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. 6-6
Supersedes TN No. 32-3

Approval Date JUN 23 1987
Effective Date OCT 01 1986

HCFA ID: 0140P/0102A
1. Inpatient hospital services other than those provided in an institution for mental diseases.
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) With limitations*

2.a. Outpatient hospital services.
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise covered under the plan.
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) 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).
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) With limitations

3. Other laboratory and X-ray services.
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
   \(\checkmark\) Provided

   c. Family planning services and supplies for individuals of childbearing age.
   \(\checkmark\) Provided: \(\checkmark\) No limitations \(\checkmark\) With limitations*

*Description provided on attachment.

TN No. 92-01 Supersedes Approval Date JUN 1 7 1992 Effective Date 1-1-92
TN No. 90-02       HCFA ID: 7986E
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 Approval Date JUN 17 1992 Effective Date 1-1-92
TN No. NEW
HCFA ID: 7986E
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
   
   [x] Provided: [ ] No limitations [ ] With limitations*

b. Optometrists' Services
   
   [x] Provided: [ ] No limitations [ ] With limitations*

c. Chiropractors' Services
   
   [x] Provided: [ ] No limitations [ ] With limitations*

d. Other Practitioners' Services
   
   [x] 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.
   
   [x] Provided: [ ] No limitations [ ] With limitations*

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

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

*Description provided on attachment.
8. Private-duty nursing services.
   \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations

9. Clinic services.
   \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations

10. Dental services.
    \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations

11. Physical therapy and related services.
    a. Physical therapy.
       \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations
    b. Occupational therapy.
       \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations
    c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
       \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) 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.
       \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations
    b. Dentures.
       \(\checkmark\) Provided: \(\underline{\_}\) No limitations \(\underline{\checkmark}\) With limitations

*Description provided on attachment.
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
c. Intermediate care facility services.
   \( \square \) Provided: \( \square \) No limitations \( \square \) 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.
   \( \square \) Provided: \( \square \) No limitations \( \square \) With limitations*

   b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
   \( \square \) Provided: \( \square \) No limitations \( \square \) With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.
   \( \square \) Provided: \( \square \) No limitations \( \square \) With limitations*

17. Nurse-midwife services.
   \( \square \) Provided: \( \square \) No limitations \( \square \) With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act):
   \( \times \) Provided: \( \square \) No limitations \( \times \) With limitations*

*Description provided on attachment.

\begin{tabular}{ll}
\textbf{TN No.} & \textbf{94-12}  \\
\textbf{Supersedes} & \textbf{85-02}  \\
\textbf{Approval Date} & NOV 0 4 1994  \\
\textbf{Effective Date} & JUL 0 1 1994  \\
\end{tabular}
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

[ ] Not provided.

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 Approval Date 11/1/91 Effective Date 1/1/92
TN No. 90-5

HCFA ID: 7986E
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  Approval Date JUN 17 1992  Effective Date 1-1-92
Supersedes TN No. 87-04  HCFA ID: 7986E
24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   a. Transportation.
      [x] Provided: [ ] No limitations [x]/With limitations*
      [ ] Not provided.
   b. Services of Christian Science nurses.
      [ ] Provided: [ ] No limitations [x]/With limitations*
      [x] Not provided.
   c. Care and services provided in Christian Science sanitoria.
      [x] Provided: [ ] No limitations [x]/With limitations*
      [ ] Not provided.
   d. Nursing facility services for patients under 21 years of age.
      [x] Provided: [ ] No limitations [x]/With limitations*
      [ ] Not provided.
   e. Emergency hospital services.
      [x] Provided: [ ] No limitations [x]/With limitations*
      [ ] Not provided.
   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.
      [x] Provided: [ ] No limitations [x]/With limitations*
      [ ] Not provided.

*Description provided on attachment.
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).
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)

x Limitations Described on Attachment

_____ Not provided.

TN No. 01-17
Supersedes
TN No. 96-10
Approval Date APR 10 2002
Effective Date 11/1/02
State/Territory: _West Virginia_

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY 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.

<table>
<thead>
<tr>
<th>TN No: 22-0002</th>
<th>Approval Date: 03/23/2022</th>
<th>Effective Date: 01/01/2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes: New</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>