DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

August 12, 2026

Christy Donohue, Commissioner
West Virginia Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3706

Dear Ms. Christy Donohue:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving West Virginia's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on December 2, 2025, and a final revised preprint was received on June 29, 2026. The proposal has a control name of WV_Fee_IPH.OPH.AMC_Renewal_20250701-20260630**.**

CMS has completed our review of the following Medicaid managed care SDP(s):

- The Uniform Increase for eligible Acute Care Hospitals established by the state for Inpatient, Outpatient, and Physician Services for the rating period covering July 1, 2025 through June 30, 2026, incorporated in the capitation rates through a separate payment term up to $1,963,638,753.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state

must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, this SDP proposal does not qualify for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21) because it was submitted after July 4, 2025. Rather, the preprint named WV_Fee_IPH.OPH.AMC.PC_Renewal_20240701-20250630 submitted on December 10, 2024 with a total dollar amount of $1,336,557,110 likely qualified for the temporary grandfathering period in section 71116. CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of $1,336,557,110 for the grandfathered SDP with the control name of WV_Fee_IPH.OPH.AMC.PC_Renewal_20240701-20250630 submitted on December 10, 2024 (as specified in item 4 of the applicable SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

CMS appreciates the information that West Virginia has provided as part of the July 1, 2025 through June 30, 2026 preprint review regarding the total payment rate analysis and average commercial rate calculations in accordance with 42 CFR 438.6(c)(2)(iii). CMS is approving this preprint with the condition that the state continue to work with CMS to further refine the total payment rate analysis and average commercial rate demonstration for July 1, 2026 through June 30, 2027.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.08.12 15:11:06 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2025 - June 30, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Mountain Health Trust, including MCO contracts with UniCare Health Plan of West Virginia, Aetna Better Health of West Virginia, Highmark Health Options West Virginia, and The Health Plan
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $1,963,638,753
   a. Identify the estimated federal share of this state directed payment: $1,606,490,173
   b. Identify the estimated non-federal share of this state directed payment: $357,148,580

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

SFY 2016 - SFY 2025

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☒ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Managed care plans will make separate, directed payments to in-state licensed hospital providers serving Medicaid managed care enrollees. Hospital eligibility will be determined annually for each state fiscal year as of July 1.
The State will calculate an access fee quarterly to be allocated based on base payments reported by MCOs for services provided to eligible managed care enrollees for the rating period, of which eighty percent will be distributed. Hospital performance will be measured using quality metric(s) to determine eligibility for distribution of the remaining twenty percent with the fourth quarter installment.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://bms.wv.gov/cms/waiver-approvals

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

West Virginia is proposing a uniform percentage increase of 303% of base inpatient payments, 314% of Medicaid MCO base outpatient payments, and 85% of Medicaid MCO base academic physician group payments. Each quarterly payment poo

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

WV will continue its directed payment program that provides qualifying providers with additional dollars as an access fee for Medicaid members utilizing their services (Inpatient hospital, Outpatient hospital and Physician). WV will make payments to providers based upon MCO payments for utilization of services at each provider during the quarter. MCOs are required to report the date and amount of payments made to providers. The state will use these reports to ensure all payments are made as directed. Any discrepancies will be addressed with the MCO and corrected.
This uniform increase approach was developed to ensure critically needed funding is directed to West Virginia hospitals for inpatient hospital, outpatient hospital, and physician services. Reimbursements after directed payments are less than 100% of average commercial rate (ACR). See Table 2 reflecting the reasonableness of payment amounts.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The SFY26 DPP amounts are allocated by category of service (Inpatient (IP), Outpatient (OP), and Academic Physician (APG)). For non-APG pools, allocations are limited to Inpatient/Outpatient, as supplemental payments for physicians are limited to the APG pool. The allocations are based on completed managed care claims. Reimbursements after directed payments total less than 100% of estimated payments based on average commercial rates (ACR). WV will continue its directed payment program that provides qualifying providers with additional dollars as an access fee for IP, OP, and Physician services provided for Medicaid members in four categories of aid, including TANF, Pregnant Women, Expansion, and SSI. WV will make payments to providers based upon member utilization of services at each provider during the quarter. Surveyed hospital providers reported 5, and no less than 3, commercial rates for each of the covered procedure codes within calendar year 2023. These were used to calculate an average commercial rate (ACR) by inpatient day and each code for outpatient and physician services. The statewide average commercial rate per inpatient day was compared to the Medicaid base payment per day, projected to the payment period for the ACR demonstration. For outpatient and physician, survey results were used to calculate an average commercial rate (ACR) for each code. Each per unit ACR was multiplied by the reported Medicaid units for the survey period of calendar year 2023. Commercial equivalent payments were then compared to Medicaid payments reported on the survey to determine a ratio of commercial equivalent payments to Medicaid. The ratio is multiplied by SFY 2025 Medicaid managed care base payments to calculate equivalent commercial payments for the base period. Applying the ratio to base payments allows for the variation in services performed and varying rates across each service. The Medicaid base rate per visit is projected to the payment period by applying the unit cost trend developed for the SFY 2026 rate certification. For the rate demonstration, projected Medicaid base payments, state directed payments, and commercial equivalent payments are divided by base period visits. The resulting rates are compared to demonstrate Medicaid payment rates do not exceed the ACR for managed care services. SFY 2024 and SFY 2025 managed care encounter payments and units were used to calculate the statewide ACR payment rate demonstrations. MCOs are required to report the date and amount of payments made to providers. The state will use these reports to ensure all payments are made as directed. Any discrepancies will be addressed with the MCO and corrected. This uniform increase approach was developed to ensure critically needed funding is directed to West Virginia hospitals for services provided to its most vulnerable populations. See Table 2 reflecting the reasonableness of payment amounts.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☒ outpatient hospital service
- ☒ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Qualified providers include any inpatient or outpatient hospital conducting business in West Virginia that is not a state-owned or designated facility.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

West Virginia is a rural state. Abrupt hospital closures in West Virginia, and throughout the United States, have left patients seeking health care outside of their communities. A study released by the Chartis Center for Rural Health prior to COVID-19 cited a rural health crisis saying: "As of January 1, 2020, the rural hospital closure crisis has claimed 120 facilities across the nation over the past 10 years."

Directed payments to providers advance the goals and objectives in the State Medicaid Managed Care Quality Strategy by providing additional funding to promote a health care delivery system that consistently offers timely access, effective communication, and team-based approaches to better coordinate care across the full continuum of health care.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

Access payments are proposed for inpatient services, outpatient hospital services, and services provided by academic physician groups (APG). Quarterly payment pools are fixed, uniform amounts allocated to hospitals based on the volume of payments reported by Medicaid managed care organizations (MCOs) for the provision of services. The fixed, uniform quarterly payment pools for inpatient and outpatient are allocated to hospitals based on the proportionate volume of MCO payments for inpatient and outpatient services provided during the period, respectively. Likewise, the fixed, uniform quarterly payment pool for APG services is allocated to hospitals based on the proportionate volume of MCO payments for physician and outpatient services provided during the period. All quarterly distributions are limited to eighty percent of allocations. With fourth quarter distributions, each hospital will receive all or a portion of the remaining twenty percent of allocations if minimum or higher tier quality measure performance targets are met.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☐

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Inpatient hospital services	24%	72%			96%
b. Outpatient hospital services	15%	45%			60%
c. Academic hospital physicians	39%	32%			71%
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Average commercial payer rates.

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The data sources utilized to determine the analysis in Question 23 include the aggregation of each provider's ACR%, Average Commercial Reimbursement. To calculate the Average Commercial Rate, surveyed hospitals and academic physician groups in West Virginia submitted data from their top five commercial payers. ACRs were calculated at the procedure code level and applied to Medicaid claims data to determine the ACR percentage of Medicaid. Following repricing, all eligible providers' Average Commercial Reimbursement and Base Medicaid Reimbursement are aggregated across the eligible providers in the class. Please see Table 2 for the information in terms of % ACR payments.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

In aggregate for all provider groups, payment levels after directed payments are less than 100% of ACR. WV hospitals were closing at an unprecedented rate prior to COVID, with increased financial urgency due to the pandemic and its effect on hospital revenues. Continuation of this program helps support continued solvency of these critical providers.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

MCR-WV-0003-MHTWVHBEXPANSION

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 7.5.6 p. 170

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-WV-MHTWVHBEXPANSION-20250701-20260630-CERTIFICATION-20250604	06/04/2025	Yes	Section I.4.D starting from page 35
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Quarterly payment by separate term allows for state and MCO administrative ease in reviewing and tracking payments. It also ensures that the application of the uniform dollar increases are applied correctly and distributed uniformly among participating providers even in times of changing utilization patterns. The separate payment term is a predetermined pool amount that is allocated retroactively based on utilization during the rating period.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☒ State general revenue
- **b.** ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☒ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Acute Care tax assessment (WV §11-27-38)	Inpatient hospital services	Yes	Yes	Yes		No
ii. Acute Care tax assessment (WV §11-27-38)	Outpatient hospital services	Yes	Yes	Yes		No
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%20DoHS%20BMS
- **b.** The effective date of quality strategy. July 1, 2024

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Improve the health and wellness of the state's Medicaid and the WVCHIP populations through use of preventive services.	*Increase number of enrollees receiving preventive care to meet or exceed the NCQA Quality Compass National Medicaid Average. *Increase number of enrollees attending well and preventive visits to meet or exceed the NCQA Quality Compass National Medicaid Average.	Page 13, Table 1
b. Improve behavioral health outcomes.	*Increase number of enrollees receiving followup care after behavioral health treatment to meet or exceed the NCQA Quality Compass National Medicaid Average. *Increase number of enrollees receiving behavioral health care and treatment.	Page 13, Table 1
c. Reduce burden of the SUD.	*Increase number of enrollees receiving treatment for SUD to meet or exceed the NCQA Quality Compass National Medicaid Average. *Improve coordination of care for enrollees receiving the SUD treatment.	Page 13, Table 1
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

For SFY26, 20% of funding will be tied to meeting quality performance measures, one for each of four goals for each hospital type (5% for each goal) and one measure and goal for the academic physician groups (20% for one goal). Funds withheld and earned for distribution based on quality measure evaluations will be distributed as an additional payment with the Quarter Four (Q4) distribution of funds. Funds not earned by a hospital will be forfeited. The measures to be evaluated are related to quality strategy goals for improving the health and wellness of the state's Medicaid populations through use of preventive services, to improve behavioral health outcomes, and to improve behavioral health outcomes and reduce burden of the substance use disorder (SUD). Each hospital will be evaluated and paid based on performance results based on the thresholds described below.

Non-CAH Short Term Acute Care Hospitals:
• To advance the goal of improving the health and wellness of the state's Medicaid populations through use of preventive services, a non-CAH short term acute care hospital achieving a score of 91 or greater on the Employee Influenza Vaccine measure, will earn the full withhold. Hospitals achieving from 81.5 - 90.99 will receive half of the withhold for the measure. Anything less than 81.5 will result in the forfeiture of quality funds.
• On the Sepsis and Septic Shock, a non-CAH short term acute care hospital achieving a score of 62 or greater will earn the full withhold. Hospitals achieving from 36 - 61.99 will receive half of the withhold for the measure. Anything less than 36 will result in the forfeiture of quality funds.
• 5% total is withheld for two measures, each given a 50% weight (each has a 2.5% withhold): Catheter Associated Urinary Tract Infections and C. diff. On the catheter infections, a non-CAH short term acute care hospital achieving a rate of 0.743 or less will earn the full withhold. Hospitals achieving from .744 - 1 will receive half of the withhold for the measure. Anything greater than 1 will result in the forfeiture of quality funds. On the C. diff measure, a hospital achieving a rate of 0.606 or less will earn back the full withhold. Hospitals achieving from 0.607 - 1 will receive half of the withhold for the measure. Anything greater than 1 will result in the forfeiture of quality funds.
• On the Screening for health-related social needs, a non-CAH short term acute care hospital achieving a score of 88 or greater will earn the full withhold. Hospitals achieving from 80 - 87.99 will receive half of the withhold for the measure. Anything less than 80 will result in the forfeiture of quality funds.

Critical Access Hospitals:
• To advance the goal of improving the health and wellness of the state's Medicaid populations through use of preventive services, a critical access hospital achieving a score of 91 or greater on the Employee Influenza Vaccine measure, will earn back the full withhold. Hospitals achieving from 81.5 - 90.99 will receive back half of the withhold for the measure. Anything less than 81.5 will result in the forfeiture of quality funds.
• To advance the goal of improving the health and wellness of the state's Medicaid populations through use of preventive services, a critical access hospital achieving a score of 2 or less on the measures of the rates of patients leaving without being seen, will earn the full withhold. Hospitals achieving 2-3 will receive half of the withhold for the measure. Anything greater than 3 will result in the forfeiture of quality funds.
• 5% total is withheld for two measures, each given a 50% weight (each has a 2.5% withhold): Catheter Associated Urinary Tract Infections and C. diff. On the catheter infections, a critical access hospital achieving a rate of 0.743 or less will earn back the full withhold. Hospitals achieving from .744 - 1 will receive back half of the withhold for the measure. Anything greater than 1 will result in the forfeiture of quality funds. On the C. diff, a hospital achieving a rate of 0.606 or less will earn back the full withheld. Hospitals achieving from 0.607 - 1 will receive back half of the withhold for the measure. Anything greater than 1 will result in the forfeiture of quality funds.
• On the Screening for health-related social needs, a critical access hospital achieving a score of 88 or greater will earn back the full withhold. Hospitals achieving from 80 - 87.99 will receive back half of the withhold for the measure. Anything less than 80 will result in the forfeiture of quality funds.
Long Term Acute Care Hospitals (LTAC):
• To advance the goal of improving the health and wellness of the state's Medicaid populations through use of preventive services, a LTAC achieving a score of 70 or greater on the Employee Influenza Vaccine measure, will earn back the full 5% withhold. Hospitals achieving from 56 - 69.99 will receive back half of the withhold for the measure. Anything less than 56 will result in the forfeiture of quality funds.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Care Transitions (HCAHPS composite measure) COMP-7-SA and COMP-7-A	2017-2018	95%	Increase patient satisfaction with understanding care transition and meet 94% average hospital score	State evaluation of this measure is a "met" or "unmet" of the performance target
ii. Influenza Vaccination Coverage among Healthcare Personnel IMM-3 Adult Breast Cancer Screening, Age 50-74 (HEDIS)	2017-2018 SFY 2019	80% 59%	Increase vaccination rate for the flu and meet 88% average score (56% for LTAC, 69% Rehab) Increase breast cancer screening rates and meet 61% average by Academic Physician Groups	State evaluation of this measure is a "met" or "unmet" of the performance target.
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Quality evaluation results varied across providers, with most providers' evaluation results fluctuating since the baseline statistic.

Quality evaluation results for SFY 2024:

Flu Vaccination (IMM) - 84% of (non-APG) participants met the target for improvement
Care Transitions (COMP7) - 88% of (non-APG) participants met the target for improvement
Breast Cancer Screening (BCS-AD) - 100% of (APG) participants met the target for improvement