Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L ☐

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: Adult Expansion Group

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

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

Geographic Area

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

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

PRA Disclosure Statement

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Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L ☐

OMB Expiration date: 10/31/2014

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

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. **No**

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

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

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

☒ Letter

☐ Email

☐ Other

Alternative Benefit Plan

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

An attachment is submitted.

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

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

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

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

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

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

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

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

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

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

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Alternative Benefit Plan

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

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

Describe:

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

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

- ☒ Copy of correspondence sent to the individual.
- ☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- ☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

PRA Disclosure Statement

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Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L ☐

Enrollment Assurances - Mandatory Participants **ABP2c**

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

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

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

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

☐ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

☒ Self-identification

Describe:

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

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

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

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

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

☐ Other

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

Alternative Benefit Plan

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

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

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

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

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

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

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

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

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

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

of benefit plan packages if they so choose.

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

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package **ABP3**

Select one of the following:

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

Name of benefit package: WV Health Bridge Plan

Selection of the Section 1937 Coverage Option

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

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

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

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

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

The ABP benefit package closely mirrors the WV Medicaid State Plan coverage. Any differences or limitations are noted in ABP5. An overview of the two plans comparison shows the following differences between: PT/OT - in the traditional Medicaid State plan a beneficiary receives 20 visits per year combined with PA required for overage and in the ABP the limit is increased to 30 visits combined per year; Home Health in the traditional Medicaid State Plan is 60 visits/year with additional PA for overage and in the ABP, 100 visits/year; and Personal Care Services and long term institutional services (NF and ICF/IID) are covered under the traditional State plan and not covered under the ABP.

Selection of Base Benchmark Plan

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

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

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

Alternative Benefit Plan

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Highmark WV Benchmark Plan

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

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

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-L. ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing **ABP4**

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

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

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Description **ABP5**

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Highmark West Virginia: Super Blue Plus 2000

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

Secretary-Approved

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services

Collapse All

Benefit Provided: Physician Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Medical Office Visit / Office Consultation (Includes Specialist/Specialist Virtual Visit) – Applies to Charges for Visit only. Does not apply to other Services received during Visit.

Benefit Provided: Podiatry: Other Licensed Practitioner

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Chiropractic: Other Licensed Practitioner

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 24 treatments/year

Duration Limit: None

Scope Limit:

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

Remove

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

Benefit Provided: Diagnostic x-ray

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Outpatient Hospital Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Certain services require Prior Authorization and concurrent review for further services if identified as a high utilization/abuse. If services have been identified as having a high rate of utilization/abuse they will receive a more intense review and PA process.
An example of hospital outpatient services that require a PA would be surgical procedures: acne surgery - criteria requires review of less invasive procedures to ensure medical necessity; reconstruction procedures

(jaw, nose, brow repair) to ensure medical necessity and not cosmetic; all unlisted surgical procedures to ensure there is no appropriate CPT code and that the procedure is not experimental/research.

Remove

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided: Outpatient Hospital Services/Emergency Room

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Any other medical care/Transportation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Must be to nearest appropriate provider

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

All inpatient services require prior authorization (PA). The State has a retroactive PA process in place for all inpatient hospital care as a result of entrance through ER (to include emergency and non-emergency) visits that result in inpatient care. This retroactive prior authorization process allows the facility 10 days to submit necessary information to determine medical necessity required for processing to allow authorization for these services.
In the event that the authorized inpatient stay exceeds the original authorization in scope, the provider will be required to submit an additional request for authorization for the continued stay or service modifications.

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care

Collapse All

Benefit Provided: Hospital Inpatient Services/maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Hospital Inpatient/maternity medical and surgical services for pregnancy and complications of pregnancy and miscarriage. The services for this benefit also include physician services covered in EHB 1

Benefit Provided: Hospital Outpatient Services/Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Outpatient/maternity medical and surgical services for pregnancy and complications of pregnancy and miscarriage. The services for this benefit also include physician services covered in EHB 1

Add

Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided: Physician: Outpatient Psychiatric Treatment

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 12 sessions per year

Duration Limit: None

Scope Limit: None

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

Services require Prior Authorization and concurrent review for further services if identified as a high utilization/abuse.

Benefit Provided: Rehab: Rehabilitative Psychiatric Treatment

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

These services are aimed at those with severe mental illness. Full clinical review prior authorization is required for all services with no hard limits. WV has two levels of prior authorization, an initial level and a second more intense level for both MH and substance abuse services. In West Virginia most of these types of services are provided in the community mental health centers. These centers provide both individual and group psychotherapy services.
At the State discretion services may require Prior Authorization if services have been identified as having a high rate of utilization/abuse.

Benefit Provided: Inpatient Hospital: Psychiatric Hospital Care

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

5 day stay

Duration Limit:

None

Remove

Scope Limit:

None

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

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

Add

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

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

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: Physical Therapy
Source: Base Benchmark Commercial HMO — Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: 30 visits/yr combined PT/OT rehab/hab
Duration Limit: None
Scope Limit: None

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

PA for 6 visits, must have plan of care and additional more intensive PA for up to 24 visits (PA Process is from the State Plan). Visit totals include PT and OT combined for rehabilitative and habilitative services The Physical Therapy rehabilitative and habilitative services are a combination of the WV State Plan PA process and the base benchmark benefit limitations. EPDST services for children under 21 are not subject to these limitations.

Benefit Provided: Occupational Therapy
Source: Base Benchmark Commercial HMO — Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: 30 visits/yr combined PT/OT rehab/hab
Duration Limit: None
Scope Limit: None

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

PA for 6 visits, must have plan of care and additional more intensive PA for up to 24 visits (PA process is in the State Plan). Visit totals include PT and OT combined for rehabilitative and habilitative.
The Occupational Therapy rehabilitative and habilitative services are a combination of the WV State Plan PA process and the base benchmark benefit limitations. EPDST services for children under 21 are not subject to these limitations.

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

Amount Limit:
20 visits per year

Duration Limit:
None

Remove

Scope Limit:
None

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

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

Benefit Provided:
Rehab: Cardiac rehabilitation

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
36 sessions in a 12 week period

Duration Limit:
None

Scope Limit:
None

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

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

Benefit Provided:
Rehab: Pulmonary Rehabilitation

Source:
State Plan 1905(a)

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
20 sessions

Duration Limit:
None

Scope Limit:
None

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

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

Remove

Benefit Provided: Home Health: Durable medical equipment

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Durable medical equipment must be prescribed by a Physician or Professional Other Provider acting within the scope of their license.

Benefit Provided: Orthotics and prosthetics

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Orthotics and prosthetics must be prescribed by a Physician or Professional Other Provider acting within the scope of their license.

Benefit Provided: Home Health

Source: Base Benchmark Commercial HMO

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 100 visits per year

Duration Limit: None

Scope Limit:

None

Remove

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

Review for the first 60 visits, beyond 60 visits full clinical criteria review required. 100 visits per year will be a hard limit on this service. Children are covered by EPSDT and are not subject to the hard limit applied to adults for this service.

Benefit Provided:

Other Services: Rehabilitation Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All

Benefit Provided:

Laboratory Services and Testing

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add

Alternative Benefit Plan

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

Collapse All ☐

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

Benefit Provided: Preventative Services: Diabetes Education

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

☒ Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visits to Treat an Injury or Illness

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Specialist Visit

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Primary Care Well Visits

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visit

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Diagnostic Test (X-Ray and Lab Testing)

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Outpatient Hospital / Facility Services

Source: Base Benchmark

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

Duplication: Outpatient Hospital Services under Essential Health Benefit 1.

Remove

Base Benchmark Benefit that was Substituted: Hospice

Source: Base Benchmark

Remove

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

Duplication: Hospice under Essential Health Benefit 1.

Base Benchmark Benefit that was Substituted: Emergency Room Services

Source: Base Benchmark

Remove

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

Duplication: Outpatient Hospital Services/Emergency Room under Essential Health Benefit 2.

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance

Source: Base Benchmark

Remove

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

Duplication: Any other medical care/Transportation under Essential Health Benefit 2.

Base Benchmark Benefit that was Substituted: Inpatient Hospital/Facility Services

Source: Base Benchmark

Remove

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

Duplication: Inpatient Hospital Services under Essential Health Benefit 3.

Base Benchmark Benefit that was Substituted: Birthing Center Care/Maternity Services

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Maternity Care

Source: Base Benchmark

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

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

Remove

Base Benchmark Benefit that was Substituted: Outpatient Mental Health Services

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Outpatient Substance Abuse Services

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Rehabilitative Psychiatric Treatment

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Inpatient Mental Health Care Services

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Inpatient Substance Abuse Case Services

Source: Base Benchmark

Remove

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

Duplication: Inpatient Hospital: Psychiatric Hospital Care under Essential Health Benefits 5

Base Benchmark Benefit that was Substituted: Prescription Drugs/Retail Pharmacy

Source: Base Benchmark

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

Duplication: Prescription Drugs under Essential Health Benefit 6

Remove

Base Benchmark Benefit that was Substituted: Speech Therapy

Source: Base Benchmark

Remove

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

Duplication: PT and related services: Speech Therapy under Essential Health Benefit 7.

Base Benchmark Benefit that was Substituted: Respiratory, Hyperbaric and Pulmonary Therapy

Source: Base Benchmark

Remove

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

Duplication: This one service under the Base Benchmark is duplicated under both Rehab: Cardiac Rehabilitation and Rehab: Pulmonary Rehabilitation under Essential Health Benefit 7.

Base Benchmark Benefit that was Substituted: Durable medical equipment and Oxygen at home

Source: Base Benchmark

Remove

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

Duplication: Home Health; Durable medical equipment under Essential Health Benefit 7.

Base Benchmark Benefit that was Substituted: Orthotic Devices and Prosthetic Appliances

Source: Base Benchmark

Remove

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

Duplication: Orthotics and prosthetics under Essential Health Benefit 7.

Base Benchmark Benefit that was Substituted: Diabetes Education

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Eye Glasses for Children

Source: Base Benchmark

Alternative Benefit Plan

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

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

Remove

Base Benchmark Benefit that was Substituted:

Dental Check-up for Children

Source:

Base Benchmark

Remove

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

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

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Well Baby Care

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

The ABP population is for the new adult group, ages 19-64. As such "Well Baby Care" is for ages 0-6, therefore, would not apply to this population.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Well Child Care

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

The ABP population is for the new adult group, ages 19-64. As such "Well Child Care" is for ages 6-17, therefore, would not apply to this population.

Add

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided: Family Planning Services and Supplies

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Other 1937 Benefit Provided: Preventative Services: Nutritional Education

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications: Medicaid State Plan

Amount Limit:

Duration Limit: None

Scope Limit:

Other:

Other 1937 Benefit Provided: Tobacco Cessation Counseling for Pregnant Women

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Provider Qualifications: Medicaid State Plan

Amount Limit:

Duration Limit: None

Scope Limit:

Other:

Remove

Add

Alternative Benefit Plan

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

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V.20130814

Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Assurances **ABP7**

EPSDT Assurances

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

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

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

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

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

◉ Through an Alternative Benefit Plan.

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

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

Prescription Drug Coverage Assurances

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

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

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

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

Other Benefit Assurances

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

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

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

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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V.20130807

Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Service Delivery Systems **ABP8**

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

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

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☐ Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The Medicaid Program provides healthcare benefits to approximately three hundred fifty thousand (350,000) people, on a monthly basis, in fifty-five (55) counties using a network of twenty-four thousand (24,000) active providers. The MMIS processes nineteen million and a half (19,500,000) claims annually, including pharmacy claims. Ninety two and a half percent (92.5%) of claims are received electronically, of which, forty-seven percent (47%) were pharmacy. One hundred eighty-eight thousand (188,000) Medicaid members (families with dependent children, low-income children and pregnant women) are enrolled in three (3) HMOs or in the Bureau's Primary Care Case Management program, the Physician Assured Access System (PAAS). The Medicaid program pays for certain carved-out services for HMO recipients, specifically pharmacy and behavioral health services. The Medicaid MMIS also processes claims for three (3) waiver programs and several State-funded eligibility programs, including Children with Special Health Care needs (CSHCN).

On January 1, 2014 West Virginia expanded its Medicaid program in accordance with the rules established by the Affordable Care Act at 42 §CFR 435.119 to include non-pregnant, childless adults with income at or below 133% of the federal poverty level. The new adult group receives all ABP benefits through a fee for service delivery system with WV Medicaid paying qualified providers for services.

Additional Information: Fee-For-Service (Optional)

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

PRA Disclosure Statement

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V.20130718

Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	Yes

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

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

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

General Assurances

ABP10

Economy and Efficiency of Plans

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

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

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/ territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20130807