

WEST VIRGINIA CODE: §9-11-6

§9-11-6. Centers for Medicare and Medicaid Authority.

(a) On or before October 1, 2026, the Bureau for Medical Services, to the extent necessary, shall submit a state plan amendment for the appropriate Center for Medicare and Medicaid Services (CMS) authority to implement any payment and coverage changes necessary to effectuate this article. The amendment shall include, but not be limited to:

(1) Development of the value-based payment model, which shall include, but not be limited to, enhanced payments for provider outcomes for meeting or exceeding the outcome measures as set forth in this article and reduces payments to providers who fail to meet outcome measures;

(2) The payment model shall account for a baseline year in which data is collected, communicated to providers to allow notice of performance, and to establish the baseline;

(3) The model shall allow for an annual review of performance measures to permit flexibility and to address quality outcomes;

(4) Provisions for a provider to be de-certified, to have specific code blocked, to be terminated, or otherwise be excluded from the Medicaid program when the provider fails to meet the established outcome measures for three consecutive quarters;

(5) Specific performance measures; and

(6) System-level outcomes that the performance-based model shall produce with common return-on-health-investment measures that can be used to compare the investments in a specific system of care relative to the outcomes.

(b) The provisions of this article shall have no force or effect if CMS does not approve the state plan amendment as required by this section.