



Alternative Benefit Plan

Attachment 3.1-C- ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Benefits Description	ABP5
<p>The state/territory proposes a “Benchmark-Equivalent” benefit package. <input data-bbox="873 415 950 468" type="text" value="No"/></p>	
<p>Benefits Included in Alternative Benefit Plan</p>	
<p>Enter the specific name of the base benchmark plan selected:</p>	
<div>Lovelace Classic PPO</div>	
<p>Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter “Secretary-Approved.”</p>	
<div>Secretary-Approved</div>	



Alternative Benefit Plan

☒ Essential Health Benefit 1: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Cancer Clinical Trials

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covers routine patient costs associated with Phase I, II, III and IV cancer clinical trials.

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

Benefit Provided:

Dental Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Annual limits on some services

Duration Limit:

None

Scope Limit:

Includes diagnostic dental, dental radiology, preventive dental, restorative dental, removable prosthodontics, oral surgery, and endodontic services for anterior teeth.

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. This benefit has been added through substitution. Some services subject to a periodicity schedule.

Benefit Provided:

Dialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

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:

Remove

Benefit Provided:

Holter Monitors & Cardiac Event Monitors

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:

Home Health Care & Intravenous Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to 100 four-hour visits per year.

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

Benefit Provided:

Hospice Care Services

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

None

Remove

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. Recipients who are 19 or 20 years-old may receive curative treatment concurrent with hospice care services.

Benefit Provided:

Outpatient Diagnostic Labs, X-Ray & 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:

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:



Alternative Benefit Plan

Benefit Provided:		Source:	Remove
Primary Care to Treat Illness/Injury		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	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:		Source:	Remove
Radiation Therapy and Chemotherapy		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	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:		Source:	Remove
Specialist Visits		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	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

Benefit Provided:		Source:	Remove
Treatment of Diabetes		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	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.			

Benefit Provided:		Source:	Remove
Vision Care for Eye Injury or Disease		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	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:		Source:	
Vision Hardware		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
Prior Authorization	Medicaid State Plan		
Amount Limit:	Duration Limit:		
One complete set of contact lenses or eyeglasses	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.			



Alternative Benefit Plan

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

Remove

Benefit Provided:

Podiatry and Routine Foot Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

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.

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:

Chiropractic Care

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2000

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Covered for all individuals who have a primary diagnosis of neck pain, back pain, musculoskeletal pain, or headaches.

Remove

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

☒ Essential Health Benefit 2: 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

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.

Remove

Add



Alternative Benefit Plan

☒ Essential Health Benefit 3: 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 co-morbidity 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

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to two per lifetime

Duration Limit:

None

Scope Limit:

Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants.



Alternative Benefit Plan

Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs.

Remove

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

The Lovelace Classic PPO transplant benefit is limited to \$1 million per lifetime. This limitation was converted to an actuarially-equivalent amount limit, which is reflected in New Mexico's ABP. Outpatient immunosuppressive drugs do not apply toward the transplant benefit limit and are covered without limitation under the prescription drug benefit.

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

☒ Essential Health Benefit 4: 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

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

Collapse All ☐

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification.

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

Does not include inpatient services in Institutions for Mental Diseases (IMDs) for recipients ages 21-64. Prior authorization required for admission to separate psychiatric units within acute care hospitals. The source plan for this benefit is the Medicaid State Plan, since inpatient hospital services covered under the base benchmark plan include IMD services.

Benefit Provided:

Medication-Assisted Therapy for Opioid Addiction

Source:

State Plan 1905(a)

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:

The source plan for this benefit is the New Mexico Medicaid State Plan. This benefit has been added through substitution.

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

Remove

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

Benefit Provided:

Drug/Alcohol Dependency Treatment Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Includes outpatient detoxification, therapy, partial hospitalization, 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:

Prior authorization required for partial hospitalization.

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)

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Remove

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. This benefit has been added through substitution.

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:

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. This benefit has been added through substitution.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription 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.



Alternative Benefit Plan

☒ Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided:

Autism Spectrum Disorder

Source:

Base Benchmark Small Group

Remove

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.

Benefit Provided:

Cardiovascular Rehabilitation

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 cardiac event. Exceptions made based on medical necessity. Long-term therapy is not covered.

Benefit Provided:

Durable Medical Equipment & Supplies

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage of medical supplies is limited to diabetic supplies and contraceptive supplies.



Alternative Benefit Plan

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.

Remove

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 hospitals 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:

Orthotic Appliances

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

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

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Remove

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.



Alternative Benefit Plan

Benefit Provided:		Source:	Remove
Pulmonary Therapy		Base Benchmark Small Group	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
None	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

☒ Essential Health Benefit 8: 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

☒ Essential Health Benefit 9: 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

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Remove

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



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Remove

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:



Alternative Benefit Plan

Benefit Provided:		Source:	Remove
<input type="text" value="Periodic Glaucoma Test (Age 35 or Older)"/>		<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	<input type="text" value="None"/>	Provider Qualifications:	
		<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	
		<input type="text" value="None"/>	
Scope Limit:			
<input type="text" value="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:			
<input type="text"/>			

Benefit Provided:		Source:	Remove
<input type="text" value="Periodic Colorectal Examination (Age 35 or Older)"/>		<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	<input type="text" value="None"/>	Provider Qualifications:	
		<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	
		<input type="text" value="None"/>	
Scope Limit:			
<input type="text" value="Coverage includes a yearly fecal occult blood test (FOBT); flexible sigmoidoscopy every five years; double contrast barium enema every five years; and colonoscopy every 10 years."/>			
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text"/>			

Benefit Provided:		Source:	
<input type="text" value="Periodic Mammograms (Age 35 or Older)"/>		<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	<input type="text" value="None"/>	Provider Qualifications:	
		<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	
		<input type="text" value="None"/>	
Scope Limit:			
<input type="text" value="Coverage includes, at a minimum, one baseline mammogram to persons age 35 through 39; one mammogram biennially to persons age 40 through 49; and one mammogram annually to persons age 50 and over."/>			



Alternative Benefit Plan

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

Remove

Benefit Provided:

Annual Stool Examination

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:

Other Preventive Care and Screenings

Source:

Other state-defined

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 US Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.

Benefit Provided:

Voluntary Family Planning Services

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Sterilization reversal is not covered.

Remove

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

☒ Essential Health Benefit 10: 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

<input type="checkbox"/> Other Covered Benefits from Base Benchmark	Collapse All <input type="checkbox"/>
---	---------------------------------------



Alternative Benefit Plan

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
<p>Base Benchmark Benefit that was Substituted:</p> <div style="border: 1px solid black; padding: 2px;">Acupuncture (\$1,500 per year)</div>	<p>Source:</p> <p>Base Benchmark</p>	<div style="border: 1px solid black; padding: 2px; background-color: #f0f0f0;">Remove</div>
<p>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:</p> <div style="border: 1px solid black; padding: 5px; min-height: 20px;">Substituted with dental services within the Ambulatory Patient Services category.</div>		
<p>Base Benchmark Benefit that was Substituted:</p> <div style="border: 1px solid black; padding: 2px;">CMJ and TMJ Conditions</div>	<p>Source:</p> <p>Base Benchmark</p>	<div style="border: 1px solid black; padding: 2px; background-color: #f0f0f0;">Remove</div>
<p>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:</p> <div style="border: 1px solid black; padding: 5px; min-height: 20px;">Substituted with dental services within the Ambulatory Patient Services category.</div>		
<p>Base Benchmark Benefit that was Substituted:</p> <div style="border: 1px solid black; padding: 2px;">Special Medical Foods</div>	<p>Source:</p> <p>Base Benchmark</p>	<div style="border: 1px solid black; padding: 2px; background-color: #f0f0f0;">Remove</div>
<p>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:</p> <div style="border: 1px solid black; padding: 5px; min-height: 20px;">Substituted with dental services within the Ambulatory Patient Services category.</div>		
<p>Base Benchmark Benefit that was Substituted:</p> <div style="border: 1px solid black; padding: 2px;">Infertility (Diagnosis, Treatment & Correction)</div>	<p>Source:</p> <p>Base Benchmark</p>	<div style="border: 1px solid black; padding: 2px; background-color: #f0f0f0;">Remove</div>
<p>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:</p> <div style="border: 1px solid black; padding: 5px; min-height: 60px;">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.</div>		
<p>Base Benchmark Benefit that was Substituted:</p> <div style="border: 1px solid black; padding: 2px;">Inpatient Rehabilitation for Substance Abuse</div>	<p>Source:</p> <p>Base Benchmark</p>	<div style="border: 1px solid black; padding: 2px; background-color: #f0f0f0;">Remove</div>
<p>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:</p> <div style="border: 1px solid black; padding: 5px; min-height: 40px;">Substituted with Medication-Assisted Therapy for Opioid Addiction, Assertive Community Treatment (ACT), and Psychosocial Rehabilitation (PSR) within the Mental Health and Substance Use Disorder Services category.</div>		
<p>Base Benchmark Benefit that was Substituted:</p> <div style="border: 1px solid black; padding: 2px;">Behavioral Health Inpatient Hospital Services</div>	<p>Source:</p> <p>Base Benchmark</p>	



Alternative Benefit Plan

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:

Duplicates EHB5 Mental Health and Substance Use Disorder services, including Behavioral Health Treatment: Inpatient Hospital Services. The base benchmark includes coverage of Institutions for Mental Diseases (IMDs) for recipients ages 21-64 as part of this benefit. IMDs are excluded from coverage under the Medicaid ABP.

Remove

Add



Alternative Benefit Plan

☒ 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, and all newborn services are covered under the Medicaid State Plan.

Add



Alternative Benefit Plan

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

Other 1937 Benefit Provided:
Non-Emergency Transportation

Authorization:
Other

Amount 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.

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Provider Qualifications:
Medicaid State Plan

Duration Limit:
None

Remove

Add



Alternative Benefit Plan

☐

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

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.20130814