



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

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



Alternative Benefit Plan

Describe:

All HIP Link enrollees must make two distinct opt-in choices to enroll in HIP Link: (1) the HIP Link enrollee must have requested HIP Link as their coverage option and (2) the HIP Link enrollee must separately enroll with the employer in a HIP Link eligible health plan by completing the employer's enrollment paperwork.

Applicants may enroll in HIP Link by making the selection of HIP Link on the application and providing the HIP Link employer information. Current HIP members and conditional HIP members may make the election to enroll in HIP Link by calling the Division of Family Resources and using the change reporting process to request a transfer from HIP to HIP Link. No applicant or member is enrolled in or transferred to HIP Link without making an affirmative selection of HIP Link either through the application for health coverage or through the change reporting process. In addition, to be HIP Link eligible an applicant must have completed the group health coverage enrollment paperwork with their employer and already be receiving ESI benefits or have an employer confirmed start date for ESI benefits for HIP Link eligibility to be established.

Prior to enrollment in HIP Link the applicant's or member's employer will verify that the applicant or member is enrolled in HIP Link eligible ESI plan. Once the employer receives a request for verification, the employer will have five business days to complete the verification. If the employer does not complete the verification in five business days, current member's will remain in HIP Plus, HIP Basic, or HIP State Plan benefits, as applicable. Applicants will be enrolled into HIP as a HIP Plus or HIP State Plan Plus conditional member. The employer's failure to comply with the five day time line does not prevent the applicant from requesting HIP Link again in the future, but rather it establishes a specific time frame for the employer to help ensure timely enrollment into HIP Link when requested by the applicant. Verification of HIP Link eligibility can be appealed by the member to the state through the standard appeals process, and members may also request, via the change reporting process, to have their HIP Link eligibility verified again at any time. Appeals of HIP Link eligibility are handled by the state through the standard appeals process. If the employer confirms the applicant's or member's enrollment in HIP Link eligible ESI benefits, HIP Link benefits will begin as described below.

For current HIP members, as with other changes to HIP eligibility, HIP Link benefits begin the first of the month following the employer's verification of active enrollment in ESI, such that there is no overlap between HIP and HIP Link coverage. For example, if the employer confirms in July that the employee is eligible for and enrolled in HIP Link eligible ESI as of July 3rd, then the HIP member will transfer to HIP Link on August 1st. If the employer confirms in July that the employee ESI benefits will begin August 17th, then the HIP Member will transfer from their active HIP benefits to HIP Link on September 1.

For new applicants, HIP Link benefits begin the first day of the month where employer confirms the member was actively enrolled in ESI on the first of the month. For example, if the employer confirms in July that the applicant was enrolled in HIP Link eligible ESI on July 1, then HIP Link benefits will begin July 1. If the employer confirms in July that the applicant's ESI benefits will begin August 17th, then the applicant may enroll in HIP pending their HIP Link enrollment effective September 1. Individuals that lose eligibility for HIP Link due to loss of access to employer sponsored insurance will be immediately transferred from HIP Link to HIP Plus or HIP State Plan Plus as applicable for the individuals eligibility group, individuals that lose access to ESI will not experience a gap in coverage during the transition back to HIP coverage.

Current members that request a transfer to HIP Link will be notified at the time of request that selection of HIP Link will mean that they will be enrolled HIP Link until their next annual redetermination or the end of their employers insurance, which could be up to a period of 12 months depending on when the member requests the transfer to HIP Link. Information will be provided when the member requests a HIP Link transfer on the opt-out at anytime option for frail members and how to contact the enrollment broker for benefits counseling. Members may withdraw requests for transfers to HIP Link as long as the employer has not verified that the member is enrolled in ESI and the member has not been receiving premium reimbursement checks.

Members eligible to disenroll from HIP Link due to medically frail status may do so at any time. To disenroll, medically frail individuals utilize the change reporting process to request transfer from HIP Link to HIP Plus. When the medically frail individual makes the request, they will receive a form by mail which they must complete to attest to their medically frail condition. Effective the first of the month following the receipt of the completed form by the state, the medically frail individual will be transferred from HIP Link to HIP State Plan Plus. Members will have to separately contact their employer to disenroll from the employer sponsored insurance.



Alternative Benefit Plan

All applicants and HIP members that request a transfer to HIP Link will receive an eligibility notice from the state that informs them if their HIP Link eligibility was verified with their employer and if so, what their HIP Link start date is. This notice also provides information on how to access enrollment counseling for information on the differences between the HIP and HIP Link benefit packages, advises the member that individuals with serious medical or mental health conditions may transfer from HIP to HIP Link at any time, and informs the member that those age 19 and 20 will receive EPSDT benefits that includes all medically necessary 1905(a) benefits via use of the HIP Link card if these benefits are not provided under their employer health plan. Information on enrollment counseling and the ability for some groups to transfer from HIP Link to HIP at any time is also included in member materials and HIP Link marketing and informational materials accessible through the HIP Link website.

The time between the receipt of the member eligibility notice, and the start of the HIP Link benefits will vary based on the date which the applicant or member has active enrollment in HIP Link eligible ESI. The applicant may receive their HIP Link approval notice during the month in which their HIP Link enrollment begins if they are already enrolled in ESI. Or the applicants that have a waiting period for ESI enrollment will receive the HIP Link eligibility notice in the month or months prior to the start of HIP Link enrollment. During any applicable ESI waiting period, the member may access the standard HIP conditional enrollment process to gain coverage for the months between authorization and the start of their HIP Link benefits.

Regardless of the HIP Link start date, at any time applicants, prospective applicants, or members can contact the enrollment broker for counseling on the differences between HIP Link and the applicable HIP benefits. All members seeking counseling who are medically frail based on their case record will receive counseling from the enrollment broker about the the differences between the individual's current HIP State Plan Basic or HIP State Plan Plus benefits and the benefits available under the HIP Link approved ESI as well as counseling on cost-sharing. The enrollment broker will have access to the benefit documents provided by the HIP Link approved employer health plans and the HIP Link Employer Counseling Team's plan review notes to assist them in advising the member on the differences between HIP Basic and HIP Plus and HIP State Plan benefits and cost sharing. For applicants and prospective applicants, the enrollment broker will advise the individuals that if they have a health condition that may qualify them as medically frail then they may qualify for enhanced benefits under the HIP option that are not available under the HIP Link option. Enrollment counseling is not required for applicants or members to enroll in HIP Link, but it is an option for all prospective HIP Link enrollees, including the medically frail. Enrollment counseling continues to be available after the individual enrolls in HIP Link to help individuals decide if HIP Link remains the best coverage option. The medically frail can leverage ongoing enrollment counseling to support decision making around transferring from HIP Link to HIP.

In addition to the eligibility notice and enrollment counseling tailored to the benefits and cost sharing of the specific employer sponsored health plan, HIP Link members will also receive a member manual that serves as a comprehensive program guide and covers content relevant to members from eligibility, calculation of their contribution and the member prepayment schedule. The member manual includes information on the benefits in HIP Link and the potential benefit differences between their HIP Link employer plan and the benefits available in HIP. The member manual details benefits that are available to the medically frail through the HIP State Plan benefit option. The member manual provides reference for the qualifying events, including becoming medically frail, that allow an individual to transfer from HIP Link back to HIP and provides a guide of how to request a transfer to HIP utilizing the change reporting process. All HIP Link members will receive a HIP Link member manual when they enroll into HIP Link.

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?

Applicants and current members that request a transfer to HIP Link will receive notification on the times outlined above. Depending on the start date of their HIP Link eligible ESI, applicants may be directly enrolled into HIP Link effective the first of the month in which they receive their eligibility notice.



Alternative Benefit Plan

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.

The medically frail may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the existing change reporting process to request a transfer from HIP Link to HIP. Individuals requesting a transfer from HIP Link to HIP due to medically frail status are provided with a health condition questionnaire. To complete the transfer the individual must complete the questionnaire. The health conditions indicated by the individual are not subject to verification to transfer from HIP Link to HIP. The transfer to HIP will occur effective the first of the month following the receipt of the medically frail attestation form.

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

Describe:

All individuals that enroll in HIP Link will may access options counseling through the enrollment broker and will be informed that upon enrollment into HIP Link they will be covered by their employer sponsored insurance and not HIP. Individuals that call for options counseling will have their request for counseling documented in the enrollment brokers call tracking system. Information on how to access options counseling for HIP Link is provided in general HIP Link marketing and outreach materials, including materials posted online, member manuals and other member material, all specific notices that go to individuals requesting HIP Link, and by the call center when members ask about HIP Link or request a transfer from HIP to HIP Link.

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

- Copy of correspondence sent to the individual.
- Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- Other

Describe:

Eligibility notices sent to HIP Link members inform all members of the option for enrollment counseling via the enrollment broker and that individuals who are medically frail may disenroll at any time through the change reporting process. For individuals that contact the enrollment broker for specific options counseling, record that the individual took part in the enrollment counseling will be noted in the individuals record. Depending on if the individual contacts the enrollment broker for HIP Link options counseling during the application process or after being determined eligible for HIP, the record of the counseling process may be associated with the member's name as provided to the enrollment broker, or the members identification number.



Alternative Benefit Plan

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

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.20131219