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State Name: West Virginia

State Plan Amendment (SPA) #: 10-05

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

JUN 15 2011

Ms. Nancy V. Atkins
Commissioner
Bureau for Medical Services
Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Ms Atkins:

We reviewed West Virginia's State Plan Amendment (SPA) 10-05, which allows caretaker relatives to voluntarily enroll under your benchmark program, the Mountain Health Choice Program. This SPA also brings your State Plan into compliance with the final benchmark regulations.

Enclosed is a copy of the approved SPA and signed CMS-179. The SPA is effective July 1, 2010.

If you have any questions, please contact Donna Fischer of my staff at (215) 861-4221.

Sincerely,

/S/

Ted Gallagher
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 1 0 - 0 5
2. STATE: West Virginia
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2010

5. TYPE OF PLAN MATERIAL (Check One)

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440, Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $ $939,695 (Increase)
b. FFY 2011 $ $3,562,804 (Increase)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1C Pages 1 through 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable).
Attachment 3.1C Pages 1 through 10

10. SUBJECT OF AMENDMENT:
Revisions to benchmark plan dealing with optional eligibility groups.

11. GOVERNOR'S REVIEW (Check One):

[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[X] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[ ] OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/S/

13. TYPED NAME:
Nancy V. Atkins, RN, MSN, NP-BC

14. TITLE:
Commissioner

15. DATE SUBMITTED:
9/29/10

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 29, 2010

18. DATE APPROVED
JUN 15 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Ted Gallagher

22. TITLE
Associate Regional Administrator, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92) INSTRUCTIONS ON BACK

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State provides benchmark benefits:

X Provided

__ Not Provided

States can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State and would correlate to "Plan B" only.)

X	Title of Alternative Benefit Plan A: Mountain Health choices, Basic Plan The state plan preprint pages refer to both plan A and plan B
X	Title of Alternative Benefit Plan B: Mountain Health Choices, Enhanced Plan The state plan preprint pages refer to both plan A and plan B
__	Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X a) **Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs should include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please

indicate in the chart below:

- Each eligibility group the State will require to enroll in the alternative benefit plan;
- Each eligibility group the State will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		Statewide
X		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		Statewide
X		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		Statewide
X		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		Statewide
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • • • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
X		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		Statewide
X		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		Statewide
X		Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)		Statewide
Required Enrollment	**Opt-In Enrollment**	**Full-Benefit Eligibility Group and Federal Citation**	**Targeting Criteria**	**Geographic Area**
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • • • •		

__ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act		Statewide
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
Opt-In Enrollment	**Included Eligibility Group and Federal Citation**	**Targeting Criteria**	**Geographic Area**
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

__ (iii) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan. If an exempt individual chooses to opt out of the benchmark program, he/she will be enrolled in Mountain Health Trust, the managed care plan under WV's 1915(b) Waiver Program.

Further information is provided to caretaker relatives by the enrollment broker in the form of a caretaker relative cover letter, benefit plan comparison, member check list, health improvement plan, member personal responsibility agreement and other relevant documentation.

__ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, States may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

__ (i) The State has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Specify whether the benchmark will cover these individuals statewide or otherwise.

__ (ii) For optional populations/individuals [checked above in b(i)], describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

2. Description of the Benefits

__ The State will provide the following alternative benefit package (check the one that applies).

a. Benchmark Benefits

__ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

__ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State Employee Benefit Package.

__ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served.

Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

See Attachment 3.1C, Attachment 2, pages 2 & 3

__ b) Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

__ (i) Inclusion of Required Services - The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

__ (ii) Additional services

Insert below a full description of the benefits in the plan including any limitations.

See Benchmark Plans, attached.

__ (iii) The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;

- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

__ iv The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Vision services, and/or
- Hearings services

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

__ c) Additional Benefits

Insert a full description of the additional benefits including any limitations.

- Other Additional Benefits (If checked, please describe)

3. Service Delivery System

Check all that apply.

__ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

X The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

X The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

__ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

__ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

X The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.) Depending on the county, beneficiaries will have a choice between a PCCM (services provided under fee for service) and an MCO; between two or more MCOs; or in rural counties, a choice of two PCPs in the one MCO.

4. Employer Sponsored Insurance

__ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

X Through Benchmark only

__ As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Please see West Virginia State Plan, Attachment 3.1-D, page 1.

X The State assures that effective January 1, 2014 any benchmark benefit plan provides at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

X The State assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement 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.

7. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

X The State will implement this State Plan amendment on July 1, 2010.