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State/Territory Name: West Virginia

State Plan Amendment (SPA) #: 25-0001

This file contains the following documents in the order listed:

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

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

Medicaid and CHIP Operations Group

September 24, 2025

Cynthia Beane, Commissioner
West Virginia Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301

Re: West Virginia State Plan Amendment (SPA) – WV-25-0001

Dear Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) has reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0001. This SPA amends the Medicaid State Plan to provide for mandatory coverage in accordance with section 1902(a)(84)(D) of the Social Security Act (the Act) for eligible juveniles that are incarcerated in a public institution post-adjudication of charges.

We conducted our review of your submittal according to statutory requirements in section 1902(a)(84)(D) of the Act. This letter informs you that West Virginia's Medicaid SPA TN 25-0001 was approved on September 22, 2025, effective January 1, 2025, and will sunset on December 31, 2026.

Enclosed are copies of the Form CMS-179 and approved SPA pages to be incorporated into the West Virginia State Plan.

Please note that accompanying this approval of WV-25-0001, there is an enclosed companion letter regarding the need for West Virginia to address identified actions that must be completed by December 31, 2026, to fully implement mandatory coverage in accordance with section 1902(a)(84)(D) of the Act. CMS is issuing the companion letter to document these actions and establish a timeframe for their completion.

If you have any questions, please contact Nicole Guess at (872) 287-1397 or via email at Nicole.Guess@cms.hhs.gov.

Sincerely,

[redacted]

Nicole McKnight
On Behalf of Courtney Miller, MCOG Director

Enclosures

cc: Sarah Young
Anita Hayes
Riley Romeo

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

Medicaid and CHIP Operations Group

September 24, 2025

Cynthia Beane
Commissioner
West Virginia Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301

Re: West Virginia State Plan Amendment (SPA) – WV-25-0001

Dear Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) is sending this companion letter to WV-25-0001 approved on September 22, 2025. This State Plan Amendment (SPA) amends the Medicaid State Plan to provide for mandatory coverage in accordance with section 1902(a)(84)(D) of the Social Security Act (the Act) for eligible juveniles who are incarcerated in a public institution post-adjudication of charges. As noted in the approval letter and the State Plan, this SPA is effective as of January 1, 2025, and will sunset on December 31, 2026. The state must complete the actions identified in this letter by the sunset date. Once these actions are completed, the state should submit a SPA to remove the sunset date from the State Plan.

Effective January 1, 2025, section 1902(a)(84)(D) of the Act requires states to have an internal operational plan and, in accordance with such plan, provide for the following for eligible juveniles as defined in section 1902(nn) of the Act (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children under 42 C.F.R. § 435.150 who are at least age 18 but under age 26) who are within 30 days of their scheduled date of release from a public institution following adjudication:

- In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, the state must provide any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.

- In the 30 days prior to release and for at least 30 days following release, the state must provide targeted case management services, including referrals to appropriate care and

services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid State Plan (or waiver of such plan).

We appreciate the state's efforts to implement this mandatory coverage and recognize the progress that has been made, as well as the complexities associated with full implementation. However, during the review of WV-25-0001, CMS identified actions that must be completed to fully implement mandatory coverage in accordance with section 1902(a)(84)(D) of the Act. CMS is issuing this companion letter to document these actions and establish a timeframe for their completion.

The state must complete the following actions by December 31, 2026, to fully implement section 1902(a)(84)(D) of the Act. Once these actions are completed, the state should submit a SPA to remove the sunset date from the State Plan.

1. **Systems changes for the Medicaid Management Information System (MMIS) and Eligibility & Enrollment (E&E) System**: The Bureau of Medical Services (BMS) will work with systems vendors to assess and plan for necessary configuration updates and change requests needed to support these updates to support implementation of, and where appropriate, billing and claiming for 5121 services. The State will conduct outreach, training, and technical assistance to help ensure that relevant stakeholders are informed and aware of system changes and the capacities needed to support the 5121 implementation.

2. **Confirming and/or establishing workflows and data/information sharing between Medicaid and Corrections:** BMS will work with Corrections partners at the Bureau for Juvenile Services (BJS) and Department of Corrections and Rehabilitation (DCR) to augment existing Medicaid eligibility and enrollment workflows and data-sharing processes. The State agencies will partner to update and/or establish data-sharing arrangements to identify and communicate eligible 5121 youth members who are incarcerated. Activities include confirming Medicaid applications are completed, confirming Corrections stakeholders are aware of who is eligible for Medicaid and services under Section 5121, and helping ensure members' anticipated release dates are communicated from Corrections to Medicaid.

3. **Medicaid and correctional policy and process flow updates**: BMS will update policy manuals as necessary to clarify the Section 5121 scope of services for which the target population is eligible. This includes clarifying updates to policy manual sections such as eligibility and Targeted Case Management (TCM) policies. BMS will update Medicaid eligibility processes where applicable and confirm Corrections partners' policy and process flow updates where applicable to align with Medicaid. These updates relate to, for example, timing of Medicaid application support and meeting service/documentation requirements when applicable.

4. **Provider strategy confirmation and provider enrollment**: BMS will conduct provider engagement, readiness assessments, and training.

5. **Managed Care Organization (MCO) engagement, training, contract updates and system configuration**: BMS will use managed care to deliver 5121 services. BMS will engage MCOs for awareness on continued planning in support of Section 5121 services. BMS will conduct specific training with MCOs on the 5121 scope and implications for managed care engagement, such as during and following the eligible youth's 30-day pre-release period. BMS will review the MCO contract(s) to help ensure the contract is updated appropriately to include details with specific expectations of the MCOs in support of this population. BMS will work with MCO partners and systems teams to help ensure the MCOs' systems are configured to capture claims for the 5121 services appropriately.

As always, CMS is available to provide technical assistance on any of these actions. If you have any questions, please contact Nicole Guess at (872) 287-1397 or via email at Nicole.Guess@cms.hhs.gov.

Sincerely,

[redacted]

Nicole McKnight
On Behalf of Courtney Miller, MCOG Director

Enclosures

cc: Sarah Young
Anita Hayes
Riley Romeo

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0001

2. STATE: WV

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

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

4. PROPOSED EFFECTIVE DATE
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
1902(a)(84)(D); 42 C.F.R. § 435.150

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 20,600

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1- M Pages 1 & 2

Supplement 1 to Attachment 3.1-A and 3.1-B, Pages 15 - 21

Attachment 4.19-B, Page 13

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
New Attachment 3.1-M

New Supplement 1 to Attachment 3.1-A and 3.1-B

Attachment 4.19-B, Page 13

9. SUBJECT OF AMENDMENT
SPA 25-0001 attests that BMS will provide coverage for screening and diagnostic services, as well as Targeted Case Management (TCM) services, to eligible justice-involved members in accordance with Section 5121 CAA, 2023 requirements. This SPA establishes coverage of TCM for the target population of eligible juveniles and updates the correlated case management reimbursement language in Attachment 4.19-B.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Cynthia Beane

13. TITLE
Commissioner, WV Bureau for Medical Services

14. DATE SUBMITTED
03/28/2025

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

FOR CMS USE ONLY

16. DATE RECEIVED
03/28/2025

17. DATE APPROVED
09/22/2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Nicole McKnight

21. TITLE OF APPROVING OFFICIAL
On Behalf of Courtney Miller, MCOG Director

22. REMARKS

State Plan under Title XIX of the Social Security Act
State/Territory: West Virginia

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Eligible juveniles as defined in §1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution **following adjudication,** and for at least 30 days following release.

Post Release TCM Period beyond 30 day post release minimum requirement:
☐ State will provide TCM beyond the 30 day post release requirement. **[explain]:** West Virginia will provide TCM for the 30 day post-release window as required.

Areas of State in which services will be provided (§1915(g)(1) of the Act):
☑ Entire state

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
☑ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management (TCM) services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

State Plan under Title XIX of the Social Security Act
State/Territory: West Virginia

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

The periodic reassessment is conducted every (check all that apply):

- ☐ 1 month
- ☐ 3 months
- ☐ 6 months
- ☐ 12 months
- ☑ Other frequency **[explain]:** Once during the 60-day period.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities are:
  activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Frequency of additional monitoring:
Specify the type and frequency of monitoring (check all that apply)

☐ Telephonic. Frequency:

☑ In-person. Frequency: Once a month.

☑ Other **[explain]:** Once a month via telehealth.

☑ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. For instance, a case manager might also work with state children and youth agencies for children who are involved with the foster care system.
(42 CFR 440.169(e))

☑ If another case manager is involved upon release or for case management after the 30-day post release mandatory service period, states should ensure a warm hand off to transition case management and support continuity of care of needed services that are documented in the person-centered care plan. A warm handoff should include a meeting between the eligible juvenile, and both the pre-release and post-release case manager. It also should include a review of the person-centered care plan and next steps to ensure continuity of case management and follow-up as the eligible juvenile transitions into the community.

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[**Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]**

Providers of 5121 Targeted Case Management must meet the following qualifications:

Entities providing Targeted Case Management (TCM) to eligible juveniles must demonstrate a capacity to provide TCM through either of the following:

1) A comprehensive inter-agency agreement between the West Virginia Medicaid agency and the West Virginia Department of Corrections and Rehabilitation; or

2) Current licensure as a behavioral health agency pursuant to applicable West Virginia Code.

AND (all of the following specified in 1 - 5):

1) Demonstrated capacity to link eligible juveniles to a comprehensive array of services;

2) Assurance that entity staff are sufficient in number and appropriately qualified through training and experience to address the needs of eligible juveniles;

3) Attestation to administrative capacity to ensure quality of services, documentation of services, and maintenance of individual eligible juvenile records in accordance with state and federal requirements;

4) Assurance that the entity has the financial management capacity to prepare and submit claims for these services;

5) Assurance that all staff providing TCM are employed by an entity that meets the qualifications above and possess at least one of the following credentials:

i. A Licensed Psychologist or Supervised Psychologist;

ii. A Licensed Independent Clinical Social Worker(LICSW), Licensed Certified Social Worker (LCSW), or Licensed Graduate Social Worker (LGSW);

iii. A Licensed Professional Counselor;

iv. A registered nurse;

v. A Doctorate, Masters, or Bachelor's degree in a human service, behavioral science, or a healthcare discipline; or

vi. An individual with any four-year degree (BA or BS) with at least two years' documented experience in case management, care management, care coordination, or working in the behavioral health field.

State Plan under Title XIX of the Social Security Act
State/Territory: West Virginia

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Freedom of choice (42 CFR 441.18(a)(1)):

☑ The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services below.]

Click or tap here to enter text.

State Plan under Title XIX of the Social Security Act
State/Territory: West Virginia

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

☑ The state assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plans.
- Delivery of TCM and the policies, procedures, and processes developed to support implementation of these provisions are built in consideration of the individuals release and will not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Payment (42 CFR 441.18(a)(4)):

☑ The state assures payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):

☑ The state assures providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

☑ The state assures that case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

☐ State has additional limitations **[Specify any additional limitations.]**
Click or tap here to enter text.

**Mandatory Coverage for
Eligible Juveniles who are
Inmates of a Public Institution
Post Adjudication of Charges**

State/Territory: West Virginia

General assurances. State must indicate compliance with all four items below with a check.

☑ In accordance with section 1902(a)(84)(D) of the Social Security Act, the state has an internal operational plan and, in accordance with such plan, provides for the following for eligible juveniles as defined in 1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication:

> ☑ In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.
>
> ☑ In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

☑ The state acknowledges that a correctional institution is considered a public institution and may include prisons, jails, detention facilities, or other penal settings (e.g., boot camps or wilderness camps).

Additional information provided (optional):

☐ No

☑ Yes [provide below]

The authority to provide for mandatory coverage for eligible juveniles who are inmates of a public institution post adjudication of charges will cease on December 31, 2026.

The State may determine that it is not feasible to provide the required services during the pre-release period in certain other carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g., unexpected release or short-term stays). The State will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the State determines that it is not feasible to provide for the required services during the pre-release period. This information is available to CMS upon request. In these cases, services will be provided to eligible individuals post-release, including the mandatory 30-days of targeted case management, screening, and diagnostic services.

The State will maintain clear documentation in the internal operational plan indicating which carceral facility/facilities are furnishing required services during the pre-release period but not enrolling in or billing Medicaid. This information is available to CMS upon request.

4.19 Payments for Medical and Remedial Care and Services

D. Cap on Overall Hospice Reimbursement

The overall aggregate payments made to a hospice during a cap period from November 1 each year through October 31 of the next year will be limited based on services rendered during the cap year on behalf of all Medicaid recipients receiving services during the cap year. Any payment in excess of the cap must be refunded by the hospice.

19. Case Management

Payment for case management services will not duplicate payment made to public agencies or private entities under other programs authorized for the same purpose. Medicaid will be the payor of last resort.

Other than the Birth to Three target group, reimbursement for Targeted Case Management (TCM) for individuals meeting the criteria for the specified target group will be based on a fee schedule developed by the West Virginia Medicaid agency (State). Unless otherwise noted in the Plan, the State-developed fee schedule rates are the same for both governmental and private providers.

Payment for Birth to Three Early Intervention Services will be through an agreement with the state Title V agency. Payments shall be based on total cost of service provision. The Title V agency must maintain, in auditable form, all records of cost of services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for TCM reimbursement. The agency's fee schedule rate was set as of January 1, 2025, and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at: West Virginia Medicaid Physician's Fee Schedules.

20. c. Expanded Prenatal Services

Reimbursement for expanded prenatal care services, as defined in Supplement 2 to ATTACHMENT 3.1-A and 3.1-8, 20.c., will be based on units of services. Each defined activity will be weighted and assigned a time value which will convert to dollars for reimbursement purposes.

Payment for expanded prenatal services will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid will be the payor of last resort.

(v) Respirator Care Services

Payment is made for ventilator equipment and supplies, the respiratory therapist, or other professional trained in respiratory therapy, at the lowest customary charge from qualified providers serving the geographical area of the recipient's residence.