State/Territory: West Virginia

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   Provided: ☑ No limitations ☐ With limitations*

2.a. Outpatient hospital services.
   Provided: ☑ No limitations ☐ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise included in the State plan.
      ☑ Provided: ☑ No limitations ☐ With limitations*
      ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
      Provided: ☑ No limitations ☐ With limitations*

3. Other laboratory and x-ray services.
   Provided: ☑ No limitations ☐ With limitations*

*Description provided on attachment.

Supersedes: 90-07 Approval Date 6-17-92 Effective Date 1-1-92

HCFA ID: 7985E
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided:  □ No Limitations  □ With Limitations *

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

Provided:  □ No Limitations  □ With Limitations *

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided:  □ No Limitations  □ With Limitations *

4.d. Tobacco Cessation Counseling Services for Pregnant Women:

1. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women:

Provided:  □ No Limitations  □ With Limitations *

*Recommended benefit package should include at least four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period. Any counseling benefit package that does not meet this standard should be described below.

Please describe any limitations:

2. Face-to-Face Counseling Services provided by:

   (i) By or under supervision of a physician;
   (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
   (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided:  □ No Limitations  □ With Limitations *

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TN No: 12-009  Approval Date: DEC 04 2012  Effective Date: 07/01/12
Supersedes: 92-001
5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: [ ] No Limitations [X] With Limitations *

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: [ ] No Limitations [X] With Limitations *
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/ x / Provided: / / No limitations / x / With limitations*
/ / Not provided

c. Chiropractors' services.

/ x / Provided: / / No limitations / x / With limitations*
/ / Not provided

d. Other practitioners' services. Psychologists

/ x / Provided: Identified on attached sheet with description of limitations, if any
/ / Not provided

Home health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations / x / With limitations*
b. Home health aide services provided by a home health agency.

Provided: / / No limitations / x / With limitations*
c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations / x / With limitations*

*Description provided on attachment

TN No. 99-01
Supersedes Approval Date APR 24 1999 Effective Date 1/1/99
TN No. 92-01
HCFA ID: 7986E
d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

8. Private duty nursing services.

- Provided: ☑ No limitations ☑ With limitations*
- Not provided.

*Description provided on attachment.
9. Clinic services.
   /X/ Provided: /\ No limitations /X/ With limitations
   /\ Not provided.

10. Dental services.
    /X/ Provided: /\ No limitations /X/ With limitations
    /\ Not provided.

11. Physical therapy and related services.
    a. Physical therapy.
       /X/ Provided: /\ No limitations /X/ With limitations
       /\ Not provided.

    b. Occupational therapy.
       /X/ Provided: /\ No limitations /X/ With limitations
       /\ Not provided.

    c. Services for individuals with speech, hearing, and language disorders
       (provided by or under the supervision of a speech pathologist or
       audiologist).
       /X/ Provided: /\ No limitations /X/ With limitations
       /\ Not provided.

*Description provided on attachment.

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OEI NO.: 0998-0193

IN No. 96-09
Superseded Approval Date SEP 20 1996
IN No. 92-01 Effective Date APR 01 1996

HCFA ID: 0069P/00C
AMOUNT, DURATION AND SCOPE OF MEDICAL 
AND-REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
   a. Prescribed drugs.
      \[X\] Provided: \[\]/ No limitations: \[\]/ With limitations*
      \[/\] Not provided.
   b. Dentures.
      \[X\] Provided: \[\]/ No limitations: \[\]/ With limitations*
      \[/\] Not provided.
   c. Prosthetic devices.
      \[X\] Provided: \[\]/ No limitations: \[\]/ With limitations*
      \[/\] Not provided.
   d. Eyeglasses.
      \[X\] Provided: \[\]/ No limitations: \[\]/ With limitations*
      \[/\] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
   a. Diagnostic services.
      \[/\] Provided: \[\]/ No limitations: \[\]/ With limitations*
      \[X\] Not provided.

*Description provided on attachment.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEED-

b. Screening services.
   ☐ Provided ☐ No limitations ☐ With limitations*
   ☐ Not provided

c. Preventive services.
   ☐ Provided: ☐ No limitations ☐ With limitations*
   ☐ Not provided.

d. Rehabilitative services.
   ☐ Provided ☐ No limitations ☐ With limitations*
   ☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.
   a. Inpatient hospital services.
      ☐ Provided: ☐ No limitations ☐ With limitations*
      ☐ Not provided.

   b. Skilled nursing facility services.
      ☐ Provided ☐ No limitations ☐ With limitations*
      ☐ Not provided.

   c. Intermediate care facility services.
      ☐ Provided ☐ No limitations ☐ With limitations*
      ☐ Not provided.

* Description provided on attachment.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[ ] Provided  [ ] No Limitations
[ ] With Limitations *  [ ] Not Provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[ ] Provided  [ ] No Limitations
[ ] With Limitations *  [ ] Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[ ] Provided  [ ] No Limitations
[ ] With Limitations *  [ ] Not Provided

17. Nurse-midwife services.

[ ] Provided  [ ] No Limitations
[ ] With Limitations *  [ ] Not Provided

18. Hospice care (in accordance with section 1905 (o) of the Act).

[ ] Provided  [ ] No Limitations
[ ] With Limitations *  [ ] Not Provided

*Description provided on attachment

TN No: 11-005  Approval Date: MAR 02 2012
Supersedes: 94-12  Effective Date: 10/01/11
19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[ ] Provided: [ ] With limitations
[ ] Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

[ ] Provided: [ ] Additional coverage

b. Services for any other medical conditions that may complicate pregnancy.

[ ] Provided: [ ] Additional coverage

[ ] Not provided.

c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a)(10)(A)(ii)(IX) of the Act.

[ ] Provided: [ ] Additional coverage

[ ] Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy. Recipient is eligible for all Medicaid covered services as described in ATTACHMENT 3.1-A & 3.1-B.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 92-01 Supersedes Approval Date JUN 17 1992 Effective Date

TN No. 90-5

HCFA ID: 7986E
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
   ☐ Provided: ☐ No limitations ☐ With limitations*
   ☑ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
   ☑ Provided: ☐ No limitations ☐ With limitations*
   ☐ Not provided.

Certified

23. Pediatric or family nurse practitioners' services.
   Provided: ☑ No limitations ☐ With limitations*

*Description provided on attachment.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY.

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   a. Transportation
      - Provided
      - No Limitations
      X With Limitations*
      - Not Provided
   b. Services of Christian Science nurses.
      - Provided
      - No Limitations
      - With Limitations
      X Not Provided
   c. Care and services provided in Christian Science sanitoria.
      - Provided
      - No Limitations
      - With Limitations
      X Not Provided
   d. Nursing facility services for patients under 21 years of age.
      X Provided
      - No Limitations
      X With Limitations*
      - Not Provided
   e. Emergency hospital services.
      X Provided
      - No Limitations
      X With Limitations*
      - Not Provided

* Description provided on attachment.
24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Rural Primary Care Hospital services as defined in Section 1820 of the Social Security Act and in the Regulations at 42 CFR 440.170, Subpart (g).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia
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PERSONAL CARE

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY.

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

   Provided   X Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual’s family, and (C) furnished in a home.

   X Provided,   X State Approved (Not Physician) Service Plan Allowed.
   X Services Outside the Home Also Allowed
   X Limitations Described on Attachment

   Not Provided

TN No: 09-08 Approval Date: 1 Oct 2009
Supersedes: 96-10 Effective Date: 1 Oct 2009
Freestanding Birth Center Services

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDED.

27. A. Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: □ No Limitations  X With limitations  □ None, licensed or approved

Please describe any limitations:

a. Facilities must:
   i. Be licensed by the Department of Health and Human Resources ("DHHR") or its designee;
   ii. Be specifically approved by DHHR to provide birthing center services; and
   iii. Maintain standards of care required by DHHR for licensure.

B. Licensed or Otherwise State-Recognized Covered Professionals Providing Services in the Freestanding Birth Center

Provided: □ No limitations  X With limitations (please describe below)

□ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

X (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

The following practitioners may provide birthing center services and must be licensed in the state of West Virginia as:

i. Physician under the relevant West Virginia Code section
   ii. Nurse-midwife under the relevant West Virginia Code section

X (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs) and any other type of licensed midwife).*

N/A (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

* For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: Women's Health Nurse Practitioner
State/Territory: _West Virginia_

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: __x____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

__x__ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

__x__ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

__x__ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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