name drug co-pay.</td>
<td>• Psychotropic drug items are exempt from the brand-name drug co-pay.</td>
</tr>
<tr>
<td>Outpatient office visits</td>
<td>$0</td>
<td>$8</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• See exceptions to cost-sharing, above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-emergency use of the emergency department</td>
<td>$8</td>
<td>$8</td>
<td>$8</td>
</tr>
<tr>
<td>Inpatient hospital admission</td>
<td>$0</td>
<td>$25</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• See exceptions to cost-sharing, above.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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