

WEST VIRGINIA LEGISLATURE

**LEGISLATIVE OVERSIGHT COMMISSION ON HEALTH AND HUMAN RESOURCES
ACCOUNTABILITY**

2015- 2016 Interims

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Final Report of

**LEGISLATIVE OVERSIGHT COMMISSION ON HEALTH AND HUMAN RESOURCES
ACCOUNTABILITY**

The Legislative Oversight Commission on Health and Human Resources Accountability was appointed pursuant to the provisions of West Virginia Code §16-29E-1, *et seq.* following the 2015 Regular Session of the 82nd Legislature.

During the 2015-2016 interim period the Legislative Oversight Commission on Health and Human Resources Accountability (hereinafter the Commission) met and received information on various topics of study and other important healthcare and human services issues from state agencies, political subdivisions, advocacy groups and other pertinent sources. The Commission studied six topics during the 2015-2016 interim period. These topics were:

HCR. 143. Requesting the Joint Committee on Government and Finance, to study the public-private partnership model for the operation and maintenance of all or some of the State's hospital and nursing facilities.

HCR. 138. Requesting the Joint Committee on Government and Finance to study and review the managed care system within the Bureau for Medical Services.

HCR. 135. Requesting the Joint Committee on Government and Finance to study state hospitals in regards to the Hartley Case.

Study of school based Medicaid programs.

Drug testing for welfare recipients and/or for teens obtaining a driver's license.

Structure and Authority of the Department of Health and Human Resources.

The Commission Reports as follows:

ASSIGNED STUDY TOPICS

HCR. 143. Requesting the Joint Committee on Government and Finance, to study the public-private partnership model for the operation and maintenance of all or some of the State's hospital and nursing facilities.

The Commission felt that the issue of privatization of state run hospitals and nursing facilities was a complex issue and required intensive and specialized study. Consequently a request was sent to Arnett, Carbiss and Toothman to gain some insight into what such a study would entail and the estimated cost to conduct such a study. They replied and indicated the items they would need to conduct the study, the scope of their work which would include an Operational and Clinical Assessment and a Business Valuation Process and a breakdown of their costs. The cost ranged from \$35,000 to \$40,000 per facility for a total cost of approximately \$183,000. Due to the cost it was decided not to pursue an outside study. A copy of that letters is attached to this report.

Following the receipt of this correspondence, a series of internal meetings occurred with staff from the House and Senate Health and Human Resources Committees, the House and Senate Finance Committees and the Department of Health and Human Resources. The meetings are ongoing. A number of issues have been discussed ranging from a total sale, a sale of the just the beds, a sale of the physical plant and the real estate and a number of combinations of all of these.

The Commission **RECOMMENDS** that no action be taken on this issue at this time. The Commission encourages the continued involvement of all the aforementioned parties and would like at some point to have a presentation to the Commission of the actions of this group. Potentially, the Commission would like a draft plan – including any necessary legislation – to begin the process of privatization of all state hospitals and nursing facilities.

HCR. 138. Requesting the Joint Committee on Government and Finance to study and review the managed care system within the Bureau for Medical Services.

In anticipation of a presentation regarding Managed Care, the Co-Chairs sent an e-mail to Acting Commissioner of the Bureau for Medical Services, Cindy Beane. That e-mail contained a series of questions which the Co-Chairs wanted covered during any presentation to the Commission. Here is a list of the questions posed by the Co-Chairs:

1. What is managed care?
2. How many companies participate in managed care?
3. How many providers?
4. How many West Virginians are enrolled in managed care plans?
5. How much does West Virginia spend on managed care?
6. What is the current MLR of each company?
7. How is quality health care affected by managed care?
8. How is consumer access to care assured and monitored under managed care?
9. Do consumers have appeal rights if services are denied by a plan?
10. Discussion on the changes in the current managed care contract?

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The Co-chairs would also asked the Secretary to specifically address her vision for managed care with an emphasis on the following questions.

1. The changes which have occurred since she took over?
2. The changes in the managed care contract?
3. Which populations are being added to managed care and her proposed timeline?
4. Anything else the Secretary would like to address concerning managed care.

During September Interims, the Commission heard from Jeremiah Samples, Deputy Secretary of the Department of Health and Human Resources (hereinafter the Department) regarding Managed Care. Mr. Samples provided the Commission with a comprehensive overview of managed care issues. He discussed the health of West Virginia's citizens relative to risk factors, behavioral health, and factors that fold into health outcomes. Additionally, he provided the Commission with an overview of the Department's budget and specifically the budget of the Bureau for Medical Services (hereinafter Medicaid). This included information regarding:

1. West Virginia's rank in terms of spending (12th) and health outcomes (44th);
2. Funding Sources for Medicaid; and,
3. Medicaid cost for the past three years.

His presentation also provided answers to all of the questions presented by the Co-Chairs prior to the meeting.

Various interest groups also provided the Commission with valuable information regarding specific topics relative to managed care; most notably pharmacy care. Additionally, the Co-Chairs were kept abreast of the ongoing litigation regarding the bidding process and the awarding of the managed care contracts to provide services to the Medicaid population. That lawsuit has now been settled.

The Commission **RECOMMENDS** that they continue to monitor managed care as it relates to the Medicaid population as part of their ongoing oversight of the Department pursuant to the provisions of Article 29-E of Chapter 16 of the West Virginia Code. Specifically as contracts are required to be subject to state purchasing requirements, the Commission will be particularly concerned with costs expenditures and cost savings.

HCR. 135. Requesting the Joint Committee on Government and Finance to study state hospitals in regards to the Hartley Case.

To gain some insight into the ongoing litigation on the E.H. v. Matin case, often referred to as the “Hartley” case, the Co-Chairs requested an update from the Department on the current posture of the case. Correspondence was received from Karen Villanueva Matkovich, General Counsel at the Department, dated June 5, 2015. That correspondence provided the Commission with a procedural history of the case from its filing in 1981 to its current status.

The case initially sought a Writ of Mandamus in the West Virginia Supreme Court to alleviate what then Justice Richard Neely referred to as “Dickensian Squalor of unconscionable magnitudes” in the state rule mental facilities. Following the mandamus action, the case continued in the Kanawha County Circuit Court. The litigation remains ongoing.

The litigation has resulted in a number of decisions impacting not only the physical condition of the state run hospitals but also resulted in 1983 in a 330 page report setting forth a “Behavioral Health System Plan”. Litigation has continued over the years resulting from such issues as a failed attempt in the early 1990’s to construct a new state hospital, the appointment of a court monitor to oversee implementation of the courts orders, overcrowding of patients of the state operated facilities and the salaries of employees at the state run hospitals.

The Commission **RECOMMENDS** continued oversight of the actions of the Department and the Court in the Hartley decision. No further Legislative action is necessary at this time.

Study of school based Medicaid programs.

To address this issue a request was made to the Department for an update on the level of services provided in a school based setting. The Commission received a copy of a letter from the Department to Senate President Cole dated April 13, 2015. This letter contained detail relating to West Virginia's school based health initiatives and was accompanied by extensive attachments detailing Medicaid's involvement in providing school based health care services.

The letter offered some detail on the level of services which the West Virginia Medicaid program covered in our schools, particularly with respect to special needs students. It discussed a State Plan Amendment submitted in 2000 that provided for school based health services throughout the state. The letter also went into detail about a potential \$23,000,000 disallowance which could have potentially resulted in an overpayment by the Federal Government to West Virginia. Following an appeal the West Virginia expenditures were upheld and no repayment was necessary.

Finally, the letter indicated the Department continues to work with the Department of Education in providing effective school based health services within the confines of the State Plan Amendment and the direction provided by the Centers for Medicare and Medicaid Services. A copy of that letter is attached to this report.

The Commission **RECOMMENDS** that no additional action be taken on this measure but that in its continued oversight of the Department through the provisions of Article 29-E of Chapter 16 of the West Virginia Code that the Commission continue to monitor the provisions of school based health care offered by the Medicaid program.

Drug testing for welfare recipients and/or for teens obtaining a driver's license.

The Commission began its work this interim period with an overview of drug testing of public assistance recipients. To gain a national perspective and learn from the lessons of other states, the Commission reached out to the National Conference of State Legislatures (NCSL). Rochelle Finzel, Group Director of NCSL conducted a video conference with the Commission. She discussed the federal authority which allows states to implement drug testing programs. In addition she gave the Commission a perspective on current trends which states are employing as they consider drug testing of public assistance applicants. Ms. Finzel also provide insight on lessons learned by states and

provided the Commission with some considerations they may want to take into account in their deliberations.

Prior to the October meeting of the Commission, the Co-Chairs requested state specific data from the Department. Correspondence was sent to the Department asking that they address four (4) questions. Nancy Exline, Commissioner for Children and Families along with Kathy Paxton, Substance Abuse Specialist from the Bureau for Behavioral Health and Health Facilities and Anne Williams, Deputy Commissioner from the Bureau for Public Health provided the Department's response.

These questions and the Department's response were as follows:

1. Anticipated costs to do a targeted type of enforcement on specific populations such as persons with a criminal history or persons with prior drug convictions utilizing the most cost efficient drug test available.

Response: The cost for a drug test is \$56.50 per test. At this time, the anticipated costs are unknown for the criminal background check as the department does not conduct a background check on individuals applying for assistance. This particular drug test is a urine drug test that screens for various substances that the Bureau for Children and Families currently utilizes in child protective services cases.

2. How many individuals does the DHHR anticipate having an adverse event from this type testing based upon our population, the percentage of our population which is drug addicted and the percentage of our population on TANF.

Response: The anticipated adverse event is unknown at this time. The Department does not have statistics on the percentage of our population which is drug addicted. We do know the national use of illicit drugs is 8.3%. National Survey on Drug Use and Health, November 28, 2014.

The Department records indicate TANF caseload for 2015 is 7,936.

- # of individuals receiving TANF – 13,980 adults and children/ 2697 adults
- 1,852,994 population of WV
- Percent of population on TANF - .00145%

3. What is the impact on pregnant women who abuse illicit drugs while pregnant and who give birth to children who are either suffering from withdraw or have

babies who test positive for some type of illicit substance. How many women have tested positive for an illicit substance while pregnant? How many children have tested positive for an illicit substance after birth? How many pregnant women receive TANF?

Response: The Department does not have the information on the impact on pregnant women who abuse illicit drugs while pregnant and who give birth to children who are either suffering from withdrawal or have babies who test positive for some type of illicit substance.

DHHR is unaware of the number of women who have tested positive for illicit drugs while pregnant and is unaware of the number of children who have tested positive for illicit substances at birth. Further, DHHR does not keep data on the number of pregnant women who receive TANF. However, DHHR began tracking child protective services referrals involving illicit drug affected infants in August 2014. From August 1, 2014 to July 31, 2015 there were 161 illicit drug affected infant referrals.

The Bureau for Public Health's Office of Maternal, Child and Family Health does not collect data on the number of women who test positive for an illicit substance while pregnant, or the number of children who have tested positive for an illicit substance after birth. The Office of Maternal, Child and Family Health is aware that some hospitals do test mothers and infants, but is unaware of a central repository for that data.

4. Are there other options available beyond drug testing that might prove effective in curbing drug abuse in the public assistance population?

Continue to follow the recommendations of the Governor's Advisory Council on Substances Abuse Strategic Goals.

Goal 1: Implement an integrated approach for the collection, Assessment and Planning analysis, interpretation and use of data to inform planning, allocation and monitoring of the West Virginia substance abuse service delivery system.

Goal 2: Build the capacity and competency of West Virginia's Capacity Substance Abuse Workforce and other stakeholders to effectively plan, implement and sustain comprehensive, culturally relevant services.

Goal 3: Increase access to effective substance abuse prevention, implementation of early identification, treatment and recovery management that is high quality and person-centered.

Goal 4: Manage resources effectively by promoting good sustainability stewardship and further development of the West Virginia substance abuse service delivery.

Options available beyond drug testing that might prove effective in curbing drug abuse in the public assistance population

Risk Associated with the Population	Option
Ability to pay for behavioral health care	<ol style="list-style-type: none"> 1. Medicaid Expansion 2. Medicaid Coverage expansion for behavioral health services including medication
Inability to access and navigate behavioral health care services (including transportation)	<ol style="list-style-type: none"> 1. Help Line: 24/7/365 with clinical and peer staff providing education, crisis and referral support in accessing and navigating behavioral health services. The staff also provides follow up, helps in accessing payment systems and transportation. 1-844-HELP4WV 2. Increase in the number of primary care sites offering behavioral health service 3. Increased the number of treatment and recovery beds for those seeking help from 409 759 4. Reentry Substance use services have been expanded in 22 counties with 242 individuals served through Treatment Supervision 5. Availability and expanded coverage of telehealth services for rural areas where transportation may be an issue or workforce 6. Provided payment codes for Screening, Brief Intervention & Referral to Treatment (SBIRT) in emergency rooms and DHHR offices
Lack of Housing Opportunities	Safe and Affordable Housing (The Coalition to End Homelessness)

Generational Use	<ol style="list-style-type: none"> 1. Substance Use in Pregnancy Prevention Programs in all regions 2. Implementing the START Program in January 2016, providing early intervention and family treatment teams for pregnant and postpartum women that have a substance use disorder. 3. Expanded school based behavioral health services 4. Safe at Home providing intensive family based wrap around services in home and community 5. Juvenile Justice Programs to focus on early intervention and connection to community services vs. punitive action 6. 4 Moms and Babies 3 year Integrated Recovery Programs to improve health outcomes of mom and child 7. Developing Regional Youth Service Centers to support families close to home 8. 13 Youth Liaisons provide resource coordination and referral supports for youth and families in each comprehensive behavioral health center
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At the October meeting, Counsel to the Commission also provided the membership with two bills from the 2015 Regular Session of the Legislature pertaining to this subject. The first was Senate Bill 348 – Creating pilot program for drug screening of cash assistance applicants. The second was House Bill No. 2012 - Implementing drug screening for recipients of federal-state and state assistance. The difference and similarities between the two pieces of legislation was discussed with Commission members to help guide their deliberations. At the November meeting of the Commission, draft legislation was presented.

The Commission **RECOMMENDS** the passage of legislation during the 2016 Regular Session of the Legislature that would require specified populations seeking public assistance who raise a reasonable suspicion with the Department be tested for substance abuse. A positive test would result in a prohibition from receiving assistance. The time

of the prohibition would be on a sliding scale depending upon whether the test resulted in a positive test and whether it was the first, second or third offense.

Structure and Authority of the Department of Health and Human Resources.

The Commission continues to struggle with the size of the Department. They are concerned that services which the Department are required to provide are impacted by the magnitude of bureaucracy and the inefficiencies inherent in an operation of that size. Although the Commission continues to monitor various operations of the Department pursuant to the provisions of West Virginia Code, Chapter 16, Article 29-E, it is their belief that an independent consulting firm should be contracted to provide a study that would offer options for partitioning the Department into two or more entities. The end result would be delivery of a plan that would provide guidance on what would be most cost effective to the state, what would provide a more efficient operation and offer a structure that would provide the best delivery of services to the citizens of West Virginia.

The Commission **RECOMMENDS** that the Legislature contract with an independent consultant with an expertise in business management and delivery of services to conduct a thorough analysis of the Department and report back with findings and recommendations on the best way to separate the Department into manageable entities. This should include a cost analysis, organizational structure recommendations and a timeline. The study should be returned to both the Joint Commission on Government and Finance and this Commission.

Draft copies of all legislation which would be recommended for passage during the 2016 Regular session of the Legislature are attached to this report.

Respectfully submitted:

Senator Ryan J. Ferns
Co-Chair

Delegate Joe Ellington
Co-Chair

West Virginia Legislature
Legislative Oversight Commission on Health and Human Resources

Abstract

Short Title:

Drug Testing of Public Assistance Recipients

Date Introduced

November 16, 2015

Code Reference

West Virginia Code §9-3-6 – NEW.

Proposed Law Presented to the Committee

This bill would create a pilot program to drug test applicants for benefits for Temporary Assistance to Needy Families (TANF). The bill defines key terms. Most important among these is the term “drug screen”. The bill also defines a “drug test” as a five panel drug test and sets forth the substances for which it would test.

The bill would require a statewide three year pilot program that would be operated according to federal approval. To comply with federal court cases, the bill would require that prior to any drug test, that the Department have “reasonable suspicion” of substance abuse. There are two (2) ways to establish reasonable suspicion. First, would be from the initial screen where an applicant would demonstrate “qualities indicative or substance abuse”. Second would be a prior conviction of a drug-related offense within the five years immediately preceding the application. There is an exception if the applicant can produce a valid prescription

If an applicant is reasonably suspected from the drug screen of substance abuse, they are required to take a drug test. The cost of the test is paid by the Department. After a positive test, the applicant may request further testing at his or her own expense. Following a positive test there is a sliding scale of action to be taken. The first positive test requires completion of a substance abuse and job training program but as long as they remained enrolled in these programs they may continue to receive assistance. A second positive test requires a second round of treatment and requires suspension from TANF for a 12 month period. A third positive test requires permanent termination. Any

person with a positive test is subject to periodic drug screening and testing as set forth in legislative rule. Refusal to take a drug test renders an applicant ineligible.

Any applicant found ineligible to receive TANF as a result of a positive test or a refusal to take a test is subject to an immediate investigation from Child Protective Services. The bill provides for a mechanism for the child to continue to receive assistance through a designated payee should a parent be ineligible.

There is a two year lock out for persons found to be ineligible to receive assistance unless they have a permanent ban. Additionally, there is a provision for reapplication should an applicant demonstrate successful completion of drug treatment plan. There are also provisions for a due process review for a denial. The bill contains confidentiality provisions, grants rulemaking authority to the Secretary, and sets out penalties of \$100 to \$1000 for the misdemeanor offense of misrepresentation of a material fact. The bill would also require a report to the Joint Committee on Government and Finance by December 31, 2016, and every year thereafter during the operation of the pilot program. The bill sets forth what is required to be included in the report. Finally, the bill contains a provision that would require the Secretary to operate the program as consistent as possible with the provisions of the bill for any portion of the law not approved federally.

Government Agencies Affected

Department of Health and Human Resources, Bureau for Children and Families.

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2 S.B./H. B.

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10 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new
11 section designated §9-3-6, relating to drug screening for applicants of benefits from
12 the temporary assistance for needy families program; requiring drug testing of
13 applicants for whom there is a reasonable suspicion of substance abuse; creating
14 a pilot program; setting forth an effective date; defining terms; providing basis for
15 reasonable suspicion of drug use; requiring participation in a substance abuse
16 treatment, counseling and job skills program with an adverse drug test; precluding
17 assistance for refusal to take a drug test; establishing administrative review of
18 decisions to deny benefits; providing a mechanism for dependent children to receive
19 benefits if a parent is deemed ineligible; setting forth prohibition from benefits for an
20 adverse drug test; requiring investigation by Child Protective Services upon denial

1 of benefits from an adverse drug test; setting forth a procedure for reapplication for
2 benefits; authorizing emergency and legislative rulemaking; requiring results of the
3 drug screen or drug test remain confidential; providing criminal penalties; requiring
4 an annual report to the Legislature; setting out elements of the annual report;
5 requiring federal approval the program; requiring an alternative program is federal
6 approval is denied and allowing for exceptions.

7 *Be it enacted by the Legislature of West Virginia:*

8 That the Code of West Virginia, 1931, as amended, be amended by adding thereto
9 a new section designated §9-3-6 to read as follows:

10 **ARTICLE 3. APPLICATION FOR AND GRANTING OF ASSISTANCE.**

11 **§9-3-6. Pilot program for drug screening of applicants for cash assistance.**

12 (a) As used in this section:

13 (1) "Applicant" means a person who is applying for or who has applied for
14 benefits from the Temporary Assistance for Needy Families Program;

15 (2) "Board of Review" means the board established in section six, subdivision
16 thirteen of this article;

17 (3) "Caseworker" means a person employed by the Department with
18 responsibility for making a reasonable suspicion determination during the application
19 process for Temporary Assistance for Needy Families;

20 (4) "Child Protective Services" means the agency within the Department

1 responsible for investigating reports of child abuse and neglect as required in section eight
2 hundred two, article two, chapter forty-nine of this code;

3 (5) "Department" means the Department of Health and Human Resources;

4 (6) "Drug Screen" or "Drug Screening" means any analysis regarding substance
5 abuse conducted pursuant to the Emotional Health Inventory (EHI) administered
6 through a contract with the West Virginia Department of Education.

7 (7) "Drug Test" or "Drug Testing" means a five panel drug test which tests urine
8 for five specific categories of drugs. The categories include cocaine, amphetamines,
9 methamphetamine, opioids, and Tetrahydrocannabinol (THC) .

10 (8) "Secretary" means the Secretary of the Department or his or her designee.

11 (9) "Temporary Assistance for Needy Families Program" means assistance
12 provided through ongoing cash benefits pursuant to 42 U.S.C. §601, *et seq* operated in
13 West Virginia as the West Virginia Works Program pursuant to article nine of this chapter.

14 (b) By July 1, 2016, and subject to federal approval, the Secretary shall
15 implement and administer a three year pilot program to drug screen any adult applying for
16 assistance from the Temporary Assistance for Needy Families Program.

17 (c) Reasonable suspicion exists if:

18 (1) If a case worker determines based upon the result of the drug screen that the
19 applicant demonstrates qualities indicative of substance abuse based upon the indicators
20 of the drug screen.

1 (2) An applicant has been convicted of a drug-related offense within the five
2 years immediately prior to an application for Temporary Assistance for Needy Families and
3 whose conviction becomes known as a result of a drug screen as set forth in this section.

4 (3) The applicant or applicants are the parent or parents of a newborn infant who
5 within five days of birth test positive for certain controlled substances which are not legally
6 prescribed. These controlled substances are amphetamines, tetrahydrocannabinol,
7 oxycodone, cocaine, phencyclidine (PCP) , any opiate, barbiturate, benzodiazepine,
8 methamphetamine, propoxyphene, and any tricyclic antidepressants. Additional
9 substances may be added by the Secretary in rule. If the parents agree to undergo a
10 course of substance abuse education and treatment as prescribed in article fifteen, chapter
11 sixty-two of this code, or the substantial equivalent, the parents are eligible to apply for the
12 benefits, subject to the imposition of further mandatory drug testing consistent with the
13 provisions of this section.

14 (4) Presentation of a valid prescription for a detected substance that is prescribed
15 by a health care provider authorized to prescribe a controlled substance is an absolute
16 defense for failure of any drug test administered under the provisions of this section.

17 (d) Upon a determination by the case worker of reasonable suspicion as set forth
18 in this section an applicant shall be required to complete a drug test. The cost of
19 administering the drug test shall be deducted from the applicant's first payment of
20 Temporary Assistance to Needy Families. If the drug test is negative, the costs shall be

1 reimbursed to the applicant. Any applicant whose drug test results are positive may
2 request that the drug test specimen be sent to an alternative drug testing facility for
3 additional drug testing. Any applicant who requests an additional drug test at an
4 alternative drug testing facility shall be required to pay the cost of the alternative drug test.
5 Any applicant who requested an alternative drug test and who tests negative for unlawful
6 use of a controlled substance shall be reimbursed for the cost of the alternative drug test.

7 (e) Any applicant who has a positive drug test shall complete a substance abuse
8 treatment and counseling program and a job skills program approved by the Secretary.
9 Subject to applicable federal laws, any applicant for Temporary Assistance to Needy
10 Families Program who fails to complete or refuses to participate in the substance abuse
11 treatment and counseling program or job skills program as required under this subsection
12 is ineligible to receive Temporary Assistance to Needy Families until completion of the
13 substance abuse treatment and counseling and job skills programs. Upon completion of
14 both a substance abuse treatment and counseling program and a job skills program, the
15 applicant is subject to periodic drug screening and testing as determined by the Secretary
16 in rule. Upon a second positive drug test an applicant shall be ordered to complete a
17 second substance abuse treatment and counseling program and job skills program. He
18 or she shall be suspended from the Temporary Assistance to Needy Families Program for
19 a period of twelve months, or until he or she completes both a substance abuse treatment
20 and a job skills programs, whichever is later. Upon a third positive drug test an applicant

1 shall be permanently terminated from the Temporary Assistance to Needy Families
2 Program subject to applicable federal law.

3 (f) Any applicant who refuses a drug screen or a drug test is ineligible for
4 assistance.

5 (g) The Secretary shall order an investigation and home visit from Child
6 Protective Services on any applicant who is declared ineligible for failure to pass a drug
7 test. This investigation and home visit shall take place within 48 hours from the date of the
8 Secretary's decision that the applicant is ineligible. This investigation and home visit may
9 include a face-to-face interview with the child, if appropriate, the development of a
10 protection plan and, if necessary for the health and wellbeing of the child, may also involve
11 law enforcement. This investigation and home visit shall be followed by a report detailing
12 recommended action which Child Protective Services shall undertake. This report shall
13 be compiled within 14 days of the investigation and home visit by Child Protective Services.
14 Child Protective Services shall be responsible for providing, directing or coordinating the
15 appropriate and timely delivery of services to any child who is the subject of any
16 investigation and home visit conducted pursuant to this section. In those cases where
17 Child Protective Services determines that the best interests of the child requires court
18 action, they shall initiate the appropriate legal proceeding.

19 (h) Any other adult members, of a household that includes a person declared
20 ineligible for the Temporary Assistance for Needy Families Program pursuant to this

1 section shall, if otherwise eligible, continue to receive Temporary Assistance for Needy
2 Families benefits.

3 (i) (1) No dependent child's eligibility for benefits under the Temporary
4 Assistance for Needy Families Program may be affected by a parent's failure to pass a
5 drug test.

6 (2) If pursuant to this section a parent is deemed ineligible for the Temporary
7 Assistance for Needy Families Program, the dependent child's eligibility is not affected and
8 an appropriate protective payee shall be designated to receive benefits on behalf of the
9 child.

10 (3) The parent may choose to designate another person as a protective payee
11 to receive benefits for the minor child. The designated person shall be an immediate family
12 member or, if an immediate family member is not available or declines the option, another
13 person may be designated.

14 (4) The designated person shall be approved by the Secretary and shall also
15 undergo drug screening prior to approval to receive benefits on behalf of the child. If the
16 results of the drug screen are unsatisfactory to the Secretary, the designated person shall
17 be required to submit to a drug test. If the results of the drug tests indicate the presence
18 of a controlled substance the person is ineligible to receive benefits on behalf of the child
19 and an alternative payee shall be designated. The cost of administering the drug test shall
20 be paid by the alternative payee.

1 (j) (1) An applicant who is found to be ineligible pursuant to the provisions
2 of (d) of this section is eligible to reapply for benefits two years from the date the
3 Secretary determined the applicant to be ineligible unless he or she meets the
4 requirements of subdivision (2) of the subsection. An applicant determined to be
5 ineligible under provisions of this section shall submit to a mandatory drug screen as part
6 of a reapplication for the Temporary Assistance for Needy Families Program and is subject
7 to the provisions of subsection (e) of this section.

8 (2) An applicant who is determined by the Secretary to be ineligible to receive
9 benefits pursuant to subsection (e) of this section who can document successful
10 completion of a drug treatment program approved by the Secretary, he or she may reapply
11 for benefits six months after the Secretary has declared the applicant ineligible. An
12 applicant who has met the requirements of this subdivision and reapplies shall also be
13 required to submit to a drug test and is subject to the provisions of subsection (e) of this
14 section.

15 (3) An applicant may reapply only once pursuant to the exceptions contained in
16 this subsection.

17 (4) The cost of any drug screen or test and drug treatment provided under this
18 subsection is the responsibility of the individual being screened and receiving treatment.

19 (k) An applicant who is denied assistance under this section may request a
20 review of the denial by the Board of Review. The results of a drug screen or test are

1 admissible without further authentication or qualification in the review of denial by the
2 Board of Review and in any appeal. The Board of Review shall provide a fair, impartial and
3 expeditious grievance and appeal process to applicants who have been denied Temporary
4 Assistance to Needy Families pursuant to the provisions of this section. The Board of
5 Review shall make findings regarding the denial of benefits and issue a decision which
6 either verifies the denial or reverses the decision to deny benefits. Any applicant adversely
7 affected or aggrieved by a final decision or order of the Board of Review may seek judicial
8 review of that decision.

9 (l) The Secretary shall ensure the confidentiality of all drug screen and drug test
10 results administered as part of this program. Drug screen and test results shall only be
11 used for the purpose of determining eligibility for the Temporary Assistance for Needy
12 Families Program. At no time may drug screen or test results be released to any public or
13 private person or entity or any law-enforcement agency, except as otherwise authorized
14 by this section.

15 (m) The Secretary shall promulgate emergency rules pursuant to the provisions
16 of article three, chapter twenty-nine-a to prescribe the design, operation, and standards for
17 the implementation of this section.

18 (n) A person who intentionally misrepresents any material fact in an application
19 filed under the provisions of this section is guilty of a misdemeanor and, upon conviction
20 thereof, shall be punished by a fine of not less than \$100 or more than \$1,000 or by

1 imprisonment in jail not exceeding six months or by both fined and imprisoned.

2 (o) The Secretary shall report to the Joint Committee on Government and
3 Finance by December 31, 2016, and annually thereafter until the conclusion of the pilot
4 program on the status of the pilot program described in this section. The report shall
5 include, but is not limited to:

6 (1) the total number of applicants who were deemed ineligible to receive benefits
7 under the program because of a positive drug test for controlled substances;

8 (2) the number of applicants for whom there was a reasonable suspicion because
9 they had a conviction of a drug-related offense within the five years prior to an application
10 for assistance;

11 (3) the number of applicants for whom there was a reasonable suspicion because
12 thy are the parent or parents of a newborn child who tests positive for the controlled
13 substances set forth in subdivision (3) of subsection (c) of this section;

14 (4) the number of those applicants that receive benefits after successful
15 completion of a drug treatment program as specified in this section; and

16 (5) the total cost or operate the program.

17 (p) Should federal approval not be given for the program as set forth in this
18 section, the Secretary shall implement a three year pilot program for drug screening
19 applicants which meets with federal approval and is consistent with the purpose of this
20 section .



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July 20, 2015

Honorable Eric Nelson
Room 462M, Building 1
State Capitol Complex
Charleston, WV 25305

Re: House Concurrent Resolution No. 143

Honorable Eric Nelson,

Introduction. You provided Arnett Carbis Toothman LLP (**ACT**) a copy of House Concurrent Resolution No. 143 which addresses the feasibility of divestiture and privatization or development of a performance-based, public-private partnership model for the operation and maintenance of all or some of the State's hospital and nursing facilities. In our communication, you requested that we provide you with a list of items we may need, and a timeline and cost for ACT to conduct the following for the state owned **nursing facilities**:

1. An operational and clinical assessment, and
2. A business valuation to determine the value of the assets.

Nursing Facilities. We are initially addressing the following Nursing Facilities:

1. Hopemont Hospital
2. Jackie Withrow Hospital
3. John Manchin Sr. Health Care Center
4. Lakin Hospital
5. West Virginia Veterans' Nursing Facility

We can address the Hospital facilities in a separate letter should you desire we provide information on those as well, but we have not addressed the Hospital facilities in this letter.

Items Needed. Should we begin the processes above, we would request significant information. Items we would need now would include the financial statements of each entity over the most recent five years.

Our Understanding. We understand that the State owned nursing homes are licensed by the West Virginia Department of Health & Human Services, Office of Health Facility Licensure & Certification (**OHFLAC**). We believe that the State owned nursing homes complete the Minimum Data Set (MDS) on residents, and are subject to regular surveys and investigations by OHFLAC. We understand the services provided by the State owned nursing homes.

Reasons for an Operational and Clinical Assessment. The key reasons to conduct an operational and clinical assessment include:

- a. Should the State decide not to divest or privatize the nursing facilities, it provides a comparison to best practices and includes recommendations for efficiencies.
- b. Outcomes from the assessment could materially impact the business valuations. Improvements in efficiency would likely increase the marketability and value in a sale.

Operational and Clinical Assessment. An operational and clinical assessment of the nursing facilities would include the following:

1. **Leadership Team Assessment.** Evaluate the leadership team and skill set present and, if appropriate, recommend training and enhancements to the skill sets present. This would include key management that directs the day to day operations of the Nursing Home (Administrator, Director of Nursing, and Charge Nurses).
2. **Financial Performance / Operational Cost Analysis.** Compare financial performance and operating costs at the departmental level to benchmarks to determine areas where efficiencies may be gained.
3. **Education & Training.** Conduct training and educational sessions with key management and nursing personnel related to management best practices for areas with identified need as the engagement progresses.
4. **Therapy Productivity.** Evaluate therapy services and make recommendations to achieve optimal levels of productivity and care.
5. **Staffing Mix.** Evaluate the staffing mix to recommended optimal levels.
6. **MDS Compliance.** Evaluate compliance with Minimum Data Set (MDS) coding guidelines as documented in the Resident Assessment Instrument User's Manual. Review of Quality Measure, PEPPER (Program for Evaluating Payment Patterns Electronic Report) and CASPAR (Certification and Survey Provider Enhanced Reports) reports for operational implications and need for corrective action.
7. **Documentation Practices.** Review documentation for consistency with guidelines to support the MDS and build a Resource Utilization Group (RUG) that supports Medicare and / or Medicaid RUG groupers.
8. **Optimize Documentation.** Provide training to appropriate members of the interdisciplinary team on how to optimize documentation, capture it in the MDS, and maintain compliance with regulatory guidelines.
9. **Clinical Monitoring.** Conduct clinical audits and monitoring to evaluate (or implement) requirements of the Patient Protection and Affordable Care Act to test for criminal, civil or administrative violations.
10. **PPACA Systems.** Evaluate internal auditing and monitoring policies and procedures, training programs and reporting processes and controls that are designed to prevent criminal, civil or administrative violations. Assess existing information and processes to determine baseline policies and procedures. Review baseline information and use GAP or SWOT analysis to determine short-falls as compared regulations for preventing and

detecting criminal, civil and administrative violations. Testing policies and processes for PPACA compliance effectiveness. Assessment includes review of compliance policies and procedures, training programs and monitoring and reporting processes. Assess effectiveness of tracking and risk management tools and processes in place.

11. **Quality Assurance Performance Improvement (QAPI).** Evaluate QAPI monitoring, systems and reporting processes and activities of the QAPI Committee. Document and assess existing information to determine baseline policies and procedures. Review baseline information and use GAP or SWOT analysis to determine short-falls as compared regulations for preventing and detecting criminal, civil and administrative violations. Assess quality assessment and performance improvement measures and utilization of dashboards for collecting and monitoring processes considering CMS guidelines and the PPACA. Reassess process for ensuring compliance with specifications, requirements and standards and identifying indicators for performance monitoring and compliance with standards.

Business Valuation Purpose. The purpose of the business valuation would be to determine the potential value the State could realize upon sale of the nursing facility assets. The specific assets sold may be different depending on the nursing facility. Options for valuing the assets include:

1. Value of licensed beds, if the real property is sold separately.
2. Value of the real property separately.
3. Value of the operating entity, including all real and personal property.

Considering the age of some of the buildings, differing options should be considered.

Business Valuation Process. The business valuation process involves three approaches generally categorized as follows:

1. Income-based Approach
2. Asset-based Approach
3. Market-based Approach

We would follow professional valuation standards and consider each valuation approach. Within each of these approaches there are different methods for determining business value. The business valuator must prudently assess the applicability of each broad approach and the subset of methods contained thereunder, given the facts and circumstances of the particular assignment. In addition, some valuation methods are based on some combination of the above approaches.

A brief, high-level summary of items included in the business valuation are:

- a. Significant analysis of financial data.
- b. Normalization adjustments made to reflect economic reality.
- c. All approaches to value considered.
- d. Impact of discounts and premiums carefully considered.
- e. Research on the industry conducted and impact reflected.

- f. Research on the competition conducted and impact reflected.
- g. Research on the economy (local, regional, national) conducted and impact reflected.
- h. Report covering relevant information.

Fees. The estimated fee to complete the operational and clinical assessments and the business valuations follow.

#	Name	Location	Licensed Beds (1)	Funding (1)	Clinical & Operational Assessment Fee	Business Valuation Fee (2)
1	Hopemont Hospital	Terra Alta	98	Medicaid & Private	\$ 40,000	\$ 35,000
2	Jackie Withrow Hospital	Beckley	199	Medicaid & Private	40,000	35,000
3	John Manchin, Sr. Health Care Center	Fairmont	41	Medicare, Medicaid & Private	40,000	35,000
4	Lakin Hospital	West Columbia	114	Medicaid & Private	30,000	38,000
5	West Virginia Veterans' Nursing Facility	Clarksburg	120	Private Pay	38,000	40,000

(1) Source: OHFLAC Website.

(2) A fee for a real estate appraisal would be added to ACT's fee. The real estate appraiser's fee has yet to be determined.

Including the operational and clinical assessments result in a lower fee for the business valuations since information obtained would be used in the business valuations.

Timeline. To compete the operational and clinical assessments and the business valuations we would need **four months** of time.

Please let us know if you have questions.

ARNETT CARBIS TOOTHMAN LLP



Lane Ellis, Jr., CPA, CISA, CVA, ABV, CGMA
Partner



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Medical Services
Commissioner's Office
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1451

Karen L. Bowling
Cabinet Secretary

April 13, 2015

Office of the Senate President – Lt Governor
William P. Cole
Room 229M, Building 1
State Capitol Complex
Charleston, WV 25305

RE: School Based Health Services

Dear Senate President Cole:

Thank you for your interest in the Bureau for Medical Services ("Bureau") School Based Health Services ("SBHS") program. It is my understanding there may be questions as to whether or not the Bureau is accessing all Medicaid funds which may be available for SBHS. A history of the Bureau's SBHS program will help you understand why the Bureau is currently accessing all Medicaid funds available for SBHS.

In the late 1990's, the Bureau decided to cover additional SBHS for Medicaid eligible special needs students in public schools. The Bureau determined that seven (7) additional categories of services should be covered as SBHS. These were: (1) Health Needs Assessment and Treatment Planning (Triennial Assessment); (2) Health Needs Assessment and Treatment Planning (Annual Assessment); (3) Personal Care Services (Half-Day); (4) Personal Care Services (Full-Day); (5) Specialized Transportation (Vehicle); (6) Specialized Transportation (Aide); and (7) Care Coordination.

In 2000, the Bureau submitted and the Centers for Medicare and Medicaid Services ("CMS") approved a State Plan Amendment ("SPA") modifying the SBHS services and reimbursement methodology for those services. Specifically, the SPA provided that payment to the school district was:

Reimbursement for shall be fee-for service. Reimbursement interim rates are based on statewide historical cost for [each service] Cost not to exceed actual, reasonable costs and must be cost settled on an annual basis.

(W.V. State Plan, Attachment 4.19-B)

Subsequently, in or around 2009 and consistent with their statutory and regulatory authority the Federal Office of Inspector General (“OIG”) began an audit of the Bureau’s SBHS program. The OIG concluded, in its audit, that the federal government had improperly provided \$22,806,230 in Federal Financial Participation (“FFP”) for SBHS for the period October 1, 2001 through September 30, 2003. Therefore, the Bureau faced a potential disallowance of almost \$23 million dollars. The Bureau, however, appealed this determination.

By decision dated September 20, 2013, the Departmental Appeals Board (“DAB”), Appellate Division, reversed the OIG’s determination and found that West Virginia had reasonably interpreted its State Plan by including certain costs which the OIG had excluded in its audit. Thus, the Bureau avoided a significant payback to CMS on SBHS.

In an almost simultaneous time period as the audit, the Bureau submitted to CMS a State Plan Amendment unrelated to SBHS for approval. However, as a result of the submission, CMS was able to mandate the Bureau to revise its SBHS SPA. The process of revising the SBHS SPA began on or around September 2011.

For almost a year, the Bureau worked with CMS on revising the SBHS SPA. In September 2012, the Bureau submitted the SPA to CMS for their approval. The effective date of this SPA was to be July 1, 2012.

However, due to concerns by CMS about certain provisions of the SBHS SPA, the Bureau and CMS agreed to work collaboratively and revise the SPA. The collaboration resulted in the effective date of the SPA changing from July 1, 2012 to July 1, 2014. During this period the Bureau had multiple conversations with the Department of Education (“DOE”) and kept DOE apprised on all matters relating to the revised SBHS Methodology. This new SBHS Methodology was approved by CMS on November 25, 2014.

As you can see from the history of the Bureau’s School Based Health Services Program, all efforts have been utilized to maximize Medicaid dollars which may be available. For your convenience, I have attached a copy of the Departmental Appeals Board Decision as well as the recently approved State Plan Amendment.

Should you have any questions or comments, please do not hesitate to contact me.

Kindest regards,



Alva Page III, Esquire
General Counsel

West Virginia Bureau for Medical Services

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

SWIFT #091220124038

NOV 25 2014

Ms. Cynthia E. Beane, MSW, LCSW
Acting Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Acting Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) has reviewed West Virginia's School Based Health Services State Plan Amendment (SPA) 12-006, in which you propose to more accurately match payments to the cost of services being provided to Medicaid members receiving direct medical services outlined on the Individualized Education Plan (IEP) in the school setting. West Virginia SPA 12-006 is a response to CMS companion letters for SPA 09-02 and SPA 11-011.

This SPA is acceptable. Therefore, we are approving SPA 12-006 with an effective date of July 1, 2014. Enclosed are the approved SPA pages and the signed CMS-179 form. Please note that accompanying this approval of SPA 12-006, there is an enclosed companion letter addressing unrelated issues that arose in review of this SPA.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

A handwritten signature in black ink, appearing to read "Francis McCullough". The signature is fluid and cursive, written over the printed name and title.

Francis McCullough
Associate Regional Administrator

Enclosures

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School-Based Health Services (Special Education):

The School-Based Health Services program includes medically necessary covered health care services identified pursuant to an IEP Plan provided by or through the West Virginia Department of Education (DOE) or a Local Education Agency (LEA). These medically necessary health care services must be ordered by a physician or other licensed practitioners of the healing arts within the scope of license as defined under the West Virginia Code to eligible special education students from birth to age 21. The State assures full EPSDT services as defined under 1905(r) will be provided for individuals under 21 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.

The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. The Medicaid-eligible individual may obtain Medicaid Services from any institution, agency, pharmacy, person or organization that is qualified to perform services.

The services are defined as follows:

A. Audiology, Speech, Hearing and Language Disorders Services:

Definition: Per 42 CFR §440.110 (c): Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

Services may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Central auditory function;
- Testing to determine the child's need for individual amplification; selection and fitting of aid(s);

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- Hearing aid evaluation;
- Auditory training; and training for the use of augmentative communication devices.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110 and be licensed by the WV Board of Examiners of Speech, Language Pathology, and Audiology. Speech, hearing, and language disorders services can also be provided by a Speech-Language Pathology Assistant or Audiology Assistant provided the requirements outlined in W.Va. Code St. R. §29-2-1 *et seq.* (1994) are met.

B. Occupational Therapy Services:

Definition: Per 42 CFR §440.110 (b)(1) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes necessary supplies and equipment.

Services may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Activities of daily living assessment and training;
- sensory integration;
- sensorimotor assessment and training;
- neuromuscular assessment and development;
- muscle strengthening and endurance training;
- fine motor assessment and skills facilitation;
- feeding/oral motor assessment and training;
- adaptive equipment application;
- visual perceptual assessment and training;
- perceptual motor development assessment and training;
- musculo-skeletal assessment;
- fabrication and application of splinting and orthotic devices;
- manual therapy techniques;
- gross motor assessment and skills facilitation; and
- functional mobility assessment.

All services shall be fully documented in the medical record.

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Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110 and be licensed by the West Virginia Board of Occupational Therapy. Occupational Therapy services can also be provided by a certified occupational therapy assistant (COTA) under the supervision of a licensed occupational therapist, provided the conditions outlined in W.Va. Code St. R. §13-1-1 et seq. (2010) are met.

C. Physical Therapy Services:

Definition: Per 42 CFR §440.110 (a) (1) Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

Service may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Neuromotor assessment;
- range of motion;
- joint integrity and functional mobility;
- flexibility assessment;
- gait, balance and coordination assessment and training;
- posture and body mechanics assessment and training;
- soft tissue assessment;
- pain assessment;
- cranial nerve assessment;
- clinical electromyographic assessment;
- nerve conduction;
- latency and velocity assessment;
- therapeutic procedures;
- hydrotherapy;
- manual manipulation;
- gross motor development;
- muscle strengthening;
- functional training;
- facilitation of motor milestones;
- sensory motor assessment and training;
- manual muscle test;
- activities of daily living assessment and training;
- therapeutic exercise;

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- cardiac assessment and training;
- Manual therapy techniques;
- fabrication and application of orthotic devices;
- pulmonary assessment and enhancement;
- adaptive equipment application; and
- feeding/oral motor assessment and training.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110 and be licensed by the West Virginia Board of Physical Therapy. Physical therapy services can also be provided by licensed physical therapy assistants under the direct supervision of a licensed physical therapist provided the conditions outlined in W.Va. Code St. R. §16-1-1 *et seq.* (2011) are met.

D. Psychological Services:

Definition: Per 42 CFR §440.60 (a) "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law. Psychological services include those services related to the evaluation, testing, diagnosis and treatment of social, emotional or behavioral problems.

Service may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Cognitive assessment;
- emotional/personality assessment;
- adaptive behavior assessment;
- behavior assessment;
- perceptual or visual motor assessment;
- Cognitive-behavioral therapy;
- rational-emotive therapy;
- family therapy;
- individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication; and
- sensory integrative therapy.

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All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.60. Minimum qualification for providing services are current licensure by the WV Board of Examiners of Psychologists as a licensed psychologist, licensed School psychologist or licensed School psychologist independent practitioner.

E. Nursing Services:

Definition: Per 42 CFR §440.60 (a), Federal regulations identify medical or other remedial care provided by licensed practitioners as “any medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.”

Nursing services include, but are not necessarily limited to:

- anaphylactic reaction;
- manual resuscitator;
- postural drainage and percussion;
- catheterization;
- mechanical ventilator;
- seizure management;
- measurement of blood sugar;
- subcutaneous insulin infusion;
- emergency medication administration;
- oral suctioning;
- subcutaneous insulin infusion by injection;
- enteral feeding;
- ostomy care;
- tracheostomy care;
- epinephrine auto-injector;
- oxygen administration;
- inhalation therapy;
- peak flow meter; and
- long-term medication administration.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 C.F.R. §440.60 (a) and be licensed by the West Virginia Board of Examiners for Registered Professional Nurses as a registered professional nurse (RN).

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F. Personal Care Services:

Definition: Per 42 CFR §440.167, Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disability, or institution for mental disease that are (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) Furnished in a home, and at the State's option, in another location.

Services related to a child's physical and behavioral health requirements may include, but are not limited to, the following:

- Assistance with eating, dressing, personal hygiene;
- Activities of daily living;
- Bladder and bowel requirements;
- Use of adaptive equipment;
- Ambulation and exercise;
- Behavior modification; and/or
- Other remedial services necessary to promote a child's ability to participate in, and benefit from the educational setting.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.167. Services are furnished by providers who have satisfactorily completed a program for home health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions.

G. Targeted Case Management:

Definition: Targeted Case Management services, provided in accordance with 1902(a)(10)(B) of the Act and as defined under 1905(a)(19) of the Act and 42 CFR 440.169, are activities that assist Title XIX eligible school-age children who are referred for, or are receiving, medical services pursuant to a Service Plan.

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 N/A Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

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

- Entire State
 Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

Targeted Case Management services are a component of the TCM Service Plan. Targeted Case Management identifies and addresses special health problems and needs that affect the student's ability to learn, assist the child to gain and coordinate access to a broad range of medical, social, educational, and other services, and ensures that the student receives effective and timely services appropriate to their needs.

In accordance with State Medicaid regulations, the school district shall complete and submit to the State a TCM Service Plan for the delivery of Targeted Case Management services. The district shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the TCM Service Plan. Included in the TCM Service Plan is the provision for coordination of benefits and Targeted Case Management across multiple providers to:

- Achieve service integration, monitoring and advocacy;
- Provide needed medical, social, educational, and other services;
- Ensure that services effectively complement one another; and
- Prevent duplication of services.

The school district shall inform the family of a Medicaid-eligible student receiving Targeted Case Management services from more than one provider that the family may choose one lead case manager to facilitate coordination.

Targeted Case Management services must include any of the following activities:

- Needs Assessment and Reassessment;
- Development and Revision of Service Plan;

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- Referral and Related Activities; or
 - Monitoring and follow-up activities;
1. Needs Assessment and Reassessment: Reviewing of the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. Results of assessments and evaluations are reviewed and a meeting is held with the individual, his or her parent(s) and /or guardian, and the case manager to determine whether services are needed and, if so, to develop a service plan. At a minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed.
 2. Development and Revision of the TCM Service Plan: Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parents(s) or legal guardian, and the case manager. Development (and periodic revision) of the TCM Service Plan will specify the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually.
 3. Referral and Related Activities: Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the individual, his or her parent(s) or legal guardian and the case manager and between the individual, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual. This may also include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

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4. **Monitoring and Follow-up Activities:** The case manager shall conduct regular monitoring and follow-up activities with the client, the client's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the individual's TCM Service Plan. Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of Targeted Case Management services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties. The periodic reviews will be conducted as necessary but at least annually.

All services shall be fully documented in the medical record.

Non-Duplication of Services: To the extent any eligible School-Based Health Services recipients are receiving Targeted Case Management services from another provider agency as a result of being members of other covered targeted groups; the School-Based Health Services providers will ensure that Targeted Case Management activities are coordinated to avoid unnecessary duplication of service.

Targeted Case Management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. Targeted Case Management activities shall not restrict or be used as a condition to restrict a client's access to other services under the state plan.

Qualified Practitioner: Targeted Case Management activities may be provided by any willing qualified provider pursuant to 1902(a)(23) of the Social Security Act. Case Managers must be affiliated with a licensed Behavioral Health Services Provider or School Based Health Services Provider and possess one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
 - o Psychology
 - o Criminal Justice
 - o Board of Regents with health specialization

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- Recreational Therapy
- Political Science
- Nursing
- Sociology
- Social Work
- Counseling
- Teacher Education
- Behavioral Health
- Liberal Arts or;
- Other degrees approved by the West Virginia Department of Education (WVDE).

Note: West Virginia does not enroll independent Target Case Manager Providers.

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

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

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

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

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case

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management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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H. Specialized Transportation:

Definition: Per 42 CFR §440.170 (a)(1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient. This service is limited to transportation of an eligible child to health related services as listed in a recipient's IEP.

Covered Services and Limitations: Specialized transportation is Medicaid reimbursable if:

1. It is provided to a Medicaid eligible EPSDT recipient who is enrolled in an LEA;
2. It is being provided on a day when the recipient receives an IEP health-related Medicaid covered service;
3. The Medicaid covered service is included in the recipient's IEP;
4. The recipient's need for specialized transportation is documented in the child's IEP; and
5. The driver must meet all State and County license and certification requirements.

Each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

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Attachment for A, D, and E of
Supplement 1 to Attachment 3.1-A

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9. **Clinic Services**

Services may be limited by prior authorization.

10. **Dental Services**

Prior Authorization may be required for restorative/replacement procedures. For prior authorization criteria see generally www.wvdhhr/bms/manuals Chapter 505; Dental: sections 505.8, 505.10 and Attachments 1,2 and 3. Dental service limits provided under EPSDT can be exceeded based on medical necessity. Certain emergency dental services are covered for adults, see section 505.7

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4.19 Payments for Remedial Care and Services

Inpatient Hospital Services

- 8. Private Duty Nursing Services
Payment is based on an hourly rate by skill level; i.e., R.N., LPN, Aide, considering customary charges and rate paid for these services by private insurance, or other state agencies.

- 9. Clinic Services
Payment for services provided by established clinics may be an encounter rate based on all inclusive costs, or on a fee for the services provided in the clinic. Payment not to exceed that allowed for the services when provided by other qualified providers. Payment for free standing ambulatory surgery center services shall be the lesser of 90% of the Medicare established fee or the provider billed charge.

- 10. Dental; Services

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4.19 Payments for Medical and Remedial Care and Services

23. Pediatric or Family Nurse Practitioner Services

Payment may not exceed the amount paid to physicians for the service the provider is authorized by State Law to perform, or the provider's customary charge, whichever is less.

For services provided on and after 11.01.94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

1. a. Transportation

Payment is made for transportation and related expenses necessary for recipient access to covered medical services via common carrier or other appropriate means; cost of meals and lodging, and attendant services where medically necessary.

Reimbursement Upper Limits:

- (i) Common Carriers (bus, taxi, train or airplane) – the rates established by any applicable regulatory authority, or the provider's customary charge to the general public.
- (ii) Automobile – Reimbursement is computed at the prevailing state employee travel rate per mile.
- (iii) Ambulance – Reimbursement is the lesser of the Medicare geographic prevailing fee of EMS provider charge to the general public as reported on the State Agency survey.
- (iv) Meals - \$5.00 per meal during travel time for patient, attendant, and transportation provider.
- (v) Lodging – At cost, as documented by receipt, at the most economical resource available as recommended by the medical facility at destination.

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PERSONAL CARE

4.19 Payments for Medical and Remedial Care and Services
Methods and Standards for Establishing Payment Rates

26. Personal Care Services

Personal Care services will be reimbursed using a statewide fee-for-service rate schedule based on units of services authorized in the approved plan of care. Payment for Personal Care services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Medicaid will be the payer of last resort. Unless specifically noted otherwise in the plan, the state-developed fee schedule rate is the same for both governmental and private providers. Providers will be reimbursed at the lesser of the provider's usual and customary billed charge or the Bureau for Medical Services (Bureau) fee schedule.

Personal care services are limited on a per unit, per month basis (15 minutes per unit) with all services subject to prior authorization. Individuals can receive up to a maximum of 840 units (210 hours) each month.

Rate Methodology:

Rates for Personal Care services are developed using a market-factor rate-setting model. The model reflects individual service definition, operational service delivery, administrative, capital and technology considerations. The following factors are used in determining the rates:

- **Wage** - Wage data is obtained from the Bureau for Labor Statistics (BLS). The wage is based on two elements consisting of occupation/wage categories reported by BLS and identified by Medicaid staff as comparable to services delivered under the personal care program as well as results of a formal provider survey.
- **Inflation** - The base wage is adjusted by an inflationary factor determined by the percent change in Consumer Price Index (CPI-U, U.S. City: All Items 1982-84 = 100) from base period 2009 to current rate period.
- **Payroll Taxes** - The payroll taxes factor represents the percentage of the employer's contribution to Medicare, Social Security, workers' compensation and unemployment insurance.
- **Employee Benefits** - The employee benefits factor represents the percentage of employer's contribution to employee health insurance and retirement benefits. The employee benefit factor varies by employee type. This factor is discounted to reflect the Medicaid agency's share of cost based on the Medicaid payer mix.
- **Allowance for Administrative Costs** - The allowance for administrative costs factor represents the percentage of service costs that results from non-billable administrative activities performed by direct care staff and services provided by employer administrative support and executive staff. This factor is discounted to the Medicaid payer mix as determined by provider survey conducted in 2010 and 2011.
- **Allowance for Transportation Costs** - The allowance for transportation costs factor represents an allowance for average travel time by the provider as indicated by the provider survey.
- **Allowance for Capital and Technology** - The allowance for capital and technology factor represents weighting of various income and balance sheet account information and provider survey data to calculate a capital and technology cost per dollar of employee wages. This factor is discounted to reflect the Medicaid agency's share of cost based on the Medicaid payer mix.
- **Room and Board** - Room and Board shall not be a component used in developing the rate methodology.

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REIMBURSEMENT TO SCHOOL-BASED SERVICE PROVIDERS:

A. Reimbursement Methodology for School-Based Service Providers

Reimbursement to Local Education Agencies (LEAs) for School-Based Service Providers is based on a cost based methodology.

Medicaid Services provided by School-Based Service Providers are services that are medically necessary and provided to Medicaid recipients by LEAs in accordance with an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA):

1. Audiology and Speech-Language Pathology Services
2. Occupational Therapy Services
3. Physical Therapy Services
4. Psychological Services
5. Nursing Services
6. Personal Care Services
7. Targeted Case Management Services
8. Specialized Transportation

Providers will be paid interim rates based on historical cost data for school-based direct medical services. For the initial periods covered by this SPA the interim rate will be based on the current rates for school based health services until sufficient cost data has been collected through the annual cost report process to establish revised interim rates. Annually, provider specific cost reconciliation and cost settlement processes will occur to identify and resolve all over and under payments.

B. Direct Medical, Personal Care Services, and Targeted Case Management Payment Methodology

Effective for dates of service on or after July 1, 2013, the Bureau for Medical Services (BMS) will institute a cost based payment system for all School-Based Service Providers. As a cost based methodology, this system will incorporate standard cost based components: payment of interim rates; a CMS approved Random Moment Time Study (RMTS) approach for determining the allocation of direct service time; a CMS approved Annual Cost Report based on the State Fiscal Year (June 30 end); reconciliation of actual incurred costs attributable to Medicaid with interim payments; and a cost settlement of the difference between actual incurred costs and interim payments.

To determine the allowable direct and indirect costs of providing medical services to Medicaid-eligible clients in the LEA, the following steps are performed on those costs pertaining to each of

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the three cost pools; direct services, personal care services, and targeted case management services:

- 1) Direct costs for medical services include unallocated payroll costs and other unallocated costs that can be directly charged to medical services. Direct payroll costs include the total compensation (i.e. salaries and benefits) to the service personnel identified for the provision of health services listed in the description of covered Medicaid services delivered by LEAs.

Other direct costs include costs related to the approved service personnel for the delivery of medical services, such as materials, supplies and equipment and capital costs such as depreciation and interest. Only those materials, supplies, and equipment that have been identified and included in the approved BMS Medicaid cost reporting instructions are allowable costs and can be included on the Medicaid cost report.

Total direct costs for medical services are reduced on the cost report by any credits, adjustments or revenue from other funding sources resulting in direct costs net of federal funds.

- 2) The net direct costs for each service category are calculated by applying the direct medical services percentage from the approved time study to the direct costs from Item 1 above.

The RMTS incorporates a CMS approved methodology to determine the percentage of time medical service personnel spend on IEP related medical services, and general and administrative time. This time study will assure that there is no duplicative claiming of administrative costs.

- 3) Costs incurred through the provision of direct services by contracted staff are allowable costs net of credits, adjustments or revenue from other funding sources. This total is then added to the net direct costs identified in Item 2 above.
- 4) Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its net direct costs identified in Item 3 above. West Virginia LEAs use predetermined fixed rates for indirect costs. The West Virginia Department of Education is the cognizant agency for LEAs, and approves unrestricted indirect cost rates for LEAs for the United States Department of Education. Only allowable costs are certified by LEAs.
- 5) Net direct costs, from Items 2 and 3 above, and indirect costs from Item 4 above are combined.

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- 6) Medicaid's portion of total net costs is calculated by multiplying the results from Item 5 above by the cost pool specific IEP ratio. West Virginia LEA's use a different IEP ratio for each of three service type cost pools, including direct services, personal care services, and targeted case management services. For direct services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a direct medical service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a direct medical service outlined in their IEP. For personal care services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a personal care service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a personal care service outlined in their IEP. For targeted case management services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a targeted case management service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a targeted case management service outlined in their IEP.

C. Specialized Transportation Payment Methodology

Effective for dates of services on or after July 1, 2014, providers will be paid on a cost basis. Providers will be paid interim rates based on historical cost data for specialized transportation services. For the initial periods covered by this SPA the interim rate will be based on the current rates for school based health services until sufficient cost data has been collected through the annual cost report process to establish revised interim rates. Annually, provider specific cost reconciliation and cost settlement processes will occur to identify and resolve all over and under payments.

Specialized transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

1. Specialized transportation is specifically listed in the IEP as a required service;
2. The child required specialized transportation in a vehicle that has been modified as documented in the IEP; and
3. The service billed only represents a one-way trip; and
4. A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with specialized transportation reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

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1. **Personnel Costs** – Personnel costs include the salary and benefit costs for transportation providers employed by the school district. The definitions for allowable salary and benefit costs for transportation services are the same as for direct medical service providers. The personnel costs may be reported for the following staff:
 - a. Bus Drivers
 - b. Attendants
 - c. Mechanics
 - d. Substitute Drivers
2. **Transportation Other Costs** – Transportation other costs include the non-personnel costs incurred in providing the transportation service. These costs include
 - a. Lease/Rental costs
 - b. Insurance costs
 - c. Maintenance and Repair costs
 - d. Fuel and Oil cost
 - e. Contracted – Transportation Services and Transportation Equipment cost
3. **Transportation Equipment Depreciation Costs** – Transportation equipment depreciation costs are allowable for transportation equipment purchased for more than \$5,000.

The source of these costs will be audited general ledger data kept at the LEA level.

LEAs may report their transportation costs as specialized transportation only costs when the costs can be discretely identified as pertaining only to specialized transportation or as general transportation costs when the costs cannot be discretely identified as pertaining only to specialized transportation.

All specialized transportation costs reported on the annual cost report as general transportation costs will be apportioned through two transportation ratios; the Specialized Transportation Ratio and the Medicaid One Way Trip Ratio. All specialized transportation costs reported on the annual cost report as specialized transportation only will only be subject to the Medicaid One Way Trip Ratio.

- a. **Specialized Transportation Ratio** – The Specialized Transportation Ratio is used to discount the transportation costs reported as general transportation costs by the percentage of Medicaid eligible IEP students receiving specialized transportation services. This ratio ensures that only the portion of transportation expenditures related to the specialized transportation services for Medicaid eligible students are included in the calculation of Medicaid allowable transportation costs.

The Specialized Transportation Ratio will be calculated based on the number of Medicaid eligible students receiving specialized transportation services in the school district. The numerator for the ratio will be the total number of Medicaid eligible IEP students receiving

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specialized transportation services. The denominator for this ratio will be the total number of all students receiving transportation services. The data for this ratio will be based on the same point in time as is used for the calculation of the IEP ratio.

The Specialized Transportation Ratio is defined by the following formula:

Numerator = Total number of Medicaid eligible students receiving Specialized Transportation services per their IEP

Denominator = Total number of all students receiving transportation services

An example of how the Specialized Transportation Ratio will be calculated is shown below:

Specialized Transportation Ratio	
Total Number of Medicaid Eligible Students Receiving Specialized Transportation Services per their IEP	100
Total Number of ALL Students Receiving Transportation Services (Specialized or Non-Specialized)	1,500
	7%

- b. **Medicaid One Way Trip Ratio-** An LEA-specific Medicaid One Way Trip Ratio will be established for each participating LEA. When applied, this Medicaid One Way Trip ratio will discount the transportation costs by the percentage of Medicaid IEP one way trips. This ratio ensures that only Medicaid allowable transportation costs are included in the cost settlement calculation.

The Medicaid One Way Trip Ratio will be calculated based on the number of one way trips provided to students requiring specialized transportation services per their IEP. The numerator of the ratio will be based on the Medicaid paid one way trips for specialized transportation services as identified in the state's MMIS data. The denominator will be based on the school district transportation logs for the number of one-way trips provided to Medicaid eligible students with specialized transportation in the IEP. The denominator should be inclusive of all one way trips provided to students with specialized transportation in their IEP, regardless of whether the trip qualified as Medicaid specialized transportation or not. The data for this ratio will be based on the total number of trips for the entire period covered by the cost report, i.e. all one way trips provided between July 1 and June 30.

The Specialized Transportation Ratio is defined by the following formula:

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Numerator = Total Medicaid paid one way trips for specialized transportation services per MMIS

Denominator = Total one way trips for Medicaid eligible students with specialized transportation in their IEP (from bus logs)

An example of how the Specialized Transportation Ratio will be calculated is shown below:

Medicaid One Way Trip Ratio	
Total Number of Paid Medicaid One Way Trips for Specialized Transportation Services (per MMIS)	250
Total Number of ALL One Way Trips for Medicaid Eligible Students with Specialized Transportation in their IEP (per bus logs)	600
	42%

D. Annual Cost Report Process

Each provider will complete an annual cost report for all school-based services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 31st of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total allowable costs for delivering services by School-Based Service Providers, including direct costs and indirect costs, based on cost allocation methodology procedures; and
2. Reconcile interim payments to total allowable costs based on cost allocation methodology procedures.

All filed annual Cost Reports are subject to a desk review.

E. Certification of Funds Process

On an annual basis, each LEA will certify through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the nonfederal share.

F. The Cost Reconciliation Process

The total allowable costs based on cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school-based service providers during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation. West Virginia will complete the review of the cost settlement within a

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reasonable time following the submission of the annual cost reports and the completion of all interim billing activities by the providers for the period covered by the cost report.

G. The Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual School Based Service Providers Cost Report is due on or before December 31st of the same year.

If a provider's interim payments exceed the actual, certified costs of the provider for school-based services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school-based services exceed the interim Medicaid payments, BMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment.

BMS shall issue a notice of interim settlement that denotes the amount due to or from the provider. West Virginia will process the interim settlement within 6 to 12 months following the submission of the annual cost reports. BMS shall also issue a notice of final settlement that denotes the final amount due to or from the provider upon completion of the final cost reconciliation. The final settlement will be issued within 24 months following the final submission of the annual cost reports.

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Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

West Virginia Department of Health and Human Resources
Docket No. A-13-31
Decision No. 2536
September 20, 2013

DECISION

The West Virginia Department of Health and Human Resources (West Virginia or State) appeals a November 21, 2012 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow \$22,806,230 in federal financial participation (FFP). The State sought that FFP for payments that its Medicaid program made for certain school-based health services (SBHS) furnished to Medicaid-eligible children during state fiscal years (SFYs) 2001, 2002, and 2003.

West Virginia's Medicaid program pays for SBHS using per-unit rates (*e.g.*, dollars per student encounter) that, in turn, are based on school districts' costs of providing the covered services. Initially, the State's payment rates for SBHS, and corresponding FFP claims for SFYs 2001 through 2003, reflected only the school districts' salary and fringe benefit expenses. Later, the State increased the rates for those years to reflect two additional categories of school district costs ("operating" and "indirect costs"), made additional payments to the school districts based on the rate increases, and claimed FFP for the additional payments.

The basis for CMS's disallowance is a finding by the Department of Health & Human Services (HHS) Office of Inspector General (OIG) that West Virginia violated its approved Medicaid plan by including operating and indirect costs in its calculation of SBHS payment rates. We conclude, however, that the adjustment of SBHS rates for SFYs 2001 through 2003 in order to reflect those costs, and the claiming of FFP based on the adjusted rates, were authorized by West Virginia's Medicaid plan and consistent with the State's reasonable interpretation of that plan. For that reason, we reverse the disallowance in its entirety.

... program created under title XIX of the Social Security Act (Act), federal financial assistance is available to states that provide health care to persons with low income and resources. Act §§ 1901, 1902(a)(10); 42 C.F.R. § 430.0. Within constraints established by title XIX (and its corresponding regulations), states that participate in Medicaid have considerable flexibility to determine program eligibility, the scope of covered health benefits, and payment levels for medical services. 42 C.F.R. § 430.0.

In order to participate in Medicaid, a state must have a "State plan" that is approved by the Secretary of Health & Human Services (Secretary). Act § 1901. A State plan is a "comprehensive written statement . . . describing the nature and scope" of a state's Medicaid program and "giving assurance that it will be administered in conformity with the specific requirements of title XIX," the regulations implementing that title, and other "applicable official issuances" of the Secretary. 42 C.F.R. § 430.10. In general, a State plan must specify or describe the healthcare services covered under the state's Medicaid program, the groups of persons eligible for coverage, and "the policy and the methods to be used in setting payment rates for each type" of covered service. *See* Act § 1902(a)(10); 42 C.F.R. §§ 430.12(a), 435.10(b), and 447.201(b) (citation for the quoted passage).

A state with an approved State plan is eligible to receive federal matching funds, also known as FFP, for "medical assistance under the State plan."² Act § 1903(a)(1). "Medical assistance" is defined in the Medicaid statute to mean the state's payments for covered "care and services." *Id.* § 1905(a). Medical assistance may include a state's payments for healthcare services provided by public school employees to Medicaid-eligible children. *See Texas Health and Human Servs. Comm.*, DAB No. 2187, at 2 (2008). In order to be eligible for FFP, a state's payments for covered healthcare services

The current version of the Social Security Act can be found at <http://www.socialsecurity.gov/OP-Home/ssact/ssact.htm>. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

² Payments for certain services that fall within the definition of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) are eligible for FFP regardless of whether they are specified in the State plan. *See* Act § 1905(r)(5) (providing that the EPSDT benefit covers "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan"). In general, the EPSDT benefit covers comprehensive diagnostic, prevention, and treatment services that are provided to Medicaid-eligible children who are under 21 years of age. Act §§ 1905(a)(4)(B), 1905(r); *Texas Health & Human Servs. Comm.*, DAB No. 2235, at 2-3 (2009).

The State asserts that it has always interpreted SPA 00-01 as (1) authorizing payment for SBHS based on school districts' operating and indirect costs and (2) permitting a retrospective adjustment of SBHS rates to include such costs. The amendment's text does not rule out either element of that interpretation. Regarding the first element, SPA 00-01 does not, as we earlier noted, specify the categories of costs that may (or must) be reflected in the rates. The amendment states that costs must be "actual" and "reasonable," but neither of those limitations excludes operating and indirect costs by definition or implication. Including operating and indirect costs is consistent with federal cost principles for grants to state and local governments in OMB Circular A-87.¹⁶ See 2 C.F.R. Part 225, Att. B, ¶¶ 25, 26, & 37 (identifying various cost items as allowable, including "[m]aterials and supplies," building and equipment rental, and maintenance and repair) & Att. A, ¶ D.1 (indicating that the "total cost" of a federal award includes "an allocable portion of allowable indirect costs"); cf. *Medicare Provider Reimbursement Manual*, CMS Pub. 15-1 (setting out principles of "reasonable cost" reimbursement for the Medicare program and defining "reasonable cost" in section 2102.1 (of Part 1) as "tak[ing] into account both direct and indirect costs of providers of services" and further stating that the "intent of the [Medicare] program" is that "providers are reimbursed the actual costs of providing high quality care"). Furthermore, the State introduced evidence, not rebutted by CMS, that its interpretation of SPA 00-01 is consistent with its interpretation or implementation of other (non-SBHS) cost-based payment provisions to capture a Medicaid provider's *total* actual costs of providing a service. See WV Ex. 23, ¶¶ 8-11 (stating that "[i]t has always been [the State's] practice to capture full allowable incurred costs, including operating and indirect costs, during cost settlement in order to reimburse the total, actual costs of providing Medicaid services that are reimbursed on a cost basis"). The State's cost reimbursement practices in these other areas support the State's interpretation of the cost-based reimbursement provision in SPA 00-01. Cf. *New York Dept. of Social Servs.*, DAB No. 151, at 7, 9 (1981) (holding that it was "appropriate to look to relevant State law and practices" to assess the reasonableness of the State's view about whether the State plan permitted a "fee schedule" to be adjusted retroactively in order to recognize categories of costs that had been omitted from the original fee schedule amounts).

As for the second element of the State's interpretation, it is consistent with the retrospective rate methodology authorized by SPA 00-01, which permits retroactive adjustment of SBHS rates but places no limit in the scope of the adjustment (other than that supporting costs be "actual" and "reasonable"). The "cost settlement" language in

¹⁶ CMS does not dispute that operating and indirect costs reflected in the State's payments for SBHS for SFYs 2001 through 2003 were actually incurred to provide those services, nor does it contend that those costs were not "reasonable" under applicable principles for determining allowable costs.

SPA 00-01 was included at CMS's insistence, yet CMS failed to produce contemporaneous evidence that the language's intended meaning is anything other than what the State contends it means. CMS has also failed to establish that the State violated any accepted cost settlement principles in determining final SBHS payment rates.

Not only is the State's interpretation consistent with applicable State plan language, it is reasonable in light of the circumstances surrounding the development and use of the initial interim rates. The State presented un rebutted evidence that it had always intended to base its SBHS rates on *total* statewide costs of providing SBHS, an intention that is not inconsistent with the amendment's open-ended language (permitting the inclusion of costs "not to exceed" actual and reasonable costs) and with the State's administration of other cost-based payment methodologies. *See* WV Ex. 23, ¶¶ 9-10, 12. However, when the State developed the initial interim rates, it did not have "historical cost experience" regarding any of the school-based services that it intended to cover under SPA 00-01. CMS Ex. 8, ¶ 6; WV Ex. 4, at 4 (indicating that the rates reflected "data for which reimbursement occurs today"). Not until late 2002 or 2003 did the State have a management information system in place (namely, the WVEIS) that was capable of "extract[ing] the necessary elements to determine total SBHS costs and develop rates that reflected total costs." WV Ex. 23, ¶ 12. Only then was the State able to obtain complete and reliable cost data relevant to the services covered by SPA 00-01. Under these circumstances, the State was not unreasonable in waiting until it had amassed adequate cost experience with respect to the newly covered SBHS before attempting to incorporate operating and indirect costs into the applicable payment rates.

It is true that the State did not include any estimate or placeholder to reflect future inclusion of operating and indirect costs in developing the initial interim rates. The State explains that the absence of prior experience and data in 1999 and 2000, and an abundance of caution in avoiding any excess interim payments that might lead to a disallowance later, led it to "conservatively" calculate its initial interim rates (*see* WV Ex. 23, ¶ 7). This approach had the effect of causing the rates to understate total actual costs, but we do not view this decision as evidencing a commitment by the State not to include total actual costs in calculating reimbursement rates as it generally does in implementing other cost-based reimbursement methodologies once the relevant data became available.

In *New York Department of Social Services*, the Board considered whether Medicaid payments to publicly operated intermediate care facilities for the mentally retarded (ICF/MRs) – payments based on an annual "fee schedule" – could be retroactively increased in order to account for types of costs that were not included in the calculation of the fee schedule payment rates (as well as to correct for an annual six-month lag in applying newly established fee schedule rates). DAB No. 151, at 4-6. In accordance with New York law, fee schedule amounts were intended to capture "the actual costs incurred" by ICF/MRs to provide their Medicaid-covered services. *Id.* at 7. New York explained, however, that its fee schedules for ICF/MR were developed using cost

estimates and projections of service utilization rather than “actual allowable costs and actual patient days.” *Id.* at 7. During the relevant period, New York had a statute which required that fee schedules be based “on the costs of services, care, treatment, maintenance, overhead, and administration” and authorized the relevant state agency to establish rates “which assure maximum recovery of such costs.” *Id.* at 3. New York’s State plan did not indicate whether retroactive payment adjustments were permitted; it merely stipulated that the method of reimbursement for ICF/MRs would be a “fee schedule.” *Id.* at 2. The Board concluded that there was nothing in federal or state law or in the record that “exclude[d] the possibility of retroactive adjustment” of fee schedule amounts, and it further found that “given the State statutory requirements,” it would be “illogical to assume that the State would deliberately set up a reimbursement methodology that would not capture all possible allowable costs.” *Id.* at 7, 9.

Like New York’s fee schedule payment system for ICF/MRs, SPA 00-01 contemplated that providers (that is, school districts) would ultimately receive reimbursement for Medicaid-covered services based upon the actual costs incurred to provide those services. And while New York had a statute that permitted the relevant state agency to establish fee schedule payments that assured “maximum recovery” of costs, West Virginia had – and still has – a statute (enacted in 1990) that *requires* it to “maximize federal reimbursement” for the Medicaid-covered services in question, W.Va. Code § 18-2-5b(a),¹⁷ and that also requires the creation of a “school health services advisory committee” whose mission is to advise the State on ways “to ensure that the school-based medicaid service providers bill for and receive “*all the medicaid reimbursement to which they are entitled,*” *id.* § 18-2-5b(b) (italics added). Finally, like New York, West Virginia did not have complete, reliable cost information when it initially set payment rates for the covered services and was able to acquire that information only after providers had actually incurred costs to provide the services. For these reasons, we find that the State acted reasonably to include previously unidentified – but otherwise allowable – categories of costs in its final SBHS rates, just as the Board found New York reasonably made retroactive adjustments to account for costs not reflected in its fee schedules.

¹⁷ Section 18-2-5b(a) of the West Virginia code provides:

The state board [of education] shall become a medicaid provider and seek out medicaid eligible students for the purpose of providing medicaid and related services to students eligible under the medicaid program and to maximize federal reimbursement for all services available under the Omnibus Budget Reconciliation Act of one thousand nine hundred eighty-nine [Pub. L. No. 101-239], as it relates to medicaid expansion and any future expansions in the medicaid program for medicaid and related services for which state dollars are or will be expended[.]

Among other things, the 1989 federal law cited in this provision strengthened the Medicaid coverage available to children under the EPSDT benefit. Pub. L. No. 101-239, § 6403, 103 Stat. 2262 (1989).

In short, we conclude that the State's interpretation of SPA 00-01 is reasonable and entitled to deference and reject CMS's arguments to the contrary. CMS asserts that its approval of SPA 00-01 was "based on the SBHS methodology West Virginia had submitted to CMS" in its February 2000 slide presentation. Response Br. at 12. Pointing to the title of the presentation ("Calculation of Final Rates for Special Education Medicaid Reimbursable Services"), CMS asserts that the State identified its "final" SBHS rates – rates that reflected only salaries and fringe benefits – then made payments and claimed FFP based on those rates for almost three years afterward. *Id.* According to CMS, the February 2000 presentation and use of the rates consistent with that presentation as initial interim rates "are evidence that West Virginia historically interpreted its State Plan to include only the costs of salaries and fringe benefits for SBHS." *Id.* CMS asserts that the State's current interpretation of SPA 00-01 is inconsistent with that historical interpretation and for that reason deserves no deference. *Id.* at 18.

The trouble with this argument is that, notwithstanding the use of the word "final" in the slide presentation's title, the February 2000 rates were not, in fact, "final" under the State plan. CMS approved SPA 00-01 shortly after the slide presentation, but the actual language of the state plan amendment does not use the word "final" or refer to any specific formula for setting final rates. Furthermore, the slide presentation itself states that the analysis done for rate development was limited but that "any refinement of existing rates will occur in the next phase of the project." WV Ex. 4, at 4. Thus, CMS could not have concluded that no further changes could occur. Instead, the amendment plainly indicates that, for a given cost period, the State would initially pay for SBHS services based on "interim" rates subject to retrospective adjustment. Although SPA 00-01 may have been unclear about the nature and scope of the State's cost settlement authority, the State retained considerable discretion and flexibility to decide how to finalize its SBHS payment rates for SFYs 2001 through 2003 and what types of costs to include in calculating those rates. The actions taken by the State in 2003 in response to PCG's recommendation represented the State's **initial** exercise of that discretion based on actual cost experience for the seven school-based services covered by SPA 00-01. Therefore, we agree with the State that the most relevant evidence of the State's understanding or interpretation of SPA 00-01 are its efforts in 2003 and 2005 to finalize SBHS rates for SFYs 2001 through 2003. *Cf. Texas Health and Human Servs. Comm.*, DAB No. 2176, at 11 (stating that "a state does not violate or act inconsistently with its state plan merely because it exercises discretion conferred by the plan"). Focusing on the State's actual cost settlement practices during those years is appropriate because "[u]nder a retrospective system, . . . what is ultimately considered expended in accordance with the state plan . . . is determined by the state plan rate-setting methodology for establishing final rates." *District of Columbia Dept. of Human Servs.*, DAB No. 1617, at 27 n.12 (1997).

There is no dispute that, from the first determination of final rates under SPA 00-01, the State incorporated operating and indirect costs into the SBHS rate calculations, that the interim rates established thereafter consistently included those costs and that the actual amounts of those costs were included in reconciliation of all subsequent final cost settlements. WV Ex. 23, ¶¶ 19-20, 24. These circumstances constitute relevant evidence of the State's historical interpretation of SPA 00-01. Thus, we reject CMS's contention that the payment rate adjustments to include those costs for SFYs 2001 through 2003 were inconsistent with that interpretation.

CMS asserts that the retrospective adjustments of the SBHS rates for SFYs 2001 through 2003 were not, in fact, "cost settlements" reflecting "the difference between estimates and settled actual costs" but, rather, an "attempt to add two entirely new categories of costs – operating and indirect costs – at the direction of PCG outside of the annual cost settlement process."¹⁸ Response Br. at 20. However, the State plan is silent about how the final "cost-settled" rates would be calculated, and CMS presented no evidence that the State's cost settlement process deviated from some normal or typical process for settling costs of school-based providers. We also agree with the State that "[t]he non-restrictive language of the State Plan is broad enough to encompass a cost settlement process that updates SBHS rates to include cost information," such as the cost data relating to the newly covered school-based services, "that was not readily available when interim rates were developed." Reply Br. at 15. The initial interim rates were based purely on cost estimates not derived from any actual or historical cost experience relating to the services covered by SPA 00-01. In contrast, the rate adjustments proposed by PCG and implemented in 2003 were based on actual cost experience (from SFY 2001) relating to those covered services.

CMS contends that the Board "specifically found" in the State's prior disallowance appeal "that the adjustments at issue here were not consistent with the concept of 'cost settlement' as that term is usually understood" and were "inconsistent with" and "not contemplated by" the payment methodology laid out in SPA 00-01. Response Br. at 10-11, 13-14, 20 (*quoting* DAB No. 2365, at 8). CMS asserts that these prior findings "largely determine[] the ultimate issue in the instant case" *Id.* at 10-11. We find this argument to be without merit. The Board's previous findings were made in support of its resolution of an entirely different legal issue. The "sole question before [the Board]" in the State's prior appeal was whether a disallowed FFP claim based on an adjustment to the State's **interim** SBHS rates to include additional estimated costs met the regulatory definition of an "adjustment to prior year costs," and, therefore, fell within an exception to the timely claims provision. DAB No. 2365, at 6. The Board has held

¹⁸ We see no significance in the role that PCG played in the cost settlement process. The validity of the adjustments stands or falls on the reasonableness of the State's interpretation of SPA 00-01 and whether the actions and calculations supporting the supplemental FFP claims are consistent with that interpretation.

that, to constitute an “adjustment to prior year costs” for purposes of the exception, an adjustment must be consistent with the state plan methods and procedures for determining rates. The untimely adjustments to the interim SBHS rates did not meet that test. The State did not show that the concept of “cost settlement” in its State plan would have put CMS on notice that entirely new categories of costs excluded from the interim rates might be added to the calculation of rates years later. Such a difference in how rates are calculated is not merely the unavoidable consequence of making interim payments based on estimates that must later be reconciled when actual costs are calculated.

In contrast, the dispositive legal issue in this case is whether the State could, consistent with a reasonable interpretation of its state plan, revise the costs included in its rate calculations based on its evolving experience and collection of actual cost data. What is significant here is that the State included the actual operating and indirect costs the first time the State calculated any final SBHS rates based on actual costs from the relevant cost reporting period. While the change in the categories of costs on which the rate is calculated was not merely an inevitable part of the usual cost settlement process for retroactive payment systems nor expressly contemplated in the state plan language, we do not find anything in the state plan that precluded the state from making such a change going forward. The fact that it did make this change from its first opportunity and did so consistently in all its later rate calculations convinces us that the change reflected a reasonable interpretation of the state plan. Also, the State timely claimed the expenditures resulting from the corresponding adjustments to the interim rates for later periods, so it did not need to show that an exception to the timely claims provisions applied.

We also find CMS’s contention that this case is factually indistinguishable from the circumstances in *Colorado Department of Health Care and Policy Financing* to be without merit. In that case, CMS approved a 1997 State plan amendment which stated that SBHS payment rates would be determined “according to Department formula.” DAB No. 2057, at 3. The amendment did not specify the formula, but two years later, in a September 10, 1999 letter, Colorado’s Medicaid agency proposed a formula and asked CMS to approve it. *Id.* Although the formula was never approved by CMS or incorporated into Colorado’s Medicaid plan, Colorado continued to use the formula for the next four to five years to calculate its Medicaid payment rates for SBHS. *Id.* at 3-5, 13. Then, in 2005, the state Medicaid agency unilaterally made various changes to the formula, such as “including additional costs and changing some of the algebraic processes.” *Id.* at 4, 10. Based on those changes, Colorado recalculated its SBHS payment rates for 2003 and 2004 and submitted FFP claims for the additional payments that resulted from the rate recalculations. *Id.* at 4. CMS disallowed those claims, and the Board upheld the disallowance. *Id.* at 4-6. The Board found that the formula that Colorado had proposed in September 1999, coupled with the use of that formula to claim FFP for SBHS, were “evidence of Colorado’s historical interpretation and application of”

the 1997 State plan amendment. *Id.* at 6. The Board also found that the “retroactive” FFP claims for 2003 and 2004 were “based on a methodology . . . not described in the” 1997 State plan amendment, were “not consistent with Colorado’s interpretation” of the amendment, and were unallowable for those reasons.¹⁹ *Id.* at 9.

A material difference between *Colorado* and the appeal now before us is that unlike the State plan amendment in Colorado, SPA 00-01 established a retrospective payment methodology that expressly authorized SBHS payment rate adjustments based on more complete data about actual costs. In *Colorado*, the disallowance and the Board’s decision were based in part on the fact that the relevant State plan amendment did not provide for retrospective adjustment of SBHS payment rates. DAB No. 2057, at 5, 16. Another important difference is that, unlike Colorado, West Virginia did not deviate from a specific rate formula that it identified as the State-plan-authorized payment methodology. The State plan amendment in *Colorado* expressly stated that SBHS rates would be calculated according to a “formula” which Colorado would (and did) later specify. SPA 00-01, on the other hand, did not specify or even refer to a “formula” for calculating SBHS costs; it merely stated that SBHS would be paid under an interim rate that would be later be subject to retrospective adjustment during a cost settlement process whose contours were left to the State to define. For these reasons, we conclude that *Colorado* does not dictate the outcome here.

Finally, CMS contends that the inclusion of operating and indirect costs in the calculation of SBHS payment rates for SFYs 2001 through 2003 constituted a “material modification” to the SBHS rate methodology that required amendment of the State plan in order to become effective. Response Br. at 15-16. In support of that assertion, CMS relies on 42 C.F.R. § 430.12(c)(ii), which says that a State plan “must provide that it will be amended whenever necessary to reflect . . . [m]aterial changes in State law, organization, or policy, or in the State’s operation of the Medicaid program.” *Id.*

We disagree that the State was obligated to amend its State plan to permit the inclusion of operating and indirect costs in its SBHS rates. SPA 00-01 expressly authorized the State to finalize its cost-based “interim” rates, subject only to the requirements that the rates be based on “actual” and “reasonable” costs. The recalculation of SBHS rates to include operating and indirect costs was part of the State’s effort to finalize those rates for SFYs 2001 through 2003 to reflect the actual costs incurred. We have concluded that the State’s implementation of its cost settlement authority for those years constituted its

¹⁹ The Board stated that it gave no deference to Colorado’s interpretation of the 1997 State plan amendment as permitting the 2005 revisions to the SBHS rate methodology because the interpretation was, in the Board’s view, inconsistent with Colorado’s “prior interpretation” of the amendment “as evidenced by its letter of September 10, 1999 and its prior administrative practice” of applying the formula specified in that letter. DAB No. 2057, at 10.

historical interpretation of SPA 00-01. Because the disputed rate recalculations do not violate the express terms of SPA 00-01 and are consistent with the State's reasonable interpretation of that amendment, they cannot fairly be characterized as a "material change" in State law, organization, policy, or program operation.

Conclusion

For the reasons discussed above, the Board reverses CMS's November 21, 2012 disallowance of \$22,806,230 for the period October 1, 2001 through September 30, 2003.

_____/s/
Judith A. Ballard

_____/s/
Leslie A. Sussan

_____/s/
Stephen M. Godek
Presiding Board Member