Table of Contents

State/Territory Name: West Virginia

State Plan Amendment (SPA) #: 22-0008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

October 5, 2022

Cynthia Beane, MSW, LCSW
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

Re: West Virginia State Plan Amendment (SPA) 22-0008

Dear Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0008. This amendment proposes to update the state's premium assistance program requirements.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that West Virginia Medicaid SPA 22-0008 was approved on October 4, 2022 with an effective date of January 1, 2022.

CMS will continue to work with West Virginia on the implementation and operation of the premium assistance program.

If you have any questions, please contact Dan Belnap at 215-861-4273 or via email at Dan.Belnap@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

cc: Sarah Young
Riley Romeo

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0008

2. STATE: WV

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/2022

5. FEDERAL STATUTE/REGULATION CITATION
Section 1906

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Section 4.22 page 70
Attachment 4.22-C pages 1-4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Section 4.22 page 70
Attachment 4.22-C page 1

9. SUBJECT OF AMENDMENT

Health Insurance Premium Payment Program

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Cynthia Beane

13. TITLE
Commissioner, Bureau for Medical Services

14. DATE SUBMITTED
03/24/2022

15. RETURN TO
Bureau for Medical Services
350 Capitol Street Room 251
Charleston, West Virginia 25301

FOR CMS USE ONLY

16. DATE RECEIVED
March 24, 2022

17. DATE APPROVED
10/04/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2022

19. SIG[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITL
Director, Division of Program Operations

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Attachment 4.22-C State Method on Cost Effectiveness of Employer-Based Group Health Plans

Citation	Condition or Requirement
1906 of the Act	

Enrollment in the West Virginia Health Insurance Premium Payment (HIPP) program is voluntary.

A) Cost Effectiveness Calculation:

1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles, benefits wrap, cost-sharing, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.

a) When determining cost effectiveness of a group health insurance plan, the State shall consider the following information:

i) The cost of the insurance premium, coinsurance, and deductible;
ii) The scope of services covered under the insurance plan, exclusions to enrollment, and lifetime maximum benefits imposed;
iii) The average anticipated Medicaid utilization:
1) By age, sex, and coverage group for persons covered under the insurance plan; and
2) Using a statewide average for the geographic component
iv) The specific health-related circumstances of the persons covered under the insurance plan; and
v) Annual administrative expenditures of an amount determined by the State per Medicaid recipient covered under the group health insurance plan.

All relevant information is gathered and evaluated by the State's third party liability (TPL) vendor. The TPL vendor determines HIPP eligibility, processes payments, and performs eligibility reviews utilizing the State's cost effectiveness calculation described above.

2) If the Medicaid beneficiary who has access to a group health insurance plan is not deemed cost effective for enrollment in premium assistance and a family member has a high-cost condition and Medicaid coverage, the State will conduct a family-based cost effectiveness test to determine if it will be less expensive for the State to cover the cost of health insurance premiums and cost sharing for the entire family.

B) Cost Effectiveness Review:

1) The State shall complete a cost effectiveness review:

a) At least once every six (6) months for an employer-related group health insurance plan.

2) The State shall perform a cost effectiveness re-determination if:

a) A predetermined premium rate, deductible, or coinsurance increases;
b) Any of the individuals covered under the group health plan lose full Medicaid eligibility; or
c) There is a:
i. Change in Medicaid eligibility;
ii. Loss of employment when the insurance is through an employer; or
iii. A decrease in the services covered under the policy.

3) Changes in enrollment

a) A HIPP recipient, who is a Medicaid enrollee, shall report all changes concerning health insurance coverage to the recipient's local DHHR representative within ten (10) business days of the change.
b) Except as allowed in section four (4) below, if a Medicaid recipient who is a HIPP program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program. Individuals who remain eligible for Medicaid will receive medical assistance under the State Plan.

4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection three (3) of this section.

5) Good cause for failing to comply with subsection three (3) of this section shall exist if:

a)There was a serious illness or death of the recipient, parent, guardian, or caretaker or a member of the recipient's, parent's, guardian's, or caretaker's family;
b) There was a family emergency or natural disaster – for example, a fire, flood, tornado, or similar;
c) The recipient, parent, guardian, or caretaker offers a good cause beyond the recipient's, parent's, guardian's or caretaker's control; or
d) There was a failure to receive the department's request for information or notification for a reason not attributable to the recipient, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the recipient, parent, guardian, or caretaker.

C) Coverage of Non-Medicaid Family Members.

1) If determined to be cost effective, the department shall:
a) Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and
b) Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.

D) Beneficiary Protections:

1) Individuals enrolled in the State's premium assistance program are afforded the same beneficiary protections provided to all other Medicaid enrollees. 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.

2) The State will provide a benefits wrap to all services and benefits available under the Medicaid State Plan that are not provided through the Employee Sponsored Insurance (ESI) plan.

a) After providers submit an explanation of benefits to Medicaid showing that the services were not covered through the ESI, Medicaid will then pay primary for these Medicaid covered services. The State will inform beneficiaries how to obtain benefits through the benefits wrap.

3) The State will provide a cost-sharing wrap to any cost-sharing amounts that exceed the cost-sharing limits described in the State Plan. For the cost sharing wrap around:

a) The State has implemented a provider enrollment strategy to enroll non-participating Medicaid providers. The State educates non-participating Medicaid providers on how to enroll in Medicaid for the specific (and sole) purpose of receiving payment from the State for cost sharing amounts that exceed the Medicaid permissible limits for the patient responsibility portion of the claim.

b) The State will assist beneficiaries in choosing in-network providers of the health plan that are also Medicaid enrolled providers.

c) The State will encourage HIPP program beneficiaries to access services from an ESI in-network provider that is also a Medicaid provider. The State will inform beneficiaries that if the beneficiary wants to seek care from a non-Medicaid provider, they should request their provider to contact Provider Enrollment for assistance with enrolling in Medicaid for the purposes of cost-sharing. The beneficiary can also request assistance from Member Services. Provider Enrollment can contact the provider to explain that the State will pay the total patient responsibility amount once the provider contracts to become a Medicaid provider. Medicaid will pay secondary on claims for services rendered by out-of-network providers, only if the ESI covers out-of-network providers.

d) The State allows HIPP beneficiaries to obtain services from any provider in the Medicaid network for any Medicaid State Plan Service or Medicaid Waiver Service (if the beneficiary meets waiver criteria as applicable).

4) The State will provide pre-payment for the beneficiary portion of the premiums for a cost effective ESI directly to the policy holder using the following process:

a) As the State is requiring the HIPP TPL contractor to prefund their bank account for reimbursements to policy holders. The contractor will follow the process of presenting a funding request to the State so that they are aware and agree with the premiums being reimbursed. Once approved, the contractor will fund their bank account and distribute reimbursements to the appropriate policy holder via direct deposit or paper check (whichever method is selected by the policy holder).
b) In addition to the monthly check runs scheduled near the first of each month, another check run occurs on the fifteenth of each month to help ensure direct payment of premium payments to employers, ESI plans, and COBRA administrators and to help ensure payment for cases pended and released later in the month.

c) Direct payments are scheduled for release two weeks prior to the official premium due dates to avoid late payments or interruptions in coverage.