Table of Contents

State/Territory Name: West Virginia

State Plan Amendment (SPA) #: WV-24-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

September 18, 2024

Stacey L. Shamblin
Deputy Commissioner, WVCHIP
West Virginia Department of Human Services
350 Capitol Street, Room 251
Charleston, WV 25301

Dear Director Shamblin:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), WV-24-0003, submitted on June 10, 2024, with additional information submitted on September 17, 2024, has been approved. The overall effective date of this SPA is July 1, 2023.

Through this SPA, West Virginia amends the benefit package for children under the CHIP state plan from benchmark to Secretary-approved coverage that mirrors the Medicaid state plan benefit package for children. Effective July 1, 2023, medical, dental, and behavioral health benefits align with West Virginia Medicaid benefits for children and pregnant women in respect to amount, duration, and scope of services, as well as exclusions and limitations. Any limits to the amount, duration, and scope of benefits may be exceeded as medically necessary for WVCHIP members up to age 21. Pharmacy is the one exception to full alignment with Medicaid.

Specifically, the state adds the following benefits:

- Non-emergency medical transportation;
- Medication Assisted Treatment (MAT) has been expanded to treat individuals with Alcohol Use Disorder;
- Peer support services; and
- Behavioral health care coordination.

In addition, effective February 10, 2024, the state implemented a $1,000 annual limit on dental services, excluding emergent dental services, for members ages 21 and over to mirror Medicaid. Subsequent to the state's effective date, CMS published a final rule that requires states to eliminate all existing annual and lifetime monetary limits under the CHIP state plan by no later than June 3, 2025. West Virginia has informed CMS that it intends to submit a future state plan amendment to remove this limit by January 1, 2025.

Your Project Officer is Ticia Jones. Ticia is available to answer your questions concerning this amendment and other CHIP-related matters. Ticia's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8145
E-mail: Ticia.Jones@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: West Virginia
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Secruity Act, (42 CFR, 457.40(b)) _____ (Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Stacey Shamblin Position/Title: Deputy Commissioner, CHIP, BMS
Name: Cynthia Beane Position/Title: Commissioner, BMS
Name: Cynthia Persily Position/Title: Cabinet Secretary, DoHS

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

#19	Effective: Implemented: Approved:	January 1, 2021 January 1, 2021 August 5, 2021	WV-20-0006 Managed Care To transition program to managed care
#20	Effective: Implemented: Approved:	April 1, 2022 April 1, 2022 September 8, 2022	WV-22-0017 Expanded Post-Partum Coverage To expand post-partum coverage to 12 months consistent with the state Medicaid program.
#20	Effective: Implemented: Approved:	March 11, 2021 March 11, 2021 July 7, 2022	WV-22-0018 American Rescue Plan To demonstrate WVCHIP compliance with the American Rescue Plan Act provisions that require states to cover treatment, testing, and vaccinations for COVID-19 without cost sharing
#21	Effective: Implemented: Approved:	July 1, 2023 July 1, 2023	WV-24-0003 CHIP BMS Integration To adopt Medicaid child & pregnant women's medical , dental & behavioral health benefits packages and align program operations across Medicaid and CHIP, and add new benefits: 6.2.26 enabling services (NEMT); 6.3.2.3.2 MAT/BH Alcohol Use Disorder; 6.3.2.4 Peer Support; and 6.3.7 Behavioral Health Care Coordination.
	Effective: Implemented: Approved:	February 10, 2024 February 10, 2024	To include a $1,000 limit on dental services, excluding emergent dental services, for members ages 21 and over. This limit will phase out on January 1, 2025.

MAGI SPA Roster

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)

matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice. There are no federally recognized tribes in West Virginia.

Section 3. Methods of Delivery and Utilization Controls

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP

populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

- The State of West Virginia provides health insurance benefits through a plan managed by the Children's Health Insurance Agency, within the Bureau for Medical Services, Department of Human Services, using the same fiscal agent as the state Medicaid program. Pharmacy benefits are administered by a Pharmacy Benefit Manager (PBM) used by the state employees' insurance agency. Primary care centers and school-based health centers, which provide low-income families with health care services, are included in the provider network to assure access for children in rural areas served by these facilities, as well as emphasis on preventive services. Members are required to enroll in managed care and a small fee-for-service program remains to serve members that are newly enrolled for 30 – 45 days to allow members time to choose a managed care organization.

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

Pharmacy is carved out and services are provided through a pharmacy benefits manager. Also, Birth-to-Three services are carved out and paid by fee-for-service. Members that have received or will receive an organ transplant are carved-out of managed care and served under fee-for-service.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☒ Capitation payment
  Describe population served: All WVCHIP members, except organ transplant recipients Members that have received or will receive an organ transplant are carved-out of managed care and served under fee-for-service.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

☐ Coordination with behavioral health systems/providers
☐ Other (please describe)

3.1.2.2 ☒ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☒ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.

enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different

coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section

2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

Coverage is the same in CHIP for both children and pregnant women for all benefits except as noted for members over age 21.

6.1.4.1. ☐ Coverage of all benefits that are provided to children under the the same as Medicaid State plan, including Early Periodic Screening Diagnosis and Treatment (EPSDT)

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☒ Other (Describe)
Effective July 1, 2023, medical, dental, and behavioral health benefits mirror WV Medicaid benefits for children and pregnant women in respect to scope, amount and duration of services, as well as exclusions and limitations.. Covered benefits are the same as included in the Bureau for Medical Services (Medicaid) policy manuals. The only exception to alignment with Medicaid is for pharmacy benefits.

Any limits to the amount, duration, and scope of benefits may be exceeded as medically necessary for WVCHIP members up to age 21.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

. Inpatient care is covered when it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. The services must be consistent with the diagnosis or treatment of the patient's condition, and must be rendered in accordance with tandards of good medical practice and be considered medically necessary. Unlimited medically necessary days are provided to all members for confinement in a facility, including semi-private rooms, special care units, and related services and supplies during confinement.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

Diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital, alternative facility or physician's office are covered. Certain outpatient procedures may require pre-certification.

6.2.3. ☒ Physician services (Section 2110(a)(3))

Professional services of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits).

6.2.4. ☒ Surgical services (Section 2110(a)(4))

Includes cosmetic/reconstructive suregery when required as the result of accidental injury or disease, or when performed to correct birth defects, such as cleft lip and palate.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital outpatient setting or in an ambulatory surgical facility are covered. Immunizations are covered.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

Prescription benefit services are covered with mandatory generic substitution, including oral contraceptives. Formulary coverage includes generic and brand drugs, with prior approval through a step therapy process for some brand drugs in some drug classes. Non-formulary drugs are at 100% cost to the participant, except where medical necessity is shown for clinical exception.

Effective January 1, 2006, program participants who are currently taking a drug

that is used to treat, or is sensitive to, mental conditions, can continue to have their current prescription(s) covered even if their current medication is not on the Preferred Drug List when it is in one of the following seven drug classes:

Antipsychotics; Serotonin Selective Response Inhibitors (SSRI's); Central Nervous System Stimulants; Anticonvulsants; Sedative Hypnotics; Aliphatic Phenothiazines; and Attention Deficit Disorder Drugs.

Program participants who are newly prescribed a drug used to treat, or is sensitive to, mental conditions in one of the seven drug classes named above will have coverage from the Preferred Drug List at the time the new prescription is filled, except where there has been a demonstrated need for exception due to medical necessity.

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
These are permitted in some therapeutic classes as listed on the Preferred Drug List when accompanied by a prescription.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
Pre-pregnancy family services and supplies, are covered. Oral contraceptives are included within the pharmacy benefit. Contraceptive devices and contraceptive implants are covered under medicalbenefit.

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
Medically Necessary supplies, orthotics, prosthetics, and durable medical equipment. Certain orthotics, prosthetics, and durable medical equipment require prior approval. Certain procedures have service limits.
Eyeglassses including frames, and other aids to vision. Contact lenses covered for certain diagnosis.

Hearing aids are covered if determined to be medically necessary with prior approval. Effective July 1, 2000, all infants at the time of birth are screened for hearing loss. Hospitals report information on children with medical confirmed hearing loss to the Office of Maternal and Child Health by the hospital.

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))
As medically necessary.
Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.12. ☐ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.13. ☒ Nursing care services (Section 2110(a)(15))
Skilled nursing services are covered when prior approved for medical necessity.

6.2.14. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
A physician shall provide written certification of medically necessary abortions. All services require prior approval unless a medical emergency exists endangering the life of the mother.

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
Children receive: routine semi-annual exams, x-rays, and other dental services necessary to prevent disease, restore oral structures to health and function, and to treat emergency conditions.

Pregnant women under 21 years of age: routine semi-annual exams, x-rays, and other dental services necessary to prevent disease, restore oral structures to health and function, and to treat emergency conditions.
Pregnant women over 21 years of age: Emergent procedures to treat fractures, reduce pain, or eliminate infections that includes x-rays, anesthesia, and extractions are covered with no limits; Other diagnostic, preventive, and restorative services services require prior authorization and are limited to $1,000 annually. This limit will phase-out on January 1, 2025. For more detail on

covered dental services, see Section 6.2.-D.

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))
Children receive: examinations, diagnosis, and treatment services. Eyeglass frames and lenses, and contacts are covered under durable medical equipment.

Pregnant women under 21 years of age: examinations, diagnosis, and treatment services. Eyeglass frames and lenses, and contacts are covered under durable medical equipment.

Pregnant women over 21 years of age: limited services for specific medical conditions are covered.

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))
Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs are limited to enrollees under age twenty-one (21) Certain procedures, including cochlear implants, may have service limits or require prior authorization. Augmentation communication devices limited to children under twenty-one (21) years of age and require prior approval.

6.2.18. ☒ Case management services (Section 2110(a)(20))

6.2.19. ☒ Care coordination services (Section 2110(a)(21))

6.2.20. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.21. ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for section 6.1.4.1 for a guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.22. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial,

therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.24. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.25. ☒ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.26. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

Non-emergency medical transportation is covered under a PAHP.

6.2.27. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Early Intervention Services provided by this state's Birth-To-Three (Individuals with Disabilities and Education Act) Program are covered for children ages birth through three years who have been assessed and met medical necessity criteria for developmental delay(s). Both assessments and services must be provided from a network of early intervention service providers certified by the WV Birth-to-Three Program.

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in sections 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccines: coverage is provided for COVID-19 vaccines and their administration in accordance with requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing: coverage is provided for COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act. The State assures that COVID-19 testing coverage is consistent with the Centers for Disease Control (CDC) definitions of diagnostic screening and testing for COVID-19 and its

recommendations for who should receive diagnostic and screening tests for COVID-19. Coverage includes all types of U.S. Food & Drug Adminitration (FDA) authorized COVID-19 tests.

COVID-19 Treatment: coverage for the following COVID-19 treatments are provided without limitations for amount, duration, or scope, in accordance with requirements of section 2103(c)(11)(B) of the Act:

- specialized equipment and therapies, including preventive therapies;
- non-pharmacological items and services described in section 2110(a) of the Act, that are medically necessary for treatment of COVID-19; and
- coverage of any drug or biological that is approved, or licensed, by the FDA or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with applicable authorizations.

Coverage for Conditions That May Seriously Complicate the Treatment of COVID-19: coverage for treatment of a condition that may seriously complicate COVID-19 treatment without limitation of amount, duration, or scope, during the time when a member is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☒ State-developed schedule
American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify:)
☐ Other (please describe:)

The 2023 state periodicity schedule is here:
https://dhhr.wv.gov/HealthCheck/providerinfo/SiteAssets/Pages/PeriodicitySchedule/2023%20Periodicity%20Schedule%20-%20APPROVED%20rev1.11.24%20%281%29.pdf

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

Unchecked services are not covered under the WVCHIP State Plan. Referrals are made to other state agency programs or outside community-based programs, that may fund services with other grant sources.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

Further diagnostic and appropriate treatment services are included when indicated by screenings and assessments.

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

WVCHIP partners with the State's HealthCheck program (EPSDT) to ensure the use of validated screening tools identified and adopted by Bright Futures and the AAP. These tools are for use in primary care settings and are included in the AAP's Periodicity Schedule for an age specified well-child visit. HealthCheck provides education, training, and technical resources regarding the proper use of these tools. HealthCheck is the state Medicaid's EPSDT program that also helps

enrolled providers secure the validated screening and assessment tools and forms they need to complete comprehensive well child exams. This partnership assures consistent messaging and expectations with the state's Medicaid program to WV's medical providers. Bright Futures also provides access to and resources to AAP members and providers that are contained within the Periodicity Table.

WVCHIP facilitates the use of age-appropriate validated behavioral health screening tools by providing feedback directly to providers as determined necessary through desk-audits of primary care services based on randomized samples conducted quarterly. A review of medical records that indicates the lack of validated behavioral health screening tools (or any other screening tools) are communicated to the provider with an explanation and listing of validated screening tools, how to obtain those tools and training on using those tools through state partners, such as HealthCheck. The communication may include any descriptions of sanctions WVCHIP will impose should the provider not adopt the validated screening tools. These sanctions could include takeback of funds.

Similarly, WVCHIP follows the state's Office of Maternal and Child Health (OMCH) and state Medicaid's program lead to facilitate the use of validated screening tools for pregnant women. The USPSTF required screenings for pregnant women have been adopted by both these programs. The OMCH provides training and resources directly to providers in the state.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Includes evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (outpatient includes physician, psychologists, licensed therapists, and counselor offices). Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. Benefit includes one 12-week cycle of medication therapy that may be exceeded by medical necessity review.

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Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

MAT is available for members per FDA guidelines and as prior authorized. All FDA approved medications are included in the benefit and must be provided in a BMS-approved methadone clinic in accordance with ASAM criteria. Counseling and therapy services are also included in this benefit.

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☐ Mental Health ☒ Substance Use Disorder

WV behavioral health providers offer peer support specialists for SUD and incorporate them into most levels of care.

6.3.2.5- BH ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Behavioral health providers may offer referrals to caregiver supports based on assessment of needs made during family therapy sessions.

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Behavioral health providers may offer referrals to other sources of respite care based on assessment of needs made during family therapy sessions.

6.3.2.7- BH ☐ Intensive in-home services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

WVCHIP's MCO's will coordinate referrals to services through other state programs as needed, including Birth-to-Three, WV Bureau for Behavioral Health, or the Bureau for Children and Families. Also, WVCHIP will help facilitate application to the state Medicaid's IDD waiver when appropriate for members whose conditions indicate a need for these services.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

. Intensive Outpatient Services (IOS) are a combination of specific services for a targeted population to be used on a frequent basis for a limited period. Services are covered for BMS approved IOS programs and require prior authorization. Services must be rendered according to American Society of Addiction Medicine (ASAM®) Level 2.1 criteria. IOS programs address mental health and substance use problems and allow for multiple levels of care to be offered which enhance

the continuum of services. Revision of program description components allow for greater comparison within levels of care, program evaluation, and identification of multiple funding sources

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The National Alliance on Mental Illness (NAMI) describes psychosocial rehabilitation as those services that help people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. Psychosocial rehabilitation uses two strategies for intervention: learning coping skills so that they are more successful handling a stressful environment and developing resources that reduce future stressors. Treatments and resources vary from case to case but can include medication management, psychological support, family counseling, vocational and independent living training, housing, job coaching, educational aide and social support.

WVCHIP provides coverage for many treatments considered "psychosocial rehabilitation" and providers can offer referrals to outside sources for vocational and independent living training, housing, job coaching, educational aide and social supports.

Specific services that require prior authorization include:

Behavioral Health Rehabilitation Services: Services that are medical or remedial that are recommended by a physician, PA, APRN, licensed psychologist, or supervised psychologist for the purpose of reducing a physical or mental disability and restoration of a member to his/her best function level. These services are designed for all members with conditions associated with mental illness, substance abuse and/or dependence. Services may be provided to members in a variety of settings, including in the home, community, or a residential program, but do not include services provided in an inpatient setting.

Comprehensive Community Support Services: Services that are long-term, preventive, and rehabilitative service designed to serve members with severe and persistent mental illness whose quality of life and level of functioning would be negatively impacted without structured, ongoing skill maintenance and/or enhancement activities. This is a structured program of ongoing, regularly scheduled activities designed to maintain a member's level of functioning, prevent deterioration which could result in the need for institutionalization, and/or facilitate a member's return to their previously demonstrated level of functioning. This may be accomplished through skill maintenance and/or development and behavioral programming designed to maintain or improve adaptive functioning. This service emphasizes community-based activities.

Assertive Community Treatment (ACT) Services: Services that are an inclusive array of

community-based rehabilitative mental health services for members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization and therefore, require a well-coordinated and integrated package of services, provided over an extended duration, to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have co-occurring conditions including mental health and substance use or mental health and mild intellectual disability. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT team members in the member's community environment. ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a more supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Day treatment is considered the same as intensive outpatient or partial hospitalization. Day Treatment is a comprehensive range of services including individual counseling, group therapy, psychotherapy and/or addiction education and relapse prevention classes, weekly drug testing, and family therapy programs and after care services, depending on the program. Clients learn about impulse control, relapse prevention, cross addiction, life skills, how to plan their environment, how to sleep better and how to set themselves up for success. These programs are staffed with licensed clinical staff and trained behavioral health technicians. Psychiatrists evaluate patients weekly to monitor progress and medications and adjust treatments as necessary. Programs are generally 4 to 6 weeks long, requiring 3 to 5 days of treatment per week. Members can access these services directly without prior authorization but coverage beyond 26 visits (a visit is one day of treatment) requires prior authorization and medical necessity review in order to assess the member for any case management services that may be needed.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Partial hospitalization is an outpatient hospital service rendered in a treatment setting, where an interdisciplinary program of medical therapeutic services is provided for the treatment of psychiatric and substance abuse disorders. The interdisciplinary program of medical therapeutic services may be delivered through one of the two following program formats (services may not be provided under both formats concurrently): (1) a 4 hour structured treatment program, which may be offered either during the day or evening hours, or (2) a short-term intensive program for those individuals whose needs can be met through an intensive outpatient program consisting of 6 to 10 hours of group therapy per week, delivered in 2 hour per day group therapy sessions. ASAM levels of care guidelines are applied to determine the appropriate intensity of services. Benefit requires prior authorization and continued stay reviews.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Inpatient services must be consistent with the diagnosis or treatment of the patient's condition, and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Members who are admitted to distinct part psychiatric units of acute care hospitals must have an admission diagnosis of a mental illness.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Residential treatment for mental health and substance use disorder is covered so long as the member meets the appropriate level of care. This includes inpatient Psychaitric Residential Treatment Facilities (PRTF)

Regardless of the type of setting that residential treatment is provided in, the state considers it to be inpatient care (see Section 6.3.4 above), and the subset of services provided are the same, such as access to a treatment team (that includes the resident, family members, and a multidisciplinary team of providers), group and individual therapies, behavior management, and medication monitoring. Residential treatment services are subject to prior authorization, but there are no hard limits. The state does not have a waiting list for these services.

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

Detoxification services are covered. Services include counseling, individual and group therapies. Medications and inpatient detox are covered as prescribed and ordered by a physician. Medications are covered within FDA guidelines. Some services require prior authorization.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Includes evaluation, referral, diagnostic, therapeutic, and crisis intervention services

performed on an inpatient or outpatient basis (outpatient includes physician offices).

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Multiple services designed to address and stabilize crisis situations are covered. Crisis Intervention is an unscheduled, direct, face-to-face intervention with a member in need of psychiatric interventions to resolve a crisis related to acute or severe psychiatric signs and symptoms. Depending on the specific type of crisis, an array of treatment modalities is available. These include, but are not limited to, individual intervention and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation, stabilize and create a plan as quickly as possible. Due to the comprehensive nature of this service, no other services (other than Targeted Case Management) may be reimbursed when Community Psychiatric Supportive Treatment is on-going.

Community Psychiatric Supportive Treatment is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time of days in which a person exhibits acute or severe psychiatric signs and symptoms. If the member experiences more than one crisis, each crisis is considered a separate crisis episode. This physician driven service is intended for persons whose conditions can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

Chilren's mobile crisis services response teams are covered.

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6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Includes evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (outpatient includes physician offices).

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Primary care providers are responsible for coordinating member care. WVCHIP MCOs also offer case management services that include care coordination. MCOs must initiate care coordination services for members being discharged from crisis stabilization units. For members identified as having a dependence disorder, MCOs must assign a Care Coordinator for the duration of the treatment.

6.3.7.1- BH ☐ Intensive wraparound
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Intensive wraparound services are provided by the Bureau for Behavioral Health.

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Care transition services are provided by the WVCHIP MCOs as appropriate. WVCHIP's nurse works directly with members, their families, and healthcare providers to transition care to settings that are included in the benefit. Transitions usually occur when a member newly enrolled in WVCHIP is in an episode of care (course of treatment) that is not typically covered under the plan.

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Targeted Case Management (TCM) is the coordination of services to ensure that eligible WVCHIP members have access to a full array of needed services including the appropriate medical,

educational, or other services. TCM is responsible for identifying a member's problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist members and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the member are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs. Targeted Case Management is not a direct service. TCM is composed of a number of federally designated components: Needs assessment and Reassessment; Development and Revision of TCM Service Plan; Referral and Related Activities; and Monitoring and Follow-up.

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☒ Mental Health ☒ Substance Use Disorders

*NOTE: by checking both MH and SUD we mean the Dually Diagnosed population; or singular SUD; ASAM Criteria – Defines criteria for 6 levels of care/placement options; Use of the "ASAM CONTINUUM" assessment leads to match up to one of the 6 Levels of Care; SUD programs across the State and funded by WV Bureau for Behavioral Health are required to use the ASAM criteria with the bio-psychosocial "ASAM Continuum"; MH – Specific Assessments not required.

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☐ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☐ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☒ Substance Use Disorders

Bureau for Behavioral Health requires use of CANS for Expanded School Mental Health Programs, Children's Mental Health Wraparound program, Children's Mobile Crisis Response; Bureau for Children and Families requires CANS in their "Safe at Home WV" program.

☐ State-specific criteria (e.g. state law or policies) (please describe)
☐ Mental Health ☐ Substance Use Disorders

☒ Plan-specific criteria (please describe)
☒ Mental Health ☒ Substance Use Disorders

WVCHIP requires the current ABAS (functional assessment) for members seeking Applied Behavior Analysis services; Psychiatric Evaluation or Psychological Evaluation is required every 2 years with sue of the "Severity Scale" to determine levels of function per current DSM requirements.

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

WVCHIP partners with other state agencies and programs that concentrate on state level directors identifying nationally-recognized evidence based clinical treatments within their scope of responsibilities. Those partners keep behavioral health specialized providers up to date on clinical guidelines or education on use of "best practice" treatment modalities. Those programs facilitate trainings with certifications. For example, the Bureau for Behavioral Health's focus on "trauma informed" treatment. Trauma-based screening tools become a part of the program's "clinical best practice" when a child or adult is exhibiting psychiatric symptoms or school deficits. The Bureau's grant funded clinical programs will then require a program to be a "trauma-based women's SUD treatment program" to be awarded

funding through that agency. WVCHIP partners with sister agencies by recognizing those validated assessment tools for treatments by emphasizing the same in the WVCHIP benefit.

6.2.5- BH Covered Benefits: The State assures the following related to the provision of behavioral health benefits in CHIP:

☒All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR

457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

All WVCHIP MCOs are required to be NCQA accredited and follow comprehensive quality assurance activities conducted and detailed in the Mountain Health Trust MCO contract, In addition, WVCHIP monitors the quality and appropriateness of care providedthrough a variety of strategies, including:

- Identification of children with special needs through the prior approval process, claims review and self-identification by parents and guardians in response to literature sent through the benefit welcome kit
- Tracking of complaint data received by the toll-free number, the WVCHIP central office, and the contract agencies
- An annual satisfaction survey of parents/guardians
- Through discussions with the health care community via provider workshops, newsletters and periodic contacts with their association representatives

- Through consumer education utilizing newsletters to beneficiary families, information dissemination with outreach workers and public relations activities

On a monthly basis, WVCHIP receives utilization management reports detailing the top diagnostic categories of CHIP beneficiaries from its vendor for utilization management services, which will better position the program to track trends and facilitate the development of appropriate intervention strategies.

WVCHIP will have access to comparative data. Not only will this data enable the program to better assess its standing in relation to national trends, but it will permit a broader discussion on innovative approaches used elsewhere.

7.1.1. ☒ Quality standards
The same tools in place for Medicaid managed care are used for WVCHIP.

7.1.2. ☒ Performance measurement
The same tools in place for Medicaid managed care plans are used for WVCHIP.

7.1.2 (a) ☒ CHIPRA Quality Core Set

7.1.2 (b) ☒ Other
HEDIS

7.1.3. ☒ Information strategies

7.1.4. ☒ Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

- Well Child Visits measured for birth through six years of age.
- Well Child Adolescent visits 6 years to 19 years.
- Access to Primary Care Visits measured for children ages 1 to 19 years who had visits coded to primary care services only.

- Dental Visits measured for children ages 2 to 18 who had a dental check-up coded to preventive dental services only.
- Vision Visits measured for children of all ages who received vision services from a physician or ophthalmologist coded for preventive vision services only.
- WVCHIP added the following preventive measures in its 2010 Annual Report:
    - Childhood immunizations for 2 year-olds
    - Adolescent immunizations for 13 years-olds
    - BMI – Nutrition and counseling for ages 2 – 17 years

WVCHIP reports annually on these measures, both in its Annual Framework Report and in the WVCHIP Annual Report submitted to the WV Legislature each year.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

WV's EQRO contractor evaluates access to and availability of services as part of their quarterly Network Adequacy Validation (NAV) activities and also monitors compliance with access to covered services as part of the annual Systems Performance Review (SPR).

WVCHIP monitors utilization and access to care through monthly, quarterly, and annual reporting from each MCO.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

WVCHIP reports HEDIS measures annually on the appropriate treatment of three chronic conditions:

Proper Use of Asthma Medications

- Reports children with persistent asthma enrolled for the prior year and the current annual report period who were prescribed appropriate medication.

Diabetic Care

- Reports the number of children enrolled an entire year with Type 1 and 2 diabetes shown to have had a blood (HbAlc) test; a serum cholesterol level screening; and in eye exam are a screen for kidney disease.

Emotional/Behavioral Conditions

- Follow-up after hospitalization for mental illness – 6 years and older
- Follow-up care for children prescribed ADHD medications

Families are notified of the availability of case management services upon enrollment

through their copy of the WVCHIP Summary Plan Description.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.
The MCOs are required to maintain authorization policies in accordance with WV State Code and federal regulations. Standard authorization decisions must be made within 7 calendar days while expedited decisions must be made as expeditiously as the member's condition warrants, but no later than 2 calendar days of receipt of a request for the services.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

☒ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The State (WV) assures that the total cost of premiums and copayments (as described in Sections 8.2.1. and 8.2.3. respectively) do not exceed 5% of a family's total annual income as shown in the tables below:

A) Single Child Family Annual Premium/Copayment Maximum Cost
(as a % of family income levels)

	At or Under 200% FPL			Over 200% FPL				
Family Size	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
2	$250	$29,420	0.8%	$420	$450	$870	$44,130	1.9%
3	$250	$37,060	0.7%	$420	$450	$870	$55,590	1.6%
4	$250	$44,700	0.6%	$420	$450	$870	$67,050	1.3%

B) Two Child Family Annual Premium/Copayment Maximum Cost
(as a % of family income levels)

	At or Under 200% FPL			Over 200% FPL				
Family Size	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
3	$500	$37,060	1.3%	$852	$800	$1,652	$55,590	2.9%
4	$500	$44,700	1.1%	$852	$800	$1,652	$67,050	2.5%
5	$500	$52,340	0.9%	$852	$800	$1,652	$78,510	2.1%

C) Three or More Child Family Annual Premium/Copayment Maximum Cost
(as a % of family income levels)

	At or Under 200% FPL			Over 200% FPL				
Family Size	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
4	$750	$44,700	1.7%	$852	$1,100	$1,952	$67,050	2.9%
5	$750	$52,340	1.4%	$852	$1,100	$1,952	$78,510	2.5%
6	$750	$59,980	1.3%	$852	$1,100	$1,952	$89,970	2.2%

D) Pregnant Women's Coverage >211% FPL - $35 per month premium; no copayments

	Under 211% FPL	Over 211% FPL				
Pregnant Women	No cost-share	Annual Premium	Max Copay	Total Exp.	Income	Exp. %
		$420	$0	$420	$44,130	0.9%

The State assures that families are exempt from cost sharing upon reaching the maximum co-pays through processes administered by separate medical and pharmacy benefit managers:

Medical Plan Process

WVCHIP MCOs are required to have a process to track out-of-pocket maximums and accumulations for members and families as dictated by WVCHIP plan design. In addition, BMS' claims processor maintains a parallel tracking process to ensure that cost sharing information is available and can be shared in cases where a member may move MCOs or come in or out of coverage. They maintain a separate subgroup file for those enrollees at and under 150% net FPL to assure that copayments amount no higher than those permitted under 457.555 are allowed. WVCHIP also assures that its members are aware of this through its program materials.

Prescription Plan Process

The Pharmacy Benefit Manager similarly tracks co-pays through an electronic Point of Sale (POS) system, which is accumulated as each prescription is filled. Upon reaching the cap, the message is conveyed to individual pharmacies through the POS that no co-pay is due, and none is collected.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Native Americans are excluded from cost-sharing by self-declaration on the joint WVCHIP/Medicaid application.

WVCHIP will notify applicants that membership in designated tribes excludes families from cost sharing. Applications can be obtained through a toll-free telephone line for the WVCHIP Call Center or Helpline. Although West Virginia does not have any designated tribes, the Call Center will maintain a list of designated tribes in case applicants do not know if their tribe is a designated tribe. Applicants so choosing to identify themselves as members of a designated tribe will then be issued a card indicating they are exempt from co-pays. When beneficiaries disclose designated tribal membership, it will be accepted unless it is questionable.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
WVCHIP Advisory Board meetings are held by call of the Director. WVCHIP provides notice of Board meetings according to State law through the Secretary of State's Office. During each Board meeting, time is allotted for public comment and inquiry. Comments are solicited in writing from interested and affected persons.

The WVCHIP state plan amendments are placed in each of the DHHR County offices inviting public comment and on the WVCHIP website. Public notice of the state plan amendments will be posted in local Social Security offices.

In addition, press releases are sent to all major daily newspapers in the State.

Providers are notified of plan changes through communications from the BMS fiscal agent and the contracted MCOs.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))
West Virginia has no Federal or State recognized tribes. Public hearings and WVCHIP Board meetings are open to all Native American and advocacy organizations, and these groups are included in advance notice of public meetings and invited to participate in the ongoing design of the program.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).
West Virginia has no Federal or State recognized tribes. Public hearings and WVCHIP Board meetings are open to all Native American and advocacy organizations, and these groups are included in advance notice of public meetings and invited to participate in the ongoing design of the program.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
    - Projected amount to be spent on health services;
    - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
    - Assumptions on which the budget is based, including cost per child and expected enrollment.
    - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
    - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

CHIP Budget

STATE: WV	**FFY Budget**
Federal Fiscal Year	**2024**
State's enhanced FMAP rate	**81.87%**
Benefit Costs	
Insurance payments	
Managed care	$53,485,348
per member/per month rate	$208.80
Fee for Service	$16,992,686
Total Benefit Costs	**$70,478,034**
(Offsetting beneficiary cost sharing payments)	($2,226,000)
Net Benefit Costs	**$68,252,034**
Cost of Proposed SPA Changes – Benefit	**$4,875,724**
Administration Costs	
Personnel	$264,893
General administration	$49,054
Contractors/Brokers	$1,339,182
Claims Processing	$3,252,301
Outreach/marketing costs	$0
Health Services Initiatives	$225,000
Other	
Total Administration Costs	**$5,130,430**
10% Administrative Cap	$7,583,560
Cost of Proposed SPA Changes	$73,382,464
Federal Share	$60,078,223
State Share	$13,304,241
Total Costs of Approved CHIP Plan	**$73,382,464**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State general appropriations

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.
All WVCHIP applicants and participants have the right of appeal through the same fair hearing process that is utilized by Medicaid participants for eligibility and enrollment matters.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

WVCHIP members may file a grievance regarding any aspect of service delivery provided or paid for by their MCO at any time. Participating MCOs must establish and maintain a grievance and appeal procedure in accordance with federal regulations and which has been approved by the State, to provide adequate and reasonable procedures for the expeditious resolution of grievances initiated by members or their providers concerning any matter relating to any provision of the MCO's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, reductions, cancellations or nonrenewals of member coverage; failure to provide services in a timely manner, observance of a member's rights as a patient; and the quality of the health care services rendered. A detailed description of the grievance and appeals process is included in the MCO Member Handbook and each MCO has at least one dedicated grievance coordinator.

WVCHIP members may request a fair hearing before the Department of Health and Human Resources as part of a member's right to fair hearing related to decisions to suspend, terminate, or reduce services as specified in 42 CFR §431.220, 42 CFR §457.1260 and 42 CFR §438.400. The MCO must implement any decision made by WVCHIP pursuant to such a review. Members must exhaust all MCO grievance and appeals procedures and receive notice that the MCO is upholding the adverse benefit determination prior to requesting a state fair hearing. The member must request a state fair hearing no later than one hundred twenty (120) calendar days from the date of the MCO's notice of resolution. In the event the MCO fails to adhere to the notice and timing requirements related to the appeal procedures contained herein, the member shall be deemed to have exhausted the MCO's appeals process, and the member may initiate a state fair hearing.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

WVCHIP does not participate in premium assistance programs.