Alternative Benefit Plan

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Attachment 3.1-L- ☐

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.

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

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

☑ 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

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.