Alternative Benefit Plans for the Medicaid Expansion Population: Trends in Approved Benefit Plans and Tools for Advocates

Prepared By: Michelle Lilienfeld[1]
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Alternative Benefit Plans (ABPs), formerly known as Medicaid benchmarks, have existed since the Deficit Reduction Act of 2005 gave states the authority to develop alternative Medicaid benefit packages for select groups of Medicaid beneficiaries. Prior to the Affordable Care Act (ACA), only a few states had selected this option. But the ACA brought new significance to ABPs by making them the benefit packages offered to the newly eligible Medicaid expansion population. The ACA also made important changes to ABPs, including a new requirement that ABPs provide, at a minimum, the Essential Health Benefits (EHBs.)

States implementing the Medicaid expansion must obtain approval from the Centers for Medicare and Medicaid Services (CMS) of a State Plan Amendment (SPA) establishing an ABP for the adult expansion group. CMS developed a new ABP SPA template for states to use when submitting their ABP selection. The first ABP SPA approvals for the Medicaid expansion population were issued in December 2013 and others have followed.[2] To date most states participating in the Medicaid expansion have aligned their ABP for the expansion population with their traditional Medicaid benefits package. This alignment of benefits for all Medicaid populations can be advantageous for a number of reasons, including ensuring comprehensive services for beneficiaries, minimizing disruption for individuals moving among different eligibility categories, and reducing the state's administrative burden.

This fact sheet provides an overview of aligned and non-aligned benefits, trends in approved ABP SPAs for the expansion population, and other important considerations and tools for advocates.

I. Aligned Benefits

So far, of the 27 states (including D.C.) implementing the Medicaid expansion in 2014, seventeen have aligned their ABPs with their Medicaid state plan benefits, five states

[1] Sara Popovich, a rising third-year law student at UC Davis School of Law contributed extensively to the preparation of this Fact Sheet.
[2] Approved ABP SPAs are posted on the "Medicaid.gov" website.

have not aligned benefits, and five states are still pending ABP SPA approval. (*See Appendix 1 for a list of approved SPAs.*)

What does "aligned benefits" mean?

"Aligned benefits" means the state modeled its ABP package after the state's existing Medicaid state plan benefits rather than after a public employee or commercial market plan. However, "aligned" does not necessarily mean the benefit packages offered to the expansion and traditional Medicaid populations are **exactly** the same.

As of January 1, 2014, ABPs must provide at least the EHBs. However, this EHB requirement does not apply to the traditional Medicaid benefits package. Therefore if a state decides to align its ABP with the state plan benefits, but the state plan benefits are missing any of the EHBs, the state must supplement those "missing" benefits to ensure all ten EHB statutory benefit categories are accounted for in the ABP. Some states have gone a step further and decided to offer those "missing" EHBs to their traditional Medicaid population as well. In those states, the ABP and state plan benefits are aligned and *identical*. But since states do not get an enhanced federal match for providing additional EHBs to the traditional Medicaid population, some states are only offering those additional EHBs to the expansion population through the ABP. In those states, the ABP is still considered "aligned" because it includes all state plan benefits, but it is not identical to the state plan because it includes additional benefits.

Figure 1: Example of aligned states supplementing EHBs

- California supplemented its ABP with the mental health and substance use disorder services from the state's EHB base-benchmark for the commercial market and offered those additional benefits to the traditional Medicaid population as well.[3]
- Nevada added habilitation-maintenance therapy to both the ABP and state plan benefits.[4]
- Michigan and Colorado offer additional habilitative and preventive services in their ABPs, but not in their state plan.
- Ohio's ABP is based on the state plan, but the ABP does ***not*** include the state plan quantitative limitations applied to Mental Health outpatient services, AOD intensive outpatient services, and psychologist services.

[3] To the extent behavioral health treatment services are considered a mental health service in the EHB base-benchmark plan, those behavioral health services for Medicaid populations in California continue to only be available to individuals receiving the services through an existing home and community-based services waiver.

[4] See *Nevada State Plan Amendment #13-033* (Mar. 7, 2014), *available at* http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-13-033.pdf (adding a description of maintenance therapy services.)

Why is alignment important?

Under federal Medicaid law that existed before the enactment of the ACA, certain groups of "exempt" individuals cannot be required to enroll in ABPs, and must have the option to receive state plan benefits instead. (*See Figure 3 for a list of exempt individuals*.) The ACA does not change this law, so non-aligned states are required to outline in their ABP SPA a process for identifying and notifying exempt individuals about their benefit options. Aligned states do not have to establish such a process, so this administrative simplicity is one of the reasons most states have decided to align benefits.

- *Technical Note:* The adult expansion group is required to have its benefits provided through an ABP. This applies even to individuals that meet the exemption criteria. Yet individuals who meet an ABP exemption must have the option of receiving state plan benefits. To satisfy both requirements, CMS calls the state plan option for exempt individuals in the adult expansion group an ABP.[5] Therefore, in non-aligned states exempt individuals have the option of receiving: 1) the state-selected ABP which includes EHBs and is subject to the requirements in section 1937 of the Act or 2) an ABP that is the state's approved Medicaid state plan benefits package and is not subject to the inclusion of EHBs and section 1937 requirements.[6] In this fact sheet the latter is referred to as a "benefits package equal to the state plan."

Figure 2: Advantages of aligning benefits for all Medicaid populations

- minimize churning since individuals will not have to move from the ABP to a benefits package equal to the state plan due to differences in benefits
- lessen disruptions for individuals moving among different eligibility categories
- administrative simplicity since aligned states do not have to identify and notify "exempt" individuals (i.e., those who cannot be required to enroll in the ABP) of their different benefit options
- simpler eligibility and enrollment process
- administrative cost-savings for the state

II. Non-aligned benefits

Some non-aligned ABPs may closely mirror the state plan benefits, but are not considered aligned because they do not offer *all* benefits in the state plan. For example, New Jersey's ABP offers the state plan benefits plus additional mental health and substance use services, but is not aligned because it ***excludes*** certain long-term services and supports (LTSS) like nursing home care and other home and community-based services. In West Virginia, the ABP offers similar benefits to state plan benefits,

[5] *See* 42 U.S.C. §§ 1396a(k), 1396b(i)(26); Medicaid: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 42,192 (July 15, 2013).
[6] 42 U.S.C. § 1396u-7.

and the ABP actually offers an increased number of visits for occupational therapy, physical therapy and home health, but it does ***not*** cover personal care or nursing home services; therefore it is not aligned.[7]

Not every non-aligned state is using its state plan as the starting point for its ABP. For example, Iowa based its two separate ABPs for the Medicaid expansion population on public employee and commercial market plans. Iowa provides individuals with income from 0 to 100% of the Federal Poverty Level (FPL) with the Iowa Wellness Plan which is a combination of state employee coverage and state plan benefits. For individuals with income from 101-133% FPL, the state provides the Iowa Marketplace Choice Plan based on the benefits offered in Iowa's Marketplace (i.e., the largest small group plan) plus dental coverage from the Medicaid state plan. Of the last three approved ABP SPAs two have been for non-aligned states (New Mexico and New Hampshire.) Both of these states based their ABP coverage on a small group plan, and supplemented the coverage where needed to meet ABP requirements.

In a state that does not offer comprehensive state plan benefits, basing the ABP on a commercial market plan could potentially lead to a richer benefits package for some individuals who need services not covered in the Medicaid state plan. But it is likely true that in *most* states, and for *most* individuals, an ABP based on the state plan benefits will offer the best coverage result. Also, when a state does not align its benefit packages, it must create a clear and effective process for identifying and notifying "exempt" individuals of their benefit options, and provide them with appeal rights when exempt status is denied.

Identifying and notifying "exempt" individuals about benefit options in non-aligned states

Non-aligned states must establish a process for identifying exempt populations and provide them a choice of receiving either the state's approved ABP package or a benefits package that equals the state plan benefits.[8] Even states that are *almost* aligned must clearly convey to beneficiaries the ABP exemption process. For example in New Jersey, exempt beneficiaries enrolled in the ABP will have to rely on the exemption process to access certain LTSS benefits not offered in the ABP but available through the state plan. Therefore, exempt individuals in all non-aligned states will need clear, consumer-friendly information and benefits counseling to help them understand their benefits options.

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[7] *See* West Virginia Department of Health and Human Resources Bureau for Medical Services, *Benefit Plan Comparison Chart* (Jan. 1, 2014), *available at* http://www.dhhr.wv.gov/bms/news/Documents/FFS_ABP_Plan%20Compare_FINAL_v3%200_FINAL%20%282%29.pdf.

[8] *See* sources cited *supra* note 5.

Figure 3: Who is considered "exempt" for ABP purposes?

- Pregnant women;
- Individuals who are blind or have a disability;
- Individuals who are dually eligible for Medicaid and Medicare;
- Terminally ill hospice patients;
- Individuals who are eligible on the basis of hospitalization;
- Individuals who are medically frail or have special medical needs;
- Individuals qualifying for long term care services;
- Children in foster care receiving child welfare services and children receiving foster care or adoption assistance;
- TANF and 1931 parents (i.e., individuals who would have been eligible for Aid to Families with Dependent Children);
- Women in the breast or cervical cancer program;
- Limited services beneficiaries who qualify for Medicaid based on tuberculosis or who qualify for emergency services only; and
- Medically needy or spend-down populations.

Given the eligibility criteria for the Medicaid expansion population, most "exempt" individuals will be "individuals who are medically frail or have special medical needs." Many of the other categories are not relevant for the expansion population because individuals in those groups are already eligible for Medicaid in another category and will not be enrolled in the Medicaid expansion.

Figure 4: How is "medically frail" or "special medical needs" defined? [9]

The state's definition of individuals who are medically frail or otherwise have special medical needs must at least include individuals:

- described in 42 C.F.R. § 438.50(d)(3),[10]
- with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness),
- with chronic substance use disorders,
- with serious and complex medical conditions,

[9] 42 C.F.R. § 440.315(f) (2014).

[10] Children under 19 years of age who are (i) Eligible for SSI under title XVI; (ii) Eligible under section 1902(e)(3) of the Act; (iii) In foster care or other out-of-home placement; (iv) Receiving foster care or adoption assistance; or (v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs.

- with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or
- with a disability determination based on Social Security criteria or in states that apply more restrictive criteria than the Supplemental Security Income program, the state plan criteria.

The "medically frail" definition offers a broad standard for exemption, including expansive criteria such as "serious and complex medical conditions." While a Social Security level of disability meets the medically frail standard, disabling conditions different from the Social Security criteria can also meet the standard. CMS has encouraged states to describe "medically frail" in simpler terms in notices and communication with beneficiaries. States denying a beneficiary an ABP exemption must provide the determination in writing and include an explanation of the appeals process. (*See Appendix 2 for more information about the ABP exemption process approved by CMS for three non-aligned states and Appendix 3 for a non-aligned state case study highlighting the administrative complexities of non-alignment and advocacy tips for advocates.)*

Federal matching rates and eligibility

Non-aligned states will experience administrative burdens and costs, and it is not clear they will save money by using less robust ABP coverage for the Medicaid expansion population. For individuals in the Medicaid expansion, states receive a 100% federal match through 2016 and almost full federal funding for years thereafter. This fixed federal matching rate is applicable to all expansion beneficiaries regardless of whether the state aligns or not, or whether the individual is receiving benefits through the state's ABP or a benefits package equal to the state plan benefits. Therefore perceived state "savings" by using a less robust ABP can be misleading since the federal government is paying almost all of the costs for these benefits and the state is adding administrative costs by having to set up a process to identify and notify exempt individuals of their benefit options.

Similarly, the eligibility criteria for the Medicaid expansion population is fixed, regardless of alignment status or benefits. This means the state cannot apply an assets test, ask for additional financial information (beyond what is normally required for eligibility under the expansion), or otherwise change the eligibility criteria for ABP exempt individuals in non-aligned states who decide they want to enroll in a benefits package equal to the state plan.

Figure 5: Federal Matching Rate & Eligibility Example

In a state excluding LTSS from its ABP, an ABP "exempt" individual can receive those services as covered through the state plan without going through any additional financial determination. Also, the state will receive a 100% federal match for providing those services.

Conclusion

To date, CMS has approved 22 ABP SPAs for the Medicaid expansion population. Most of the SPAs are for states aligning their ABP for the expansion population with their traditional Medicaid state plan benefits. Advocates should check to see whether their state has an approved ABP SPA, or if one is pending, and whether the benefits are aligned or non-aligned with the state plan benefits. If your state has a non-aligned ABP, determine the type of process in place to identify and notify ABP exempt individuals of their benefit options, and make sure there is an appeals system to challenge any exemption denial.

Tools for Advocates

Appendix 1: links to approved ABP SPAs, and list of pending ABP SPAs

Appendix 2: outline of the exemption process for three non-aligned states

Appendix 3: state case study highlighting the administrative complexities of non-alignment and advocacy tips for state advocates in non-aligned states or states considering non-alignment

Appendix 1
Approved ABP SPAs for the Medicaid Expansion Population[1]

State	Date of Approval	Aligned with Medicaid state plan benefits (Y/N)
Arizona http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AZ/AZ-14-0006.pdf	4/1/14	Y
California http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf	3/28/14	Y
Colorado http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-13-0055.pdf ○ ABP SPA Amendment http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-14-0010pdf	2/10/14	Y
Connecticut http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CT/CT-14-0008.pdf	2/21/14	Y
District of Columbia http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DC/DC-13-0019.pdf	1/27/14	Y
Hawaii http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/HI/HI-13-004a.pdf	4/15/14	Y
Illinois http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-14-0013.pdf	6/24/14	Y

[1] *To help decipher the ABP SPA template and process states underwent to create their ABPs, see CMS' Medicaid ABP Implementation Guides: http://157.199.113.99/MMDLDOC/abpIG.html.*

Iowa ▪ Iowa Wellness (0-100% FPL) http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IA/IA-14-004.pdf ▪ Iowa Marketplace (101-133% FPL) http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IA/IA-14-006.pdf	4/2/14	N
Kentucky http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KY/KY-13-021-ABPSPA.pdf	12/20/13	Y
Maryland http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MD/MD-13-0031.pdf	2/7/14	Y
Michigan http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-14-0001.pdf ○ ABP SPA Amendment http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-14-0170.pdf	4/30/14	Y
Minnesota http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-13-0020.pdf	12/30/13	Y
Nevada http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-13-0029.pdf	1/24/14	Y
New Hampshire http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NH/NH-14-0005.pdf	6/30/14	N
New Jersey http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NJ/NJ-13-0028.pdf	3/21/14	N

New Mexico http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NM/NM-13-30.pdf	6/12/14	N
Ohio http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-13-0032.pdf	12/16/13	Y
Oregon http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-13-019.pdf	1/9/14	Y
Rhode Island http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/RI/RI-13-028.pdf	2/12/14	Y
Vermont http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VT/VT-13-029.pdf	1/15/14	Y
Washington http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-14-0009.pdf	5/13/14	Y
West Virginia http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WV/WV-13-0009.pdf	3/17/14	N

ABP SPAs Pending Approval	**Date of Approval**	**Aligned with Medicaid state plan benefits (Y/N)**
Arkansas	TBA	TBA
Delaware	TBA	TBA
Massachusetts	TBA	TBA
New York	TBA	TBA
North Dakota	TBA	TBA

Appendix 2
ABP Exemption Process for Three Non-Aligned States[1]

State	New Jersey	West Virginia	Iowa
Identification at application	**None** New Jersey does not appear to provide a process for identification at application. The state automatically enrolls beneficiaries in the ABP, and individuals must self-identify before consideration for an exemption.	**Self-identification** 1) An individual answers the question, "Does this person (or you, depending on the person completing the form) have a physical, mental, or emotional health condition that causes limitation on activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" 2) If yes, then this will trigger the medically frail exemption.	**Self-identification OR Provider Identification** <u>Self-identification:</u> 1) Individuals answer two questions regarding receipt of Social Security income and/or having a physical, mental or emotional health condition that causes limitations in activities of daily living. 2) If an individual answers affirmatively to either or both questions, they will receive a second questionnaire to assess whether they have exempt status. 3) Based on these answers, Iowa uses a weighted scoring algorithm to determine if the individual has exempt status. **OR** <u>Provider Identification:</u> 1) Providers or other entities with a relationship to the individual can submit a referral form. 2) The person submitting the form provides attestation of the conditions that qualify the applicant as an exempt individual. 2) Iowa then reviews the form to determine if the individual meets the criteria for exemption.
Identification during the enrollment period	**Self-identification + Provider Identification** 1) The individual self-identifies by calling the Medical Hotline number on the enrollment letter. 2) The Medical Hotline gives the individual the Medical Assistance Customer Center (MACC) number.	**Self-identification** Individuals can notify the Bureau for Medical Services (BMS) who will initiate the process. After the individual makes the request, the steps are the same as the steps at the time of enrollment.	**Self-identification OR Provider Identification** At any time, an individual may self-identify by completing a questionnaire, or contacting the Iowa Medicaid Enterprise (IME) for assistance in doing so. A provider/entity may also submit a referral form at any time.

[1] Based on information available in the approved ABP State Plan Amendments for these states.

State	New Jersey	West Virginia	Iowa
	3) After the individual calls the MACC, the MACC will send the individual's provider a form to complete. 4) The MACC then evaluates the individual for exempt status based on this provider form.		
Notification of exempt status	The MACC staff will contact the individual to discuss benefit options. The individual can then choose the ABP or a benefits package equal to the state plan.	The individual will receive a "Medical Frailty Notice" and Medicaid eligibility determination notice informing the individual of the option to choose between the ABP and a benefits package equal to the state plan.	Iowa will mail a letter to the individual with enrollment options, including an opt-out-option.
Counseling services available for exempt individuals	The MACC staff members will reach out to exempt individuals. MACC staff members are clinicians trained on the differences between the ABP and the Medicaid state plan package.	At any time, choice counseling is available by county workers and fiscal agent member help line staff.	Iowa's State Plan Amendment does not appear to mention counseling services available to exempt individuals.
Disenrollment from the ABP and enrollment in coverage equal to the state plan benefits	The MACC staff will complete the necessary steps to change the beneficiary's coverage to a benefits package equal to the state plan.	Exempt individuals must request disenrollment and complete and return a form to BMS. All requests to disenroll from the ABP must be submitted in writing to BMS.	Exempt individuals are automatically enrolled in a benefits package equal to the state plan and have the option to change coverage to the Iowa Wellness Plan ABP by contacting IME.

Appendix 3
A Case Study in New Jersey
A Tool for Advocates in Non-Aligned States and States Considering Non-Alignment

New Jersey chose to create an Alternative Benefit Plan (ABP) that is non-aligned with its state plan benefits.[1] As a result, the state had to create a process to identify "exempt" individuals and notify them of their benefit options.[2] New Jersey outlines its exemption process in its ABP State Plan Amendment (SPA).[3] This Appendix discusses some issues that have arisen for New Jersey in providing beneficiaries exemption from the ABP plan. It can be difficult for non-aligned states to implement a procedure that adequately identifies exempt individuals. Advocates in non-aligned states and states considering non-alignment should look out for similar issues that may arise in their state.

Enrollment Letter

New Jersey automatically enrolls individuals eligible for the Medicaid expansion in the state's ABP. New Jersey's method of notice is an enrollment letter. This letter informs new beneficiaries about the benefits in their plan, and provides them with a hotline number to call if they believe they have "special health care needs". This is the phrase New Jersey has opted to use instead of "medically frail".

However, it is not clear from the notice that beneficiaries should call the hotline number to request an ABP exemption. Instead, the notice states this is the number to call if individuals have special health care needs and want to see if they qualify for another medical assistance program such as "Age, Blind and Disabled or Long Term Care." [4] The goal of exemption language should be to ensure that exempt individuals know they can access additional state plan services. Therefore, the notice must be written clearly, so that it is easy to read, understand and act upon.

In addition, the ABP enrollment letter states that any individual seeking exemption must submit additional "medical *and financial*" information in order for the state to do an eligibility determination.[5] However, as mentioned in the "Federal Matching Rates and

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[1] New Jersey Department of Human Services, Division of Medical Assistance and Health Services is the agency that created the state's ABP. For clarity, it is referred to as "New Jersey."
[2] For more information see section on "Identifying and Notifying 'exempt' individuals of benefits options" of this ABP Fact Sheet.
[3] For the full process by which New Jersey identifies the medically frail exemption population, please see Appendix 2. *See also New Jersey State Plan Amendment # 13-0028* (Mar. 21, 2014), *available at* http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NJ/NJ-13-0028.pdf, at ABP2a-ABP2c.
[4] *See* New Jersey FamilyCare Enrollment Letter, to NJ FamilyCare Plan ABP enrollees (July 16, 2014) (on file with author).
[5] *See id.*

Eligibility" section of this ABP Fact Sheet, the state cannot require additional financial information from those seeking exemption from the ABP.

Furthermore, the enrollment letter provides a list of the "health care services provided" for NJ FamilyCare Plan ABP enrollees.[6] According to the SPA, the NJ FamilyCare ABP covers "Family Planning Services/Supplies", a required service under §1937 of the Social Security Act.[7] However, the list of services in the ABP enrollment letter does not reflect coverage of this service. While the state may have intended to provide this list as a general guide rather than an exhaustive list, this is not obvious to the reader. Therefore, based on this list, ABP beneficiaries may falsely believe that they cannot access covered family planning services.

Finally, although the enrollment letter provides a hotline number, the notice does not contain the hours during which operators are available to answer the hotline phone. The hotline hours are 8:30 AM to 4:30 PM EST. These hours are available upon calling the hotline number, but they should also be included in the enrollment letter. This will give the beneficiary more complete information about when to call the hotline number and speak to available operators.

New Jersey Medical Assistance Hotline

Upon calling the number provided in the enrollment letter, the caller must navigate through an automated phone tree system. Here, there are nine different options presented to the caller. The caller must wait on the line through these options before the automated message will transfer the caller to an operator. This system is not user friendly, because it does not allow someone to easily access a live person.

Furthermore, none of the nine phone tree options explicitly states "special health care needs"; the phrase found in the enrollment letter. It is therefore difficult to determine which phone tree option to select in order to self-identify as an individual with "special health care needs". To improve access to those seeking to self-identify, the automated phone tree should instead have clear language matching that found in the enrollment letter. This will allow beneficiaries to easily navigate to the option where they can begin the exemption review process.

Moreover, operators should be well versed on the new ABP benefit options, and the process for exemption and enrollment into a benefits package equal to the state plan. After callers choose one of the options on the automated phone tree, operators should know where to direct callers who want to self-identify. If operators are uninformed, and they simply refer the caller back to the hotline number, individuals may not be able to access the services they need. To assure that operators are prepared for those calling to self-identify, advocates should request to see the scripts and other training materials provided to hotline operators.

[6] *See id.*
[7] *See* 42 U.S.C. § 1396u-7(b)(7).

Additionally, based on calls made to the hotline, some callers are disconnected after waiting on hold to speak to an operator. The state should ensure that it has operators available to help beneficiaries who call at any time during business hours. If a beneficiary calls to self-identify, and becomes disconnected, they may become frustrated and give up. Since in New Jersey beneficiaries enrolled in the state's ABP will only be able to access certain long-term services and supports (LTSS) through the exemption process, it is important to have a clear and effective process.

After Speaking to a Representative

After the caller navigates through the phone tree, they are given a second phone number for the Medical Assistance Customer Center (MACC). When the beneficiary makes this second call, the MACC sends the beneficiary's provider an attestation form. Requiring beneficiaries to make two phone calls before sending this provider form is unduly burdensome and may cause confusion for some beneficiaries. It also requires that the state provide an extra set of operators to speak to beneficiaries.

The provider attestation form is the tool the MACC uses to make an ABP exemption determination. A few problems arise when requiring a beneficiary's provider to complete this form. First, it assumes that an individual will have a regular provider to fill out the form. Some beneficiaries may not have a provider who knows enough about their health condition to properly fill out this form. Second, there is no way for the individual to self-identify without provider attestation. Essentially, if for some reason the provider does not return the attestation form, it appears the individual cannot get an ABP exemption and receive the state plan benefits excluded from the ABP (i.e. nursing home care and some additional home and community-based services.)

In June 2014, New Jersey sent providers a newsletter explaining how to fill out the provider attestation form.[8] While this is a step in the right direction, this does not ensure that providers will read and understand the newsletter. To guarantee easier access to the ABP exemption, New Jersey should provide an alternative so that provider attestation is not required to obtain an exemption. Beneficiaries denied an ABP exemption should also receive a notice about their right to appeal and have access to a hearing.

Upon a finding of exempt status, MACC staff provides benefit options counseling to the beneficiary. According to New Jersey's SPA, MACC staff is trained on the differences between the ABP and the state plan benefits. These counselors can therefore serve as a useful resource for beneficiaries looking to choose the best plan for their needs.

[8] New Jersey Department of Human Services, Division of Medical Assistance & Health Services, *Provider Letter: Medicaid Exempt Attestation Form for NJ FamilyCare, Vol. 24* (June 2014) (on file with author).

Conclusion

When states choose to create an ABP with non-aligned benefits, they must create a process through which they identify "exempt" individuals (i.e. individuals the state cannot require to receive ABP benefits.) This case study demonstrates that non-aligned states' processes may create deterrents for beneficiaries seeking exemption from the ABP, which may keep medically frail and other exempt beneficiaries from accessing the services they need. States are therefore encouraged to align their ABP with their Medicaid state plan benefits. In the alternative, states with non-aligned benefits are encouraged to create a streamlined system for beneficiaries seeking to identify as "exempt" individuals.

Advocacy Tips:

- If your state is creating an ABP, consider the value of aligning benefits for all Medicaid populations (expansion and traditional.)
    - Advocate for aligned benefits (if this is more advantageous for beneficiaries in your state), and explain why aligning is both easier for the state and better for beneficiaries.
- If your state has already created a non-aligned ABP:
    - Ensure enrollment letters contain clear language so that beneficiaries understand their rights regarding exemption from the ABP.
    - Ensure enrollment letters include the correct and complete information about services covered under the ABP, as well as what is required to undergo an exemption determination.
    - Request and review counselors' scripts to ensure they contain the necessary information to inform beneficiaries about their plan options. Complete information will allow beneficiaries to make the best choice regarding their benefits.
    - Advocate that states create charts and other useful materials that beneficiaries can use to compare the benefits provided in the state plan with those offered in the ABP. Beneficiaries can use these materials to choose the best plan for their needs.
    - Ensure exempt individuals enrolled in the ABP know they have the option of receiving a benefits package equal to the state plan benefits.
    - Ensure that individuals who are denied an exemption receive a notice about their right to appeal and have access to a hearing.