

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **Virginia**
Transmittal Number: **VA-22-0012**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

VA ABP - Medicaid Expansion

Description:

CMS requires that DMAS develop an Alternative Benefit Plan for the Medicaid expansion population.

- The state attests that this SPA does not make a substantive change and therefore does not require the state to provide public notice in accordance with 42 CFR 440.386.
- Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

Date public notice was issued (mm/dd/yyyy)

- The state/territory assures that it has provided the public with advance notice of the amendment and reasonable opportunity to comment.
- The state/territory assures that it has included in the notice a description of the method for assuring compliance with 42CFR 440.345 related to full access to EPSDT services.
- The state/territory assures that it has included in the notice a description of the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.
- The state/territory assures that it has performed any required tribal consultation.

Upload Public Notice Documents

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.***
- The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups. *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.***

- The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

- Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: Virginia
Transmittal Number: VA-22-0012

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2c	Enrollment Assurances - Mandatory Participants	0

Form Code	Form Name	Uploaded Form Count
ABP3	ABP3-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only if ABP has an effective date prior to 1/1/2020 or if only changing the section 1937 Coverage Option of an ABP implemented prior to 1/1/2020) or ABP3.1-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only for ABP's effective on or after 1/1/2020)	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form:
Alternative Benefit Plan Populations
Uploaded Form Name:
Date Uploaded:
ABP1 Expansion 3-11-22.pdf

Support Documents

Document	
Please provide a short description of this support document:	
Document showing no comments on public notice	
Uploaded Document Name:	Date Uploaded:
ABP Notice - No comments.pdf	
Please provide a short description of this support document:	
Public Notice	
Uploaded Document Name:	Date Uploaded:
ABP1 Expansion 3-11-22.pdf	

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form	
Please provide a short description of this ABP2a form:	
Voluntary Benefit Package Selection Assurances	
Uploaded Form Name:	Date Uploaded:
ABP_2a Expansion 3-11-22.pdf	

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form

Support Documents

Document

Form ABP3: ABP3-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only if ABP has an effective date prior to 1/1/2020 or if only changing the section 1937 Coverage Option of an ABP implemented prior to 1/1/2020). Or ABP3.1-Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (Use only for ABP's effective on or after 1/1/2020).

ABP3 Forms List

Form	
Please provide a short description of this ABP3 form:	
Selection of Benchmark Benefit Package	
Uploaded Form Name:	Date Uploaded:
ABP3 Expansion 3-11-22.pdf	

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form	
Please provide a short description of this ABP4 form:	
Alternative Benefit Plan Cost-Sharing	
Uploaded Form Name:	Date Uploaded:
ABP4 Expansion 3-11-22.pdf	

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form	
Please provide a short description of this ABP5 form:	
Benefits description	
Uploaded Form Name:	Date Uploaded:
ABP5 4-6-22.pdf	

Support Documents

Document

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form	
Please provide a short description of this ABP7 form:	
Benefits Assurances	
Uploaded Form Name:	Date Uploaded:
ABP7 Expansion 3-11-22.pdf	

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form	
Please provide a short description of this ABP8 form:	
Service delivery systems	
Uploaded Form Name:	Date Uploaded:
ABP8 Expansion 4-7-22.pdf	

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form	
Please provide a short description of this ABP9 form:	
Employer Sponsored Insurance and Payment of Premiums	
Uploaded Form Name:	Date Uploaded:
ABP9 Expansion 3-11-22.pdf	

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form	
Please provide a short description of this ABP10 form:	
General Assurances	
Uploaded Form Name:	Date Uploaded:
ABP10 Expansion 3-11-22.pdf	

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form

Form
Please provide a short description of this ABP11 form:
Payment Methodology
Uploaded Form Name:
Date Uploaded:
ABP11 Expansion 4-7-22.pdf

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: Virginia
Transmittal Number: VA-22-0012

- One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.**
 - This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**
 - The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- Indian Tribes**

Indian Tribes	

Indian Tribes	
Name of Indian Tribe:	Monacan, Chickahominy, Eastern Chickahominy, Rappahannock
Date of consultation:	02/24/2022 (mm/dd/yyyy)
Method/Location of consultation:	Letter sent via email.

Indian Health Programs

Indian Health Programs	
Name of Indian Health Programs:	Garrett, Tabitha (IHS/NAS/RIC)" <tabitha.garrett@ihs.gov>,
Date of consultation:	02/24/2022 (mm/dd/yyyy)
Method/Location of consultation:	Letter sent via email.

Urban Indian Organization

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Document	
Please provide a short description of this support document:	
Uploaded Document Name:	Date Uploaded:
Tribal Notice letter.pdf	

Indicate the key issues raised in Indian consultative activities:

Access

Summarize Comments

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Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

Service delivery

Summarize Comments

Summarize Response

Other Issue

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Virginia**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

VA-22-0012

Proposed Effective Date

01/01/2022 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Public Law 111-148 (ACA)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2022	\$ 0.00
Second Year	2023	\$ 0.00

Subject of Amendment

Medicaid Expansion - Alternative Benefit Plan - amended to include coverage of items related to clinical trials.

Governor's Office Review

- Governor's office reported no comment
 Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
 Other, as specified

Describe:

Virginia Secretary of Health and Human Resources reviewed and approved.



Signature of State Agency Official

Submitted By: Meredith Lee

Last Revision Date: Apr 11, 2022

Submit Date: Mar 28, 2022