discuss the appeal with the Bureau for Medical Services. Any applicant or recipient requesting a hearing shall be advised, in writing, on the "Request for Hearing" form or on the notice of adverse action of his or her right to have a pre-hearing conference with an employee of the Department who was involved in the decision making process on the applicant's or recipient's case.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☐ The Medicaid agency

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☒ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☐ The Medicaid agency

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☐ Medicaid agency

☒ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☒ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Name of entity: HHS Appeals Entity

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

◉ Yes ○ No

State Plan Administration
Organization and Administration **A2**

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Bureau for Medical Services, the single State agency, is the Office of State Government responsible for the administration of the plan under Title XIX of the Social Security Act. The Bureau for Medical Services has the authority to make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.
The Bureau is organized into five major offices -- Office of Legal and Regulatory Services, Medical/Clinical Director, the Division of Finance & Administration, the Division of Policy Coordination, and the Division of Operations Management -- and the head of each of these answers directly to the Bureau's Commissioner.

1. The Office of Legal and Regulatory Services is headed by General Counsel who has oversight and coordination of the Bureau's legal services, including but is not limited to legal research, analysis and coordination of litigation-related services, and oversight and amendments to the Medicaid State Plan. This office also includes the Bureau's Privacy Officer.

2. The Medical/Clinical Director provides medical expertise to BMS professional staff. Primary activities include clinical research for policy development, clinical representation of the Medicaid program with external organizations or other governmental departments, clinical research of best medical practices, physician reviewer of medical necessity, prior authorization and denied services appeals, and participates on various committees, associations and boards as a representative of West Virginia Medicaid.

3. The Division of Finance & Administration is headed by a Deputy Commissioner who is responsible for planning and managing the Bureau's financial resources. Areas of responsibility include:

•Office of Budget and Accounting Services is responsible for the Bureau's administrative and medical services budget, including cash management and claims payment activities. Also included are financial reporting, resolution of provider payment issues and coordination of financial audit activities.

•The Office of Procurement Services is responsible for the Bureau's procurement activities to ensure compliance with the WV Division of Purchasing requirements, accounts payable and grant administration functions.

•The Office of Program Integrity completes the activities required under 42 CFR Section 456. This mandate requires post payment review of paid claims to assure that the services were provided by eligible providers to eligible clients, that the services were medically necessary, appropriate to the patient's medical condition, and were provided in conformance with the service definitions set forth in the Medicaid manuals. This unit uses tools such as on-site reviews, desk reviews, and analysis of paid claims data to meet this mandate.

4. The Division of Policy and Coordination is headed by a Deputy Commissioner who is responsible for the development of Medicaid health care coverage, policy and utilization management of all Medicaid benefit programs including; practitioner services, behavioral health and long-term care services, pharmaceutical services, hospital and outpatient clinic services, rehabilitative services, home and community based services, school based services, and transportation. Areas of responsibility include:

•Office of Facility and Residential Care is responsible for developing, implementing and managing the medical assistance coverage and utilization policies for inpatient hospital, FQHC, facility based services such as Nursing Homes and ICF/IID facilities, and residential services such as Psychiatric Residential Treatment Facilities and Children's Residential Facilities.

•Office of Professional Services is responsible for developing, implementing and managing the State's medical assistance coverage and utilization policies for the following services: Out-Patient Services, Practitioner Services, Durable Medical Equipment, Orthotics & Prosthetics, Laboratory, Radiology, Transportation, Podiatry, Chiropractic, Dental, Vision, Occupational/ Physical Therapy, and Speech.

•Office of Home & Community Based Services is responsible for developing, implementing and managing the State's medical assistance coverage and utilization policies for the following programs: Home Health, Hospice, A/D Waiver, IDD Waiver, Personal Care, CDCSP, Targeted Case Management, Behavioral health clinic and rehab, Psychological and psychiatric services and school based health services.

•Office of Policy and Administrative Services is responsible for the development, coordination and maintenance of the WV Medicaid Program Provider Manuals. In addition to overseeing the distribution of policy, the office is responsible for provider enrollment policy and oversight, WV Clearance for Access: Registries and Employment Screening Program, ICD 10 compliance,

National Correct Coding initiative, and procedure code implementation.

•Office of Pharmacy Services and Drug Rebate establishes coverage and reimbursement policies for outpatient medications within federal guidelines. Included within the program responsibilities are the federally-mandated prospective and retrospective drug utilization review activities; prior authorization of high-cost, high-risk, drugs and maintenance of a Preferred Drug list. Drug coverage is provided to all Medicaid covered eligibility groups, including recipients enrolled in managed care organizations. This office also coordinates all activities involved in invoicing drug manufacturers for rebates for which the state Medicaid program is eligible, including tracking of drug rebate payments from drug manufacturers, reconciliation of amounts invoiced to actual payments received as well as meeting related reporting requirements.

•Office of Managed Care is responsible for the administration and oversight of a risk-based managed care program, Mountain Health Trust and the Physician Access System (PAAS), both of which operate under an approved 1915(b) waiver. The Bureau contracts with managed care organizations for the provision of medically necessary services. PAAS is designed to enhance access to medical care and to coordinate the health needs and services of the Medicaid recipient, while managing cost and ensuring quality care.

•Office of Special Projects is responsible for the development, management and implementation of projects within the Bureau which requires vital input from key stakeholders. The office is responsible for ensuring Medicaid members, providers, stakeholders and the public are kept informed about about the activities of the Bureau. Project management is key component of this office.

•Take Me Home, WV, is a federally funded Money Follows the Person Rebalancing Demonstration Grant Program which assists elderly and individuals with disabilities move from a long-term care setting to a home in the community. This program allows Medicaid to pay for services and supports which are not typically covered by Medicaid. In addition, participants can receive extended direct care services such as extra hours of personal care through one of the waiver programs or the Personal Care Program.

•Office of Transportation is responsible for the oversight of the Bureau's emergency and non-emergency medical transportation services, including monitoring of the NEMT broker.

5. The Division of Operations Management is headed by a Deputy Commissioner who is responsible for all Information Technology initiatives within the Bureau, including the oversight of the Office of Technology and Reporting, the Quality unit as well as leading the Bureaus' Personnel, Medicaid Information Technology Architecture (MITA), and working with the DHHR Office of Management Information Services.

•Office of Technology and Reporting is responsible for the coordination, development and implementation of HIPAA Security and Continuity of Operations Methodologies, electronic work flow and collaboration initiatives, legacy application management and quality assurance and performance metrics for the Bureau. The Office also develops, implements and maintains BMS SharePoint and Internet sites, maintains all hardware and software for the Bureau and is responsible for implementation and maintenance of new technologies such as instant messaging and OCS phone systems, and will be responsible for all reporting within the DW/DSS once developed and implemented.

•Medicaid Information Technology Architecture (MITA) Office is responsible for the development, coordination and implementation of processes, procedures and initiatives related to MITA adoption within the Bureau. This Section was developed to support the CMS objective of an integrated business and information technology transformation in all states in order to improve how Medicaid operates across the Enterprise.

•Quality Unit incorporates sustainable quality assurance and quality improvement principles in the planning, design, delivery, and evaluation of support and services; standardizes the collection, reporting, and monitoring of data, processes, and quality measures in order to support and drive decisions; and develops and implements quality management strategies that support the achievement of positive outcomes for the West Virginia Bureau for Medical Services.

•The Personnel Section is responsible for the coordination the Bureau's Human Resources operations. This includes the support for employee Information, Payroll, Benefits Coordination, internal Policy, Procedures and attendance management.

•The Medicaid Management Information System (MMIS) is managed by the Department of Health and Human Resources Office of Management information Services. The Medicaid Management Information System, a claims processing system that processes over 17 million claims annually which accounts for program expenditures in excess of $2.4 billion dollars. The Medicaid program enrolled over 405,000 members as of the end of SFY 2010 through a network of approximately 23,000 health care providers.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The WV Department of Health and Human Resources (DHHR) comprises the Office of Inspector General and five bureaus -- Bureau for Medical Services (the single state Medicaid Agency), Bureau for Behavioral Health & Health Facilities, Bureau for Public Health, Bureau for Children and Families (the Title IV-A agency) and Bureau for Child Support Enforcement. The WV DHHR is headed by a Cabinet Secretary who reports directly to the WV Governor. Each of the Bureau Commissioners reports directly to the Cabinet Secretary's Office.

The Office of Inspector General (OIG) provides autonomous, independent and neutral oversight of DHHR programs and operations through seven distinct offices.

--Board of Review (BOR) provides a fair, impartial, and expeditious hearing process to DHHR customers and providers who are impacted by DHHR programs, including but not limited to Medicaid Eligibility (including denial, termination or reduction of benefits) and Medicaid Appeals from the Federal Marketplace.

--Investigations and Fraud Management (IFM) conducts investigations of internal matters at the direction of the Inspector General and investigations of suspected fraud and abuse within the programs the DHHR administers.

--Medicaid Fraud Control Unit (MFCU) investigates allegations of fraud in the Medicaid program and allegations of criminal abuse, neglect, or financial exploitation of residents in health care facilities or board and care homes.

--Office of Health Facility Licensure and Certification (OHFLAC) promotes quality services and high standards of care within health care facilities by ensuring that such facilities are in compliance with state licensure rules and federal certification regulations.

--Olmstead Office develops and monitors the implementation of a plan that to promote equal opportunities for people with disabilities to live, learn, work, and participate in the community of their choice through West Virginia's compliance with Title II of the Americans with Disabilities Act.

--Quality Control (QC) assures the integrity of departmental programs through impartial evaluation of program benefit determinations.

--WV Clearance for Access: Registry and Employment Screening (WV CARES) establishes efficient, effective, and economical procedures for conducting background checks on all prospective direct patient access employees of long-term care facilities and providers.

The Bureau for Behavioral Health & Health Facilities (BBHHF) is the federally designated Single State Authority for mental health and substance use disorders and serves as the lead state agency for intellectual and developmental disabilities. The BBHHF operates under the auspices of the West Virginia Department of Health and Human Resources and provides funding for community-based services for persons with behavioral health needs, including those who are either uninsured or underinsured.

The Bureau for Public Health has the responsibility for the promotion of the physical and mental health of all of its citizens and to prevent disease, injury, and disability whenever possible. The Bureau is authorized to provide essential public health services and works in conjunction with local boards of health to provide basic public health services that encourage healthy people in healthy communities.

The Bureau for Children and Families (BCF), West Virginia's Title IV-A agency, is organized into three divisions: Division of Family Assistance (DFA), Division of Social Services (DSS), and Division of Early Care and Education (DECE). The DFA determines eligibility and provides financial assistance services such as Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Low-Income Heating Emergency Assistance Program (LIEAP), School Clothing Assistance, Burial Assistance, Refugee Assistance, and Emergency and Disaster Programs. The DECE manages a statewide system of Child Care Resource and Referral agencies, which provide resource information and financial assistance to eligible families. Financial assistance covers the majority of the cost of direct care and protection of children while parents work, attend training, or are otherwise unable to provide care. The DSS provides child and adult protective services, adoption and foster care services and other youth services.

The Bureau for Child Support Enforcement (BCSE), West Virginia's IV-D agency, establishes paternity and child support and enforces support from a child's parent. The Bureau for Child Support Enforcement also enforces court orders for spousal support, known as alimony.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for SSI recipients.

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ◉ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Federally-Facilitated Marketplace (FFM) will conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on MAGI income methodology and who apply through the FFM. The FFM will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost-sharing (if applicable), or assigning a benefit package. These functions will be performed by the single state agency.

Remove

Type of entity that determines eligibility:

- ◉ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Bureau for Children and Families is responsible for the operation of a number of programs that affect families and children. The Medicaid agency has a Memorandum of Agreement with the Bureau for Children and Families to conduct eligibility determinations. The Bureau for Children and Families conduct eligibility determinations for all populations under the state plan.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

◉ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The HHS Appeals Entity will conduct Medicaid fair hearings for individuals whose Medicaid eligibility has been determined and found ineligible for Medicaid by the Federally-facilitated Marketplace (FFM). These will be individuals whose income eligibility is being determined based on MAGI income methodology and who applied for health coverage through the FFM.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ◉ No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

○ Counties

○ Parishes

○ Other

Are all of the local subdivisions indicated above used to administer the state plan?

○ Yes ○ No

State Plan Administration Assurances	A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings: