



Centers for Medicaid and State Operations

MAY 3 2006

Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3706

Dear Ms. Atkins:

We are pleased to inform you of the approval of West Virginia's Medicaid State Plan Amendment (SPA) 06-02. This SPA provides for the implementation of flexibilities granted under section 6044 of the Deficit Reduction Act of 2005 (DRA), State Flexibility in Benefit Packages, which provided the addition of section 1937 of the Social Security Act (the Act). This approval allows the State to provide alternative benefit packages for Medicaid eligibles except those exempted under section 1937 of the Act. This population is primarily the healthy adults and children. The SPA is effective April 1, 2006, with the anticipated implementation date of July 1, 2006.

The four alternative benefit packages will be phased in by geographic area and delivery system availability. Prior to implementation, the Bureau for Medical Services must comply with Federal requirements of advance public notice, which can include, but is not limited to State website posting or public service announcements.

Approval of this State plan amendment is limited to the scope of the submitted benefit provision and does not constitute approval of any change in reimbursement methodologies, new reimbursement methodologies, or change in the sources of non-Federal share funding utilized by the State to make such Medicaid payments.

Enclosed is a copy of the approved SPA and the HCFA-179 form. If you have any questions, please contact Ms. Jean Sheil, Director of the Family and Children's Health Programs Group at 410-786-5647. We congratulate your State's pioneering efforts to implement the flexibility afforded to states under section 1937 of the Act for your healthy adults and children.

Sincerely,


Dennis G. Smith
Director

Enclosure

Page 2 – Ms. Nancy V. Atkins

cc: Nancy O'Connor, RA, Region III
Susan Cuerdon, ARA, DMCH, Region III

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>06</u> — <u>02</u>	2. STATE West Virginia
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	

TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2006
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5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION DEFICIT REDUCTION ACT 2005, PL 109-171, SECTION 6044	7. FEDERAL BUDGET IMPACT a. FFY _____ \$ Budget Neutral b. FFY _____ \$ _____
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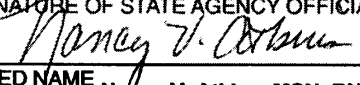
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Section 3.1-C Pages 1 through 8	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
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10. SUBJECT OF AMENDMENT

This State Plan provides an alternative benchmark benefit package.

11. GOVERNOR'S REVIEW (Check One)

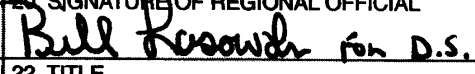
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Nancy V. Atkins, MSN, RNC, NP Commissioner Bureau for Medical Services 350 Capitol Street, Room 251 charleston, WV 25301-3706
13. TYPED NAME Nancy V. Atkins, MSN, RNC, NP	
14. TITLE Commissioner	
15. DATE SUBMITTED April 21, 2006	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED 5-3-06
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME	22. TITLE

23. REMARKS

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

1937(a),
1937(b)

X / The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

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

- a. X / Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

Full benefit eligible individuals not to include individuals determined eligible under Section 1902 (a)(10)(C) of the Act or Section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care (medically needy and spend down individuals). Additionally, the limitations in Section 1937(a)(2)(B) apply. Generally, the populations for the alternate coverage are the healthy adults and healthy children on Medicaid.

- b. / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

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For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

c. Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

The alternate benefit package will be available statewide, subject to a phase in on a county by county basis.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

See Attachment No.1.

B. Description of the Benefits

The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1. Benchmark Benefits

- a. **FEHBP-equivalent Health Insurance Coverage** –
The standard Blue Cross/Blue Shield preferred provider
- b.

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c. option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

b. ___/ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State’s employee benefits plan package.

c. ___/ **Coverage Offered Through a 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. Attach a copy of the HMO’s benefit package.

d. **X/ Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State’s plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

See Attachment No. 2. (Benchmark Plans)

See Attachment No. 3. (Member Agreement)

2. ___/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:

_____.

a. ___/ The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the

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population being served; 5) 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 6) 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. Attach a copy of the report.

b. ___/ The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach 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. ___/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) ___/ **Inclusion of Basic Services** – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

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- / Inpatient and outpatient hospital services;
- / Physicians' surgical and medical services;
- / Laboratory and x-ray 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
- / Other appropriate preventive services, as designated by the Secretary.
- / Clinic services (including health center services) and other ambulatory health care services.
- / Federally qualified health care services
- / Rural health clinic services
- / Prescription drugs
- / Over-the-counter medications
- / Prenatal care and pre-pregnancy family services and supplies
- / Inpatient Mental Health Services not to exceed 30 days in a calendar year
- / Outpatient mental health services furnished in a State-operated facility and including community-based services
- / Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
- / Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
- / Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
- / Dental services
- / Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
- / Outpatient substance abuse treatment services
- / Case management services
- / Care coordination services
- / Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

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- / Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
- / Premiums for private health care insurance coverage
- / Medical transportation
- / Enabling services (such as transportation, translation, and outreach services)
- / Any other health care services or items specified by the Secretary and not included under this section

- (2) Additional benefits for voluntary opt-in populations:
 - / Home and community-based health care services
 - / Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

3. Wrap-around/Additional Services

a. / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

See Attachment No 4.

b. / The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

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C. Service Delivery System

Check all that apply.

1. / The alternative benefit package will be furnished 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.

2. **X/** The alternative benefit package will be furnished 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 1915(b)(1).

3. **X/** The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

The current service delivery system will be followed; however, only one managed care organization (MCO) is required for each county state-wide to administer this benefit package. (See Attachment 1 for further clarification.)

4. __/ Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5. __/ Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

D. Additional Assurances

a. **X/** The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, 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).

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

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E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

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.

G. Implementation Date

The State will implement this State Plan amendment on **July 1, 2006.**

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**MEDICAID REDESIGN ELIGIBILITY GROUPS
CHILDRENS COVERAGE GROUP**

	FPL
Income Based on child No deeming	Less than 1 - 150% Continuously eligible newborns 12,279 (CEN) 1 to 6 - 133% 6 to 19 - 100% Members (133,569)
Asset Test - None Can Have Other Insurance Coverage	
12 Month Continuous Eligibility	

These groups will be enrolled into the Basic Package upon initial application or re-determination, phased in county by county as the infrastructure is developed. Advanced notification will be provided to members as they are enrolled in the Basic Benefit Plan. It is anticipated initially, that Clay, Upshur and Lincoln Counties will be started on July 1, 2006. Expansion of the program will occur over the next year as provider networks are developed. Once developed, the program will be expanded county by county until it is statewide.

**MEDICAID REDESIGN ELIGIBILITY GROUPS
ADULTS WITH CHILDREN COVERAGE GROUP**

Eligibility Categories	FPL
AFDC Medicaid AFDC Related-Medicaid (MMN) (Pregnant Women excluded)	
Income Income Test No deeming	July 16, 1996 AFDC payment levels
Asset Test	Asset Test - \$1,000 1 - \$149 2 - \$201 3 - \$253 4 - \$312
Transitional Medicaid (Up to 12 Months)	Members 3,212 Loses Medicaid due to earnings
Extended Medicaid Child Support (4 Months)	Members 294 Ineligible due to Child Support amount received

These groups will be enrolled into the Basic Package upon initial application or re-determination, phased in county by county as the infrastructure is developed. Advanced notification will be provided to members as they are enrolled in the Basic Benefit Plan. It is anticipated initially, that Clay, Upshur and Lincoln Counties will be started on July 1, 2006. Expansion of the program will occur over the next year as provider networks are developed. Once developed, the program will be expanded county by county until it is statewide.

West Virginia will offer a BASIC and an ENHANCED plan to members. The BASIC plan provides all state and federal mandatory services. The ENHANCED plan offers additional medical services to members. In order to access the Enhanced Plan, Medicaid members must voluntarily sign the Medicaid Member Agreement (see attachment 3). The member will sign the agreement at the Medical Home.

The following responsibilities will be tracked in the first year:

- 1 Screenings as directed by their health care provider.
- 2 Adherence to health improvement programs as directed by their health care provider.
- 3 Missed appointments.
- 4 Medication compliance.

Successful compliance with these four responsibilities will be monitored. The HMO/medical home will partner to monitor and report compliance with these responsibilities. If the member has fulfilled the responsibilities agreed to, he/she will remain in the Enhanced Benefit Plan. If the member does not fulfill the responsibilities, he/she will be moved to the Basic Benefit Plan subject to good cause. Members will receive advanced notification if their benefits are reduced and will have the right to appeal the decision. After twelve months in the Basic Plan and at re-determination, members will have the opportunity to sign the Member Agreement and be re-enrolled in the Enhanced Plan.

West Virginia Medicaid Redesign Benefit Packages

CHILDREN	
Basic Plan	Enhanced Plan
Inpatient Services	Inpatient Services
Outpatient Services	Outpatient Services
Physician/NP/MW Services RHC/FQHC	Physician/NP/MW Services RHC/FQHC
Home Health (limited – 25 visits per year)	Home Health
DME (limited - \$1000 per year with prior authorization if exceeded)	DME
EPSDT	EPSDT
Family Planning	Family Planning
NEMT (limited – 10 trips per year)	NEMT
Hospice	Hospice
Ambulance	Ambulance
Prescriptions (limited to 4 per month)	Prescriptions
Vision (limited – \$750 maximum per year)	Vision
Dental (limited – exam every 6 months)	Dental
Hearing (limited – annual exam and hearing aid when medically necessary)	Hearing
	Skilled Nursing Care (limited – 180 days per benefit period)
	Orthotics/Prosthetics
	Tobacco Cessation
	Nutritional Education
	Diabetes Care
	Chemical Dependency/Mental Health Services

West Virginia Medicaid Redesign Benefit Packages

ADULTS	
Basic Plan	Enhanced Plan
Inpatient Services	Inpatient Services
Outpatient Services	Outpatient Services
Physician/NP/MW Services RHC/FQHC	Physician/NP/MW Services RHC/FQHC
Home Health (limited - 25 visits per year)	Home Health
DME (limited \$1000 per year with prior authorization if exceeded)	DME
Nursing Home Services	Nursing Home Services
Family Planning	Family Planning
NEMT (limited – 5 trips per year)	NEMT
Hospice	Hospice
Ambulance (Emergency only)	Ambulance
Prescriptions (limited to 4 per month)	Prescriptions
	Cardiac Rehabilitation
	Chiropractic Services
	Dental Services (Emergent Treatment)
	Tobacco Cessation Program
	Chemical Dependency/Mental Health Services (limited – Inpatient 30 days per year/Outpatient 20 visits per year)
	Diabetes Care
	Nutritional Education

April 26, 2006

Member Name _____ Member Medicaid # _____

West Virginia Medicaid Member Agreement

This Agreement outlines your Rights and Responsibilities as a person in the West Virginia Medicaid Program. It also is about ways you can work with your doctor and other health care providers to become healthier.

MEMBER RESPONSIBILITIES

I will follow the requirements of the West Virginia Medicaid program.

- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.
- I will use the hospital emergency room only for emergencies.

MEMBER RIGHTS

1. I have the right to pick my medical home. This is where I go for check-ups or when I am sick and where my health care records will be.
2. I have a right to decide things about my health care and the health care of my children. I have a right to see my medical records. I have the right to ask questions about my health care and the health care of my children.
3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the Medicaid Program.
4. I have a right to know about all laws and rules of the Medicaid Program.
5. I can contact Medicaid or my health plan with any questions about my health care.
6. I have a right to be sent a written notice when West Virginia Medicaid decides to deny or limit my Medicaid eligibility. I have a right to appeal a decision about my eligibility.
7. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

MEMBER ACKNOWLEDGEMENT

The information in this paper has been explained to me and I agree to follow this Medicaid Member Agreement.

West Virginia Medicaid Member Signature or
Responsible party

Date

Witness:

Title:

Location:

Date

4/26/06 GW

Section 3.1-C -Attachment 4

Wrap Around Services: Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT):

Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)) and identified by an EPSDT (early and periodic screening, diagnostic and treatment services) screen will be provided either at the medical home or referred to an appropriate provider.
