Table of Contents

State/Territory Name: New Mexico

State Plan Amendment (SPA) #: 23-0018-A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

March 26, 2025

Dana Flannery
Director
Medical Assistance Division
New Mexico Human Services Department
2025 South Pacheco Drive
Santa Fe, New Mexico 87504-2348

Re: New Mexico State Plan Amendment (SPA) - 23-0018-A

Dear Director Flannery:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0018-A. This amendment proposes to update the Alternative Benefit Plan (ABP) to add Chiropractic services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR § 440.60(b). This letter informs you that New Mexico's Medicaid SPA TN 23-0018-A was approved on March 26, 2025, with an effective date of January 1, 2024.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the New Mexico State Plan.

If you have any questions, please contact Dana Brown at (410) 786-0421 or via email at Dana.Brown@cms.hhs.gov .

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Valerie Tapia
Dana Flannery

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **New Mexico**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

NM-23-0018-A

Proposed Effective Date

10/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 440.60(b)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2024	$ 157230.00
Second Year	2025	$ 204214.00

Subject of Amendment

This State Plan Amendment Establishes Medicaid Reimbursement for Chiropractic Services.

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:	**La Risa Rodges**
Last Revision Date:	**Mar 25, 2025**
Submit Date:	**Apr 4, 2024**

Alternative Benefit Plan

State Name: New Mexico

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: NM - 23 - 0018-A

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Presbyterian Health Plan - Individual Silver C HMO

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

Secretary-Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: 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: Dialysis
Source: Base Benchmark Small Group
Remove

Authorization: No
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Benefit Provided: Home Health Care & Intravenous Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: Limited to 100 four-hour visits per year.
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: The recipient must require skilled care and be unable to receive medical care on an ambulatory outpatient

basis.

Benefit Provided: Hospice Care Services

Source: Base Benchmark Small Group

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:

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.

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Outpatient Surgery

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
None

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

Benefit Provided:
Primary Care to Treat Illness/Injury

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Radiation Therapy and Chemotherapy

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:
Specialist Visits

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:
Treatment of Diabetes

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:
This benefit includes medical supplies for the treatment of diabetes.

Benefit Provided:
Vision Care for Eye Injury or Disease

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Benefit Provided:
Vision Hardware

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
One complete set of contact lenses or eyeglasses

Duration Limit:
None

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

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

Benefit Provided:
Podiatry and Routine Foot Care

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Benefit Provided:
Urgent Care Services/Facilities

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

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

Benefit Provided: Observation Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Observation services for greater than 24 hours will require Prior Authorization.

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

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

Benefit Provided: Chiropractic Services

Source: Base Benchmark Small Group

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: $2,000 annually

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:

Limitations are not applicable when documented as medically necessary for the recipient. Services in excess of $2000/annually may be subject to prior authorization.

Benefit Provided:

Source:

Remove

Authorization: None

Provider Qualifications:

Amount Limit:

Duration Limit:

Alternative Benefit Plan

Scope Limit:

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

Add

Alternative Benefit Plan

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

Benefit Provided: Emergency Ground or Air Ambulance Services
Source: Base Benchmark Small Group
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization required when taking a recipient to a facility over 100 miles from the New Mexico border.

Benefit Provided: Emergency Department Services/Facilities
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Dental Care
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Covers emergency dental care that is needed because of accidental injury from an outside force to a sound, natural tooth. To be considered sound, the tooth must not have significant decay or prior trauma.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Emergency treatment of jawbones or surrounding tissues is also covered.

Benefit Provided:

Source:

Remove

Authorization:
No

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

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Bariatric Surgery
Source: Base Benchmark Small Group
Remove

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

Benefit Provided: Inpatient Medical and Surgical Care
Source: Base Benchmark Small Group
Remove

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

Benefit Provided: Organ and Tissue Transplants
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs.

Alternative Benefit Plan

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

Benefit Provided:
Reconstructive Surgery

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Add

Alternative Benefit Plan

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

Benefit Provided: Delivery and Inpatient Maternity Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Includes lactation support, supplies and counseling.

Benefit Provided: Pre- and Post-Natal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Add

Alternative Benefit Plan

Collapse All ☐

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

Remove

Benefit Provided: Inpatient Hospital Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Refer to State Plan 1905(a)

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

Remove

Benefit Provided: Medication-Assisted Therapy for Opioid Addiction

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Refer to State Plan 1905(a)

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

Remove

Benefit Provided: Outpatient Behavioral Health Professional Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

Alternative Benefit Plan

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

Benefit Provided: Drug/Alcohol Dependency Treatment Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Refer to State Plan 1905(a)

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

Benefit Provided: Electroconvulsive Therapy (ECT)

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Assertive Community Treatment (ACT)

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Refer to State Plan 1905(a)

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

Refer to State Plan 1905(a)

Benefit Provided:

Psychosocial Rehabilitation (PSR)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Refer to State Plan 1905(a)

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

Refer to State Plan 1905(a)

Add

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	No	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

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

Alternative Benefit Plan

☑ 7. Essential Health Benefit: 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
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Coverage of medical supplies is limited to diabetic supplies, contraceptive supplies, lactation supplies, cardiac event monitors, and holter monitors.

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

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

Remove

Benefit Provided: Orthotic Appliances

Source: Base Benchmark Small Group

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.

Remove

Benefit Provided: Prosthetic Devices, Repair and Replacement

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Alternative Benefit Plan

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

Benefit Provided: Diagnostic Imaging
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Allergy Testing and Injections

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Annual Physical Exam & Consultation

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

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

Benefit Provided: Chronic Disease Management

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
None

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

Benefit Provided:
Diabetes Equipment, Supplies & Education

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Genetic Evaluation & Testing

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Benefit Provided:
Immunizations

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This benefit includes ACIP-recommended vaccines.

Benefit Provided: Insertion/Removal of Contraceptive Devices

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Osteoporosis Treatment & Management

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Periodic Glaucoma Test (Age 35 or older)

Source: Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Benefit Provided:
Preventive Care and Screenings

Source:
State Plan 1905(a)

Remove

Authorization:
No

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Refer to State Plan 1905(a)

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

Benefit Provided:
Voluntary Family Planning Services

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Sterilization reversal is not covered.

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

Alternative Benefit Plan

Benefit Provided:

Source:

Remove

Authorization:

None

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

Alternative Benefit Plan

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
The source plan for this benefit is the New Mexico Medicaid State Plan. Prior authorization required for certain services. Some services subject to a periodicity schedule.

Add

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

Alternative Benefit Plan

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

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

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

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

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

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

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

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

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

Add

Alternative Benefit Plan

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

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

Source: Base Benchmark

Remove

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

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

Add

Alternative Benefit Plan

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

Other 1937 Benefit Provided: Non-Emergency Transportation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

Other: There is no authorization requirement for this benefit.

Other 1937 Benefit Provided: Dental Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Annual limits on some services

Duration Limit: none

Scope Limit: Refer to State Plan 1905(a)

Other: Refer to State Plan 1905(a)

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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

V.20160722