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**State Name:** West Virginia

**State Plan Amendment (SPA) #:** 19-0003

This file contains the following documents in the order listed:

- 1) Approval Letter
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- 3) Approved SPA Pages
- 4) Companion Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
801 Market Street  
Suite 9400  
Philadelphia, Pennsylvania 19107-3134



**Regional Operations Group**

SWIFT # 102520194027

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December 26, 2019

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

Dear Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of West Virginia's State Plan Amendment (SPA) 19-003, Alternative Benefit Plan for Physical and Occupational Therapy. This SPA proposes to align the physical therapy and occupational therapy benefits under the Alternative Benefit Plan (ABP) with the standards for those benefits in the regular Medicaid State Plan that were recently approved by CMS under TN No. 19-002. As part of our review of SPA 19-003, we conducted a review of all individual Alternative Benefit Plan (ABP) templates in the West Virginia State Plan, consistent with CMS policy.

We are pleased to inform you that West Virginia SPA 19-003 is approved with an effective date of July 1, 2019. Enclosed is a copy of the Summary Page (CMS-179 form) and the approved ABP State Plan pages.

Please note that accompanying this approval of SPA 19-003 is a companion letter regarding the need for West Virginia to revise the premium assistance pages in the State Plan to comply with federal requirements.

If you have any further questions about this SPA, please contact Dan Belnap of my staff at 215-861-4273 or [Dan.Belnap@cms.hhs.gov](mailto:Dan.Belnap@cms.hhs.gov).

Sincerely,

/s/

Francis T. McCullough  
Deputy Group Director  
Financial Management Group  
Center for Medicaid & CHIP Services

Enclosures

## Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

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**State/Territory name:** West Virginia

**Transmittal Number:**

*Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.*

WV-19-0003

**Proposed Effective Date**

07/01/2019 (mm/dd/yyyy)

**Federal Statute/Regulation Citation**

ACA

**Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2020	\$ 0.00
Second Year	2021	\$ 0.00

**Subject of Amendment**

Alternate Benefit Plan

**Governor's Office Review**

- Governor's office reported no comment
- Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
- Other, as specified

Describe:

Not Required

**Signature of State Agency Official**

**Submitted By:** Anita Hayes

**Last Revision Date:** Dec 18, 2019

**Submit Date:** Sep 30, 2019

## Medicaid Alternative Benefit Plan: General Information

State/Territory name: **West Virginia**

Transmittal Number: **WV-19-0003**

**General Information:**

**Submission Title:**

*short (under 100 characters) label used to identify this submission in the web application*

WV ABP

**Description:**

Alternative Benefit Plan

Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

Date public notice was issued  (mm/dd/yyyy)

- The state/territory assures that it has provided the public with advance notice of the amendment and reasonable opportunity to comment.
- The state/territory assures that it has included in the notice a description of the method for assuring compliance with 42CFR 440.345 related to full access to EPSDT services.
- The state/territory assures that it has included in the notice a description of the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.
- The state/territory assures that it has performed any required tribal consultation.

Upload Public Notice Documents	
Please provide a short description of this public notice: WV 19-003 Public Notice	
<b>Uploaded Document Name:</b>	<b>Date Uploaded:</b>
WV SPA 19-003 Public Notice.pdf	

**ABP Screening Statements to Indicate Required Forms**

Select one of the following options for eligibility group coverage:

- The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP3.1, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name:

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
<b>+</b>	Adult Group	Mandatory	<b>X</b>

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

### Geographic Area

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

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

### PRA Disclosure Statement

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

V.20130724



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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

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

No

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

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

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

- Letter
- Email
- Other



# Alternative Benefit Plan

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

**An attachment is submitted.**

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

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

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

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

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

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

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

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

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

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

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



# Alternative Benefit Plan

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

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

Describe:

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

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

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

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

### PRA Disclosure Statement

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

V.20130807



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Enrollment Assurances - Mandatory Participants

ABP2c

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

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

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

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

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

Describe:

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

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

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

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

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

- Other

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



# Alternative Benefit Plan

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

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

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

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

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

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

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

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

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

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



# Alternative Benefit Plan

of benefit plan packages if they so choose.

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

### PRA Disclosure Statement

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V.20130807



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

**ABP3**

Select one of the following:

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

Name of benefit package:

## Selection of the Section 1937 Coverage Option

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

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

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

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

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

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

## Selection of Base Benchmark Plan

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

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

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

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.



# Alternative Benefit Plan

- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

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

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

### PRA Disclosure Statement

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V.20130801



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Alternative Benefit Plan Cost-Sharing

**ABP4**

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

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

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

No

Other Information Related to Cost Sharing Requirements (optional):

### PRA Disclosure Statement

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

V.20130807



# Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: WV - 19 - 0003

<b>Benefits Description</b>	<b>ABP5</b>
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The state/territory proposes a "Benchmark-Equivalent" benefit package.

**Benefits Included in Alternative Benefit Plan**

Enter the specific name of the base benchmark plan selected:

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



# Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:	Source:	Remove
Physician Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Medical Office Visit / Office Consultation (Includes Specialist/Specialist Virtual Visit) - Applies to Charges for Visit only. Does not apply to other Services received during Visit.		

Benefit Provided:	Source:	Remove
Podiatry: Other Licensed Practitioner	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Chiropractic: Other Licensed Practitioner	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
24 treatments/year	none	
Scope Limit:		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Coverage of chiropractic services is limited to one treatment per day and not more than 12 treatments		

TN NO. 19-0003

Approval Date: December 23, 2019

Effective Date: July 1, 2019

West Virginia  
Supersedes: 15-0004



# Alternative Benefit Plan

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

Benefit Provided:

Diagnostic x-ray

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Certain services require Prior Authorization and concurrent review for further services if identified as a high utilization/abuse. If services have been identified as having a high rate of utilization/abuse they will receive a more intense review and PA process.  
An example of hospital outpatient services that require a PA would be surgical procedures: acne surgery - criteria requires review of less invasive procedures to ensure medical necessity; reconstruction procedures (jaw, nose, brow repair) to ensure medical necessity and not cosmetic; all unlisted surgical procedures to ensure there is no appropriate CPT code and that the procedure is not experimental/research.

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove



# Alternative Benefit Plan

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add



# Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:	Source:	Remove
Outpatient Hospital Services/Emergency Room	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

  

Benefit Provided:	Source:	Remove
Any other medical care/Transportation	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Must be to nearest appropriate provider.		

Add



# Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

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

Add



# Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:	Source:	Remove
Hospital Inpatient Services/maternity	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Hospital Inpatient/maternity medical and surgical services for pregnancy and complications of pregnancy and miscarriage. These services for this benefit also include physician services covered in EHB 1		

  

Benefit Provided:	Source:	Remove
Hospital Outpatient Services/Maternity	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Outpatient/maternity medical and surgical services for pregnancy and complications of pregnancy and miscarriage. The services for this benefit also include physician services covered in EHB 1		

Add



# Alternative Benefit Plan

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

Collapse All

The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Benefit Provided:	Source:	Remove
Physician: Outpatient Psychiatric Treatment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Retroactive Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
12 sessions per year	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Services require Prior Authorization and concurrent review for further services if identified as a high utilization/abuse.		
Benefit Provided:	Source:	Remove
Rehab: Rehabilitative Psychiatric Treatment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
These services are aimed at those with sever mental illness. Full clinical review prior authorization is required for all services with no hard limits. WV has two levels of prior authorization, an initial level and a second more intense level for both MH and substance abuse services. In West Virginia most of these types of services are provided in the community mental health centers. These centers provide both individual and group psychotherapy services. At the State discretion services may require Prior Authorization if services have been identified as having a high rate of utilization/abuse.		
Benefit Provided:	Source:	Remove
Inpatient Hospital: Psychiatric Hospital Care	State Plan 1905(a)	



# Alternative Benefit Plan

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

5 day stay

Duration Limit:

None

Scope Limit:

None

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

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

Add



# Alternative Benefit Plan

6. Essential Health Benefit: Prescription drugs

- The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

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

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

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



# Alternative Benefit Plan

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

Collapse All

The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided:	Source:	Remove
Physical Therapy	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
20 visits/yr combined PT/OT rehab/hab	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Visit totals include PT and OT combined for rehabilitative and habilitative services. Any additional visits require PA. (PA process is from the State Plan). EPDST services for children under 21 are not subject to these limitations.		

Benefit Provided:	Source:	Remove
Occupational Therapy	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
20 visits/yr combined PT/OT rehab/hab	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Visit totals include PT and OT combined for rehabilitative and habilitative services. Any additional visits require PA. (PA process is from the State Plan). EPDST services for children under 21 are not subject to these limitations.		

Benefit Provided:	Source:	Remove
PT and related services: Speech Therapy	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	



# Alternative Benefit Plan

Amount Limit:

20 visits per year

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Rehab: Cardiac rehabilitation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

36 sessions in a 12 week period

Duration Limit:

None

Scope Limit:

None

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

Additional cardiac rehabilitation services may be medically necessary when the member has any of the following conditions:  
Another documented myocardial infarction or extension of initial infarction, or  
Another cardiovascular surgery or angioplasty; or  
New evidence of ischemia or an exercise test, including thallium scan, or  
New clinically significant coronary lesions documented by cardiac catheterization.

Benefit Provided:

Rehab: Pulmonary Rehabilitation

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 sessions

Duration Limit:

None

Scope Limit:

None

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

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



# Alternative Benefit Plan

Benefit Provided:	Source:	Remove
Home Health: Durable medical equipment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Durable medical equipment must be prescribed by a Physician or Professional Other Provider acting within the scope of their license.		
Benefit Provided:	Source:	Remove
Orthotics and prosthetics	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Orthotics and prosthetics must be prescribed by a Physician or Professional Other Provider acting within the scope of their license.		
Benefit Provided:	Source:	Remove
Home Health	Base Benchmark Commercial HMO	
Authorization:	Provider Qualifications:	
Prior Authorization	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
100 visits per year	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Review for the first 60 visits, beyond 60 visits full clinical criteria review required. 100 visits per year will		



# Alternative Benefit Plan

be a hard limit on this service. Children are covered by EPSDT and are not subject to the hard limit applied to adults for this service.

Benefit Provided:

Other Services: Rehabilitation Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add



# Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Laboratory Services and Testing

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add



# Alternative Benefit Plan

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

Collapse All

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

Benefit Provided:	Source:	Remove
Preventative Services: Diabetes Education	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text"/>		

Add



# Alternative Benefit Plan

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

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Add



# Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All



# Alternative Benefit Plan

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All

Base Benchmark Benefit that was Substituted:

Primary Care Visits to Treat an Injury or Illness

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Specialist Visit

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Primary Care Well Visits

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Other Practitioner Office Visit

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Diagnostic Test (X-Ray and Lab Testing)

Source:

Base Benchmark

Remove

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

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



# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Outpatient Hospital/Facility Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Outpatient Hospital Services under Essential Health Benefit 1.		
Base Benchmark Benefit that was Substituted: Hospice	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Hospice under Essential Health Benefit 1.		
Base Benchmark Benefit that was Substituted: Emergency Room Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Outpatient Hospital Services/Emergency Room under Essential Health Benefit 2.		
Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Any other medical care/Trnsportation under Essential Health Benefit 2.		
Base Benchmark Benefit that was Substituted: Inpatient Hospital/Facility Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Inpatient Hospital Services under Essential Health Benefit 3.		
Base Benchmark Benefit that was Substituted: Birthing Center Care/Maternity Services	Source: Base Benchmark	Remove



# Alternative Benefit Plan

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

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

Base Benchmark Benefit that was Substituted:

Maternity Care

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Outpatient Mental Health Services

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Outpatient Substance Abuse Services

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Rehabilitative Psychiatric Treatment

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Inpatient Mental Health Care Services

Source:

Base Benchmark

Remove

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

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



# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Inpatient Substance Abuse Case Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Inpatient Hospital: Psychiatric Hospital Care under Essential Health Benefits 5		
Base Benchmark Benefit that was Substituted: Prescription Drugs/Retail Pharmacy	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Prescription Drugs under Essential Health Benefit 6		
Base Benchmark Benefit that was Substituted: Speech Therapy	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: PT and related services: Speech Therapy under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted: Respiratory, Hyperbaric and Pulmonary Therapy	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This one service under the Base Benchmark is duplicated under both Rehab: Cardiac Rehabilitation and Rehab: Pulmonary Rehabilitation under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted: Durable medical equipment and Oxygen at home	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: Home Health; Durable medical equipment under Essential Health Benefit 7.		
Base Benchmark Benefit that was Substituted: Orthotic Devices and Prosthetic Appliances	Source: Base Benchmark	Remove



# Alternative Benefit Plan

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

Duplication: Orthotics and prosthetics under Essential Health Benefit 7.

Base Benchmark Benefit that was Substituted:

Diabetes Education

Source:

Base Benchmark

Remove

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

Duplication: Preventative Services: Diabetes Education under Essential Health Benefit 9.

Base Benchmark Benefit that was Substituted:

Eye Glasses for Children

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Dental Check-up for Children

Source:

Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:

Occupational Therapy

Source:

Base Benchmark

Remove

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

Duplication: Occupational Therapy is under Essential Health Benefit 7.

Base Benchmark Benefit that was Substituted:

Physical Therapy

Source:

Base Benchmark

Remove

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

Duplication: Physical Therapy is under Essential Health Benefit 7.



# Alternative Benefit Plan

	<input type="button" value="Add"/>
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# Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered Collapse All

Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Well Baby Care"/>	Source: <input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="The ABP population is for the new adult group, ages 19-64. As such 'Well Baby Care' is for ages 0-6, therefore, would not apply to this population."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Well Child Care"/>	Source: <input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="The ABP population is for the new adult group, ages 19-64. As such 'Well Child Care' is for ages 6-17, therefore, would not apply to this population."/>		
<input type="button" value="Add"/>		



# Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Family Planning Services and Supplies

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Preventative Services: Nutritional Education

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Duration Limit:

None

Scope Limit:

Other:

Other 1937 Benefit Provided:

Tobacco Cessation Counseling for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Duration Limit:

None

Scope Limit:

Other:

TN-NO. 19-0003

Approval Date: December 23, 2019

Effective Date: July 1, 2019

West Virginia

Supersedes: 15-0004



# Alternative Benefit Plan

<input type="text"/>	<input type="button" value="Add"/>
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# Alternative Benefit Plan

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

### PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Benefits Assurances

ABP7

### EPSDT Assurances

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

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

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

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

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

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

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

### Prescription Drug Coverage Assurances

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

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

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

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

### Other Benefit Assurances

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

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

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



# Alternative Benefit Plan

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

## PRA Disclosure Statement

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

V.20130807



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

- Managed care.
  - Managed Care Organizations (MCO).
  - Prepaid Inpatient Health Plans (PIHP).
  - Prepaid Ambulatory Health Plans (PAHP).
  - Primary Care Case Management (PCCM).

- Fee-for-service.
- Other service delivery system.

## Managed Care Options

### Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

### Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

### MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1932(a) mandatory managed care state plan amendment.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:



# Alternative Benefit Plan

Describe program below:

On January 1, 2014, West Virginia expanded its Medicaid program in accordance with the rules established by the Affordable Care Act at 42 §CFR 435.119 to include adults with income at or below 133% of the federal poverty level. The new adult group will receive all ABP benefits through a Managed Care delivery system once enrolled.

**Additional Information: MCO (Optional)**

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

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V.20130718



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Employer Sponsored Insurance and Payment of Premiums

**ABP9**

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

No

The state/territory otherwise provides for payment of premiums.

Yes

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

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

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

### PRA Disclosure Statement

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# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## General Assurances

**ABP10**

### Economy and Efficiency of Plans

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

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

Yes

### Compliance with the Law

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

### PRA Disclosure Statement

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V.20130807



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

## Payment Methodology

**ABP11**

### Alternative Benefit Plans - Payment Methodologies

- The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

**An attachment is submitted.**

### PRA Disclosure Statement

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V.20130807

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
801 Market Street  
Suite 9400  
Philadelphia, Pennsylvania 19107-3134



**Regional Operations Group**

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SWIFT# 102520194027

December 26, 2019

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

Dear Commissioner Beane:

This letter is being sent with the Centers for Medicare and Medicaid Services' (CMS) approval of West Virginia's State Plan Amendment (SPA) 19-0003, consistent with the State Medicaid Director letter (SMD) #10-020 published on October 1, 2010 (relating to the SPA review process), to address a problem with one of the SPA pages relating to West Virginia's premium assistance program. West Virginia's SPA 19-0003 proposes to revise the standards for physical and occupational therapy under the Alternative Benefit Plan (ABP).

On page ABP9 of SPA 19-0003, West Virginia indicates that it will provide the ABP to enrollees with access to employer-sponsored insurance through a premium assistance program. However, based on conversations with West Virginia, CMS understands that the state does not provide the necessary protections afforded under the statute to individuals enrolled in its premium assistance program.

Individuals enrolled in premium assistance arrangements must be afforded the same beneficiary protections provided to all other Medicaid beneficiaries, as articulated in section 1906(a)(3) of the Social Security Act. This means that the state must provide a benefits wrap, which ensures that individuals enrolled in the premium assistance program receive all services and benefits available under the Medicaid state plan, even if not covered under their employer's plan. The state must also provide a cost-sharing wrap to ensure that any cost-sharing amounts charged to individuals enrolled in the premium assistance program do not exceed the limitations on cost-sharing permitted under West Virginia's state plan, regardless of whether the services are furnished by a provider participating in Medicaid.

While the state's ABP9 page indicates that the state will provide both a benefits wrap and a cost-sharing wrap to individuals enrolled in its premium assistance program, the state has not described a strategy to implement these requirements. How the state will implement the benefits and cost-sharing wraps must be described in the State Plan, and both the benefits wrap and the cost-sharing wrap must be included in the state's methodology for determining the cost

effectiveness of the premium assistance program. CMS discussed its concerns with the state regarding the need for a benefits wrap and cost-sharing wrap on December 5, 2019, and we have provided technical assistance on options available to the state for implementing those wraps and including these wraps in its cost effectiveness calculation.

Under Section 1906 of the Act, states are not permitted to require a premium assistance program beneficiary to provide a receipt of payment for premium payment prior to the beneficiary obtaining reimbursement (known as the shoebox method). Section 1916A also of the Social Security Act prohibits states from imposing premiums and cost sharing on beneficiaries in excess of five percent of the family income which, in most cases would be exceeded by one month's premium payments. Prohibiting the use of the shoebox method, for both premiums and cost sharing payments, ensures that the mandated aggregate cap is not exceeded. CMS discussed options for states to provide payment to premium assistance beneficiaries for health premiums on December 5, 2019, and we have provided technical assistance on options available to the state to effectuate these payments.

During our discussion with the state on December 5, 2019, CMS explained that because page ABP9 is not integral to the purpose of the proposed SPA 19-0003, in accordance with SMD #10-020, the state has the option to resolve this issue separately from the approval of the SPA. The state informed CMS that it would like to address the steps needed to comply with federal policy governing premium assistance programs separately. This letter initiates that separate process.

As discussed, West Virginia will need to submit a new SPA to amend its premium assistance pages on attachment 4.22-C to describe how it will provide the benefits wrap and cost sharing wrap, account for both wraps in its cost-effectiveness test, and describe its strategy for effectuating health premium and cost sharing payments.

Please respond within 90 days of receipt of this letter by submitting a plan to bring the state into compliance. During this 90-day period, CMS welcomes the opportunity to work with you and your staff. Should you or your staff have any questions, please contact Stephanie Kaminsky, Director, Division of Medicaid Eligibility and Policy at [Stephanie.Kaminsky@cms.hhs.gov](mailto:Stephanie.Kaminsky@cms.hhs.gov).

Sincerely,

/s/

Francis T. McCullough  
Deputy Group Director  
Financial Management Group Center  
for Medicaid & CHIP Services