



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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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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

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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