

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: Nevada
Transmittal Number: NV 16-0013

General Information:

Submission Title:

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

NV ABP

Description:

☒ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

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, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

1

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, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: Nevada
Transmittal Number: NV 16-0013

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a		1

Form Code	Form Name	Uploaded Form Count
	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	
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
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	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: ABP1 06-16.pdf Date Uploaded:

Support Documents

Document
Please provide a short description of this support document: Notice of Public Meeting to Solicit Comments on Amendments to the State Plan for Medicaid Services May 4, 2016 Uploaded Document Name: SPA PH Agenda 06-07-16.pdf Date Uploaded:

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

ABP2a Forms List

Form

Form
Please provide a short description of this ABP2a form: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act
Uploaded Form Name: Date Uploaded:
ABP2a 06-16.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: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3 Forms List

Form
Please provide a short description of this ABP3 form: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package
Uploaded Form Name: Date Uploaded:
ABP3 06-16.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
<div> <div>Uploaded Form Name:</div> <div>Date Uploaded:</div> </div>
ABP4 06-16.pdf

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form
Please provide a short description of this ABP5 form: Benefits Description
<div> <div>Uploaded Form Name:</div> <div>Date Uploaded:</div> </div>
ABP5 06-16.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
<div> <div>Uploaded Form Name:</div> <div>Date Uploaded:</div> </div>

Form
ABP7 06-16.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: <div style="float: right;">Date Uploaded:</div>
ABP8 06-16.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: <div style="float: right;">Date Uploaded:</div>
ABP9 06-16.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: <div style="float: right;">Date Uploaded:</div>
ABP10 06-16.pdf

Support Documents			
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Document			
Form ABP11: Payment Methodology			
ABP11 Forms List			
<table border="1"><tr><td>Form</td></tr><tr><td>Please provide a short description of this ABP11 form: Payment Methodology Uploaded Form Name: ABP11 06-16.pdf</td></tr><tr><td>Date Uploaded:</td></tr></table>	Form	Please provide a short description of this ABP11 form: Payment Methodology Uploaded Form Name: ABP11 06-16.pdf	Date Uploaded:
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Date Uploaded:			
Support Documents			
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Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: Nevada
Transmittal Number: NV 16-0013

☒ 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 Health Programs
- ☐ 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: Tribal Letter dated April 18, 2016 Uploaded Document Name:

Document	
	Date Uploaded:
Tribal Letter - SPA 16-0013 04-18-16.pdf	

Indicate the key issues raised in Indian consultative activities:

☐ Access

Summarize Comments

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: Nevada

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.

NV 16-0013

Proposed Effective Date

07/01/2016

(mm/dd/yyyy)

Federal Statute/Regulation Citation

State Plan Under Title XIX of the Social Security Act: 42 CFR 447

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	\$0.00
Second Year	2016	\$0.00

Subject of Amendment

Adding Community Paramedicine Services to the Alternative Benefit Plan State Plan

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:

The Governor's Office does not wish to review the State Plan Amendment.

Signature of State Agency Official

Submitted By: Ellen Felsing

Last Revision Date: Jun 29, 2016

Submit Date: Jun 20, 2016