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**State/Territory Name: New Mexico**

**State Plan Amendment (SPA) #: 13-30**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Dallas Regional Office  
1301 Young Street, Suite 833  
Dallas, Texas 75202



**DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI**

June 12, 2014

Ms. Julie Weinberg, Director  
Medical Assistance Division  
New Mexico Department of Human Services  
P.O. Box 2348  
Santa Fe, New Mexico 87504

RE: New Mexico State Plan Amendment (SPA) Transmittal Number 13-30

Dear Ms. Weinberg:

Enclosed for your records is an approved copy of New Mexico's proposed Alternative Benefit Plan (ABP) State Plan Amendment (SPA) TN# 13-30. This ABP, which was submitted on March 18, 2014, meets all federal statutory and regulatory requirements for establishing an ABP. The state has selected (the) Lovelace Classic Preferred Provider Organization (PPO) 2013 base benchmark and has chosen to not align all of the benefits with its currently approved section 1905(a) Medicaid State plan.

All requirements pertaining to Alternative Benefit Plans must be met, including payment rates and reimbursement methodologies, cost-sharing state plan pages, and (if applicable) managed care service delivery systems. These must be updated as necessary to reflect other changes required by federal statute and regulation within allowable parameters.

Please note that we are aware that due to the ongoing system changes occurring with change requests, the State will not be able to immediately apply the revised language CMS approved for the beneficiary notices related to the ABP SPA. However, we respectfully request that the State send out the changes within the revised beneficiary notices no later than 90 days from the approval date of this ABP SPA.

This ABP SPA is approved effective 1/1/2014 as requested by your state. If you have any questions, please contact Stacey Shuman at (214) 767-6479.

Sincerely,

A black rectangular redaction box covering the signature of the sender.

for

Bill Brooks  
Associate Regional Administrator  
Division of Medicaid & Children's Health

Enclosures

## 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-13-0030

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Affordable Care Act and Section 1937 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	\$ 621098699.00
Second Year	2015	\$ 1102541586.00

Subject of Amendment

New Mexico Alternative Benefit Plan (New Adult Group):  
Populations, Voluntary Benefit Package Selection Assurances - Eligibility Group, Enrollment Assurances ,  
Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package, Cost-Sharing Benefits  
Description and Assurances, Service Delivery Systems, Employer Sponsored Insurance and Payment of  
Premiums, General Assurances and Payment Methodology

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: **Caitlin Kuennen Breen**  
Last Revision Date: **Jun 9, 2014**  
Submit Date: **Mar 18, 2014**

Date Received: March 18, 2014

Date Approved: June 12, 2014

Signature of Regional Official:

PRINTED NAME and Title: Bill Brooks, Associate Regional Administrator  
Division of Medicaid and Children's Health

for



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name:

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?	
<b>+</b>	Adult Group	Mandatory	<b>X</b>

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

### Geographic Area

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

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

STATE: New Mexico  
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# Alternative Benefit Plan

OMB Control Number: 0938-1148

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## 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

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# 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

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



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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

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V.20130807

**STATE: New Mexico**  
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# Alternative Benefit Plan

OMB Control Number: 0938-1148

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Attachment 3.1-C-

## 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.

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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





# Alternative Benefit Plan

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

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- 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.



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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

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# Alternative Benefit Plan

OMB Control Number: 0938-1148

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Attachment 3.1-C-

## Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

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:

### 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:

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### Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.



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- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

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

The Lovelace Classic PPO plan was also chosen by the New Mexico Health Insurance Marketplace as its EHB Base Benchmark Plan.

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Attachment 3.1-C-

## 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

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Benefits Description	ABP5
The state/territory proposes a "Benchmark-Equivalent" benefit package. <input type="checkbox"/> No	
<b>Benefits Included in Alternative Benefit Plan</b>	
Enter the specific name of the base benchmark plan selected:	
Lovelace Classic PPO	
Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."	
Secretary-Approved	

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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

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

Remove

Benefit Provided:	Source:	Remove
Holter Monitors & Cardiac Event Monitors	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:	<input type="text"/>	
None		
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
Home Health Care & Intravenous Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Limited to 100 four-hour visits per year.	None	
Scope Limit:	<input type="text"/>	
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="The recipient must require skilled care and be unable to receive medical care on an ambulatory outpatient basis."/>		

Benefit Provided:	Source:	<b>STATE: New Mexico</b> <b>DATE RECEIVED: 3/18/14</b> <b>DATE APPROVED: 6/12/14</b> <b>EFFECTIVE DATE: 1/1/14</b> <b>TN: 13-30</b>
Hospice Care Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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

Remov

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:

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DATE RECEIVED: 3/18/14  
DATE APPROVED: 6/12/14  
EFFECTIVE DATE: 1/1/14  
TN: 13-30



# Alternative Benefit Plan

Benefit Provided:		Source:	
<input type="text" value="Primary Care to Treat Illness/Injury"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
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="None"/>		
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="Radiation Therapy and Chemotherapy"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
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="None"/>		
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="Specialist Visits"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
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="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>			

STATE: New Mexico  
DATE RECEIVED: 3/18/14  
DATE APPROVED: 6/12/14  
EFFECTIVE DATE: 1/1/14  
TN: 13-30

TN: NM 13-30                      Approved: 6/12/14                      Effective: 1/1/14



# 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:		STATE: New Mexico DATE RECEIVED: 3/18/14 DATE APPROVED: 6/12/14 EFFECTIVE DATE: 1/1/14 TN: 13-30
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:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

Add

**STATE: New Mexico**  
**DATE RECEIVED: 3/18/14**  
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**EFFECTIVE DATE: 1/1/14**  
**TN: 13-30**



# 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.

STATE: New Mexico  
DATE RECEIVED: 3/18/14  
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TN: 13-30



# 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

STATE: New Mexico  
DATE RECEIVED: 3/18/14  
DATE APPROVED: 6/12/14  
EFFECTIVE DATE: 1/1/14  
TN: 13-30

TN: NM 13-30

Approved: 6/12/14

Effective: 1/1/14



# Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 3: Hospitalization	Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input type="text" value="Bariatric Surgery"/></td><td style="width: 30%; border: none;">Source: <input type="text" value="Base Benchmark Small Group"/></td><td style="width: 20%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input type="text" value="Prior Authorization"/></td><td style="border: none;">Provider Qualifications: <input type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input type="text" value="Limited to one per lifetime"/></td><td style="border: none;">Duration Limit: <input type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input type="text" value="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."/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/></td></tr></table>		Benefit Provided: <input type="text" value="Bariatric Surgery"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>		Amount Limit: <input type="text" value="Limited to one per lifetime"/>	Duration Limit: <input type="text" value="None"/>		Scope Limit: <input type="text" value="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: <input type="text"/>		
Benefit Provided: <input type="text" value="Bariatric Surgery"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>														
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>															
Amount Limit: <input type="text" value="Limited to one per lifetime"/>	Duration Limit: <input type="text" value="None"/>															
Scope Limit: <input type="text" value="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: <input type="text"/>																
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input type="text" value="Inpatient Medical and Surgical Care"/></td><td style="width: 30%; border: none;">Source: <input type="text" value="Base Benchmark Small Group"/></td><td style="width: 20%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input type="text" value="Other"/></td><td style="border: none;">Provider Qualifications: <input type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input type="text" value="None"/></td><td style="border: none;">Duration Limit: <input type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input type="text" value="Surgeries for cosmetic purposes are not covered."/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Prior authorization required for use of a hospital over 100 miles from the New Mexico border, except in an emergency."/></td></tr></table>		Benefit Provided: <input type="text" value="Inpatient Medical and Surgical Care"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input type="text" value="Other"/>	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="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: <input type="text" value="Prior authorization required for use of a hospital over 100 miles from the New Mexico border, except in an emergency."/>		
Benefit Provided: <input type="text" value="Inpatient Medical and Surgical Care"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>														
Authorization: <input type="text" value="Other"/>	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="Surgeries for cosmetic purposes are not covered."/>																
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input type="text" value="Organ and Tissue Transplants"/></td><td style="width: 30%; border: none;">Source: <input type="text" value="Base Benchmark Small Group"/></td><td style="width: 20%; border: none;"></td></tr><tr><td style="border: none;">Authorization: <input type="text" value="Prior Authorization"/></td><td style="border: none;">Provider Qualifications: <input type="text" value="Medicaid State Plan"/></td><td style="border: none; vertical-align: top;"><div style="border: 2px solid red; padding: 5px; color: red; font-weight: bold;">STATE: New Mexico DATE RECEIVED: 3/18/14 DATE APPROVED: 6/12/14 EFFECTIVE DATE: 1/1/14 TN: 13-30</div></td></tr><tr><td style="border: none;">Amount Limit: <input type="text" value="Limited to two per lifetime"/></td><td style="border: none;">Duration Limit: <input type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input type="text" value="Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants."/></td></tr></table>		Benefit Provided: <input type="text" value="Organ and Tissue Transplants"/>	Source: <input type="text" value="Base Benchmark Small Group"/>		Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<div style="border: 2px solid red; padding: 5px; color: red; font-weight: bold;">STATE: New Mexico DATE RECEIVED: 3/18/14 DATE APPROVED: 6/12/14 EFFECTIVE DATE: 1/1/14 TN: 13-30</div>	Amount Limit: <input type="text" value="Limited to two per lifetime"/>	Duration Limit: <input type="text" value="None"/>		Scope Limit: <input type="text" value="Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants."/>					
Benefit Provided: <input type="text" value="Organ and Tissue Transplants"/>	Source: <input type="text" value="Base Benchmark Small Group"/>															
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<div style="border: 2px solid red; padding: 5px; color: red; font-weight: bold;">STATE: New Mexico DATE RECEIVED: 3/18/14 DATE APPROVED: 6/12/14 EFFECTIVE DATE: 1/1/14 TN: 13-30</div>														
Amount Limit: <input type="text" value="Limited to two per lifetime"/>	Duration Limit: <input type="text" value="None"/>															
Scope Limit: <input type="text" value="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

STATE: New Mexico  
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EFFECTIVE DATE: 1/1/14  
TN: 13-30

TN: NM 13-30

Approved: 6/12/14

Effective: 1/1/14





# Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 4: Maternity and newborn care		Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Delivery and Inpatient Maternity Services"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="Includes lactation support, supplies and counseling."/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Delivery and Inpatient Maternity Services"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="Includes lactation support, supplies and counseling."/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Delivery and Inpatient Maternity Services"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>															
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>																
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																	
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Pre- and Post-Natal Care"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="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."/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Pre- and Post-Natal Care"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="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."/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Pre- and Post-Natal Care"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>															
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>																
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																	
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		<input type="button" value="Add"/>															

STATE: New Mexico  
DATE RECEIVED: 3/18/14  
DATE APPROVED: 6/12/14  
EFFECTIVE DATE: 1/1/14  
TN: 13-30



# 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

STATE: New Mexico  
DATE RECEIVED: 3/18/14  
DATE APPROVED: 6/12/14  
EFFECTIVE DATE: 1/1/14  
TN: 13-30



# 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: <input type="text"/>		
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: <input type="text"/>		
Benefit Provided: Assertive Community Treatment (ACT)	Source: State Plan 1905(a)	STATE: New Mexico DATE RECEIVED: 3/18/14 DATE APPROVED: 6/12/14 EFFECTIVE DATE: 1/1/14 TN: 13-30
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		

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# 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.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

No

Provider Qualifications:

State licensed

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.

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# 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.

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# 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	STATE: New Mexico DATE RECEIVED: 3/18/14 DATE APPROVED: 6/12/14 EFFECTIVE DATE: 1/1/14 TN: 13-30
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	



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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.





# Alternative Benefit Plan

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

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# Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services	Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Imaging"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Imaging"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Imaging"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>														
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>															
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>																
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Lab Tests, X-Ray Services and Pathology"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Lab Tests, X-Ray Services and Pathology"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Lab Tests, X-Ray Services and Pathology"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>														
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>															
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>																
<input type="button" value="Add"/>																

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# 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

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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



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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: <input type="text"/>	

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: <input type="text"/>		

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: <input type="text"/>		

Benefit Provided: Immunizations	Source: Base Benchmark Small Group
------------------------------------	---------------------------------------



# Alternative Benefit Plan

Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="This benefit includes ACIP-recommended vaccines."/>		
Benefit Provided: <input type="text" value="Insertion/Removal of Contraceptive Devices"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
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="None"/>		
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: <input type="text" value="Osteoporosis Treatment &amp; Management"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<b>STATE: New Mexico</b> <b>DATE RECEIVED: 3/18/14</b> <b>DATE APPROVED: 6/12/14</b> <b>EFFECTIVE DATE: 1/1/14</b> <b>TN: 13-30</b>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		



# Alternative Benefit Plan

Benefit Provided:		Source:	
<input type="text" value="Periodic Glaucoma Test (Age 35 or Older)"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
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:	
<input type="text" value="Periodic Colorectal Examination (Age 35 or Older)"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
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."/>		

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# 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

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# 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

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Effective: 1/1/14





# Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 10: Pediatric services including oral and vision care		Collapse All <input type="checkbox"/>
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	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="None."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="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."/>		
<input type="button" value="Add"/>		

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# Alternative Benefit Plan

Other Covered Benefits from Base Benchmark

Collapse All

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# 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: <input type="text" value="Acupuncture (\$1,500 per year)"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<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> <p><input type="text" value="Substituted with dental services within the Ambulatory Patient Services category."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Chiropractic Care (\$1,500 per year)"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<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> <p><input type="text" value="Substituted with dental services within the Ambulatory Patient Services category."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="CMJ and TMJ Conditions"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<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> <p><input type="text" value="Substituted with dental services within the Ambulatory Patient Services category."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Special Medical Foods"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<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> <p><input type="text" value="Substituted with dental services within the Ambulatory Patient Services category."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Infertility (Diagnosis, Treatment &amp; Correction)"/></p>	<p>Source: Base Benchmark</p>	<input type="button" value="Remove"/>
<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> <p><input type="text" value="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."/></p>		
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient Rehabilitation for Substance Abuse"/></p>	<p>Source: Base Benchmark</p>	

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# Alternative Benefit Plan

<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> <p>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.</p>		<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted:</p> <p>Behavioral Health Inpatient Hospital Services</p>	<p>Source:</p> <p>Base Benchmark</p>	<input type="button" value="Remove"/>
<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> <p>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.</p>		<input type="button" value="Add"/>

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# Alternative Benefit Plan

<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered	Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Child Care	Source: Base Benchmark <input type="button" value="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.	
<input type="button" value="Add"/>	

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# Alternative Benefit Plan

<input checked="" type="checkbox"/> Other 1937 Covered Benefits that are not Essential Health Benefits		Collapse All <input type="checkbox"/>
Other 1937 Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Non-Emergency Transportation"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Other"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="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:	<input type="text" value="There is no authorization requirement for this benefit."/>	
<input type="button" value="Add"/>		

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TN: NM 13-30

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# 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

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# Alternative Benefit Plan

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Attachment 3.1-C-

## 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):

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### 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).

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# Alternative Benefit Plan

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Attachment 3.1-C-

## 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).

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- 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

The managed care program is operating under (select one):



# Alternative Benefit Plan

- 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:

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](http://www.state.nm.us/centennialcare).

### 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):

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# Alternative Benefit Plan

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# Alternative Benefit Plan

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Attachment 3.1-C-

## 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:

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Attachment 3.1-C-

## 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.

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# Alternative Benefit Plan

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Attachment 3.1-C-

## 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.

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