Alternative Benefit Plan (ABP)
ABP 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.

Medicaid recipients in the Other Adult Group who have special health care needs may qualify to receive Standard Medicaid services instead of the ABP. 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.

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).

Benefit Category & Service	**ABP Coverage (Recipients ages 19-64)**	**Standard Medicaid Coverage (For ages 19 and above)**
Outpatient Services		
Acupuncture	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Cancer clinical trials	Covered	Covered (Same as ABP)
Chiropractic services	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.

Dental services (8.310.7 NMAC) • Diagnostic dental • Dental radiology • Preventive dental • Restorative dental • Prosthodontics (removable) • Oral surgery • Endodontic services for anterior teeth	Covered Preventive dental services are covered based on a periodicity schedule	Covered (Same as ABP)
Dialysis	Covered	Covered (Same as ABP)
Hearing aids and hearing aid testing	Not covered, except for recipients age 19-20	Covered
Holter monitors and cardiac event monitors	Covered	Covered (Same as ABP)
Home health care and intravenous services	Covered Home health care is limited to 100 four-hour visits per year	Covered No limitation on number of visits
Hospice care services	Covered	Covered (Same as ABP)
Infertility treatment	Not covered	Not covered
Naprapathy	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Non-emergency transportation	Covered	Covered (Same as ABP)
Outpatient diagnostic labs, x-ray and pathology	Covered	Covered (Same as ABP)
Outpatient surgery	Covered	Covered (Same as ABP)
Primary care to treat illness/injury	Covered	Covered (Same as ABP)
Radiation and chemotherapy	Covered	Covered (Same as ABP)
Special medical foods for inborn errors of metabolism	Not covered, except for recipients age 19-20	Coverage is the same as ABP (covered for recipients age 19-20 only)
Specialist visits	Covered	Covered (Same as ABP)
Telemedicine services	Covered	Covered (Same as ABP)
TMJ or CMJ treatment	Not covered	Not covered
Treatment of diabetes	Covered	Covered (Same as ABP)
Vision care for eye injury or disease	Covered Does not include vision refraction, except for	Covered Standard Medicaid covers vision refraction

	recipients age 19-20	and routine vision services
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of cataracts from one or both eyes. Vision hardware covered for recipients age 19-20 following a periodicity schedule.	Covered Contact lenses require prior authorization
Emergency Services		
Emergency ground or air ambulance services	Covered	Covered (Same as ABP)
Emergency department services/facilities	Covered	Covered (Same as ABP)
Urgent care services/facilities	Covered	Covered (Same as ABP)
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		
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)

therapy)		
Outpatient services for alcoholism and drug dependency, including Intensive Outpatient Program (IOP)	Covered	Covered (Same as ABP)
Assertive Community Treatment (ACT)	Covered	Covered (Same as ABP)
Psychosocial Rehabilitation (PSR)	Covered	Covered (Same as ABP)
Electroconvulsive Therapy (ECT)	Covered	Not covered The MCOs have the option to cover this service; check with the MCO.
Behavioral health supportive services (family support, recovery services, respite services)	Not covered	Covered when provided through a MCO
Medications		
Prescription medicines	Covered	Covered (Same as ABP)
Over-the-counter medicines	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.	Coverage limitations same as ABP
Rehabilitative & Habilitative Services and Devices		
Autism spectrum disorder	Covered for recipients age 19 or younger; or age 22 or younger when enrolled in high school. Includes physical, occupational and speech therapy and applied behavioral analysis.	Coverage ends at age 21
Cardiovascular rehabilitation	Covered Limited to 36 visits per cardiac event	Covered No limitation on visits as long as medical necessity is met
Durable medical equipment (DME), medical supplies, orthotic appliances and prosthetic	Covered Requires a provider's prescription.	Coverage is the same as ABP, except that most medically necessary disposable medical

devices, including repair or replacement	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.	supplies are also covered when prescribed by a practitioner.
Inpatient rehabilitative facilities	Covered Skilled nursing or acute rehabilitation facility	Covered (Same as ABP)
Internal prosthetics	Covered	Covered (Same as ABP)
Physical, speech and occupational therapy (rehabilitative and habilitative services)	Covered Short-term therapy limited to two consecutive months per condition. Long-term therapies are not covered	Rehabilitative services covered. No limitation on duration of therapy as long as medical necessity is met. Habilitative services are not covered.
Pulmonary therapy	Covered Limited to 36 visits per year	Covered No limitation on duration of therapy as long as medical necessity is met.
Skilled nursing	Covered primarily through home health agencies; subject to home health benefit limitations (100 four-hour visits per year).	Covered through home health agencies. No limitation on number of visits as long as medical necessity is met.
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

		a set periodicity schedule.
Chronic disease management	Covered through primary care provider services. Additional benefits may be available when provided through a MCO.	Covered through primary care provider services. Additional benefits may be available when provided through a MCO.
Diabetes equipment, supplies and education	Covered	Covered (Same as ABP)
Genetic evaluation and testing	Covered Triple serum test and genetic testing for the diagnosis or treatment of a current illness	Covered (same as ABP)
Immunizations	Covered Includes ACIP-recommended vaccines	Covered (Same as ABP)
Insertion and/or removal of contraceptive devices	Covered	Covered (Same as ABP)
Nutritional evaluations and counseling	Covered Dietary evaluation and counseling as medical management of a documented disease, including obesity.	Not covered, except for age 19-20 and during pregnancy. Additional benefits may be available when provided through a MCO.
Osteoporosis diagnosis, treatment and management	Covered	Covered (Same as ABP)
Periodic glaucoma eye test (age 35 or older)	Covered	Covered (Same as ABP)
Periodic colorectal examination (age 35 or older)	Covered	Covered (Same as ABP)
Periodic mammograms (age 35 or older)	Covered	Covered (Same as ABP)
Periodic stool examination (age 40 or older)	Covered	Covered only when medically indicated
Periodic test to determine blood hemoglobin, blood pressure, blood glucose level and blood cholesterol level or a fractionated cholesterol level	Covered	Covered (Same as ABP)
Podiatry and routine foot care	Covered when medically necessary	Covered (Same as ABP)
Preventive care	Covered Includes US Preventive Services Task Force “A” & “B” recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and preventive services for women recommended by the	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.

	Institutes of Medicine	
Screening pap tests	Covered	Covered (Same as ABP)
Sleep studies	Not covered, except for age 19-20	Covered
Smoking cessation treatment	Covered Diagnosis, counseling and prescription medicines	Covered only for recipients age 21 and under, and for pregnant women. Additional benefits may be available when provided through a MCO.
Voluntary family planning services	Covered	Covered (Same as ABP)
Weight loss programs	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Long-Term Services & Supports		
Community benefits	Not covered	Covered when the requirements to access these services are met, including nursing facility level of care (NF LOC) criteria
Nursing facility care	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.	
Mi Via	Not covered	

Centennial Care 1115 Waiver Renewal Subcommittee
Issue Brief: Eligibility & Benefit Alignment
February 2017

Overview

One of the core principles of the New Mexico Centennial Care program is to improve administrative effectiveness and simplicity. In Medicaid, this is a difficult challenge – the program currently subsumes nearly 40 different categories of eligibility, multiple complicated eligibility determination methodologies, and manifold benefit packages for both children and adults. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking at opportunities to simplify some of these administrative complexities and, at the same time, is seeking innovations in program design aimed at addressing and resolving certain specific issues and concerns that are currently impeded due to limits imposed by federal regulations.

Streamlining Eligibility

- **Close gaps in eligibility for justice-involved individuals.** HSD has worked persistently to develop the IT systems, policies and processes to facilitate eligibility "suspensions" for individuals who are involved in the criminal or juvenile justice system, and to ensure timely and automated eligibility reactivations upon the release of these individuals from custody. While this process is working effectively in most instances – in particular for those in the custody of the Corrections Department – in some cases there are delays in reactivating eligibility that are due to the following issues:

    - Uncertain or undefined release date (a common problem for individuals in the county jail system)
    - Spontaneous or unplanned discharge from custody, often occurring during evening or nighttime hours
    - Postponed entry of release date into IT files coming from the prison or jail

    HSD is considering whether an eligibility waiver strategy might help to close gaps in coverage for justice-involved individuals. The State of New York has proposed allowing an earlier start-date or reactivation of eligibility – i.e., 30 days prior to release – which would ensure that individuals can have an active MCO card when they leave the facility. While HSD might consider a similar approach, concerns remain that it may not directly solve the problems noted above when the release date is either unknown or occurs spontaneously.

- **Preserve the Family Planning program for those who need it.** The Family Planning program currently covers more than 72,000 New Mexicans, providing a very limited benefit package of family planning services and contraceptives to individuals with income below 250% FPL who do not qualify for any other full coverage Medicaid category. Individuals covered under Family Planning receive those services through fee-for-service and not through Centennial Care. Only a small fraction (approximately 9 percent) of those covered under the Family Planning category actually use services or obtain contraceptives through the program. The program is administratively burdensome for HSD because all covered individuals must be renewed yearly (a volume of approximately 6,000 cases per month); in addition, many individuals are confused or

dissatisfied about the limited Family Planning benefit package and find it insufficient to meet most of their health care needs.

As it is currently structured, Family Planning operates as a limited benefit entitlement to anyone with income below the maximum threshold of 250% FPL, regardless of age or other health coverage status. HSD is considering reverting the Family Planning program to a waiver that is designed specifically for certain age groups and only for those who do not have other health insurance coverage. In effect, this would place limits on who could be covered under the Family Planning program so it would not be a catchall for everyone who does not qualify for full Medicaid. This strategy would maintain the program for those who need it but would significantly reduce the administrative burden associated with operating the program today.

- **Simplify eligibility processes.** HSD is moving toward an environment in which Medicaid eligibility – both initial determinations and renewals – is streamlined where possible. Real-Time Eligibility (RTE) is scheduled to roll-out in the Spring of 2017, meaning that many individuals will receive an eligibility determination at the point of application. However, there are some federal eligibility rules in the Medicaid environment that are structurally complicated and extremely costly for HSD to administer. HSD may consider requesting a waiver of the three-month retroactive eligibility period, which is accompanied with an intensive reconciliation process; and may also consider extending continuous eligibility to adults to reduce the administrative workload associated with mid-year redeterminations, particularly when there is a SNAP or TANF case attached to the household that results in interim reporting of income.

- **Speed up the transition off Medicaid.** Under current eligibility rules, when an individual in the Parent/Caretaker Category has earned income that increases above the eligibility threshold for that group (or the upper threshold of the Expansion Category), a 12-month Transitional Medical Assistance (TMA) eligibility span is approved. HSD may consider requesting authority from CMS for more frequent reporting of income (i.e., quarterly), a limitation of TMA to a shorter time period (i.e., 30-90 days), or elimination of the TMA program. Individuals would need to seek subsidized coverage through the Marketplace or other private insurance. It should be noted that the TMA provision pre-dates the Affordable Care Act (ACA) and was designed to protect individuals from losing coverage due to increased earned income. With other coverage options made available through the ACA, HSD believes that TMA may no longer be necessary or could be shortened to encourage individuals to obtain other coverage more quickly.

<u>Benefit Design</u>

- **Provide a uniform benefit package for most Medicaid adults.** Most adults who qualify for the Medicaid Expansion Category receive services under the Alternative Benefit Plan (ABP). The ABP is a very comprehensive benefit package that covers all services that are defined under the ACA as “essential health benefits”, including doctor visits, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more. Medicaid recipients in the Expansion Category who have a special health care need such as 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 (ADLs) may choose to receive services under the ABP *or* under Standard Medicaid. Currently, there are approximately 3,500 individuals in the Adult Expansion who have opted to receive Standard Medicaid services

instead of the ABP due to their health condition, an indication that for most of the 260,000 individuals covered by the ABP, the benefit package satisfactorily meets their health care needs.

HSD is considering seeking waiver authority that would allow the Department to cover adults in the Parent/Caretaker Category under the ABP, with a similar opt-out process for individuals with special health care needs. This would place limitations on certain services, such as physical therapy and home health services. In addition, HSD might consider a request to waive the federal provision requiring adults age 19-20 who are in the Medicaid Expansion category to be covered under the EPSDT rule, which requires full coverage of any medically necessary service regardless of whether the service is included in the benefit package. The EPSDT rule is administratively burdensome and requires that 19-20 year-olds be treated as children, even when they are covered under an adult category.

- **Increase the availability of Long-Acting Reversible Contraceptives (LARC).** HSD has made access to LARC a high priority over the past several years, successfully "unbundling" LARC reimbursement from other services in Federally Qualified Health Centers (FQHCs), School-Based Health Centers (SBHCs) and at point of labor/delivery or during postnatal care to safeguard adequate payment and to ensure that providers are not discouraged from informing women about LARC or making it readily and immediately available. HSD is considering a request for federal waiver authority to obtain increased administrative funding (i.e., 90 percent, in line with the federal matching rate for Family Planning services and contraceptives) to maintain an inventory of LARC for certain providers, such as SBHCs. Under such a proposal, the state would incur an administrative expense to purchase a stock of LARC for the provider to use for Medicaid beneficiaries; once the entire stock is used, HSD would be able to re-stock the provider with more LARC supplies.

- **Consider allowing cost-effective non-covered services as an alternative to opioids for pain management.** Given the current risk of addiction to opioids in individuals seeking to manage pain, HSD believes it is important to consider policies that present safe and cost-effective alternatives to opioid use among Medicaid beneficiaries. HSD might consider requesting waiver authority that would allow the Centennial Care MCOs to provide services not listed in the Medicaid State Plan or in the covered services section of the MCO contracts when the use of such alternative services is both medically appropriate and cost-effective. Non-covered services that present a first-stop alternative to opioid use to manage pain might include acupuncture or chiropractic services.

- **Offer affordable alternatives to full dental and vision coverage, if necessary due to cost-containment.** HSD hopes that reductions in covered services and benefits will not be necessary, but the Department may need to scale back benefit design for adults to ensure the ongoing sustainability of the Medicaid program. Services that are considered "optional" under federal law include dental and vision coverage. Should HSD need to reduce or eliminate these types of services due to financial constraints, the Department is considering the development of dental and/or vision riders that individuals could purchase at an affordable premium, similar to the design of dental and vision coverage available to state employees. The development of any type of rider program would need to be included in the waiver to ensure the availability of federal matching funds.