

State/Territory: West Virginia

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered medically needy groups

The following ambulatory services are provided.

The amount, duration and scope of services provided medically needy groups is the same as provided categorically needy groups with the same limitations as described in Attachment 3.1-A.

Ambulatory services provided are:

440.20
440.30
440.40(b)(c)
440.50
440.60
440.90
440.100
440.110(a)(c)
440.120(a)(c)(d)

*Description provided on attachment.

TN No. 86-3
Supersedes
TN No. 82-8

Approval Date JUN 23 1987 Effective Date OCT 01 1986

HCFA ID: 0140P/0102A

State/Territory: West Virginia

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

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 covered under the plan

☒ Provided: ☒ No limitations ☐ With limitations*

- 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*

- 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*

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

☒ Provided

- c. Family planning services and supplies for individuals of childbearing age.

☒ Provided: ☒ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 92-01

Supersedes

TN No. 90-02

Approval Date

JUN 17 1992

Effective Date

1-1-92

HCFA ID: 7986E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State/Territory: West Virginia

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

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*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 92-01

Supersedes

TN No. NEW

Approval Date JUN 17 1992

Effective Date 1-1-92

HCFA ID: 7986E

State/Territory: West Virginia

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

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 ☐ With limitations*

b. Optometrists' Services

☒ Provided: ☐ No limitations ☒ With limitations*

c. Chiropractors' Services

☒ Provided: ☐ No limitations ☒ With limitations*

d. Other Practitioners' Services

☒ Provided: ☐ No limitations ☒ With limitations*

7. Home Health Services

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

☒ Provided: ☒ No limitations ☐ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☒ No limitations ☒ With limitations*

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*

*Description provided on attachment.

TN No. 86-8
Supersedes _____
TN No. _____

Approval Date

JUN 23 1987

Effective Date

OCT 01 1986

HCFA ID: 0140P/0102A

State/Territory: West Virginia

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

8. Private duty nursing services.
☒ Provided: ☐ No limitations ☒ With limitations*
9. Clinic services.
☒ Provided: ☐ No limitations ☒ With limitations*
10. Dental services.
☒ Provided: ☐ No limitations ☒ With limitations*
11. Physical therapy and related services.
- a. Physical therapy.
☒ Provided: ☐ No limitations ☒ With limitations*
- b. Occupational therapy.
☒ Provided: ☐ No limitations ☒ With limitations*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
☒ Provided: ☐ No limitations ☒ With limitations*
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.
☒ Provided: ☐ No limitations ☒ With limitations*
- b. Dentures.
☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

TM No. 96-09
Supersedes
TM No. 92-01

Approval Date SEP 20 1996

Effective Date APR 01 1996

HCFA ID: 0140P/01021

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP (S):**

c. Prosthetic devices

☒ Provided: ☐ No limitations ☒ With limitations*

d. Eyeglasses.

☒ Provided ☐ No limitations ☒ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Screening services.

☐ Provided: ☐ No limitations ☐ With limitations*

c. Preventative services.

☐ Provided: ☐ No limitations ☐ With limitations*

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*

14. Services for individuals age 65 or older in institutions for mental disease.

a. Inpatient hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Skilled nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations*

* Description provided on attachment

TN No. 00-07

Supersedes

TN No. 92-05Effective Date 9/1/00

Approval Date

APR 16 2001

State/Territory: West Virginia

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

- c. Intermediate care facility services.
☐ Provided: ☐ No limitations ☐ With limitations*
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*
- 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*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
☐ Provided: ☐ No limitations ☐ With limitations*
17. Nurse-midwife services.
☐ Provided: ☐ No limitations ☐ With limitations*
18. Hospice care (in accordance with section 1905(o) of the Act):
☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 94-12
Supersedes
TN No. 88-02

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NOV 04 1994

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NOV 01 1994

HCFA ID: 0140P/0102A

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AUGUST 1991

State: West Virginia

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

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 3.1-A and 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

TN No. 90-5

Approval Date

11/17/1991

Effective Date

1-1-92

HCFA ID: 7986E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State/Territory: West Virginia

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

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.

TN No. 92-01

Supersedes

TN No. 87-04

Approval Date

JUN 17 1992

Effective Date

1-1-92

HCFA ID: 7986E

State/Territory: West Virginia

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 ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance
with a plan of treatment and provided by a qualified person under
supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

TN No. 93-07

Supersedes

TN No. 92-01

Approval Date

FEB 03 1994

Effective Date

5-1-93

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AUGUST 1991

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State: West Virginia

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.
- g. Rural Primary Care Hospital services as defined Section 1820 of the Social Security Act and in the Regulations at 42 CFR 440.170, Subpart (g).

TN No. 94-01
Supersedes
TN No. _____

Approval Date AUG 03 1995

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Revision: HCFA-PM-94-9 (MB)
December 1994

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State/Territory: West Virginia

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. f. 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.

____ Provided: ____ State Approved (Not Physician) Service Plan Allowed

____ ☒ Services Outside the Home Also Allowed (with limitations)

____ ☒ Limitations Described on Attachment

____ Not provided.

TN No. 01-17

Supersedes

TN No. 96-10

Approval Date APR 10 2002

Effective Date 1/1/02

State/Territory: West Virginia

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDED 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.

TN No:	22-0002	Approval Date:	03/23/2022	Effective Date:	01/01/2022
Supersedes:	New				

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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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.

TN No. 92-01

Supersedes 90-07 Approval Date 6-17-92

TN No. 90-07

Effective Date 1-1-92

HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

Revision: HCFA-PM-91-4 (BPD)

August 1991

Attachment 3.1-A

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**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 *

TN No: 12-009

Supersedes: 92-001

Approval Date:

DEC 04 2012

Effective Date: 07/01/12

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

Revision: HCFA-PM-91-4 (BPD)

August 1991

Attachment 3.1-A

Page 2a

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- 5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No Limitations ☒ 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 ☒ With Limitations *

TN No: 12-009

Supersedes: NEW

Approval Date: DEC 04 2012

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Revision: HCFA-PM-91-4 (BPD)
August 1991

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State/Territory: West Virginia

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

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

d. Other practitioners' services. Psychologists

☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided

7. 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 ☒ With limitations*

b. Home health aide services provided by a home health agency.

Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment

TN No. 99-01
Supersedes
TN No. 92-01

Approval Date APR 24 1999

Effective Date 1/1/99
HCFA ID: 796E



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AUGUST 1991

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State/Territory: West Virginia

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

- 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.

TN No. 92-01

Supersedes NEW

Approval Date 6-17-92

Effective Date 1-1-92

HCFA ID: 7986E

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

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ 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).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

CV No. 95-09
Supersedes
CV No. 92-01

Approval Date SEP 20 1996

APR 11 1996
Effective Date

HCFA ID: 00699/00C

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.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ 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*
☒ Not provided.

*Description provided on attachment.

TM No. 85-3
Supersedes
TM No. _____

Approval Date MAR 7 1986

Effective Date JUL 1 1985

HCFA ID: 0069P/0002P

State West Virginia

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

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.

TN No. 00-07
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Approval Date Apr 16 2001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

Revision: HCFA-PM-86-20 (BERC)

September 1986

Attachment 3.1-A

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OMB NO: 0938-0193

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 ☒ Provided in accordance with section 2302 of the Affordable Care Act
- ☒ With Limitations * ☐ Not Provided

*Description provided on attachment

TN No: 11-005

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MAR 02 2012

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AUGUST 1991

State: West Virginia

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

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.

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ATTACHMENT 3.1-A
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OMB No.: 0938-

State/Territory: West Virginia

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

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.

TN No. 92-01
Superseded 92-04 Approval Date 6-17-92 Effective Date 1-1-92
TN No. 92-04
HCFA ID: 79862

...

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PERSONAL CARE

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
- ☒ With Limitations*
- ☐ Not Provided

b. Services of Christian Science nurses.

- ☐ Provided
- ☐ No Limitations
- ☐ With Limitations
- ☒ Not Provided

c. Care and services provided in Christian Science sanatoria.

- ☐ Provided
- ☐ No Limitations
- ☐ With Limitations
- ☒ Not Provided

d. Nursing facility services for patients under 21 years of age.

- ☒ Provided
- ☐ No Limitations
- ☒ With Limitations*
- ☐ Not Provided

e. Emergency hospital services.

- ☒ Provided
- ☐ No Limitations
- ☒ With Limitations*
- ☐ Not Provided

* Description provided on attachment.

TN No: 09-08
Supersedes: 93-07

Approval Date:

SEP 03 2010

Effective Date: 1 Oct 2009

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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
 X

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

 Not Provided

TN No: 09-08
Supersedes: 96-10

Approval Date: SEP 23 2009

Effective Date: 1 Oct 2009

Freestanding Birth Center Services**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY.**

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

Provided: ☐ No Limitations ☒ 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 ☒ 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:

- ☒ (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

- ☒ (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).*

- ☐ (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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METHODS OF PROVIDING TRANSPORTATION

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDICAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

A 1. Transportation

 No Limitations
 X With Limitations

A 2. Brokered Transportation

 X Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

- (1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

 (1) Statewideness (indicate areas of State that are covered)
 (10)(B) Comparability (indicate participating beneficiary groups)
 X (23) Freedom of Choice (indicate mandatory population groups)

- (2) Transportation services provided will include:

 X Wheelchair van
 X Taxi
 Stretcher car
 X Bus passes
 X Tickets
 X Secured transportation
 Such other transportation as the Secretary determines appropriate (please describe)

TN No: 13-007 Approval Date: SEP 19 2014 Effective Date: 10/1/13
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METHODS OF PROVIDING TRANSPORTATION

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDICAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

- (3) The State assures that transportation services will be provided under a contract with a broker who:
- (i) Is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
 - (ii) Has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
 - (iii) Is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
 - (iv) Complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines appropriate);
- (4) The broker contract will provide transportation to the following categorically needy populations under section 1905(a)(i) – (xiii):
- X Low-income families with children (section 1931)
 - X Deemed AFCD-related eligibles
 - X Poverty-level related pregnant women
 - X Poverty-level infants
 - X Poverty-level children 1 through 5
 - X Poverty-level children 6-18
 - X Qualified pregnant women AFDC-related
 - X Qualified children AFDC-related
 - X IV-E foster care and adoption assistance children
 - X TMA recipients (due to employment)(section 1925)
 - X TMA recipients (due to child support)
 - X SSI recipients
 - X Individuals eligible under 1902(a)(10)(A)(i)-new eligibility group VIII (very-low income adults who are not otherwise eligible under any other mandatory eligibility group)-Becomes effective January 1, 2014, but states can elect to cover now as an early option

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METHODS OF PROVIDING TRANSPORTATION

- (5) The broker contract will provide transportation to the following categorically needy optional populations:

- ☒ Optional poverty-level – related pregnant women
- ☒ Optional poverty-level – related infants
- ☒ Optional targeted low income children
- ☒ Non-IV-E children who are under State adoption assistance agreements
- ☐ Non-IV-E independent foster care adolescents who were in foster care on their 18th birthday
- ☒ Individuals who meet income and resource requirements of AFDC or SSI
- ☐ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- ☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- ☐ Children aged 15-20 who meet AFDC income and resource requirements
- ☐ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- ☐ Individuals infected with TB
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☐ Individuals receiving COBRA continuation benefits
- ☐ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- ☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution (NEMT is provided to 1905(a) services, not to 1915(c) waived services (e.g., socialization, work training, etc.))
- ☐ Individuals terminally ill if in a medical institution and will receive hospice care
- ☐ Individuals aged or disabled with income not above 100% FPL
- ☐ Individuals receiving only an optional State supplement in a 209(b) State
- ☒ Individuals working disabled who buy into Medicaid (BBA working disabled group)
- ☒ Employed Medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group
- ☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

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METHODS OF PROVIDING TRANSPORTATION

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- ☒ Risk capitation
☐ Non-risk capitation
☐ Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?

- ☒ Broker
☐ State
☐ Other

(C) What is the source of the non-Federal share of the transportation payments? Describe below the source of the non-Federal share of the transportation payments proposed under the State Plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

General Revenue Funds
Health Provider Taxes
Lottery Funds
Medical Services Trust Fund

(D) ☒ The State assures that no agreement (contractual or otherwise) exists between the State or any form or local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) ☒ The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or from of local government (directly or indirectly).

(F) ☐ The State has included Federal Medicaid matching funds as State match when drawing down FTA SAFETEA-LU grants.

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- X (7-1) The broker is a non-governmental entity and assures that:
- (A) the broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 C.F.R. §440.170(a)(4)(ii)
- ____ (7-2) The broker is a non-governmental entity and assures that:
- (B) the broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:
- ____ (i) transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker
- ____ (ii) transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.
- ____ (iii) the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet all the need for transportation.
- ____ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation and the State assures that the governmental broker will.
- ____ (i) maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.
- ____ (ii) document that with respect to each individual beneficiary specific transportation needs, the government provider is the most appropriate and lowest cost alternative.
- ____ (iii) document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

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METHODS OF PROVIDING TRANSPORTATION

- X (9) Please provide a complete description of how the NEMT brokerage program operates. Include all services provided by the broker (call center, over-sight of providers, etc.). If applicable, describe any transportation services that will not be provided by the broker and how these services will be provided.
- A. The West Virginia NEMT brokerage program will operate as a full risk, capitated program with a single broker providing screening, scheduling, dispatching and notification of single, standing order, and commercial air trips that may include out of state travel with meals and lodging through fixed route, private auto, basic vehicle, enhanced vehicle and commercial carriers. The broker will negotiate rates with transportation providers. The brokerage program will also include transportation validation checks, vehicle inspections, provider monitoring, member satisfaction surveys, provider training, member outreach and education, data analysis and reporting.
- B. The Broker will provide oversight of the NEMT providers by scheduling trips with providers and requiring trip logs be completed by each provider prior to payment submittal. The broker will also provide oversight of the transportation providers with service level agreements or penalties built into the contract with the transportation providers that will ensure the transportation providers perform to the standards as required by the broker.
- C. The State will have oversight of the Broker and require reporting by the Broker to ensure that all prescribed deadlines and deliverables are being met. The broker will be assessed liquidated damages/penalties by the State as a set fee or a percentage of their capitated payment for failure to meet required performance standards and/or deliverables.
- D. The Broker will operate a call center.
- E. The Broker will do a Level of Need determination for the appropriate transportation. The Broker completes screening on every call to determine if the trip request is for a Medicaid covered service and that the individual is an eligible Medicaid member. The Broker will complete pre-trip and post-trip validation on a percentage of all trips. In addition, the Broker will complete 100% verification of the following: recurring trips to medical providers; mileage reimbursement trip logs for provider signatures; and driver trip logs for qualifying signatures from members.

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METHODS OF PROVIDING TRANSPORTATION

- F. Non-emergency transportation provided by ambulances will be outside of the brokerage system on a fee for service basis with the State making medical necessity decisions.

TN No: 13-007
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Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations

ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
<input checked="" type="checkbox"/>	Adult Group	Mandatory	<input checked="" type="checkbox"/>

Enrollment is available for all individuals in these eligibility group(s).

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130724



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

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

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

- ☒ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A) (i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A) (i)(VIII).
- ☒ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.
- ☒ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:
 - a) Enrollment in the specified Alternative Benefit Plan is voluntary;
 - b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and
 - c) What the process is for transferring to the state plan-based Alternative Benefit Plan.
- ☒ The state/territory assures it will inform the individual of:
 - a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and
 - b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

- ☒ Letter
- ☐ Email
- ☐ Other



Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

During the full application process, whether the application is completed in the Marketplace or in the county office, if a member answers YES the following question : "Does this person (or you, depending on the person completing the form) have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have the right to choose between the Alternative Benefit Plan (ABP) and the state's Traditional Plan.

Every member will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of the Rights and Responsibilities is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

West Virginia provides copies of "Your Guide to Medicaid" which also has information about medical frailty and who to contact if a member falls into the description. Additionally, anytime a member goes to a county office they are given a copy of the Rights and Responsibilities to sign acknowledging receipt and a copy is placed in their case file.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the full application process, whether the application is completed in the Marketplace or in the county office, if a member answers YES the following question : "Does this person (or you, depending on the person completing the form) have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have the right to choose between the Alternative Benefit Plan (ABP) and the state's Traditional Plan.

Regardless of how the member answers the aforementioned question, every member will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of the Rights and Responsibilities is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

West Virginia provides copies of "Your Guide to Medicaid" which also has information about medical frailty and who to contact if a member falls into the description. Additionally, anytime a member goes to a county office they are given a copy of the Rights and Responsibilities to sign acknowledging receipt and a copy is placed in their case file. County workers and fiscal agent member help line staff are well informed about the rights and responsibilities and are able to assist members with the necessary information to change their choice of benefit plan packages if they so choose.

A Medicaid member can self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or a physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the fiscal agent website for additional information.

☒ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

- a) Was informed in accordance with this section prior to enrollment;
- b) Was given ample time to arrive at an informed choice; and
- c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.



Alternative Benefit Plan

Where will the information be documented? (Check all that apply)

- ☐ In the eligibility system.
- ☐ In the hard copy of the case record.
- ☒ Other

Describe:

Letter will be scanned and stored in the Fiscal Agent's letter repository.

What documentation will be maintained in the eligibility file? (Check all that apply)

- ☒ Copy of correspondence sent to the individual.
- ☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- ☐ Other
- ☒ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants

ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

- ☒ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

- ☐ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)
- ☒ Self-identification

Describe:

During the full application process, whether the application is completed in the Marketplace or in the county office, if a member answers YES the following question: "Does this person (or you, depending on the person completing the form) have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have the right to choose between the Alternative Benefit Plan (ABP) and the state's Traditional Plan.

Regardless of how the member answers the aforementioned question, every member will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of the Rights and Responsibilities is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, West Virginia provides copies of "Your Guide to Medicaid" which also has information about medical frailty and who to contact if a member falls into the description. Additionally, anytime a member goes to a county office they are given a copy of the Rights and Responsibilities to sign acknowledging receipt and a copy is placed in their case file. County workers and fiscal agent member help line staff are well informed about the rights and responsibilities and are able to assist members with the necessary information to change their choice of benefit plan packages if they so choose.

A Medicaid member can self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or a physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the fiscal agent website for additional information.

BMS will also conduct provider outreach activities for medical frailty during the annual provider workshops across the state.

☐ Other

- ☒ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.



Alternative Benefit Plan

- ☒ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☐ Review at the time of eligibility redetermination
- ☐ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ☐ Monthly
- ☐ Quarterly
- ☐ Annually
- ☒ Ad hoc basis
- ☐ Other

- ☒ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals who self-identify as medically frail at the time of application, will return the notice included with their eligibility determination in order to notify the State that they would like to be disenrolled from the ABP. Instructions for completing this process are included in their eligibility determination notice.

Individuals seeking exemption from the Alternative Benefits Plan at any time during their period of eligibility will notify the Bureau for Medical Services or their designee who will initiate the change process. The appropriate contact information for the Bureau is included in their eligibility determination notice, the rights and responsibilities section of the Medicaid application, and in the "Your Guide to West Virginia Medicaid" document. Once the applicant makes the request, the same notice delivered as a part of medically frail individuals' eligibility notice will be sent to the member. They must complete the form and return it to the Bureau to complete the process. All requests to disenroll from the ABP must be submitted in writing to the Bureau.

At any time whether an individual answers the trigger question on the application or calls to self-identify as meeting the medically frail criteria, they will have access to choice counseling by a variety of avenues. County workers and fiscal agent member help line staff are well informed about the rights and responsibilities and are able to assist members with the necessary information to change their choice.



Alternative Benefit Plan

of benefit plan packages if they so choose.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

- ☐ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ☒ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: WV Health Bridge Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ☒ Benchmark Benefit Package.
- ☐ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ☐ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ☐ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ☐ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ☒ Secretary-Approved Coverage.
 - ☐ The state/territory offers benefits based on the approved state plan.
 - ☒ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

The ABP benefit package closely mirrors the WV Medicaid State Plan coverage. Any differences or limitations are noted in ABP5. An overview of the two plans comparison shows the following differences between: PT/OT - in the traditional Medicaid State plan a beneficiary receives 20 visits per year combined with PA required for coverage and in the ABP the limit is increased to 30 visits combined per year; Home Health in the traditional Medicaid State Plan is 60 visits/year with additional PA for coverage and in the ABP, 100 visits/year; and Personal Care Services and long term institutional services (NF and ICF/IID) are covered under the traditional State plan and not covered under the ABP.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. ☐ No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:



Alternative Benefit Plan

- ☒ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ☐ Any of the largest three state employee health benefit plans by enrollment.
- ☐ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ☐ Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
2. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801



Alternative Benefit Plan

Attachment 3.1-L. ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing

ABP4

☒ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Benefits Description

ABPS

The state/territory proposes a "Benchmark-Equivalent" benefit package. ☐ No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Highmark West Virginia: Super Blue Plus 2000

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



Alternative Benefit Plan

☒ Essential Health Benefit 1: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medical Office Visit / Office Consultation (Includes Specialist/Specialist Virtual Visit) – Applies to Charges for Visit only. Does not apply to other Services received during Visit.

Benefit Provided:

Podiatry: Other Licensed Practitioner

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Chiropractic: Other Licensed Practitioner

Source:

State Plan 1905(a)

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

24 treatments/year

Duration Limit:

None

Scope Limit:



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage of chiropractic services is limited to one treatment per day and not more than 12 treatments without prior Authorization. An additional 12 treatments per calendar year if medically necessary and Prior Authorized. 6 additional treatments per calendar year can be prior authorized if OT and PT services have not been utilized in combination with chiropractic services. Limits in the State Plan refer to the adult population only. Children are covered by EPSDT and are not subject to the hard limit applied to adults. Medicaid will require that prior approval for all ages be obtained by the provider for medically necessary services which are not covered or exceed the benefit limit addressed in the State Plan.

Remove

Benefit Provided:

Diagnostic x-ray

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For radiology services requiring prior authorization for medical necessity by the Utilization Management Contractor (UMC), the referring/treating provider must submit the appropriate CPT code with clinical documentation and any other pertinent information to be used for clinical justification of services by the UMC.

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Certain services require Prior Authorization and concurrent review for further services if identified as a high utilization/abuse. If services have been identified as having a high rate of utilization/abuse they will receive a more intense review and PA process. An example of hospital outpatient services that require a PA would be surgical procedures: acne surgery - criteria requires review of less invasive procedures to ensure medical necessity; reconstruction procedures



Alternative Benefit Plan

(jaw, nose, brow repair) to ensure medical necessity and not cosmetic; all unlisted surgical procedures to ensure there is no appropriate CPT code and that the procedure is not experimental/research.

Remove

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

If a person revokes 3 times they are no longer eligible for hospice.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 2: Emergency services

Collapse All ☐

Benefit Provided:

Outpatient Hospital Services/Emergency Room

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Any other medical care/Transportation

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Must be to nearest appropriate provider

Add



Alternative Benefit Plan

☒ Essential Health Benefit 3: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All inpatient services require prior authorization (PA). The State has a retroactive PA process in place for all inpatient hospital care as a result of entrance through ER (to include emergency and non-emergency) visits that result in inpatient care. This retroactive prior authorization process allows the facility 10 days to submit necessary information to determine medical necessity required for processing to allow authorization for these services.

In the event that the authorized inpatient stay exceeds the original authorization in scope, the provider will be required to submit an additional request for authorization for the continued stay or service modifications.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 4: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Hospital Inpatient Services/maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospital Inpatient/maternity medical and surgical services for pregnancy and complications of pregnancy and miscarriage. The services for this benefit also include physician services covered in EHB 1

Benefit Provided:

Hospital Outpatient Services/Maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient/maternity medical and surgical services for pregnancy and complications of pregnancy and miscarriage. The services for this benefit also include physician services covered in EHB 1

Add



Alternative Benefit Plan

☒ Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided:

Physician: Outpatient Psychiatric Treatment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

12 sessions per year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services require Prior Authorization and concurrent review for further services if identified as a high utilization/abuse.

Benefit Provided:

Rehab: Rehabilitative Psychiatric Treatment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services are aimed at those with severe mental illness. Full clinical review prior authorization is required for all services with no hard limits. WV has two levels of prior authorization, an initial level and a second more intense level for both MH and substance abuse services. In West Virginia most of these types of services are provided in the community mental health centers. These centers provide both individual and group psychotherapy services.

At the State discretion services may require Prior Authorization if services have been identified as having a high rate of utilization/abuse.

Benefit Provided:

Inpatient Hospital: Psychiatric Hospital Care

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

5 day stay

Duration Limit:

None

Remove

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient Hospital Services require Prior Authorization and concurrent review for further services. These services are not provided in facilities that are IMDs.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☐ Limit on number of prescriptions
- ☐ Limit on brand drugs
- ☒ Other coverage limits
- ☒ Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The State of West Virginia's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.



Alternative Benefit Plan

☒ Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided:

Physical Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

30 visits/yr combined PT/OT rehab/hab

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

PA for 6 visits, must have plan of care and additional more intensive PA for up to 24 visits (PA Process is from the State Plan). Visit totals include PT and OT combined for rehabilitative and habilitative services. The Physical Therapy rehabilitative and habilitative services are a combination of the WV State Plan PA process and the base benchmark benefit limitations. EPDST services for children under 21 are not subject to these limitations.

Benefit Provided:

Occupational Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

30 visits/yr combined PT/OT rehab/hab

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

PA for 6 visits, must have plan of care and additional more intensive PA for up to 24 visits (PA process is in the State Plan). Visit totals include PT and OT combined for rehabilitative and habilitative. The Occupational Therapy rehabilitative and habilitative services are a combination of the WV State Plan PA process and the base benchmark benefit limitations. EPDST services for children under 21 are not subject to these limitations.

Benefit Provided:

PT and related services: Speech Therapy

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

20 visits per year

Duration Limit:

None

Remove

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

PA is required for every member to commence the first 20 ST visits but for additional visits past the 20 limit a more subsequent intense review is required for both rehabilitative and habilitative services. Services limits for members in the ABP population are combined for hab/rehab to reach the limit per year.

Benefit Provided:

Rehab: Cardiac rehabilitation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

36 sessions in a 12 week period

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Additional cardiac rehabilitation services may be medically necessary when the member has any of the following conditions:

Another documented myocardial infarction or extension of initial infarction, or
Another cardiovascular surgery or angioplasty; or
New evidence of ischemia or an exercise test, including thallium scan, or
New clinically significant coronary lesions documented by cardiac catheterization.

Benefit Provided:

Rehab: Pulmonary Rehabilitation

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 sessions

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Pulmonary Rehabilitation Services require Prior Authorization and concurrent review for further services.

Remove

Benefit Provided:

Home Health: Durable medical equipment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Durable medical equipment must be prescribed by a Physician or Professional Other Provider acting within the scope of their license.

Benefit Provided:

Orthotics and prosthetics

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthotics and prosthetics must be prescribed by a Physician or Professional Other Provider acting within the scope of their license.

Benefit Provided:

Home Health

Source:

Base Benchmark Commercial HMO

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

100 visits per year

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Review for the first 60 visits, beyond 60 visits full clinical criteria review required. 100 visits per year will be a hard limit on this service. Children are covered by EPSDT and are not subject to the hard limit applied to adults for this service.

Benefit Provided:

Other Services: Rehabilitation Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient Rehab Hospital Services require Prior Authorization and concurrent review for further services. If services are identified as having a high rate of utilization/abuse of services or over utilization they may require an additional level of review. All services require prior authorization for payment.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 8: Laboratory services

Collapse All ☐

Benefit Provided:

Laboratory Services and Testing

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Laboratory services are limited to those tests identified by CMS for which the individual provider is CLIA certified. Not all laboratory services require a PA, but many do require a PA to be reimbursed. Laboratory services require a written practitioner's order which includes the original signature of the member's treating provider, date ordered, member's diagnosis, and the specific test or procedure requested.

Add



Alternative Benefit Plan

☒ **Essential Health Benefit 9: Preventive and wellness services and chronic disease management**

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Preventative Services: Diabetes Education

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

☒ Essential Health Benefit 10: Pediatric services including oral and vision care

Collapse All ☐

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐



Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Base Benchmark Benefit that was Substituted:

Source:

Primary Care Visits to Treat an Injury or Illness

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Combined into one benefit titled Physician Services under Essential Health Benefit 1.

Base Benchmark Benefit that was Substituted:

Source:

Specialist Visit

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Combined into one benefit titled Physician Services under Essential Health Benefit 1.

Base Benchmark Benefit that was Substituted:

Source:

Primary Care Well Visits

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: These services are provided for ages under 21 (19-20) per the Medicaid State Plan EPSDT Benefits. EPSDT coverage in Essential Health Benefit 10 is for all children under 21. These services are also duplicated in Physician Services under Essential Health Benefit 1 for all members 21-64.

Base Benchmark Benefit that was Substituted:

Source:

Other Practitioner Office Visit

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Podiatry: Other Licensed Practitioner under Essential Health Benefit 1.
Duplication: Chiropractic: Other Licensed Practitioner under Essential Health Benefit 1. Under the Base benchmark plan Limitations are for Physician and Outpatient Facility Services combined (per benefit period). Under the Base Benchmark Chiropractic (Spinal Manipulations, OT, PT, RT and SP) have a combined limit of 30 visits/benefit period.

Base Benchmark Benefit that was Substituted:

Source:

Diagnostic Test (X-Ray and Lab Testing)

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Diagnostic x-ray under Essential Health Benefit 1 and Laboratory Services and Testing under Essential Health Benefit 8.

Base Benchmark Benefit that was Substituted:

Source:

Outpatient Hospital / Facility Services

Base Benchmark



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Outpatient Hospital Services under Essential Health Benefit 1.

Remove

Base Benchmark Benefit that was Substituted:

Hospice

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Hospice under Essential Health Benefit 1.

Base Benchmark Benefit that was Substituted:

Emergency Room Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Outpatient Hospital Services/Emergency Room under Essential Health Benefit 2.

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Any other medical care/Transportation under Essential Health Benefit 2.

Base Benchmark Benefit that was Substituted:

Inpatient Hospital/Facility Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Inpatient Hospital Services under Essential Health Benefit 3.

Base Benchmark Benefit that was Substituted:

Birthing Center Care/Maternity Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Hospital Inpatient Services/maternity under Essential Health Benefit 4.

Base Benchmark Benefit that was Substituted:

Maternity Care

Source:

Base Benchmark



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Outpatient Hospital Services/maternity under Essential Health Benefit 4.

Remove

Base Benchmark Benefit that was Substituted:

Outpatient Mental Health Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Physician Outpatient Psychiatric Treatment under Essential Health Benefit 5.

Base Benchmark Benefit that was Substituted:

Outpatient Substance Abuse Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Physician Outpatient Psychiatric Treatment under Essential Health Benefit 5.

Base Benchmark Benefit that was Substituted:

Rehabilitative Psychiatric Treatment

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Rehab: Rehabilitative Psychiatric Treatment under Essential Health Benefit 5.

Base Benchmark Benefit that was Substituted:

Inpatient Mental Health Care Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Inpatient Hospital Psychiatric Care under Essential Health Benefit 5.

Base Benchmark Benefit that was Substituted:

Inpatient Substance Abuse Case Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Inpatient Hospital: Psychiatric Hospital Care under Essential Health Benefits 5

Base Benchmark Benefit that was Substituted:

Prescription Drugs/Retail Pharmacy

Source:

Base Benchmark



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		Remove
Duplication: Prescription Drugs under Essential Health Benefit 6		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Speech Therapy	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: PT and related services: Speech Therapy under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Respiratory, Hyperbaric and Pulmonary Therapy	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This one service under the Base Benchmark is duplicated under both Rehab: Cardiac Rehabilitation and Rehab: Pulmonary Rehabilitation under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Durable medical equipment and Oxygen at home	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: Home Health; Durable medical equipment under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Orthotic Devices and Prosthetic Appliances	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: Orthotics and prosthetics under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted:	Source:	Remove
Diabetes Education	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: Preventative Services: Diabetes Education under Essential Health Benefit 9.		
Base Benchmark Benefit that was Substituted:	Source:	
Eye Glasses for Children	Base Benchmark	



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Medicaid State Plan EPSDT under Essential Health Benefit 10.

Remove

Base Benchmark Benefit that was Substituted:

Dental Check-up for Children

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Medicaid State Plan EPSDT under Essential Health Benefit 10.

Add



Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative
Benefit Plan:

Source:
Base Benchmark

Well Baby Care

Remove

Explain why the state/territory chose not to include this benefit:

The ABP population is for the new adult group, ages 19-64. As such "Well Baby Care" is for ages 0-6, therefore, would not apply to this population.

Base Benchmark Benefit not Included in the Alternative
Benefit Plan:

Source:
Base Benchmark

Well Child Care

Remove

Explain why the state/territory chose not to include this benefit:

The ABP population is for the new adult group, ages 19-64. As such "Well Child Care" is for ages 6-17, therefore, would not apply to this population.

Add



Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided:

Family Planning Services and Supplies

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Preventative Services: Nutritional Education

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Duration Limit:

None

Scope Limit:

Other:

Other 1937 Benefit Provided:

Tobacco Cessation Counseling for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Duration Limit:

None

Scope Limit:

Other:



Alternative Benefit Plan

<input type="text"/>	<input type="button" value="Remove"/>
	<input type="button" value="Add"/>



Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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V.20130814



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. ☐ Yes

☒ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☒ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

☒ Through an Alternative Benefit Plan.

☐ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how EPSDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☒ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☒ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☒ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☒ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☒ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☒ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☒ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.



Alternative Benefit Plan

- ☒ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☒ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☒ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☒ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☒ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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V.20130807



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☐ Managed care.
- ☒ Fee-for-service.
- ☐ Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ☒ Traditional state-managed fee-for-service
- ☐ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The Medicaid Program provides healthcare benefits to approximately three hundred fifty thousand (350,000) people, on a monthly basis, in fifty-five (55) counties using a network of twenty-four thousand (24,000) active providers. The MMIS processes nineteen million and a half (19,500,000) claims annually, including pharmacy claims. Ninety two and a half percent (92.5%) of claims are received electronically, of which, forty-seven percent (47%) were pharmacy. One hundred eighty-eight thousand (188,000) Medicaid members (families with dependent children, low-income children and pregnant women) are enrolled in three (3) HMOs or in the Bureau's Primary Care Case Management program, the Physician Assured Access System (PAAS). The Medicaid program pays for certain carved-out services for HMO recipients, specifically pharmacy and behavioral health services. The Medicaid MMIS also processes claims for three (3) waiver programs and several State-funded eligibility programs, including Children with Special Health Care needs (CSHCN).

On January 1, 2014 West Virginia expanded its Medicaid program in accordance with the rules established by the Affordable Care Act at 42 §CFR 435.119 to include non-pregnant, childless adults with income at or below 133% of the federal poverty level. The new adult group receives all ABP benefits through a fee for service delivery system with WV Medicaid paying qualified providers for services.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):



Alternative Benefit Plan

PRA Disclosure Statement

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V.20130718



Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums

ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

No

The state/territory otherwise provides for payment of premiums.

Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

General Assurances

Economy and Efficiency of Plans

- ☒ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Yes

Compliance with the Law

- ☒ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- ☒ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- ☒ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20130807