



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024

OMB Expiration date: 10/31/2014

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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Describe:

All eligibility notices to HIP members and any notices generated when a member reports changes will indicate how to report medically frail status to the managed care entity. The medically frail confirmation process will also be described in the member manual.

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?

Individuals will be informed of the medically frail self-report process in their initial eligibility notice and in all notices received when the member has reported a an eligibility change. The process will also be detailed the member manual. Individuals confirmed medically frail will be enrolled in the State Plan ABP.

Self-report of medically frail status is only one avenue for members to be confirmed frail. All individuals with an active disability determination by the Social Security Administration or a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status. In addition, any member that has medical claims that confirm a medically frail condition throughout the year may be confirmed medically frail by their MCE without having to self-report their status.

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 that are confirmed to meet the medically frail criteria by their managed care entity will not receive the benefits described in the HIP Basic or HIP Plus ABPs and do not have the option to opt into these plans. They will receive the benefits on the State Plan ABP. These benefits will be provided through the same Managed Care Entities that provide the HIP Basic and HIP Plus ABPs. The benefits of the State Plan ABP offer additional benefits in excess of what is covered in HIP Basic and HIP Plus.

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:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans, but will be automatically assigned to the State Plan ABP.

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

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans that are the Alternative Benefit Plans (ABPs) with Essential Health Benefits, but will receive the benefits from the State Plan ABP.

- 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):

Confirmed medically frail individuals will receive benefits that are in all ways equivalent to State Plan ABP benefits and offer benefits not covered through the HIP Basic and Plus ABPs. Therefore, medically frail individuals will not need to have the choice to opt into these two less generous plans.

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.

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