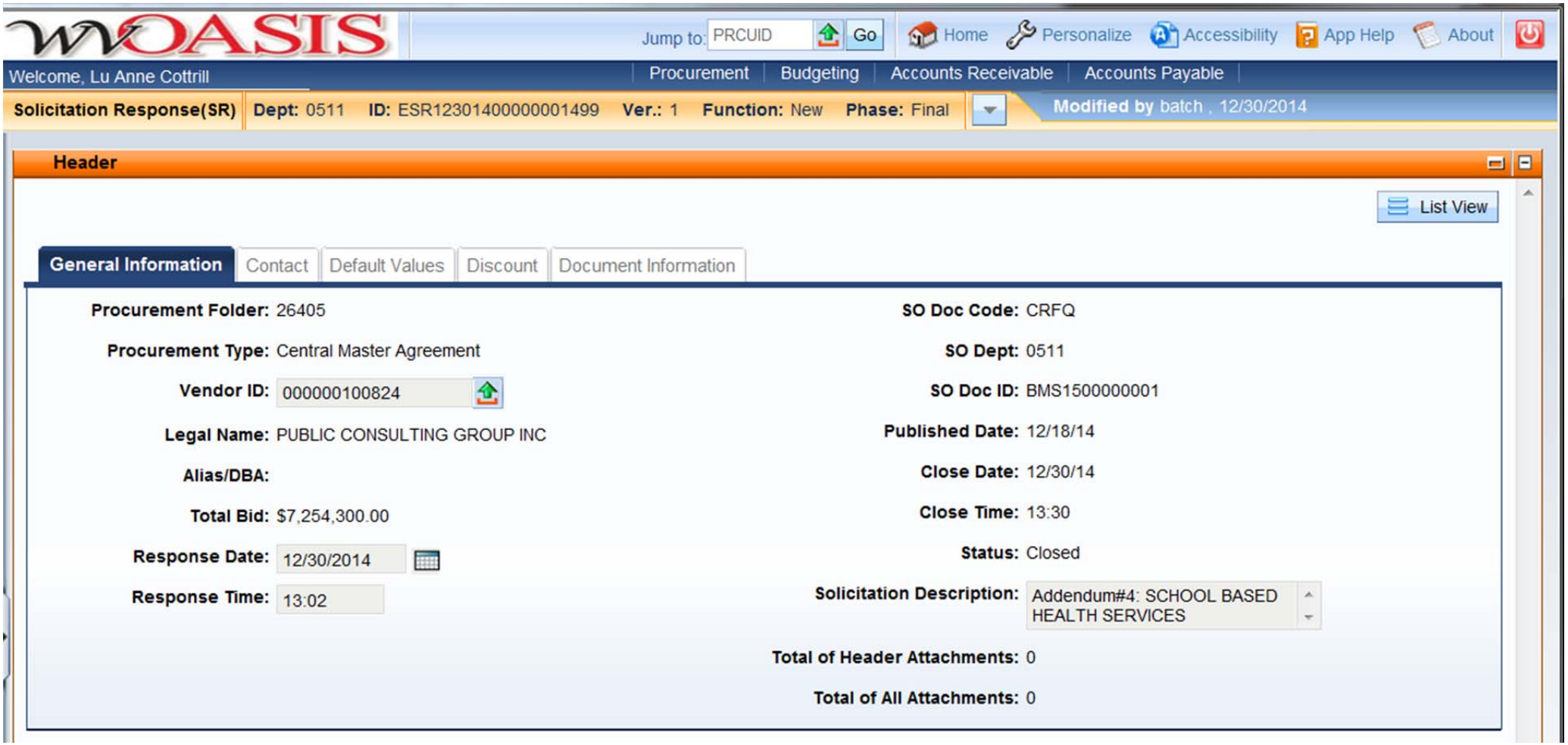
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency of the bid-opening process, this documentation submitted online is publicly posted by the West Virginia Purchasing Division at ***WVPurchasing.gov*** with any other vendor responses to this solicitation submitted to the Purchasing Division in hard copy format.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About
Welcome, Lu Anne Cottrill
Procurement
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Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR12301400000001499 Ver.: 1 Function: New Phase: Final
Modified by batch , 12/30/2014
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Document Information
Procurement Folder: 26405
Procurement Type: Central Master Agreement
Vendor ID: 000000100824
Legal Name: PUBLIC CONSULTING GROUP INC
Alias/DBA:
Total Bid: $7,254,300.00
Response Date: 12/30/2014
Response Time: 13:02
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS1500000001
Published Date: 12/18/14
Close Date: 12/30/14
Close Time: 13:30
Status: Closed
Solicitation Description: Addendum#4: SCHOOL BASED HEALTH SERVICES
Total of Header Attachments: 0
Total of All Attachments: 0

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State Of West Virginia
Solicitation Response

Proc Folder : 26405

Solicitation Description : Addendum#4: SCHOOL BASED HEALTH SERVICES

Proc Type : Central Master Agreement

Date issued	Solicitation Closes	Solicitation No	Version
	2014-12-30 13:30:00	SR 0511 ESR12301400000001499	1

VENDOR

000000100824

PUBLIC CONSULTING GROUP INC

FOR INFORMATION CONTACT THE BUYER

Robert Kilpatrick

(304) 558-0067
robert.p.kilpatrick@wv.gov

Signature X **FEIN #** **DATE**

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Base Year One - Mandatory Services				$0.00

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Mandatory Services: Section 4.1.1 through 4.1.8, all-inclusive annual cost

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Optional Year 2 - Mandatory Services				$0.00

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Mandatory Services for Optional/Renewal Year 2: Section 4.1.1 through 4.1.8, all-inclusive annual cost

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Optional Year 3 - Mandatory Services				$0.00

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Mandatory Services for Optional/Renewal Year 3: Section 4.1.1 through 4.1.8, all-inclusive annual cost

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Optional Year 4 - Mandatory Services				$0.00

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Mandatory Services for Optional/Renewal Year 4: Section 4.1.1 through 4.1.8, all-inclusive annual cost

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Additional Services Hourly Rate - Base Year One	5000.00000	HOUR	$210.00	

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Additional Services Hourly Rate for Base Year One: All inclusive hourly rate to perform Additional Services per Specifications Section 4.1.9 and per an approved Statement of Work (SOW).

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Additional Services Hourly Rate - Base Year Two	5000.00000	HOUR	$215.00	

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Additional Services Hourly Rate for Base Year Two: All inclusive hourly rate to perform Additional Services per Specifications Section 4.1.9 and per an approved Statement of Work (SOW).

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Additional Services Hourly Rate - Base Year Three	5000.00000	HOUR	$220.00	

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Additional Services Hourly Rate for Base Year Three: All inclusive hourly rate to perform Additional Services per Specifications Section 4.1.9 and per an approved Statement of Work (SOW).

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
8	Additional Services Hourly Rate - Base Year Four	5000.00000	HOUR	$225.00	

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Additional Services Hourly Rate for Base Year Four: All inclusive hourly rate to perform Additional Services per Specifications Section 4.1.9 and per an approved Statement of Work (SOW).

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
9	Prior Year Settlement	11.00000	EA	$9,500.00	

Comm Code	Manufacturer	Specification	Model #
85100000			

Extended Description : Prior Year Settlement - Lump Sum, All-inclusive Cost per Settlement Year, per Specification Section 4.1.10

PCG | Health

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State of West Virginia
Department of Health and Human Resources
Bureau of Medical Services

School Based Health Services

December 30, 2014

RFP #:CRFQ 0511 BMS 1500000001

Mr. Robert Kilpatrick
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

PUBLIC CONSULTING GROUP

148 State Street, Tenth Floor, Boston, Massachusetts 02109
Tel. (617) 426-2026, Fax. (617) 426-4632
www.publicconsultinggroup.com

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1. Transmittal Letter

PUBLIC CONSULTING GROUP

Public Focus. Proven Results.™

December 23, 2014

Mr. Robert Kilpatrick
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Dear Mr. Kilpatrick:

Public Consulting Group, Inc. (PCG) is pleased to submit this proposal in response to ***RFQ No. CRFQ 0511 BMS 1500000001, School Based Health Services (SBHS)***, requested by the Department of Health and Human Services, Bureau for Medical Services (DHHR/BMS).

PCG is pleased to have been your SBHS vendor since 2011 and we very much would like to continue our relationship with you. Working together, and partnering with the local education agencies (LEAs), PCG and DHHR/BMS have achieved great success in working together to establish a reformed SBHS program over the last three years. In fact, DHHR/BMS, with the assistance of PCG, recently received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Medicaid cost settlement and reconciliation process and program retroactive back to July, 1, 2014. The proposal that accompanies this transmittal letter builds on our current record.

As you know, the PCG model that we have used in West Virginia, as well as numerous other states, features:

- Efficient and robust school based health service claiming tools,
- High level customer service to facilitate compliant participation, and,
- Seasoned professionals with the necessary expertise and state-specific experience to assist with program implementation and on-going operations.

Our model ensures that states like West Virginia capture funding for the health-related services provided to students with disabilities while maintaining regulatory compliance and sufficient financial reporting.

As you read our proposal, we ask that you consider the following points:

- ✓ **PCG is the market leader in providing Medicaid school based consulting services.** PCG has provided school based Medicaid claiming services since the firm's inception 28 years ago. This is an unequaled track record of experience. PCG understands the funding and operational challenges faced by local and state governments, and the need to maximize all allowable revenue sources possible, particular in the schools arena. Our team brings years of experience working with state Medicaid agencies and state Education agencies to implement and manage successful school based Medicaid billing and reimbursement programs to capture funding for the health related services provided to students with disabilities. ***No vendor in the country has more experience operating school-based programs on a statewide basis.*** PCG supports Medicaid school based service claiming operations on a statewide basis in more than ten states, thus meeting and exceeding the minimum requirements. Furthermore, no vendor has generated more allowable revenue than PCG. PCG has generated more than $3 billion dollars in Medicaid reimbursements and currently has school based Medicaid engagements with more than 2,000 state departments and school districts.

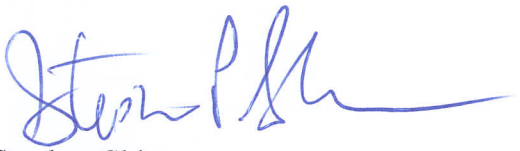
- ✓ **PCG has extensive experience implementing a random moment time study sampling process.** Leveraging our web-based solution, PCG's random moment sampling process is comprehensive with regards to meeting all CMS and DHHR/BMS policies and easy for school districts to navigate. PCG minimizes the administrative burden on school districts through the use of our robust and automated RMTS system. PCG us the industry leader in providing RMTS services to support school based services claiming.

- ✓ **PCG deploys a uniform process to leverage financial data collected from school districts for administrative claiming purposes for Medicaid cost report and cost settlement purposes.** We have designed a nationally recognized cost reporting software solution to streamline and simplify Medicaid administrative claiming and Medicaid cost reporting for school districts. Our robust, web-based application with data entry edits and built-in quality review protocols ensures the accuracy and integrity of school district cost report submissions. The system is successfully used for cost collection, cost reporting, and/or settlement across the country to streamline data collection, monitor school district submissions, and perform desk review functions.

- ✓ **PCG has had a presence in West Virginia for over a decade and a proven track record as the Department's SBHS program.** Our experience includes numerous revenue enhancement and cost savings engagements on behalf of DHHR/BMS, including a behavioral health system redesign, a comprehensive assessment and implementation plan maximizing federal recoveries for the State, as well as the current operation of the School Based Health Services program. Furthermore, we have been successfully operating and working with DHHR/BMS to design, develop, and now implement a transformed SBHS program.

In closing, PCG's extensive Medicaid school based health services experience and proven track record will ensure the continued success of your programs into the future. After all, in addition to West Virginia, PCG is currently serving the following 12 states with statewide Medicaid school health service initiatives: Arizona, Colorado, Delaware, Georgia, Indiana, Kansas, Kentucky, Michigan, New Jersey, New York, Pennsylvania, and Wisconsin. We will continue to build on our track record by assuring the identification and implementation of program improvements.

Sincerely,



Stephen Skinner
Principal
Public Consulting Group, Inc.

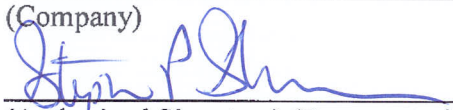
2. Certification and Signature Page

CERTIFICATIONAND SIGNATURE PAGE

By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Public Consulting Group, Inc

(Company)



Stephen P. Skinner, Principal

(Authorized Signature) (Representative Name, Title)

617-426-2026 (Phone) 617-426-4632 (Fax) December 18th, 2014

(Phone Number) (Fax Number) (Date)

3. Qualifications

PUBLIC CONSULTING GROUP

III. Qualifications

In this section, we first provide a brief overview of Public Consulting Group, Inc. (PCG) in order to provide DHHR with a description of the firm's background and provide the larger context in which to place our school-based services. Next, we inventory a number of achievements and accomplishments, drawn from our national experience including West Virginia, which set PCG's qualifications to assist West Virginia with its School Based Health Services (SBHS) reimbursement strategies for Medicaid services far apart and above those of other vendors. We next document those achievements and accomplishments within a story that is organized according to the RFP requirements defined at *Section 3.1* (statewide school-based administrative claiming, cost reporting and RMTS), *Section 3.2* (three CMS-approved statewide programs) and *Section 3.3* (Medicaid reimbursement strategies).

Company Background

Public Consulting Group (PCG) is a privately held management consulting firm that specializes in serving the public sector. Established in 1986, PCG provides a wide range of management consulting services to state, local, and municipal agencies, including financial and regulatory consulting, revenue enhancement, operations, strategy, technology, and business process consulting. Founded in the Commonwealth of Massachusetts, we currently operate 47 offices across the United States, with international offices in Montreal, Canada; Lodz and Warsaw, Poland; and London, England. Additional general information on our firm can be accessed through our firm's website, which is located at: www.publicconsultinggroup.com.

Because PCG has dedicated itself almost exclusively to the public sector for 28 years, the firm has developed a deep understanding of the legal and regulatory requirements and fiscal constraints that often dictate a public agency's ability to meet the needs of the populations it serves. We have helped numerous public sector organizations to maximize resources, make better management decisions using performance measurement techniques, improve business processes, address federal and state compliance, and improve client outcomes. Many of PCG's more than 1,600 employees have extensive experience and subject matter knowledge in a range of government-related topics, from Medicaid and Medicare policy, Temporary Assistance for Needy Families (TANF), Welfare to Work (WtW), and SNAP, to special education, literacy and learning, and school-based health finance. PCG has current contracts in 49 of the 50 states, as outlined in the map below.

PCG has five designated practice areas, as described below, each of which have a proven track record of achieving desired results for clients. The firm often combines resources from two or

professional affiliations that are regularly called upon to meet any critical client need. Numerous staff are members of Healthcare Financial Management Association (HFMA) and still others are Certified Project Management Professional (PMP), as designated by the Project Management Institute. Additionally, PCG is committed to a diverse workforce that reflects our customers and their clients: nearly 20 percent of staff classifies themselves in a minority category and over 50 percent are female.

For the purpose of this engagement, PCG will leverage the expertise of two practice areas, Health and Education, to ensure that the firm successfully meets all of the requirements outlined in the RFQ.

PCG Health

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PCG Health helps state, local, and municipal health agencies respond optimally to reform initiatives, restructure service delivery systems to best respond to regulatory change, maximize program revenue, and achieve regulatory compliance. The practice area uses industry best practices to help organizations deliver quality services with constrained resources, offering expertise in strategy and finance, revenue cycle management, and payer support services. PCG Health is a recognized leader in health care reform and health benefits exchange consulting; a leading provider of revenue enhancement, rate setting, and cost settlement services; and a leading provider of health care expense management services. ***Currently, PCG Health has projects in 31 states and the District of Columbia and serves 37 state Medicaid agencies.***

PCG Education

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Combining management consulting experience with significant K-12 educational domain expertise, PCG Education offers consulting solutions that help schools, school districts, and state education agencies/ministries of education promote student success, improve programs and processes, and optimize financial resources. Together with its state-of-the-art technology, PCG Education's consulting approach helps educators make effective decisions by transforming data into meaningful results. PCG Education has current projects in 32 states and five Canadian provinces and serves 13 of the 25 largest U.S. school districts. Its special education management systems – including EasyIEP™, GoalView™, and iep.online™ – serve more than 1.4 million special education students across the U.S. ***PCG Education has also recovered more than $3.0 billion in federal Medicaid funds for school district clients, more than any other vendor.***

PCG Human Services

Public Focus. Proven Results.™

PCG Human Services helps state, county, and municipal human services agencies to achieve their performance goals in order to better serve populations in need. The practice area's seasoned professionals offer proven solutions to help agencies design programs, services, and systems; increase program revenue; cut costs; and improve compliance with state and federal regulations. PCG Human Services is a proven national leader in management consulting services for state Temporary Assistance for Needy Families (TANF) programs, state child welfare and juvenile justice programs, workforce investment boards, Social Security advocacy management, early childhood programs, and state Supplemental Nutrition Assistance Programs (SNAP).

PCG Technology Consulting

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PCG Technology Consulting (PCG TC) offers a full spectrum of IT services to help government agencies at every stage of the IT life cycle. Services include IV&V and Quality Assurance, enterprise and technical architecture assessments, project management, procurement support, requirements definition, feasibility studies, application development, management consulting, disaster recovery and business continuity planning, security assessments, and infrastructure support services. The addition of these IT services puts PCG in a unique position to be able to offer clients specialized IT services with the various programmatic perspectives provided by our other practice areas.

PCG Public Partnerships

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PCG Public Partnerships (PPL) was initially formed to provide assistance to the Robert Wood Johnson Foundation's national pilot demonstrations in self-determination. The practice area offers a rich array of fiscal intermediary and related administrative services to public agencies and participants seeking to develop participant-directed services and supports. Currently, PPL assists more than 32,000 consumers in 20 states, and serves:

- Persons with development disabilities
- Children identified with serious emotional disturbances and their families
- Adults and elders at risk of nursing home placement

- Children and adults in protective services

We believe no firm in the country, other than Public Consulting Group, can meet all the vendor qualification standards you have defined in this *Qualifications* section. On the pages that follow, we confirm how PCG arrives at that conclusion.

Achievements and Accomplishments Relevant to Qualifications

For the last 3½ years, since July 1, 2011, PCG has been successfully performing most of the 1school-based service claiming services outlined within this task order on behalf of DHHR/BMS. During that time, PCG has successfully assisted in DHHR/BMS transforming the school-based cost settlement and MAC programs to achieve a number of significant programmatic milestones and enhancements (which are described in our response to *RFP Requirement 3.1* below).

Our ability to perform at such a high level as your partner in West Virginia is attributable to our commitment to this work. PCG has had a particular focus on successfully providing school-based Medicaid services and solutions for more than 20 years. PCG completed its first cost settlement project for Massachusetts in 1990, signed its first school district contract with Boston Public Schools in 1993, and performed its first cost-based rate setting project for Texas school districts in 2003.

Today no other vendor can provide DHHR/BMS with the breadth and depth of knowledge in *both Medicaid and Education, including special education*, as PCG can. Why? Because PCG is working with 25 Medicaid agencies on school services. We understand better than most that a successful cost settlement program must address the issues that are most important to the Medicaid agency: program design, CMS/OIG compliance, and federal reporting. And because PCG also currently operates in 4,300 school districts and understands that a successful cost settlement program must address the issues that are most important to school districts: minimize administrative burden, improve reimbursements for services, and provide training.

No vendor in the country has more experience operating school-based, Medicaid-related programs -- and no vendor has generated more revenue for such programs than PCG.

- PCG is currently serving the following 12 states with statewide Medicaid initiatives: Arizona, Colorado, Delaware, Georgia, Indiana, Kansas, Michigan, New Jersey, New York, Pennsylvania, West Virginia, and Wisconsin.

- PCG has worked hand-in-hand with four states – Arizona, Georgia, Wisconsin, and West Virginia – to revise their state plans to support a cost-based reimbursement methodology,

negotiate changes with CMS, and eventually obtain CMS approval of the State Plan Amendment. Additionally, PCG is currently working with the states of New York and New Jersey to obtain CMS approval of their revised state plans.

- PCG has conducted several Medicaid school-based services projects subject to federal oversight including Colorado, Kansas, New Jersey, and West Virginia.

- PCG is continually strategizing about how to transform the way states utilize reimbursement methodologies to incentivize the type of service utilization that will result in high-quality care, while also containing cost growth. We have completed upper payment limited-related rate-setting for Alabama, Massachusetts, Texas, Wisconsin, West Virginia, and the District of Columbia. States like Connecticut, Massachusetts, Missouri, North Carolina, New Hampshire, and Wisconsin have taken advantage of our deep knowledge of Medicaid Disproportionate Share Hospital programs. And, we have performed rate-setting projects of all types and sizes in more than a dozen states in the past decade alone.

In total, PCG has generated more than $3 billion in Medicaid reimbursement and currently has school-based Medicaid engagements with more than 4,300 state departments and school districts.

In the sections that follow below, PCG documents these statements in detail.

3.1 Minimum of three years of professional experience in administering and performing School-Based Administrative Claiming, Cost Reporting and RMTS on a statewide basis. The Vendor shall respond with a detailed description of its experience that should include specific examples of prior work performed for other states that list the following information: name of clients served, narrative description of the type of services provided, dates, quality results (CMS acceptance or denial of any aspect of the work product, description of the results of audits of the work product and whether it met or did not meet CMS requirements and applicable regulations). The vendor may include in its proposal any other information that demonstrated the Vendor's relevant experience. The proposal should correlate the components described above with the requirements of this RFP to indicate specifically which have been successfully achieved (e.g. implemented on time, methodologies and supporting materials accepted by CMS, post- implementation successful operations and acceptance by CMS of resulting claims).

Relevant Medicaid School Based Services Experience

PCG has provided school-based Medicaid claiming services since the mid 1990's and offers an unparalleled track record of experience and excellence. PCG understands the funding and operational challenges faced by local and state governments, as well as the need to maximize all allowable revenue sources possible. Our team brings years of experience in working with state Medicaid agencies and state Education agencies to implement and manage successful school-based Medicaid billing and reimbursement programs to capture funding for the health-related services provided to students with disabilities.

No vendor in the country has more experience operating school-based, Medicaid-related programs—and no vendor has generated more revenue for such programs than PCG. ***PCG has generated more than $3 billion in Medicaid reimbursements and currently has school-based Medicaid engagements with more than 4,300 state departments and school districts.***

PCG has deep experience with meeting all the requirements set forth in the mandatory contract services requirements and deliverables outlined in the RFQ for this engagement. PCG is currently serving the following 12 states with statewide Medicaid initiatives: **Arizona, Colorado, Delaware, Georgia, Indiana, Kansas, Michigan, New Jersey, New York, Pennsylvania, West Virginia, and Wisconsin.**

PCG has a proven track record of providing innovative and compliant claiming solutions for optimizing reimbursement through the Medicaid Program. Our industry experience with state agencies will continue to allow DHHR/BMS and West Virginia schools to optimize reimbursement, maintain Medicaid and IDEA compliance, and streamline the administrative burden of coordinating special education programs. The chart below highlights PCG's national Medicaid reimbursement experience. PCG's extensive work with direct services billing and administrative programs for state agencies across the country will provide DHHR/BMS with the advantage of a partnership that is nationally recognized for its excellent outcomes.

State	Fee-For-Service	Administrative Claiming	Total
Alaska	$300,000	n/a	$300,000
Arizona	$91,913,870	$14,768,728	$106,682,598
California	$7,050,834	$1,223,030	$8,273,864
Colorado	$69,995,184	$4,654,220	$74,649,404
District of Columbia	$120,000,000	n/a	$120,000,000
Florida	$15,598,545	n/a	$15,598,545
Georgia	$18,228,582	$12,263,909	$30,492,492
Illinois**	$440,652,200	$229,501,740	$734,546,358*
Indiana	$58,703	$2,556,208	$2,614,281
Kansas	$22,693,600	$36,016,117	$58,709,717
Kentucky	n/a	$25,608,777	$25,608,777
Massachusetts	$322,789,049	$156,376,691	$479,165,740
Michigan	$535,690,720	$216,578,031	$752,268,751
Minnesota	$93,747,472	n/a	$93,747,472
Missouri	$2,000,000	$3,000,000	$5,000,000
Nevada	$19,396,103	n/a	$19,396,103
New Jersey	$351,804,607	$29,573,445	$381,378,052
North Carolina	$64,135,125	$46,343,849	$110,478,974
Pennsylvania	$4,600,000	$8,800,000	13,400,000
Ohio	$1,353,323	n/a	$1,353,323
Rhode Island	$35,257,070	n/a	$35,257,070
South Carolina	$13,112,293	n/a	$13,112,293
Tennessee	$600,000	n/a	$600,00
Texas	$45,437,953	n/a	$$45,473,953
Virginia	$2,905,035	n/a	$2,905,035
Vermont	$1,200,000	n/a	$1,200,000
West Virginia	$40,000,000	n/a	$40,000,000
Wisconsin	$155,000,000	$59,000,000	$214,000,000
Total	$2,475,520,268	$846,264,745	$3,321,785,013

* includes $64M in TANF and SNAP reimbursement

Furthermore, PCG has had a specific focus on implementing school-based service MAC and cost settlement reimbursement methodologies on behalf of Medicaid programs. Our experience is comprehensive in that we have successfully assisted Medicaid programs with all facets of a MAC and Medicaid cost settlement reimbursement methodology. Our services include:

RMTS & MAC Services

- ✓ Developing a proprietary, web-based RMTS system to streamline and automate the administration and management of time study processes;
- ✓ Assisting states with the design and development of MAC programs, including the drafting of approved implementation plans;
- ✓ Establishing a centralized coding methodology to ensure compliant coding;
- ✓ Deploying our proprietary PCG Claiming System to facilitate a streamlined process to collect financial data for the calculation of MAC reimbursement;

- ✓ Performing comprehensive MAC training to school districts on how to properly complete RMTS and financial reporting requirements;
- ✓ Providing ongoing school district support throughout the MAC preparation and submission process;
- ✓ Performing comprehensive quality control measures on all submitted information; and
- ✓ Generating quarterly MAC claims to determine each district's net claim amount.

Medicaid Cost Reporting Services

- ✓ Performing Medicaid cost settlement feasibility analyses to determine project revenue potential;
- ✓ Leading program design efforts, which includes drafting Medicaid state plan amendments, Medicaid cost reporting forms, and cost report instructions;
- ✓ Assisting with obtaining Centers for Medicare and Medicaid Services (CMS) program approval;
- ✓ Deploying our proprietary PCG Claiming System to facilitate a streamlined process to collect Medicaid cost reports;
- ✓ Performing comprehensive Medicaid cost report training to school districts on how to properly complete Medicaid cost reports;
- ✓ Providing ongoing school district support throughout the Medicaid cost report preparation and submission process;
- ✓ Completing desk reviews and validation of Medicaid cost reports submitted for cost settlement; and
- ✓ Processing Medicaid cost settlement amounts.

To substantiate our experience, the table on the following page lists PCG's state-level contracts as they relate to this engagement.

PCG School Based Health Services Qualifications						
PCG Project	**Length of Engagement**	**State Plan Development (3.1a and 4.19b)**	**CPE Reimbursement Methodology Implementation**	**Random Moment Time Study (RMTS) Implementation**	**Cost Reporting & Rate Setting**	**Medicaid Administrative Claiming (MAC)**
AZ AHCCCS MAC and Cost Settlement Program	February 2009 - Present	✓	✓	✓	✓	✓
CO DHCPF: School Health Services Medicaid Reimbursement Design and Development	July 2006 - Present	✓	✓	✓	✓	✓
DC DHCF: School Based Health Services Medicaid Reimbursement Design and Operations	January 2009 - September 2011	✓	✓	✓	✓	
GA DCH: Medicaid Administrative Claiming for Education and Medicaid Cost Settlement Services	July 2010 - Present	✓	✓	✓	✓	✓
IN DOE: Indiana Statewide Electronic IEP System	September 2010 - Present	✓	✓	✓	✓	✓
KS KHDE: Statewide School District Administrative Claim Program and Cost Settlement	February 2006 - Present	✓	✓	✓	✓	✓
KY DOE: Statewide School Based Administrative Claiming (SBAC) Program	July 2010 -June 2014	✓	✓	✓	✓	✓
LA DHH: Revenue Maximization Consulting Services	May 2003 – June 2007	✓	✓	✓	✓	
MI DCH: Reimbursement Methodology for School Based Health Services	May 2005 – June 2006	✓			✓	
MI DCH: Statewide Contract for the Administrative Outreach Program	October 2003 – Present			✓	✓	✓
NC Public Schools: Local Education Authority School Based Services Program	1995 - Present			✓	✓	✓
NJ Treasury: Statewide Special Education Medicaid Initiative & MAC and Cost Reimbursement	February 2005 - Present	✓	✓	✓	✓	✓
NY DOH: Cost Study and Implementation of Revised Reimbursement Methodology for the Preschool/School Supportive Health Services Program (SSHSP)	January 2012 – Present	✓	✓	✓	✓	
PA DPW and PDE: School Based Access Program (SBAP) FFS, Medicaid Administrative Claiming, and Cost Settlement Services	July 2013 – Present	✓	✓	✓	✓	✓
SD DSS: School Based Medicaid Administrative Claiming	July 2013 -Present	✓	✓	✓	✓	✓
WI DHS: School Based Services and Medicaid Cost Reports	November 2008 - Present	✓	✓	✓	✓	
WV BMS: Statewide School Health Service Medicaid Cost Reimbursement	July 2011 - Present	✓	✓	✓	✓	✓

PCG has developed a number of special techniques that apply to its cost settlement approach; these have been gained only through years of actual experience *across both program areas.* No other vendor can provide DHHR/BMS with the breadth and depth of knowledge in *both Medicaid and Education, including special education*, as PCG can. The techniques PCG will employ to implement a Medicaid cost settlement process are borne of more than two decades years working with Medicaid and Education agencies on this type of scope of work. PCG completed its first cost settlement project for Massachusetts in 1990, signed its first school district contract with Boston Public Schools in 1993, and performed its first cost-based rate setting project for Texas school districts in 2003.

Today PCG is working with 25 Medicaid agencies on school services – PCG understands that a successful cost settlement program must address the issues that are most important to the Medicaid agency: program design, CMS/OIG compliance, and federal reporting. PCG also currently operates in 4,300 school districts and understands that a successful cost settlement program must address the issues that are most important to school districts: minimize administrative burden, improve reimbursements for services, and provide training.

West Virginia-Specific Experience

Since July 1, 2011, PCG has been successfully performing most of the school-based service claiming services outlined within this task order on behalf of DHHR/BMS. Since that time, PCG has successfully assisted in DHHR/BMS transforming the school-based cost settlement and MAC programs to achieve a number of significant programmatic milestones and enhancements.

Thus far during the term of this contract, PCG has successfully:

- ✓ Implemented an automated time study process through PCG's proprietary Random Moment Time Study (RMTS) web-based system, EasyRMTS™.

- ✓ Implemented a centralized coding methodolgy for the RMTS, thereby reducing programmatic risk and enhancing program compliance. PCG is responsible for the coding of all moments, ensuring consistency, and reducing programmatic risk in case of a CMS or Office of Inspector General (OIG) audit.

- ✓ Automated a financial collection process for Medicaid administrative claiming program and Medicaid cost reporting through the deployment of PCG's web-based Medicaid Cost Reporting and Claiming System (MCRCS), and most recently through our new and improved PCG Claiming System.

- ✓ Restructured Medicaid State Plan to enhance Medicaid cost settlement reimbursement.
  - PCG authored a Medicaid state plan to change cost allocation processes and introduce a new direct medical service, Targeted Case Management.

- ✓ Implemented Medicaid cost reporting and MAC training and support functions.
  - PCG developed training programs surrounding both the MAC and Medicaid cost settlement programs.
  - PCG developed a toll-free hotline and email support to provide school districts with the necessary guidance and support to successfully and compliantly participate in the school-based service program.

- ✓ Supported DHHR/BMS throughout a comprehensive CMS program audit.

Given PCG's past accomplishments and successful partnership with DHHR/BMS, we are confident that we can continue to meet and exceed West Virginia's expectations in performing the services outlined in this RFQ.

CMS Audits of Medicaid School Based Services Projects

PCG has conducted numerous Medicaid school-based services projects, detailed throughout this proposal, which were subject to federal oversight. In addition, PCG has conducted multiple revenue enhancement projects subject to federal scrutiny. The following list identifies and describes the projects in which PCG claiming services for clients have been subject to an OIG audit. PCG works with states throughout the audit process, providing audit assistance. In many of these cases, the audit results have been overturned or settled, and have had minimal financial impact on the state.

1. **West Virginia #1: Retroactive Claims:** The OIG issued its initial retroactive costs findings in late January, 2009. The findings were limited to the narrow issue of whether $4.1 million in retroactive costs claimed for a six-month period in 2001 were truly "retroactive" claims, as opposed to "new" claims. The OIG accepted a portion of the claim as retroactive, but recommended a disallowance of $2.3 million of the remainder. In April 2009, the OIG rejected the West Virginia objections and recommended to CMS that the disallowance be upheld. West Virginia appealed the decision to the HHS Department Appeals Board (DAB) and argued that the adjustment in prior year costs was permissible and not a basis for a disallowance. The decision was affirmed by the federal district court in September 2012.

2. **West Virginia #2: Operating and Indirect Cost Calculation:** The OIG also investigated the West Virginia rate calculations from 2001-2003 and the application of older claiming

methodology used by WV. In April 2011, the OIG issued a final report and recommended a $23 million disallowance. The report was submitted for final review to CMS, which adopted the OIG report in November 2012 and ordered a $23 million disallowance. In December 2013, the Department Appeals Board overturned the disallowance and confirmed that the interpretation advanced by West Virginia was a reasonable exercise of the state's rate calculation authority under the state Medicaid plan.

3. **Colorado: Cost reporting:** In 2009, the OIG initiated a review of Colorado school billing projects. The OIG's focus was the sufficiency of service documentation maintained by the school districts and the accuracy of documentation for the cost-based billing system that had been previously approved by CMS. The OIG issued a draft report in August 2011 that found errors in the random moment time study methodology in 2% of the 9,000 samples reviewed. The state objected to the recommended OIG disallowance and contended that the miscoding error rate was negligible and did not warrant a disallowance. PCG's involvement only pertained to the RMTS and PCG was not responsible for any of the fee for service billing issues. In addition, our client found no deficiencies in the RMTS processes completed by PCG.

4. **New Jersey Medicaid School-Based Health Claiming:**

A. 2003-2006 Audit Period

Two OIG reports related to the Medicaid school-based health claiming program in New Jersey have been issued. The first, issued in April 2010, addressed deficiencies in claims filed by Maximus, PCG's predecessor, during the period of 2001 to 2004. The primary causes of the deficiencies were documentation errors, for which the OIG has directed a return of funds to the federal government. Although Maximus and the school districts were responsible for most of the claims, PCG inadvertently submitted a small portion of the disallowed claims retroactively during the transition period from the Maximus contract, at the beginning of the PCG contract in 2005, as resubmitted claims.

B. 2005-2007 Audit Period

A second, more recent OIG report related to claiming during the 2005 to 2007 audit period. The OIG issued a final report in September 2010, concluding that New Jersey was improperly reimbursed $5.6 million for claims during that period. The disallowance was derived from a small sample that found deficiencies in credentialing and service documentation. The report was critical of school-based health providers who did not comply with federal guidance and of officials for not adequately monitoring the claims and providing sufficient documentation. Following its review of the OIG report and

recommendations, CMS concurred with most of the disallowances. Following a further appeal by New Jersey to the Department Appeal Board, New Jersey and CMS in April 2013 reached a settlement agreement, to the satisfaction of the state, which finally resolved both of the long-standing audits.

3.2 Implemented a CMS approved program in a minimum of three State Medicaid programs. The proposal should include documentation of CMS approval of implemented programs, and references from three states for verification.

PCG has unparalleled and extensive Medicaid experience within school-based service programs, having successfully designed, developed, and implemented the services described in this engagement in more than a dozen states.

In the following four states – Arizona, Georgia, Wisconsin, and West Virginia – PCG has worked hand in hand with states to revise their state plans to support a cost-based reimbursement methodology, negotiate changes with CMS, and eventually obtain CMS approval of the State Plan Amendment. Additionally, PCG is currently working with the states of New York and New Jersey to obtain CMS approval of their revised state plans.

Per the RFQ, PCG has provided three client references for Arizona, Georgia, and Wisconsin that we encourage DHHR/BMS to contact to verify our performance and success in implementing CMS approved school based health service programs. Following the reference information, we have provided the approved state plan amendments for the these states, as well as for West Virginia, thus providing DHHR/BMS with the necessary documentation to substantiate our qualifications.

Arizona

Client	**Arizona Health Care Cost Containment System (AHCCCS)**
Project	**AHCCCS MAC and Cost Settlement Program**
Timeframe	2009 – Present
Description of Services Performed	PCG was selected as the third-party administrator for the Medicaid Direct Service and Administrative Claiming programs for over 150 Local Education Agencies (LEAs) that participate or would like to participate in Medicaid School-Based Claiming. PCG performs the following services on behalf of AHCCCS: • Program promotion, education, training, and technical assistance to LEAs (Local Education Agency) • Develop Administrative Claiming Methodology and Manual • Administer quarterly random moment time study • Implement the Medicaid Cost Reporting and Claiming System, a web-based cost reporting system used for collecting quarterly and annual expenditures • Prepare and submit financial Medicaid administrative claims • Develop and implement a comprehensive School Based Claiming Program Handbook • Process and pre-adjudicate direct service claims from all LEAs prior to submission for approval to AHCCCS • Disburse Medicaid interim direct service and administrative claim payments to LEAs • Conduct Annual LEA Compliance reviews • Provide in-depth training during regional information sessions and webinars • Provide ongoing compliance and program support to AHCCCS In 2011, PCG supported AHCCCS in the development of a cost-based reimbursement methodology and state plan amendment. The change from a Fee for Service mode to cost-based reimbursement was requested by CMS. PCG assisted the Agency in negotiations with CMS, identified and implemented program and operational changes needed, and conducted state-wide trainings and communications regarding the changes to the program.
Client Contact	Melinda Hollinshead 701 E. Jefferson MD-8500 Phoenix, AZ 85034 (602) 417-4746 Melinda.hollinshead@azahcccs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DEC 16 2011

Thomas J. Betlach, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

Enclosed is an approved copy of Arizona State Plan Amendment (SPA) No. 11-007. This SPA revises the reimbursement methodology for school-based claiming to provide a more comprehensive, cost-based reconciliation process to enhance the identification of actual costs and improve the accuracy of claims reimbursement in compliance with Section 1905(a)(5) of the Social Security Act; the Individuals with Disabilities Education Act (IDEA) Part B; 42 CFR 440.60, 42 CFR 42 CFR 440.110, 42 CFR 440.130, 42 CFR 440.167, and 42 CFR 441.62. This SPA also revises the school-based services pages in Attachment 3.1-A Limitations to clarify the descriptions of services and provider qualifications for the therapies, nursing, transportation, and behavioral health services provided under this benefit.

The effective date of this SPA is July 1, 2011 as requested. Enclosed is the following approved State Plan page to be incorporated within your approved State Plan:

- Attachment 3.1-A Limitations, pages 3-5(b)
- Attachment 4.19-B, pages 10-16

If you have any questions, please have your staff contact Cheryl Young at (415) 744-3598 or at cheryl.young@cms.hhs.gov.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Jessica Schubel
HeeYoung Ansell

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 11- 007	2. STATE Arizona
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2011	

5. TYPE OF PLAN MATERIAL *(Check One)*:

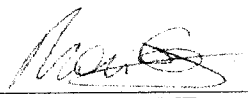
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

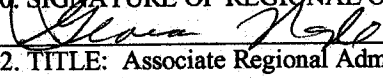
6. FEDERAL STATUTE/REGULATION CITATION: Sec. 1905(a)(5) of the Social Security Act IDEA Part B 42 CFR § 440.60, 42 CFR § 440.110, 42 CFR § 440.130 42 CFR § 440.167 42 CFR § 441.62 Arizona Administrative Code R9-22-213	7. FEDERAL BUDGET IMPACT: FFY 2012: $5,003,324.95* FFY 2013: $5,003,324.95*
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1A Limitations pp. 3-5a-5b Attachment 4.19B, pp. 10-16	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A pp. 3-5 Attachment 4.19B, pp. 10,11

10. SUBJECT OF AMENDMENT:
Revises methodology for reimbursing Medicaid services provided by a participating Local Education Agency (LEA)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Monica Coury	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: June 20, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 20, 2011	18. DATE APPROVED: DEC 16 2011
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2011	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Gloria Nagle	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:
Pen & Ink changes to Boxes 7 & 8 made by State on 9/27/11 per CMS request.

vi. Eye exams and prescriptive lenses.

vii. Outpatient occupational and speech therapy. The duration, scope and frequency of each therapeutic modality shall be authorized as part of a treatment plan.

viii. The AHCCCS Administration, in accordance with the signed Intergovernmental Agreement between AHCCCS and the Arizona Department of Education, shall provide direct Medicaid reimbursement for certain Medicaid services provided by a participating Local Education Agency (LEA). A LEA is a public school district, a charter school not sponsored by a school district and the Arizona School for the Deaf and Blind. The medically necessary Medicaid services must be provided by a qualified school-based provider to students who are Title XIX eligible and eligible for school health and school-based services pursuant to the Individuals with Disabilities Education Act (IDEA), Part B. Providers shall be registered in accordance with AHCCCS policies. AHCCCS health plans and ALTCS program contractors will continue to provide medically necessary services to all Title XIX members enrolled with AHCCCS and a health plan or program contractor.

Reimbursable Services

Medicaid covered services will only be reimbursable for persons who are at least three years of age and less than 21 years of age and who have been determined eligible for Title XIX and IDEA, Part B services. Those members age 21 to age 22 who are eligible for Medicaid services provided under IDEA are covered within the same service limitations that apply to all eligible AHCCCS members age 21 and older. The following Medicaid services will be eligible for reimbursement:

A. Assessment, Diagnosis and Evaluation services.

Services:
Assessment, diagnosis and evaluation services, including testing, are services used to determine IDEA eligibility or to obtain information on the individual for purposes of identifying or modifying the health related services on the IEP. These services are not covered if they are performed for educational purposes (e.g. academic testing or are provided to an individual who as the result of the assessment and evaluation is determined not to be eligible under IDEA).

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.130. Services must be performed by qualified AHCCCS providers as set forth in this State Plan Amendment and who provide these services as part of their respective area of practice (e.g., psychologists providing a behavioral health evaluation).

B. Outpatient Speech, Occupational and Physical Therapy Services.

Services:
Outpatient speech, occupational and physical therapy services include individual and group therapy (e.g., neuromuscular re-education, wheel chair management, aural rehabilitation). Speech services are those necessary to diagnose, evaluate, treat, and provide for amelioration activities for specific speech, language and hearing disorders. Occupational therapy services are those services provided to improve, develop, or restore functions impaired or lost through illness, injury, or deprivation. Physical therapy services are those services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.110. Services may be provided by:

- State-licensed occupational therapists and certified occupational therapy assistants;
- State-licensed physical therapists and licensed physical therapy assistants;

State-licensed speech-language pathologists and licensed speech-language pathologist assistants. In addition, persons who have a Provisional Speech and Language Impaired Certificate must be supervised by an American Speech and Language Hearing Association-certified pathologist

All licensed occupational therapy assistants, physical therapy assistants, and speech-language pathologist assistants must operate "under the direction of" or "supervised by" a state-licensed therapist/pathologist in accordance with Arizona Administrative Code or Arizona Revised Statute as identified:

- Licensed Speech Therapy Assistants, A.R.S. 36-1940.04
- Licensed Occupational Therapy Assistants, A.A.C. R4-43-401
- Licensed Physical Therapy Assistants, A.A.C. R4-24-303

C. Nursing Services.

Services:
Nursing services include direct nursing care services as identified in the IEP such as catheterization, suctioning and medication management. Services considered observational or stand-by in nature are not covered. In addition, nurses can provide personal care services. Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Personal care services include assistance to eligible members in meeting essential personal physical needs, such as dressing, toileting, transfers, positioning, mobility, grooming, use of assistive device, and feeding.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.60 and 42 CFR § 440.167. Services may be provided by:

- State-licensed Registered Nurses; or
- Licensed Practical Nurses

D. Transportation Services.

Services:
Transportation services will be provided in compliance with CMS policy and will be paid for when an eligible member's need for special transportation is specified in the IEP. These services will only be reimbursed for the same day in which the member obtains another Medicaid covered reimbursable service through the LEA. Transportation services are not covered if the eligible member is transported on a school bus with other non-IDEA eligible students who are attending school.

Providers: These services are covered in accordance with the requirements in 42 CFR § 441.62. LEAs serve as transportation providers and must meet the same provider qualifications as all AHCCCS Medicaid transportation providers (e.g., proof of insurance and appropriate transportation license of drivers).

E. Behavioral Health Services.

Services:
Medically necessary services are health care, diagnostic services, treatments and other measures to identify, correct or ameliorate any disability and/or chronic condition. Services are provided as health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical and mental health problems. Behavioral health services include individual/group therapy and counseling.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.60 and 42 CFR § 440.50. Services may be provided by:

- State licensed psychiatrists;
- State licensed Ph.D. psychologists;
- Arizona Board of Behavioral Health Examiners licensed marriage and family therapists (LMFT), licensed professional counselors (LPC), and licensed clinical social workers (LCSW); all of whom must have current licensure by the Arizona Board of Behavioral Health Examiners as a LCSW, LPC or LMFT, or if outside Arizona, be licensed or certified to practice independently by the local regulatory authority.

F. Personal Care Services.

Services:
Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Personal care services include assistance to eligible members in meeting essential personal physical needs, such as dressing, toileting, transfers, positioning, mobility, grooming, use of assistive device, and feeding.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.167. All licensed and qualified personnel may authorize personal care services contained within the IEP/service plan. Services may be provided by:

- School-based health attendants certified by the LEA in general care, to include first aid and CPR.

G. Audiological Services.

Services:
Audiology services include testing and evaluating hearing-impaired children that may or may not be improved by medication or surgical treatment. In accordance with Arizona Administrative Code, R9-22-213, annual audiological assessments will be provided to students with disabilities. These billable assessments are separate from the screenings offered to the general student population.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.110 (c)(3). Services may be provided by:

- Arizona Department of Health Services (ADHS)-Licensed Audiologist.

4.c. Family planning services and supplies for individuals of child-bearing age.

Family planning services include:

i. contraceptive counseling, medication, supplies and associated medical and laboratory exams;

ii. sterilizations; and,

iii. natural family planning education or referral.

Family planning services do not include abortion or abortion counseling.

5 b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

The following dental services are not covered under this benefit and are not considered physician services: dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

DIRECT MEDICAID REIMBURSEMENT FOR CERTAIN MEDICAID SERVICES PROVIDED BY A PARTICIPATING LOCAL EDUCATION AGENCY (LEA)

A. Reimbursement Methodology for Early and Periodic Screening, Diagnostic, and Treatment Services.

The following describes the reimbursement methodology for services provided pursuant to Attachment 3.1.A, 4.b.ix., Limitations under EPSDT services.

Direct Medicaid reimbursement for certain medical services provided by Local Education Agencies (LEAs) is based on a cost based methodology. Medicaid Services 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) and as defined in Attachment 3.1.A, 4.b.ix. These services include:

1. Speech-Language Pathology Services
2. Occupational Therapy Services
3. Physical Therapy Services
4. Nursing Services
5. Specialized Transportation Services
6. Behavioral Health Services
7. Personal Care Services
8. Audiological Services

All reimbursable services must meet the service definitions as described in the provider registration criteria and based on the definition and scope contained in the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Fee-For-Service Provider Manual. These services must be:

- Identified in an Individualized Education Plan (IEP) as a necessary service or provided as part of an assessment, diagnostic or evaluation service in order to determine a student's eligibility under IDEA, Part B. If the person is not eligible for IDEA, Part B, the assessment, diagnostic or evaluation service will not be eligible for direct reimbursement.
- Provided by a provider who is employed or under contract with the LEA. The provider must meet all applicable federal and state licensure and certification requirements and have a valid AHCCCS Provider Registration Number on the date the service was rendered.
- Provided on school grounds unless the IEP specifies that an eligible student should be educated in an alternative setting and/or the IEP service cannot appropriately be provided at the school.
- Ordered or prescribed by a qualified provider in accordance with the AHCCCS AMPM.
- Considered medically necessary as defined in the AMPM, notated in the IEP as medically necessary and supported with medical records that can be audited to establish medical necessity.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

A LEA who requests reimbursement for approved Medicaid services must be registered with AHCCCS as a group billing entity and enter into a participation agreement with the Third Party Administrator under contract with AHCCCS. As an AHCCCS registered provider, the LEA is required to comply with all applicable federal and state laws and regulations.

AHCCCS shall process claims based on Medicaid eligibility and for approved services provided on the claimed date of service. If CMS or AHCCCS disallow a claim that was already reimbursed, the LEA or former LEA shall refund the overpayment to AHCCCS. The refund may be accomplished through transfer of funds to AHCCCS, or the amount in dispute shall be withheld from a future payment to the LEA.

Audit Functions
The Third Party Administrator, with AHCCCS approval, shall establish an annual compliance audit review program to ensure that LEAs are appropriately billing for medically necessary Medicaid services for Medicaid eligible students.

B. Direct Medical Payment Methodology

Effective with dates of services on or after July 1, 2011, LEAs will be reimbursed on a cost basis consistent with a certified public expenditure (CPE) reimbursement methodology. On an interim basis, LEAs will be reimbursed an amount equal to the rate contained in the AHCCCS fee-for-service schedule for covered school-based Medicaid services or, the amount billed by the provider to a LEA, whichever is less. However, the interim payment remitted to the LEA will only be the federal share of the interim rate. Current AHCCCS rates are effective on or after the date indicated in Attachment 4.19B, p. 2, Annual Update Section. All rates are published on the Agency's website at : http://www.azahcccs.gov/commercial/ProviderBilling/rates/Physicianrates/Physicianrates.aspx.

On an annual basis a LEA-specific cost reconciliation and cost settlement for all over and under payments will be processed. Under payments will be paid to the LEAs by AHCCCS. Overpayments will be paid to AHCCCS by the LEAs. This may be accomplished through transfer of funds to AHCCCS, or the amount in dispute shall be withheld from a future payment to the LEA.

C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1) Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:
   a. School Health Services cost reports received from LEAs;

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

b. Arizona Department of Education (ADE) Unrestricted Indirect Cost Rate (UICR);
c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services-Covered as IEP Services) and Activity Code 10 (General Administration); and
d. LEA specific Medicaid IEP Ratios.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1) Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include the total compensation (i.e., salaries and benefits and contract compensation) to the direct services personnel for the provision of health services listed in the description of covered Medicaid services delivered by LEAs in Attachment 3.1.A, 4.b.ix.

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

Total direct costs for direct medical services are reduced on the cost report by any federal funding source resulting in direct costs net of federal funds.

These direct costs net of federal funds are accumulated on the annual cost report, resulting in total direct costs net of federal funds. The cost report contains the scope of cost and methods of cost allocation that have been approved by CMS. The source of this financial data will be audited Chart of Account records kept at the LEA level. The Chart of Accounts is uniform throughout the state of Arizona. Costs will be reported on an accrual basis.

a) Direct Medical Services, Non-federal cost pool for allowable providers consists of:
   i. Salaries;
   ii. Benefits;
   iii. Medically-related purchased services; and
   iv. Medically-related supplies and materials

2) Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its net direct costs. Arizona LEAs use predetermined fixed rates for indirect costs. The Arizona Department of Education is the cognizant agency for LEAs, and approves unrestricted indirect cost rates for LEAs

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

for the United States Department of Education. Only Medicaid-allowable costs are certified by LEAs. LEAs are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate:

The Arizona Department of Education UICR is the unrestricted indirect cost rate calculated by the Arizona Department of Education. Apply the Arizona Department of Education Cognizant Agency Unrestricted Indirect Cost Rate (UICR) applicable for dates of service in the rate year.

3) Net direct costs and indirect costs are combined.

4) Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results will be applied to the direct medical services cost pool. The direct medical services costs and their respective time study results must be aligned to ensure proper cost allocation. The use of the CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per OMB Circular A-87 cost allocation requirements.

5) Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the Medicaid IEP ratio. The numerator will be the number of Medicaid IEP students in the LEA who have an IEP and received direct medical services as outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP who received direct medical services as outlined in their IEP. Direct medical services are those services billable under the FFS program as defined Attachment 3.1.A, 4.b.ix of the Medicaid State Plan.

E. Specialized Transportation Services Payment Methodology

Effective dates of service on or after July 1, 2011, providers will be paid on a cost basis. Providers will be reimbursed interim rates for Specialized Transportation services at the lesser of the provider's billed charges or the statewide enterprise interim rate. However, the interim payment remitted to the LEA will only be the federal share of the interim rate. Current AHCCCS rates are effective on or after the date indicated in Attachment 4.19B, p. 2, Annual Update Section. All rates are published on the Agency's website at:
http://www.azahcccs.gov/commercial/ProviderBilling/rates/Physicianrates/Physicianrates.aspx.
On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1) Special transportation is specifically listed in the IEP as a required service;
2) The child requires transportation in a vehicle adapted to serve the needs of an individual with a disability;
3) A medical service is provided on the day that specialized transportation is billed; and
4) Transportation services are billed in units of 1-way trips. The LEA must be registered with AHCCCS as a transportation provider and must meet the same provider qualifications as all AHCCCS Medicaid transportation providers (e.g., proof of insurance and licensure of school bus drivers).

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

1) Bus Drivers
2) Mechanics
3) Substitute Drivers
4) Fuel
5) Repairs & Maintenance
6) Rentals
7) Contract Use Cost (Insurance Costs)
8) Depreciation

The source of these costs will be audited Chart of Accounts data kept at the LEA level. The Chart of Accounts is uniform throughout the State of Arizona. Costs will be reported on an accrual basis. Special education transportation costs include those for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities.

When LEAs are not able to discretely identify the special education transportation cost from the general education transportation costs, a special education transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the LEA. This rate will be based on the total number of specialized vehicles divided by the total number of vehicles used by LEAs to provide transportation to students. The result of this rate (%) multiplied by LEA Transportation Cost for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of Medicaid Eligible special education IEP One Way Trips divided by the total number of special education IEP One Way Trips. The numerator data will be provided from bus logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed under the Medicaid program.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

F. Certification of Funds Process

Each LEA will submit a Certification of Public Expenditure Form on an annual basis. On an annual basis, each LEA will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures. Providers are permitted to certify only Medicaid-allowable costs and are not permitted to certify any indirect costs outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

For Medicaid services provided in schools during the state fiscal year (July 1 through June 30) each provider must complete an annual cost report. The cost report is due five months after the fiscal year end. At the discretion of AHCCCS, providers may be granted extensions up to three months.

The primary purposes of the LEA provider's cost report are to:

1) Document the LEA provider's total CMS approved Medicaid-allowable costs of delivering Medicaid coverable services using a CMS approved cost allocation methodology.
2) Reconcile the annual interim payments to the LEA provider's total CMS approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Medicaid Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual Cost Reports are subject to desk review by AHCCCS or its designee.

H. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Medicaid Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS approved cost allocation methodology procedures, or its CMS-approved RMTS for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or RMTS for

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. The Cost Settlement Process

For services delivered for a period covering July 1st, through June 30th, the annual Medicaid Cost Report is due on or before December 1st of the preceding fiscal year (5 months after the fiscal year end), with the cost reconciliation and settlement processes completed within twenty-four months of the cost report due date.

If the LEA provider's interim payments exceed the actual, certified costs for the delivery of school based health services to Medicaid clients, the LEA provider will return an amount equal to the overpayment. AHCCCS will submit the federal share of the overpayment to CMS in the federal fiscal quarter following receipt of payment from the provider. AHCCCS will comply with the Medicaid overpayment rules and will be accountable for returning the Federal share within the time limits, even if the LEA has not returned the overpayment to the State within this timeframe.

If the LEA provider's actual, certified costs exceed the interim payments, AHCCCS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

AHCCCS shall issue a notice of settlement that denotes the amount due to or from the LEA.

Georgia

Client	**Georgia Department of Community Health (DCH)**
Project	**Medicaid Administrative Claiming for Education and Medicaid Cost Settlement Services**
Timeframe	2010 - Present
Description of Services Performed	The Georgia Department of Community Health (DCH) contracted with PCG to design, develop, and implement a Medicaid administrative claiming program and a Medicaid cost settlement process for the Children's Intervention School Services (CISS) program. The primary objectives of this project are to: • Implement a program to reimburse Local Education Agencies (LEA) for Medicaid outreach and administration activities; • Implement a reimbursement methodology for the CISS program that ensures LEAs are paid on actual and allowable costs; and • Ensure both programs are compliant with CMS policies. PCG's key achievements under for this engagement include: • Developed an implementation plan for CMS review and approval to implement the ACE program; • Implemented and operate a CMS approved statewide RMTS for over 150 LEAs; • Developed Medicaid State Plan Amendment to change reimbursement methodology to a cost based reimbursement methodology; • Developed cost reporting instructions and training materials; • Implemented a training program for LEAs on ACE and cost reporting requirements; and • Developed a web based financial collection and Medicaid cost reporting application.
Client Contact	Ben Appling 2 Peachtree Street, NW, 38th Floor Atlanta, Georgia 30303 404-463-4012 bappling@dch.ga.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

August 11, 2011

Mr. Jerry Dubberly, Chief
Medicaid Division
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

RE: Georgia Title XIX State Plan Amendment, Transmittal #10-014

Dear Mr. Dubberly:

We have reviewed the proposed amendment to the Georgia Medicaid State Plan that was submitted under transmittal number 10-014 and received in the Regional Office on October 1, 2010.

Effective October 1, 2010, this amendment modifies the reimbursement methodology for school-based services (SBS). Georgia will now reimburse schools cost. CMS has reviewed and approved the State's cost identification process and cost report. This plan also removed the Medical Transportation component of SBS.

This program is funded by certified public expenditures.

The corresponding coverage review resulted in the State making clarifying changes to the description of community rehabilitative services. In addition, clarification was made that transportation is no longer a covered service under the Children's Intervention School Services Program. As a result, attachment 3.1-A, page 9b3 was deleted from the current State Plan, regarding Specialized Transportation Services.

Based on the information provided, we are now ready to approve Georgia Medicaid State Plan Amendment 10-014. This SPA was approved on August 10, 2011 and the effective date of this amendment is October 1, 2010. We are enclosing the approved form HCFA-179 and plan pages.

If you have any questions or need any further assistance, please contact Yvette Moore at (404) 562-7327.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-014

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.206

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $3,125,000
FFY 2012 $8,100,000

"8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pp. 13.1 – 13.6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, pg. 13.1

10. SUBJECT OF AMENDMENT:
CISS AND CIS PAYMENT METHODOLOGY

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: JERRY DUBBERLY

14. TITLE: CHIEF, Medicaid Division

15. DATE SUBMITTED:

16. RETURN TO:

Department of Community Health
Medicaid Division
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
10/01/10

18. DATE APPROVED:
08/10/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following changes to item 8 as authorized by State Agency on email dated 08/04/11:

Block# 8 changed to read: Attachment 3.1-A pages 1i, 1k, 1l, 1m, 1n and 9b3; Attachment 4.19B pages 13.1 thru 13.8.

Block#9 changed to read: Attachment 3.1-A pages 1i, 1k, 1l, 1m, 1n and 9b3; Attachment 4.19B pages 13.1 thru 13.8 New

4.b. EPSDT Related Rehabilitative Services – Community Based (continued)

- Speech-Language Pathology Services
  Speech-language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications are in accordance with 42 CFR 440.110, and adhere to the scope of practice as defined by the applicable state licensure board.

- Nutrition Services
  Nutritional assessment, management and counseling to children on special diets due to genetic metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biomedical and clinical variables and anthropometric measurements). Development of a written plan to address the feeding deficiencies of the child that is incorporated into the child's treatment program. Providers' qualifications must meet the applicable State licensure and certification requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

Limitations

Provider enrollment is open only to individual practitioners, who are licensed in Georgia under their respective licensing board such as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed counselor, licensed dietician or speech language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable, providers will be in compliance with federal requirements defined in 42 CFR 440.110 or 42 CFR 440.60(a).

Prior Approval

Services which exceed the limitations as listed in the policies and procedures manual must be approved prior to service delivery.

4.b. Rehabilitative Services (continued).

EPSDT-Related Rehabilitative Services – School Based Health Services

The Children's Intervention School Services (CISS) program includes covered rehabilitative services provided by or through Georgia State Department of Education (DOE) or a Local Education Agency (LEA) to children with or suspected of having disabilities, who attend public school in Georgia, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible special education students (from ages 0-20). These services are provided pursuant to an Individual Education Program (IEP) or Individual Family Service Plan (IFSP).

The services are defined as follows:

- Audiology Services

  Audiological testing, fitting and evaluation for hearing aids. Providers' qualifications must meet the requirements of federal regulations 42 CFR 440.110.

- Nursing Services

  Skilled intermittent nursing care to administer medications or treatments. Skilled intermittent nursing care is provided by licensed nurses (registered or licensed practical nurses under the supervision of a registered nurse, licensed in the state of Georgia). Providers' qualifications are in accordance with the requirements of federal regulation 42 CFR 440.60(a).

- Occupational Therapy Services
  Occupational therapy evaluation of gross and fine motor development and clinical services related to activities of daily living and adaptive equipment needs. Providers' qualifications must meet the federal requirements in 42 CFR 440.110.

- Physical Therapy Services
  Physical therapy evaluation of neuromotor development and clinical services related to improvement of gait, balance, and coordination skills. Providers' qualifications must meet the federal requirements in 42 CFR 440.110.

4.b. Rehabilitative Services

EPSDT-Related Rehabilitative Services – School Based Health Services (continued)

- Counseling Services
  Evaluation to determine the nature of barriers (social, mental, cognitive, emotional, behavioral problems, etc.) to effective treatment that impacts the child's medical condition, physical disability and/or developmental delay and the child's family. The provision of counseling and intervention services to resolve those barriers relating to effective treatment of the child's medical condition and which threaten the health status of the child. Services are provided by Licensed Clinical Social Workers in accordance with the standards of applicable state licensure requirements, must hold a current license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

- Speech-Language Pathology Services
  Speech language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications must meet the federal requirements in 42 CFR 440.110 and adhere to the scope of practice as defined by the applicable board.

- Nutrition Services
  Nutritional assessment, management and counseling to children on special diets due to genetic, metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any other teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biochemical and clinical variables and anthropometrics measurements). Development of a written plan to address the feeding deficiencies of the child. Providers' qualifications must meet the applicable state licensure requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

4.b. Rehabilitative Services

EPSDT-Related Rehabilitative Services – School Based Health Services (continued)

Requirements

The medically necessary rehabilitative services must be documented in the Individual Education Program (IEP) or Individualized Family Service Plan (IFSP).

Limitations

The covered services are available only to the EPSDT eligible recipients (ages 0-20) with a written service plan (an IEP/IFSP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law.

Provider enrollment is only open to individual practitioners who are licensed in Georgia under their respective licensing board as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed dietician, or speech-language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable providers will be in compliance with federal requirements defined in 42 CFR 440.110 or 42 CFR 440.60(a).

4.b. Rehabilitative Services

EPSDT-Related Rehabilitative Services – School Based Health Services (continued)

Limitations (continued)

The following services are not provided through the EPSDT-Related Rehabilitative Services-School Based program:

1. Services provided to children who do not have a written service plan.

2. Services provided in excess of those indicated in the written service plan.

3. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.

4. Services of an experimental or research nature (investigational) which are not generally recognized by professions, the Food and Drug Administration, the U.S. Public Health Service, Medicare, and the Department's contracted Peer Review Organization, as universally accepted treatment.

5. Services in excess of those deemed medically necessary by the Department, its agents, or the federal government, or for services not directly related to the child's diagnosis, symptoms, or medical history.

6. Failed appointments or attempts to provide a home visit when the child is not home.

7. Services normally provided free of charge to all patients.

8. Services provided by individuals other than the enrolled licensed practitioner of the healing arts.

9. Services provided for temporary disabilities, which would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

V. Therapy Services (Includes Physical, Occupational and Speech Pathology Therapists), Nursing Services, Counseling Services, Nutrition Services and Audiology Services.

1. Reimbursement to Therapy Service providers under the Children's Intervention Services program is based on the lower of submitted charges or the state's maximum allowable rate as listed in the Policies and Procedures for Children's Intervention Services. The state's maximum allowable rate will be based on 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of therapy services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Georgia Department of Community Health Policies and Procedures Manual for Children's Intervention Services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

2. Reimbursement to Local Education Agencies (LEAs) under the Children's Intervention School Services program is based on a cost based methodology. Medicaid Services provided under the Children's Intervention School Services program 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) and defined in Attachment 3.1-A pages 1k – 1o:

    1. Audiology Services Performed by Licensed Audiologists
    2. Counseling Services Performed by Licensed Clinical Social Workers
    3. Nursing Services Performed by Licensed Registered Professional Nurses
    4. Nutrition Services Performed by Licensed Dieticians
    5. Occupational Therapy Services Performed by Licensed Occupational Therapists and/or Occupational Therapist Assistants
    6. Physical Therapy Services Performed by Licensed Physical Therapists and/or Physical Therapists Assistants
    7. Speech-Language Pathology Services Performed by Licensed Speech Language Pathologists and/or Masters Level Speech Language Pathologists (with professional certificate from GA Department of Education or Certificate of Clinical Competence in Speech Language Pathology by ASHA

    On an interim basis, providers will be paid the lower of submitted charges or the state's maximum allowable rate as outlined within Section 4.19B, page 13.1 of the Medicaid state plan and as listed in the Policies and Procedures Manual for Children's Intervention School Services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

A. Direct Medical Services Payment Methodology

Beginning with the cost reporting period October 1, 2010, the Department of Community Health (DCH) will begin using a cost based methodology for all LEAs. This methodology will consist of a Cost Report, a CMS approved Random Moment Time Study (RMTS) methodology, Cost Reconciliation, and Cost Settlement. If payments exceed Medicaid allowable costs, the excess will be recouped. If payments are less than Medicaid allowable costs, DCH will pay the federal share of the difference to the LEA and submit claims to CMS for reimbursement of that payment.

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

1) Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include the total compensation (i.e., salaries and benefits and contract compensation) to the direct services personnel identified in Section 2 on page 13.2 of Attachment 4.19-B of the Medicaid State Plan for the provision of health services listed in the description of covered Medicaid services delivered by LEAs in pages 1k – 1o of Attachment 3.1-A of the Medicaid State Plan and Section 900 of the GA DCH **Policies and Procedures for Children's Intervention School Services**.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as direct materials, supplies and equipment. Only those direct materials, supplies, and equipment that have been identified and included in the CMS approved DCH Medicaid cost reporting instructions and the Policies and Procedures for Children's Intervention School Services are Medicaid allowable costs and can be included on the Medicaid cost report.

Total direct costs for direct medical services are reduced on the cost report by any federal funding source resulting in direct costs net of federal funds.

These direct costs net of federal funds are accumulated on the annual cost report, resulting in total direct costs net of federal funds. The cost report contains the scope of cost and methods of cost allocation that have been approved by CMS.

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

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 relative to claiming for administrative costs.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

3) Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its net direct costs. Georgia LEAs use predetermined fixed rates for indirect costs. The Georgia 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 Medicaid-allowable costs are certified by LEAs. LEAs are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

4) Net direct costs and indirect costs are combined.

5) Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the IEP ratio. The numerator will be the number of Medicaid IEP students in the LEA who have an IEP and received direct medical services as outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP who received direct medical services as outlined in their IEP. Direct medical services are those services billable under the FFS program as defined in pages 1k through 1o of Attachment 3.1-A and in the Policies and Procedures for Children's Intervention School Services.

B. Certification of Funds Process

Each LEA will submit Certification of Public Expenditure Forms to DCH on an annual basis. On an annual basis, each LEA will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

C. Annual Cost Report Process

For Medicaid services provided in schools during the state fiscal year (July 1 through June 30), each provider must complete an annual cost report. The cost report is due on or before September 15 following the reporting period each year. At the discretion of DCH, providers may be granted extensions up to three months.

Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by DCH or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Department, may be subject to penalties for non-compliance.

The primary purposes of the LEA provider's cost report are to:

1) Document the LEA provider's total CMS approved Medicaid-allowable costs of delivering Medicaid coverable services using a CMS approved cost allocation methodology.

2) Reconcile the annual interim payments to the LEA provider's total CMS approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Children's Intervention School Services (CISS) Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual CISS Cost Reports are subject to desk review by DCH or its designee.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

D. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual CISS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS approved cost allocation methodology procedures, or its CMS-approved RMTS for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or RMTS for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

E. The Cost Settlement Process

EXAMPLE: For services delivered for the initial period covering October 1, 2010, through June 30, 2011, the annual CISS Cost Report is due on or before September 15, 2011, with the cost reconciliation and settlement processes completed no later than September 15, 2013.

For all future years starting July 1, 2011, services delivered during the period covering July 1 through June 30, the annual CISS Cost Report is due on or before September 15 of that same year (i.e. services delivered July 1, 2011 through June 30, 2012 would be included in the annual cost report due September 15, 2012), with the cost reconciliation and settlement processes completed within twenty-four months of the cost report due date.

If the LEA provider's interim payments exceed the actual, certified costs for the delivery of school based health services to Medicaid clients, the LEA provider will return an amount equal to the overpayment. DCH will submit the federal share of the overpayment to CMS in the federal fiscal quarter following receipt of payment from the provider.

If the LEA provider's actual, certified costs exceed the interim payments, DCH will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

Wisconsin

Client	**Wisconsin Department of Human Services**
Project	**School Based Services and Medicaid Cost Reports**
Timeframe	2008- Present
Description of Services Performed	PCG has been hired by the Department of Health Services to maximize Medicaid reimbursement to school districts under the School-Based Services Program (SBS). PCG has assumed the operation of administering the SBS program, including the completion of the financial and operational activities. PCG's key achievements under this contract include: • $59 Million in Medicaid Administrative Claim Reimbursement to date • $155 Million in SBS Cost Settlement Reimbursement to date • Worked with DCH to successfully lift a $75 Million CMS deferral • Worked with the Department of Health Services (DHS) to develop and implement a statewide methodology for Medicaid Administrative Claiming (MAC) and School Based Services (SBS) cost reporting allowing school districts and DHS to gain reimbursement for administrative and direct service costs; • Implemented the Medicaid Cost Reporting and Claiming System (MCRCS), a web-based cost reporting system used for collecting quarterly and annual expenditures; • Trained district program staff throughout the state, via live and web-based training sessions, on program changes and enhancements including identification of eligible staff and collection of the required quarterly and annual financial data used for administrative claiming and cost settlement; • Coordinated time study moment sampling, compliance, coding and calculation of time study results; • Calculated, prepared, and submitted quarterly Medicaid administrative claims for all participating districts; • Completed Medicaid cost report audits and desk reviews; • Calculated annual Medicaid cost settlements; • Developed and implemented a comprehensive MAC and SBS Program Handbook and LEA MCRCS guide; • Conducted Annual LEA Compliance reviews; • Conducted annual information sessions for school business officials at WASBO • Developed auditor's guide for WI based auditors of school Medicaid programs and provided trainings throughout the state • Provided ongoing compliance and program support to DHS
Client Contact	Steve Milioto 1 West Wilson Street, Room 265 Madison, WI 53703 (608) 266-3802 Steve.Milioto@dhs.wisconsin.gov

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

OCT 31 2011

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #09-013	- School Based Services -- Effective July 1, 2009

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-013

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE
07/01/2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(4)(B) of the SSA and
42 CFR Part 441 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 ..... $0K
b. FFY 2010 ..... $0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 16.d. and 16.e-1 to 16.e-4. .....
(a) Attachment 3.1-A, Supplement 1, pages 1.d - 1.e
(b) Attachment 3.1-B, Supplement 1, pages 1.d - 1.e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
(a) - same
(b) - same

10. SUBJECT OF AMENDMENT:

School-based services.

11. GOVERNOR'S REVIEW *(Check One)*:
☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kristen Willing

13. TYPED NAME:
Jason Helgerson

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
June 29, 2009

16. RETURN TO:
Jason Helgerson
State Medicaid Director
Division of Health Care Access and Accountability
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06-29-09

18. DATE APPROVED:
OCT 31 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
Verlon Johnson

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associated Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

The state has established controls to prevent duplicate services and assure continuity of care when a child receives services from both SBS providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers. HMOs are responsible for managing medical services for recipients receiving SBS when recipients are in HMOs. SBS and HMO providers are required to sign Memorandums of Understanding setting standards, policies and procedures to avoid duplication of services and coordinate care. Where a child served within the Medicaid fee-for-service system receives SBS, SBS providers are required to document the regular contracts between schools and community providers as appropriate for each child but at least annually. Medicaid monitors service coordination and ensures duplicate services are not provided through prior authorization.

Physical therapy can be provided by physical therapy assistants, aides, and interns under the direction of a qualified physical therapist. Occupational therapy can be provided by occupational therapy assistants, aides, and interns under the direction of a qualified occupational therapist. Speech language services for individuals with speech, hearing, and language disorders can be provided by a speech language pathology assistant and interns under the direction of a qualified speech language pathologist. Audiology can be provided by audiology assistants, interns, and interpreters under the direction of a qualified audiologist.

When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

The state has established controls to prevent duplicate services and assure continuity of care when a child receives services from both SBS providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers. HMOs are responsible for managing medical services for recipients receiving SBS when recipients are in HMOs. SBS and HMO providers are required to sign Memorandums of Understanding setting standards, policies and procedures to avoid duplication of services and coordinate care. Where a child served within the Medicaid fee-for-service system receives SBS, SBS providers are required to document the regular contracts between schools and community providers as appropriate for each child but at least annually. Medicaid monitors service coordination and ensures duplicate services are not provided through prior authorization.

Physical therapy can be provided by physical therapy assistants, aides, and interns under the direction of a qualified physical therapist. Occupational therapy can be provided by occupational therapy assistants, aides, and interns under the direction of a qualified occupational therapist. Speech language services for individuals with speech, hearing, and language disorders can be provided by a speech language pathology assistant and interns under the direction of a qualified speech language pathologist. Audiology can be provided by audiology assistants, interns, and interpreters under the direction of a qualified audiologist.

When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

28. Medicaid-Covered Services included in Medicaid-eligible Students' Individualized Education Programs (IEPs) Provided by Local Education Agencies

Overview

This section of the plan describes how:

1. The Department establishes rates for interim Medicaid reimbursement,
2. Local education agency (LEA) providers identify total allowable Medicaid costs, including the Federal and non-Federal share of expenditures for Medicaid-covered services provided by Medicaid-qualified providers, and
3. The Department reconciles interim payments to total allowed cost as reported on the CMS-approved cost report for direct medical services and specialized transportation services.

This section of the plan applies only to Medicaid-covered services identified in the child's IEP.

Payment for Medicaid-Covered Services included in Medicaid-eligible Students' IEPs Provided by LEAs

LEA providers shall be reimbursed on an interim basis and those payments shall retrospectively be reconciled to cost. Sections A and B cover the interim payment process. Sections C through F cover the process for certification and reconciliation.

Interim Payment for Covered Services Provided by LEA Providers

A. Before July2007, statewide rates will be set on an interim basis using the July 2004 school year's reimbursement updated for inflation at a rate not to exceed the qualified economic offer (QEO) annual rate. In negotiating teacher's contracts, the QEO identifies the minimum offer required by state statute that a local school district may make to avoid binding arbitration on salaries and fringe benefits.

B. After July 2007, LEA specific rates will be set on an interim basis using the LEA's most recent cost information updated to the current year for inflation at a rate not to exceed the QEO.

Identification of Total Allowed Cost

C. LEA providers are required to report annually total allowed cost, including the Federal and non-Federal share of expenditures using a CMS-approved cost report. The following steps will be used to determine cost:

1. The provider will identify cost to be included in the direct medical services cost pool.

   The pool of cost will consist of compensation to practitioners and some additional cost for clinical materials and supplies. Practitioners are licensed medical providers and other qualified providers doing delegated medical tasks under the school-based services section Attachment 3.1-A Supplement 1 and 3.1-B Supplement 1 of the Wisconsin Medicaid State Plan. Only those practitioners who are expected to deliver hands-on services to clients and who are expected to generate a service unit documented through the medical record may be included in the direct services cost pool. The cost of supervisors, program coordinators, special education teachers, administrators and other personnel are included in the cost pool only to the extent they are qualified providers and are expected to provide hands-on care. The LEA will identify individually the practitioners eligible for inclusion in the direct services cost pool. Their compensation data will be reported by individual on the CMS-approved cost report and will reflect offsetting amounts to the extent required by law for all other sources of revenue.

   Only Medicaid qualified providers that are the direct practitioners may be included in the direct services cost pool. The following practitioners must meet the requirements of 42 CFR §440.110 to report their costs: physical therapist, occupational therapist, speech language pathologist, audiologist, and aides providing medical services under the direction of the physical therapist, occupational therapist, speech-language pathologist, and audiologist. Providers of personal care services (also known as attendant care services) must meet the requirements of 42 CFR §440.167 to report their costs. Providers of psychological, counseling, and social work services must meet the requirements of 42 CFR §440.60 or 42 CFR §440.130 to report their costs. Providers of nursing services must meet the requirements of 42 CFR §440.80 and 42 CFR §440.60 or 42 CFR §440.130 (d) to report their costs.

   The Department shall specify the method for identifying these costs using the CMS-approved cost report which employs the use of data derived from the Wisconsin Uniform Financial Accounting Requirements (WUFAR), the Special Education Fiscal Report project codes and other data classifications maintained by the Department of Public Instruction (DPI). These costs shall be identified in compliance with the scope of cost that CMS has approved. DHS allows districts to report compensation data by individual and requires an offsetting adjustment for other revenue sources of revenue. However, DHS assures that the beginning balances tie to the WUFAR.

2. The provider/LEA will identify the amount of cost in the direct services cost pool that may be attributed to the provision of medical services.

   To allocate this cost, the provider multiplies the applicable statewide direct medical services time study percentage by the total direct medical services cost pool amount. The source of the direct medical services time study percentage(s) is the Medicaid Administrative Claiming Time Study for Schools (MACS), which is hereby referred to as the Medicaid Administrative Claiming Time Study for Schools (MACS). The State will supply the time study percentage(s) for direct medical services to providers. The use of this CMS-approved time study assures that no more than 100 percent of time is captured for Medicaid administrative activities and direct medical services and that the time study is statistically valid.

3. The indirect cost is determined through use of the cognizant agency unrestricted indirect cost rate.

   One plus the cognizant agency's unrestricted indirect cost rate assigned to each LEA provider is multiplied by total direct medical services cost as determined under the previous step. If a provider does not have an unrestricted indirect cost rate, the provider does not have any Medicaid-allowable indirect costs associated with direct medical services.

4. Medicaid's portion of total direct services cost will be calculated.

   The results of the previous step are multiplied by the ratio of the total number of IEP students receiving medical services and eligible for Medicaid to the total number of IEP students receiving medical services. One IEP ratio is applied to cost for all practitioner types.

Methodology for Determining Specialized Transportation Cost

D. Transportation is reimbursed only on days when a covered Medicaid service was provided pursuant to an IEP and only if specialized transportation is listed as a service in the IEP.

   Each LEA provider shall report to the Department, on an annual basis, the total allowed costs incurred for Specialized Transportation services using the following steps.

   1. Each LEA will use the CMS-approved cost report to accumulate annually direct cost, which will which will include some personnel cost, contracting cost, and specialized transportation vehicle depreciation, fuel, insurance, and repairs and servicing costs necessary for the provision of school-based IEP transportation services.

   2. Total specialized transportation cost will be determined by multiplying cost identified under Step 1 by one plus the cognizant agency's unrestricted indirect expenditure (cost) rate. If a provider does not have an unrestricted indirect cost rate, the provider does not have any Medicaid-allowable indirect costs associated with specialized transportation services.

   3. Medicaid's portion of specialized transportation cost will be identified by multiplying the results of Step 2 by the ratio of the total number of one-way Medicaid specialized transportation trips pursuant to the IEP over all one-way specialized transportation trips that were provided. The provider is responsible to maintaining one-way trip documentation.

E. Cost Reconciliation and Cost Settlement

Each LEA provider shall be required to do all of the following activities:

1. Each LEA provider must complete annually the CMS-approved cost report for direct medical services and specialized transportation. It will contain total cost incurred to provide Medicaid-covered services to Medicaid beneficiaries, including the Federal and non-Federal share of incurred cost. This cost report will be filed with the Department by March 31, 2007 for 2005-2006 state fiscal year, and the December 31 following the end of the state fiscal year for all future years. The Department will inform the provider of whether there has been an over- or underpayment.

2. The LEA provider is required to keep, maintain and have readily retrievable financial records that fully identify or support its allowable costs eligible for FFP in accordance with Federal and Wisconsin Medicaid records requirements. The LEA provider is also required to participate in statewide time studies conducted by the Department.

3. The LEA provider shall paid at cost. Using the reconciled cost as reported on the CMS-approved cost report, any settlement amount will be identified. LEA providers shall be required to reimburse overpayments of interim payments. If the interim payments underpay an LEA provider, the Department will reimburse the provider up to its cost. All costs will be settled no later than 24 months after the close of the applicable state fiscal year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

4. Special Rule for Cost Reconciliation and Cost Settlement

   Applicable to the Fiscal Year July 2005-June 2006

   For the fiscal year July 2005 - June 2006 only, cost reconciliation will be performed in accordance with a methodology submitted by the Department and approved by CMS.

F. Department's Responsibilities

1. The Department shall assure that it utilizes the CMS-approved scope of cost as reflected in the CMS-approved cost report. For costs that were reported using invoices instead of object codes, the State will assure by 7/1/07 all cost be reported using object codes. The changes in coding will be made in consultation with CMS. The Department shall review future changes in the DPI WUFAR and Special Education Fiscal Report project codes and other data and procedures as they occur to assure that costs included in cost reports are consistent with CMS-approved cost categories. Whenever there is a change in the object codes used in the cost report, the State will seek approval from CMS. This action may or may not result in the required submission of a state plan amendment. The Department shall conduct time studies that meet CMS guidelines for approved Administrative Claiming Time Studies to determine that percentage of time that school staff spend on activities related to the provision of Medicaid allowable medical services.

2. All cost will be settled no later than 24 months after the close of the applicable school year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment separately within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

3. As part of the financial oversight responsibilities, the Department shall develop review procedures for the certified expenditures that include procedures for assessment of risk that expenditures and other information submitted by the LEAs is incorrect. The financial oversight of all LEA providers shall include reviewing the allowable costs in accordance with the scope of cost approved by CMS. The scope of allowed cost approved by CMS was adjusted for services provided on or after 7/1/2009.

   If the Department becomes aware of potential instances of fraud, misuse, or abuse, it shall perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problems.

West Virginia

Client	**West Virginia Department of Health and Human Resources/Bureau of Medical Services**
Project	**School Based Health Services**
Timeframe	2011- Present
Description of Services Performed	PCG is working with the West Virginia Department of Health and Human Services (DHHR) to implement a cost-based settlement process for direct medical service costs related to the School Based Health Services Program. PCG is also implementing a Medicaid Administrative Claiming (MAC) Program to bring additional Federal revenue to the State. Per requirement of the Centers for Medicare and Medicaid Services (CMS), West Virginia engaged PCG to assist the State in drafting State Plan Amendment language to ensure continued compliance with the statutory and regulatory requirements governing SBHS and certified match funding. PCG drafted revisions to sections 3.1.a. and 4.19.b of West Virginia's State Plan and is working with the State to revise that documentation based on CMS feedback. PCG also drafted and submitted to CMS an Implementation Plan outlining the Random Moment Time Study (RMTS) process that will be used in calculating Medicaid reimbursement for direct services and administrative costs, a Cost Reporting Template and Instruction Manual governing the cost reporting process, and training materials related to both. As part of the process, PCG has conducted training sessions with school-based personnel across West Virginia regarding the RMTS process to ensure full understanding of the program and procedures among the staff responsible for participation in the process. PCG will also be training finance and business staff on the cost reporting completion and submission process.
Client Contact	Ms. Tara Buckner Chief Financial Officer Department of Health and Human Resources One Davis Square, Suite 300 Charleston, WV 25501 Phone: (304) 558-9138

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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,

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 1 2 - 0 0 6

2. STATE: West Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE
July 1, 2014

5. TYPE OF PLAN MATERIAL (Check One)

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(5) of the Social Security Act; IDE Act Part B, 42 CFR 440.60, 440.101, 440.130, 440.167 and 441.62.

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $ 50,271,000
b. FFY 2016 $ 52,332,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Addudnum 3.1-A, Pages 1 - 12 (new)
Attachment 4.19-B, Pages 18 - 22B(new) Supplement 2 to Attachment 3.1-A and 3.1-B page 3aa (Revised) Attachment 4.19-B page 6, page 14, and page 15 (revised); Attachment for A, D and E of Supplement 1 to Attachment 3.1-A pages 1-3 (TN-No 90-15)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable).
Attachment 4.19-B, page 6 and page 14 and 15; Attachment for A, D, and E of Supplement 1 to Attachment 3.1-A Page 1-3 (TN-NO. 90-15)

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is 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.

11. GOVERNOR'S REVIEW (Check One):

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Cynthia E. Beane, Acting Commissioner, MSW, LCSW

14. TITLE:
Commissioner

15. DATE SUBMITTED:
September 12, 2012

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 12, 2012

18 DATE APPROVED NOV 25 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
FRANCIS Mc Cullough

22 TITLE
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

INSTRUCTIONS ON BACK

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);

- 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.

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;

- 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.

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).

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.

__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):

___X Entire State

___ Only in the following geographic areas: **[Specify areas]**

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

___X 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;

- 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.

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:
    - Psychology
    - Criminal Justice
    - Board of Regents with health specialization

- 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

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))

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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TN No. 12-006
Supersedes TN No. 90-15 Approval Date .-- Effective Date 7/1/2014
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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

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

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 conversation 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 lessor 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.

PERSONAL CARE

4.19 Payments for Medical and Remedial Care and Services
Methods and Standards for Estahlishine 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 arc 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 arc 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 start 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.**

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

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.

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:

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

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:

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

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.

3.3 Minimum of one (1) year experience in development of Medicaid reimbursement strategies. Responses should include detailed description of the types of reimbursement methodologies developed, implemented, and supported in other States, specifically those types of methodologies that support pay for performance or that are tied to quality outcomes. Response should also describe whether the methodologies were accepted by CMS (i.e., State Plan Amendment) and whether any claims calculated utilizing the developed methodologies have been audited by CMS (and if so, the audit outcomes), as well as whether any such claims have been disallowed by CMS.

PCG is eager to assist West Virginia in strategizing reimbursement reform initiatives throughout the term of this engagement. As a firm, PCG provides Medicaid rate setting and reimbursement services for an array of healthcare services and provider types. These are core competency of PCG, borne of 25+ years of rate-setting experience. PCG is nationally known for evaluating and assessing historical payment methodologies and working with states to identify and recommend alternative payment methodologies in order to more appropriately align reimbursement to services provided and/or outcomes, as Medicaid moves towards value-based purchasing. We compare predictive models to outcomes, communicate complex reimbursement issues to the provider community, conduct peer state analyses, and implement pay-for-performance measures to improve quality of care and ensure that Medicaid programs receive value for services rendered and reimbursed.

We are confident that you will find that PCG is far and away the most qualified vendor to assist West Virginia with strategizing about how to transform the way the state utilizes reimbursement methodologies to incentivize the type of service utilization that will result in high-quality care, while also containing cost growth. We have completed upper payment limited-related rate-setting for **Alabama, Massachusetts, Texas, Wisconsin, West Virginia, and the District of Columbia.** States like **Connecticut, Massachusetts, Missouri, North Carolina, New Hampshire, and Wisconsin** have taken advantage of our deep knowledge of Medicaid Disproportionate Share Hospital programs. And, we have performed rate-setting projects of all types and sizes in more than a dozen states in the past decade alone.

PCG is the only vendor submitting a proposal for School-Based Claiming Services that has the necessary reimbursement strategy expertise and experience to guide the state through this endeavor. We bring to this engagement the technical know-how, a deep understanding of CMS guidance and requirements, and a strategic mind-set that will help you frame and shape the future of health care reimbursement in West Virginia.

Per the RFQ, we have provided several tables below to highlight the types of rate-setting projects PCG has been involved in over the years. This list is composed of recent, innovative rate-setting work that incorporates pay-for-performance (P4P) models. To our knowledge, none of the projects listed below, or any rate-setting or P4P project PCG has performed, have ever resulted in a CMS or audit finding. As you will see, we easily exceed the one-year requirement of experience in developing innovative reimbursement methodologies.

Reimbursement Type	Acute Hospital Rate Setting and Pay-for-Performance
States and Time Period	Colorado (2010-present); Wisconsin (2007-present)
Detailed Description of Type of Reimbursement Methodology developed, implemented and supported	From traditional cost-based reimbursement strategies to current episodic or grouping methodologies, to the introduction of pay-for-performance enhancements, PCG can provide West Virginia with strategic and practical advice on how best to transform provider reimbursement and behavior. Wisconsin and Colorado are a few of our more recent examples of this kind of innovative thinking in practice: ***Colorado*** – In April 2009, the State of Colorado initiated a health care reform effort with the passage of the Colorado Health Care Affordability Act (CHCAA). PCG is currently assisting the Department of Health Care Policy and Financing ("the Department") with the development and implementation of six separate projects that will fulfill the provisions of the CHCAA. There are three projects that are worthy of note: 1) One of the project areas is for Hospital Provider Fee Modeling, where PCG is providing technical assistance and analysis regarding the hospital provider fee and Upper Payment Limit (UPL) demonstrations. 2) Another project area is Hospital Rate Reform. Here, PCG has reviewed, conducted analyses, and provided recommendations to modernize rate setting methodology for inpatient and outpatient hospital services. The Department has chosen to implement the APR-DRG grouper software for inpatient hospital services. PCG is currently assisting the Department with the calculation of base

Reimbursement Type	Acute Hospital Rate Setting and Pay-for-Performance
	rates and DRG weights. In this time, PCG has gained access to the 3M APR-DRG grouper software and reviewed the MMIS data elements necessary to set new APR-DRG rates submitted a data. It has received MMIS data from the Department and successfully formatted the data to load into the 3M APR-DRG grouper software. PCG has also conducted preliminary analysis on grouper software output reports as well as research regarding best practices for special reimbursement cases, such as for newborns, hospital distinct part units, outlier payments, psychiatric hospitals, rehabilitation hospitals, and critical access hospitals. 3) Also focused on hospitals, PCG has led the state's efforts to introduce pay-for-performance measures into the reimbursement model. The Hospital Quality Improvement Program (HQIP) initiative is a collaborative effort to increase and to meet quality driven goals in hospitals across the state. The purpose of this is to address the need to hold hospitals accountable for their services to heighten the overall value of healthcare. This program provides financial incentives to hospitals, physicians, health care professionals and quality leaders to develop optimal outcomes for patients. The goal is to develop best practices through quality measure analysis. Through determining common initiatives, hospitals can make improvements to achieve high quality care. PCG aids states such at Colorado in researching potential measures, aggregating data from sources, analyzing data, and providing payment analysis. PCG collects and validates the data, determines the appropriate weighting for the measures, and assigns payment values, by hospitals, for meeting those measures. While only in its fourth year of existence, the State has already seen improvements in key measures. ***Wisconsin*** – The Department of Health Services (DHS) contracted with PCG to provide consulting services on a variety of hospital

Reimbursement Type	Acute Hospital Rate Setting and Pay-for-Performance
	reimbursement related issues. Our work has included obtaining approval from the Centers of Medicare and Medicaid Services (CMS) to implement a provider assessments on in state acute care, rehabilitation, and critical access hospitals. This provider assessment allowed the state Medicaid agency to implement an 1115 Medicaid transformation waiver to expand Medicaid eligibility to childless adults, as well as increase Medicaid payments to hospitals for inpatient and outpatient services. In addition, PCG at the direction of DHS helped to transform the payment methodology by implementing a Diagnosis Related Group (DRG) per discharge rate methodology for inpatient hospital services, performed Disproportionate Share Hospital eligibility determinations and calculations, and performed outpatient hospital rate setting calculations for rate years 2008 through 2013. Some specific accomplishments. ▪ Developed financial survey data to determine tax amounts by provider and system of providers. ▪ Modeled provider specific outcomes under assessment model and analyzed results to ensure the model passed hold harmless provisions. ▪ Performed P1P2 statistical analysis to obtain approval to waive the broad based provider assessment requirements. ▪ Meet with hospital stakeholders and representatives to present provider assessment models and analysis. ▪ Supported DHS throughout the CMS review and approval process. ▪ Developed payment methodology to increase revenues to the hospital community, both through the Medicaid fee for service program, as well as the Medicaid managed care organizations (MCOs).
Were methodologies accepted by CMS?	Yes, all methodologies were approved and have been implemented.

Reimbursement Type	Acute Hospital Rate Setting and Pay-for-Performance
Reimbursement Type	Behavioral Health Rate-Setting Initiatives
States and Time Period	Arkansas (2014), District of Columbia (2013), and Georgia (2012)
Detailed Description of Type of Reimbursement Methodology developed, implemented and supported	Behavioral health services are an integral component of a full continuum of care for Medicaid populations. Unfortunately, while states focus their reimbursement strategies on high-cost facilities services, community-based mental health services are often lagging in reimbursement innovation. This is where PCG comes into play. We have brought rate innovation to state behavioral health programs for years. The three listed here are just the latest in a long line of mental health and substance abuse rate-setting efforts. Each brings a slight nuance to it, which highlights PCG's ability to tailor rate innovation to the circumstances (i.e., the population, delivery systems, and provider networks) of each state. Naturally, we would bring a West Virginia focus to any behavioral health rate-setting project. Here are some details of what we have accomplished in each of these states. ***Arkansas*** – The Arkansas Department of Human Services contracted with PCG to assist in the transformation of its Behavioral Health System to align with the principles of the state's Arkansas Payment Improvement Initiative (ARPII). The transformation effort included a 1915(i) State Plan Amendment, which enhances access to Home and Community Based Services (HCBS) and a Behavioral Health Home State Plan Amendment. PCG was hired to establish updated, methodologically sound reimbursement rates for both the existing services that will be expanded and the new services to be reimbursed by Arkansas Medicaid. After establishing a base rate from the peer state analyses we performed for each of the procedures under review, PCG developed two different sets of rate adjustment factors to determine whether regional economic factors would have a significant impact on the final rates. It is this sort of detailed understanding of the state and populations that PCG brings to any rate-setting effort. For this

Reimbursement Type	Acute Hospital Rate Setting and Pay-for-Performance
	engagement, we will not just set good rates. ***PCG will set good rates that are good for West Virginia.*** ***District of Columbia*** – The District of Columbia Department of Behavioral Health (DBH) initiated an effort to analyze the service costs of behavioral health providers participating in its Medicaid Mental Health Rehabilitation Services (MHRS) program. PCG was contracted to analyze costs for eight service categories offered under the MHRS program. In doing so, PCG: • Established a transparent behavioral health rate review process and communication plan with DBH; • Determined a valid and reliable sample group for service cost analysis, which was approved by DBH; • Developed, distributed, and provided training for the cost survey, including all necessary support and review to ensure the integrity of survey data collection; • Conducted and calculated the service cost analysis; and • Summarized survey findings and identified improvements for future cost survey and rate setting processes. This process is now currently in used by DC DBH. ***Georgia*** – Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) selected PCG to complete a service cost analysis for behavioral health rate setting purposes. PCG drafted a survey to collect service utilization and cost data from providers that was ultimately used to review and calculate rates for behavioral health services PCG and DBHDD selected a sample of 50 behavioral health providers across the state to participate in the cost study. We developed a cost survey template that providers used to report their indirect and direct costs, as well as their behavioral health service utilization for Medicaid, State Contracted Services, and Other Payer Sources. In addition to developing rate recommendations, PCG outlined quality improvement recommendations, including changes to the Medicaid state plan language and provider requirements.

Reimbursement Type	Acute Hospital Rate Setting and Pay-for-Performance
	PCG was further contracted to perform a rate setting cost survey and analysis for Community-Based Alternatives for Youth (CBAY) providers. PCG developed a new, CBAY-oriented cost survey template, worked with providers to compile the data, and used the aggregated data to model and determine rates. PCG produced a report documenting the methodology and results of the CBAY cost survey.
Were methodologies accepted by CMS?	Yes, all methodologies were approved and have been implemented.

Reimbursement Type	Nursing Facility Pay-for-Performance
States and Time Period	Colorado (2009-present)
Detailed Description of Type of Reimbursement Methodology developed, implemented and supported	The Colorado Nursing Facility Pay for Performance (P4P) program, sponsored by the Colorado Department of Health Care Policy and Financing (the Department), has just commenced its sixth year of administration. And for the sixth consecutive year, PCG has been a partner in this person-centered P4P initiative. The purpose of the P4P program is to encourage and support the implementation of resident-centered policies and home-like environments throughout the nursing homes of Colorado. Homes that execute these changes are incentivized with supplemental payments. For six years PCG has reviewed, evaluated, and validated whether nursing homes that applied for additional reimbursement related to the P4P program are eligible for these additional funds. The performance measures serve to gauge how homes provide high quality of life and high quality of care to their residents. The P4P measures that have been established in the application reside in two domains: 1. Quality of Life

	2. Quality of Care The 2014 P4P application included 39 performance measures in the domains of Quality of Life and Quality of Care. The reimbursement for these measures is based on cumulative points received for all performance measures. PCG has played roles in: • Developing and implementing the evaluation tool that will be used to measure compliance with each P4P subcategory measure; • Making recommendations to the Department for which homes should have on-site visits and conducting review and validations of no less than 10 percent of the P4P applicants; and • Providing evaluation results of the P4P applications to the Department in a standardized format developed by the Contractor and approved by the Department.
Were methodologies accepted by CMS?	Yes, these methodologies were approved and have been implemented.

Reimbursement Type	Physician Upper Payment Limit
States and Time Period	North Carolina (2009-present)
Detailed Description of Type of Reimbursement Methodology developed, implemented and supported	Upper Payment Limit (UPL) calculations may not be eye-popping initiatives, but they are vital to the effective and efficient delivery of Medicaid services. Accurate calculations are even more important now, given CMS's new requirement to submit UPL calculations for a range of provider types prior to the beginning of each state fiscal year (and not just when SPAs are submitted). PCG is a trusted, go-to firm to perform the necessary calculations that will provide West Virginia with the flexibility it needs to successfully administer its programs.

Reimbursement Type	Physician Upper Payment Limit
	Our Physician UPL project in North Carolina is just one recent example of this work. Beginning with services provided during the State Fiscal Year 2011, PCG has contracted with the Division of Medical Assistance (DMA), the University of North Carolina Physicians and Associates (UNC), and the East Carolina University Medical Faculty Practice Plan (ECU) to perform a quarterly Medicaid Upper Payment Limit (UPL) analysis for payments made to UNC and ECU physicians. The State Plan (SPA) that was approved by the Centers for Medicare and Medicaid Services (CMS) allows DMA to make supplemental payments to UNC and ECU for incremental revenues that could have been received on previously processed Medicaid claims were these claims instead paid at the average rates of the top five commercial payers to each plan.
Were methodologies accepted by CMS?	Yes, all methodologies were approved and have been implemented.

4. Mandatory Requirements

PUBLIC CONSULTING GROUP

4.1.1
Random Moment Time Study

IV. Mandatory Requirements

4.1 Mandatory Contract Services Requirements and Deliverables: Contract Services must meet or exceed the mandatory requirements listed [in the RFQ].

4.1.1 Random Moment Time Study (RMTS)

Overview

PCG brings a unique and unmatched set of skills and experience to the scope of work outlined by DHHR, as PCG has generated over $3.5B in school based service Medicaid Revenue for our clients. PCG is currently the preferred statewide vendor of all of the states that have hired a vendor for this type of work and we have experience in many of the states participating in Random Moment Time Study (RMTS) and the Medicaid Administrative Claiming (MAC) programs. We currently manage school based service programs for the states of Arizona, Colorado, Delaware, Georgia, Indiana, Kansas, Michigan, New York, New Jersey, Pennsylvania, Wisconsin and West Virginia. PCG also currently provides MAC support services directly to LEAs in the states of California, Massachusetts and North Carolina. We have worked with states to implement new programs, transition from existing practices or vendors, as well as provide enhancements to existing programs in an effort to generate additional revenue sources. While this national experience is unmatched by other vendors, we also recognize the fact that every state is different. To complement our national experience, PCG will continue to bring over 10 years of experience in school-based Medicaid claiming to West Virginia. With our national and proven West Virginia experience, PCG is confident we can successfully complete the services requested under this RFQ.

4.1.1.1 – The Vendor must be responsible for developing, implementing, and reporting to DHHR/BMS the results of quarterly, statewide time study that is consistent with State Plan authority and based on a Random Moment Sampling methodology to determine the amount of time and associated costs LEA staff provides in support of the Medicaid SBHS program.

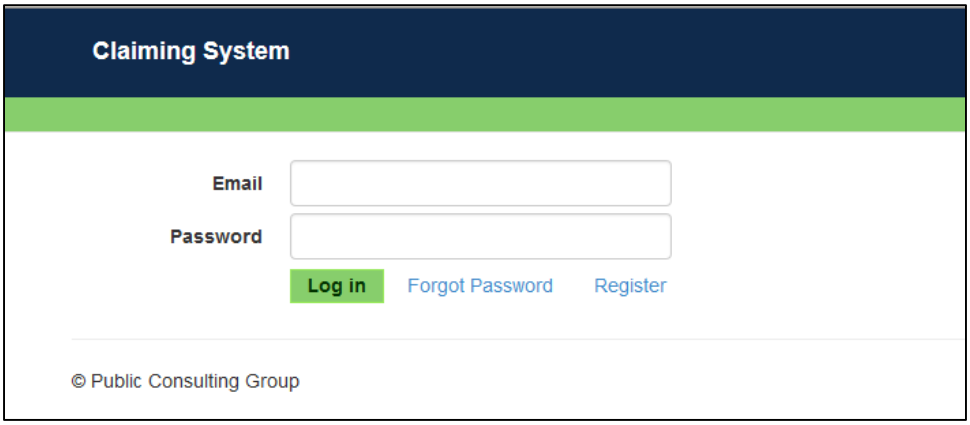
The random moment time study (RMTS) is a necessary component to calculate the Medicaid reimbursement percentage for quarterly Administrative Claiming, as well as used to support the calculation of Medicaid cost settlements under the SBHS program. As described below, the time study process includes the collection of eligible participants to participate in the time study, the generation of the random moments, the completion of the random moments, the centralized coding of the random moments, and the performance of quality checks on all received data.

PCG has an established and implemented random moment time study process in West Virginia that is comprehensive and CMS compliant. Our process and proven approach includes a streamlined process to collect the information to ascertain the tasks SBHS participants are performing during the workday, along with a centralized coding process to accurately record the activities of SBHS staff.

The LEAs are guided by PCG to update their staff pool list from the previous quarter through our web-based application. LEAs are provided detailed instruction on how to log into PCG's Claiming System website, where they will be able to construct their staff pool list. However, since West Virginia is an existing customer, LEAs will be able to see the list of staff members that they previously added to their roster. If there have been any staff additions, subtractions, or changes, LEAs have the ability to simply make the necessary updates and click 'Certify.' One of the major benefits of PCG's web-based RMTS system is that the staff that are verified by the district prior to each quarter are the same staff members that the district's business/finance director sees when logging into PCG's financial reporting site. This allows the LEAs to ensure that the participants match up properly, increasing compliance and decreasing the audit risk of claiming costs for unallowable participants. *A comprehensive overview of our RMTS solution and workflow process is articulated in Section 4.1.2.3.*

District contacts in West Virginia have become familiar with navigating through the PCG Claiming System Web site to update their staff pool list, navigate through the application to view whether participants completed assigned random moments, and generate reports from the system. Furthermore, our system has been configured to meet the program needs of West Virginia. We know that LEAs will be ready and able to use our system because they have been trained and the system is currently in operation**. *PCG is the only vendor that can remove 100% of the transition risk and cost from both the state and participating LEAs for this project*.**

On the following several pages we outline the functionality and features of our proprietary, web-based system. Our RMTS Claiming System process is user friendly and comprehensive in regards to documenting and reporting to ensure proper time study administration processes comply with federal reporting requirements.



Generating Random Moments

When randomly generating moments, our system takes into account each district's calendar and school shifts (shifts are staff work hours) in order to properly generate moments only for those time periods in which LEAs are in session. We are the only vendor with a system that allows for not only district and school level calendars, but also the ability to differentiate part-time staff hours from full-time staff hours in

the sampling process. This functionality allows for a more accurate sampling and RMTS process. Our time study sampling process then uses random sampling with replacement moments, in which moments from the available pool are randomly selected, and then randomly matched with staff eligible on that date and time. This process meets the CMS sampling rules and regulations required for the Medicaid School Based Administrative Claiming Program. The use of district specific calendars, as well as the individual shifts, results in a more accurate sample and reduces significantly the times when a staff person at a local district may be sampled at a moment in which they are not working, while allowing the full universe of work time to be included in the sample universe.

PCG's random moment time study sampling methodology meets statistical validity at a confidence level of 95% with a precision level of +/- 2%. For West Virginia, we will sample 3,000 moments each for the 4 time study pools; Direct Service Providers, Targeted Case Management Providers, Personal Care Providers and Administrative Service Providers in accordance with CMS approved processes**.**

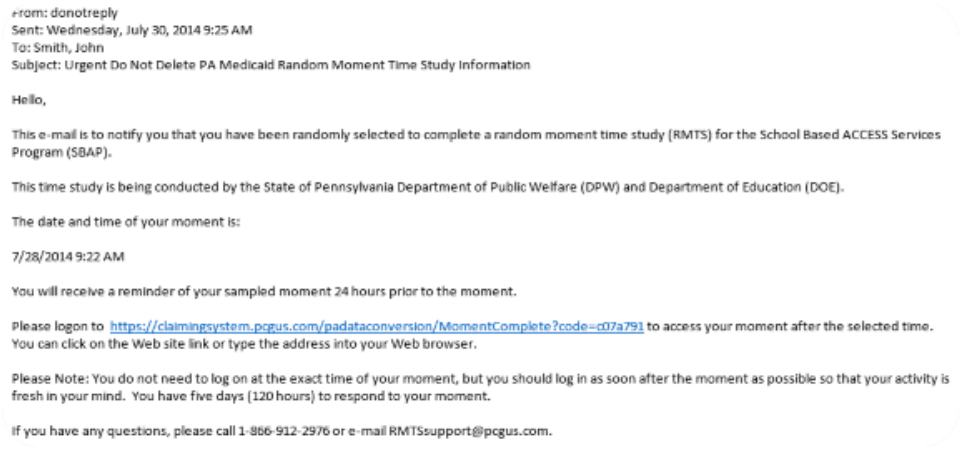
The number of moments selected each quarter is monitored based on return rates from previous quarters to meet statistical sampling requirements. The size of the sample for each cost pool can be increased or decreased based on return results. For example, if one of the cost pools has a decrease in the number of working moments, PCG will inform DHHR/BMS so that we can discuss the possibility of increasing the number of sampled moments for that particular cost pool. PCG recommends discussing these options with DHHR/BMS prior to generating the quarterly sample. Even if there are more completed random moments than needed in a given quarter, all returned moments would be utilized in the calculation of the time study results.

Completing a Random Moment

When a participant is chosen for a random moment, they will first receive an email notification with information on the Random Moment Time Study, as well as a link that will direct the participant to the Claiming System. Additionally, the system also automatically generates reminder and late notifications for participants who have not responded to their moment. PCG's system also copies district RMTS coordinators on late notifications so that they can perform follow up individually with participants who did not complete a random moment in a timely manner. *Additional information on PCG's late notification process can be found in Section 4.1.1.8.*

The first notification to the random moment participant is an auto-generated email that is sent five days prior to the random moment and includes the time and date of the moment as well a site link, which will direct the participant to RMTS system. An example of this email is seen in Figure 1.

Figure 1



From: donotreply
Sent: Wednesday, July 30, 2014 9:25 AM
To: Smith, John
Subject: Urgent Do Not Delete PA Medicaid Random Moment Time Study Information

Hello,

This e-mail is to notify you that you have been randomly selected to complete a random moment time study (RMTS) for the School Based ACCESS Services Program (SBAP).

This time study is being conducted by the State of Pennsylvania Department of Public Welfare (DPW) and Department of Education (DOE).

The date and time of your moment is:

7/28/2014 9:22 AM

You will receive a reminder of your sampled moment 24 hours prior to the moment.

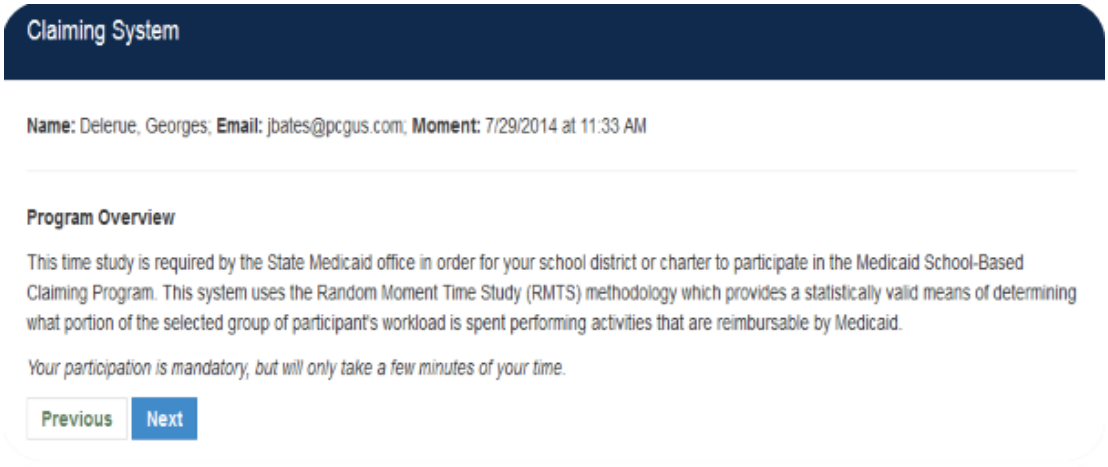
Please logon to https://claimingsystem.pcgus.com/padataconversion/MomentComplete?code=c07a791 to access your moment after the selected time. You can click on the Web site link or type the address into your Web browser.

Please Note: You do not need to log on at the exact time of your moment, but you should log in as soon after the moment as possible so that your activity is fresh in your mind. You have five days (120 hours) to respond to your moment.

If you have any questions, please call 1-866-912-2976 or e-mail RMTSsupport@pcgus.com.

After clicking on the link to and logging on to the Claiming System, participants are directed to an instruction screen, which provides a brief overview of the RMTS program as shown in Figure 2. This allows PCG and our customers to demonstrate that every sampled participant completed training on the RMTS process prior to completing the sampled moment.

Figure 2



Claiming System

Name: Delerue, Georges; **Email:** jbates@pcgus.com; **Moment:** 7/29/2014 at 11:33 AM

Program Overview

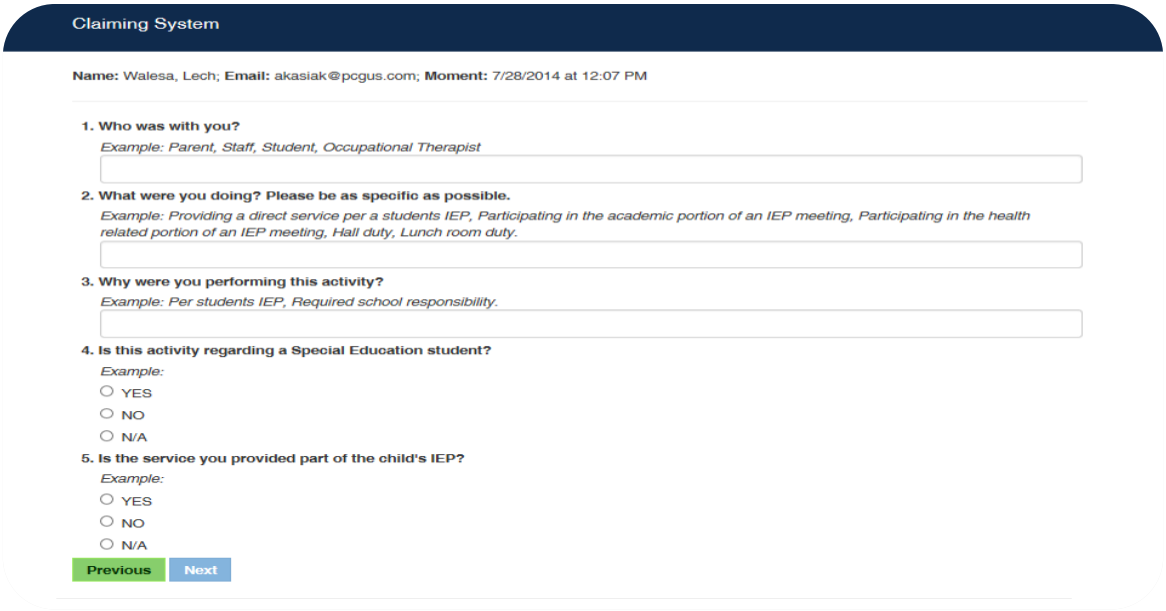
This time study is required by the State Medicaid office in order for your school district or charter to participate in the Medicaid School-Based Claiming Program. This system uses the Random Moment Time Study (RMTS) methodology which provides a statistically valid means of determining what portion of the selected group of participant's workload is spent performing activities that are reimbursable by Medicaid.

Your participation is mandatory, but will only take a few minutes of your time.

Previous Next

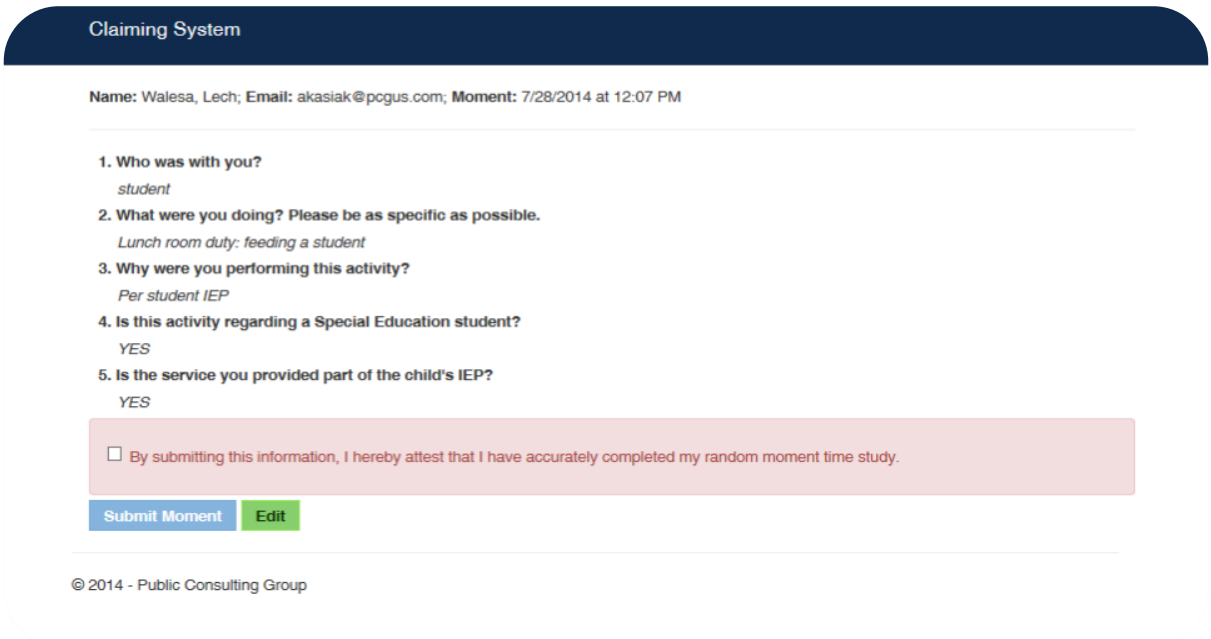
After pressing the "Next" button, participants are then directed to five questions required to complete the Random Moment Time Study is seen in Figure 3.

Figure 3



After answering the questions, the system will ask the participant to review their responses for accuracy, then check the "*Submit*" checkbox along with clicking the "*Submit Moment*" button as shown in Figure 4.

Figure 4



As the RMTS is taking place throughout the quarter, sampled participants respond to their moments via the above web-based system. As part of the ongoing process, PCG uses the approved activity codes to centrally code all moments that are completed and have responses. Follow-up activities are performed as necessary. This allows the PCG team to obtain the necessary clarification or gather additional information about a

moment response in order to select the correct activity code; PCG's follow-up activity and responses are recorded within the RMTS site. This allows for all information regarding a moment that may be requested in the event of an audit or review is housed within the system and easily retrievable. PCG has a series of on-demand reports that can be run at any time, allowing for instantaneous data extraction. Additionally, our centralized coding team and quality control group keep up to-date on coding, meaning that when current RMTS results are requested, they can be provided quickly.

Upon completion of the coding and QC process, PCG runs a Time Study Results Summary Report. This report shows the number of responses assigned to each activity code. This information will be quality checked for accuracy and then sent to DHHR/BMS. We also have a report that can compile every RMTS form into a single Microsoft Excel file, allowing staff at PCG and the state agency to comprehensively review participant responses in one convenient location.

4.1.1.2 – The Vendor shall be responsible for documenting RMTS procedures and providing DHHR/BMS with a Time Study Implementation Guide. The Time Study Implementation Guide must be approved by DHHR/BMS prior to distribution.

PCG will document RMTS procedures and provide DHHR/BMS with a Time Study Implementation Guide. Components of the Time Study Implementation Guide include required personnel, RMTS methodology, RMTS sampling requirements, RMTS process, Time Study participants, Time Study compliance, oversight and monitoring, Time Study activity definition and coding, Medicaid eligibility rate development and financial data collection. PCG understands that the Time Study Implementation Guide must be approved by DHHR/BMS prior to distribution. This will be kept current and revised on an ongoing basis based on any changes to process or to the program. In terms of CMS approval, PCG has extensive knowledge and experience in all components of the approval process including: guide drafting and development, internal (state) approval, CMS submission, responses to CMS inquiries, and final approval.

4.1.1.3 – The Vendor shall include a statement in the proposal that acknowledges their understanding that CMS approval of RMTS procedure is required prior to implementation of RMTS methodology.

PCG understands that CMS approval of RMTS procedure is required prior to implementation of RMTS methodology. In fact, PCG has been working with DHHR/BMS to obtain approval of the implementation plan. PCG has assisted DHHR/BMS to submit a RMTS implementation plan to CMS and it is currently under evaluation and close in receiving approval.

4.1.1.4 – The Vendor shall conduct the RMTS on a quarterly basis. Quantified results from the time study will be used to allocate the amount of time spent on Medicaid and non-Medicaid reimbursable activities. The results will also be used to calculate the relevant statewide percentages used in the calculation of LEA-specific Direct Service rates. The Vendor will perform these calculations and provide no later than the 15th of the month following the quarter end.

As outlined throughout *Section 4.1.1 Random Moment Time Study RMTS;* PCG remains committed to conducting the quarterly RMTS using our Claiming System. PCG understands the premise of the RMTS is to calculate the relevant statewide percentages used in the calculation of LEA-specific Direct Service rates. As part of this process and highlighted through this section, PCG codes all moments, conducts thorough QA processes, and aggregates the moments by activity code to calculate statewide time study percentages. Furthermore, PCG understands these calculations are to be provided no later than the 15th of the month following the quarter end.

4.1.1.5 – The Vendor shall propose a sampling methodology for the RMTS that is consistent with and complies with the sampling plan criteria delineated in CMS SBHS Claiming Guide of May 2003, OMB Circular A-87 included in Exhibit C, and any applicable federal rules. Upon approval from CMS, the approved sampling methodology will be used for the RMTS. If subsequent guidance is issued by CMS, the Vendor will be responsible for modifications to the sampling methodology to comply with any changes.

PCG will propose a sampling methodology for the RMTS process that is consistent with federal guidance and SBHS claiming rules. Generally, PCG recommends the implementation of a quarterly RMTS process. The following are the quarters typically followed for the RMTS program:

- October 1 – December 31
- January 1 – March 31
- April 1 – June 30
- July 1 – September 30

On an annual basis, PCG will review LEA calendars for each quarter to determine the date parameters for which ALL schools are in session during that quarter. Those dates and times will be included in the sample. *(additional details on specific sampling methodology is listed in Section 4.1.1.7.)* PCG will document and report this process annually to DHHR/BMS.

PCG will use an average of the three (3) previous quarter's time study results to calculate a claim for the July-September period. The three previous quarters utilized for the average for the July – September quarter would be the previous October – December, January – March and April –June quarters. This is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, specifically on page 42. This means there will be no time study conducted for the July to September quarter, as most SBHS staff are not working due to summer recess. The average results of the RMTS process for the prior three quarters are typically applied to the July to September period in order to allocate the associated permissible costs paid during the summer. In general, this is acceptable if administrative activities are not actually

performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break.

PCG understands and will fully comply with any directives or modifications made by CMS to the sampling methodology.

4.1.1.6 – The Vendor must establish cost pools, at a minimum, for Direct Service Providers, Targeted Case Management Providers, Personal Care Providers and Administrative Service Providers. For the quarter October-December 2013, approximatly 4,550 medical and non-medical personnel participated in RMTS.

Since 2011, PCG has been responsible for conducting the quarterly RMTS using the established four required cost pools, and will continue to fulfill this requirement. Aditionally, PCG will continue to analyze and present quarterly results to ensure that West Virginia is maximinzing reimbursement based on the current cost pool structure.

During the October-December 2013 RMTS quarter, there were 4,578 active statewide participants throughout the four established cost pools. The below chart highlights the number of participants per cost pool, as well as an average number of moments per participant.

Cost Pool	Number of Participants	Number of Moments	Average Moments Per Participant
Administrative Service	396	3000	7.58
Direct Service	768	3000	3.91
Targeted Case Management	2976	3000	1.01
Personal Care	438	3000	6.85

The rationale for utilizing multiple time study cost pools in West Virginia is to best group 'like' professionals together to ensure that LEAs are receiving an appropriate amount of reimbursement for these services. This allows for the most accurate depiction of how health professionals, operating in the school setting, spend their time.

4.1.1.7 – The Vendor shall assure that the sample size is statistically valid, and at a minimum, includes a confidence level of ninety-five percent (95%) with a precision level of +/- two percent (2%). The proposal shall include a description of the sample size determiniation methodology and calculations used to determine actual sample size will be used.

PCG will continue to fulfill this requirement. In order to achieve statistical validity, PCG will maintain program efficiencies and reduce unnecessary administrative burden for providers. PCG will continue to implement a consistent sampling methodology for all activity codes and groups to be used. PCG has

constructed the Statewide RMTS sampling methodology to achieve a level of precision of +/- 2% (two percent) with a ninety-five percent (95%) confidence level for activities.

Statistical calculations show that a minimum statewide sample of 2,401 completed moments quarterly, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected quarterly to account for any invalid moments. Invalid moments are observations that cannot be used for analysis, i.e., moments selected for staff who are no longer at the school, or who changed jobs and are no longer in an allowable position and their old position has not been filled.

The following formula is used to calculate the number of moments sampled for each time study cost pool:

$$Ss = \frac{Z2 * (p) * (1-p)}{c2}$$

where:

Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal (.5 used for sample size needed)
c = confidence interval, expressed as decimal (e.g., .02 = ±2)

Correction for Finite Population

$$new\ ss = \frac{Ss}{1 + \frac{ss-1}{Pop}}$$

where:

pop = population

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments will be selected to account for invalid moments, as previously defined. An over sample of 15% will be used to account for invalid moments as seen in the table in Figure 5.

Figure 5

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2740
400,000	2387	2745
500,000	2390	2749
750,000	2393	2752
1,000,000	2395	2755
3,000,000	2399	2759
>3,839,197	2401	2762

4.1.1.8 – The Vendor shall have sample selection procedures to randomly select a sample staff and moments using statistically valid methodology, including procedures of how Vendor will notify the participants of their selected moment and the timing of the notification via email, including timelines for reiminder emails in the event the sampled participant does not respond. Notification procedures should include capacity to include other staff (e.g. supervisor) on the indivdual notification email and reminder emails.

As highlighted in the RMTS process overview in *Section 4.1.1.1*, PCG will continue to utilize our proven approach in sampling staff and moments using a CMS approved methodology. Part of this approach involves a moment notification and reminder process to ensure that the RMTS response rate is statistically valid while producing accurate representative time study results.

When a participant is chosen for a random moment, they will first receive an email notification that includes information on the Random Moment Time Study, the date and time of their selected moment, as well as a link that will direct the participant to the Claiming System site. Additionally, the system also generates reminder and late notifications for participants who are late in completing their moment. PCG's system also copies district RMTS coordinators on late notifications so that they can follow up individually with participants if they did not complete a random moment in a timely manner.

The first notification to the random moment participant is an auto-generated email that includess the time of the moment as a link to click for direct access to the Claiming System site.The participant receives a late notification and the district contact is copied on the email notification if the random moment is not completed within 24 hours following the time of the random moment.. Another reminder is sent if the moment was not responded to after 48 hours. This gives the district contact alerts that the participant has not yet completed their random moment. They have the option to personally follow-up with the participant at this time. The district contact can always directly check the compliance information at any time in the RMTS system.

The system is very flexible and can be updated easily to increase or decrease the number (and frequency) of notification and reminder messages to the participant and the coordinator. The process outlined above

has been utilized to help achieve high return rates of sampled moments. PCG monitors these return rates and discusses any trends with DHHR/BMS. We would discuss with DHHR/BMS the value of increasing or decreasing these notifications if the return results warrant a change, prior to implementation of any change.

For West Virginia RMTS coordinators, PCG provides multiple tools to ensure that the participants from their staff pool list are completing their RMTS moments. Each district coordinator creates a unique password for accessing district-specific RMTS information. This gives them access to real-time RMTS return compliance data which can be accessed through a number of on-demand real-time reports:

- **Individual Master Sample File-** This report shows the time and dates of moments up to five days in advance of the sampled moment up to the minute that the report is run. This provides the Coordinators an advance view of their participants with upcoming moments.

- **Compliance Report-** The compliance report is used to ensure that all moments have been completed and that all LEAs remain in compliance. The report allows coordinators to view all moments that have occurred through the generation of the report, it also displays the time and date the moment was submitted to PCG. Coordinators can easily view which participants have not completed their moments, and conduct follow-up with them to assure completion of the moment within the allowed timeframe.

In addition to running these reports, access to the RMTS website also allows coordinators to easily update contact information for staff members as well as add/remove staff members each quarter as needed. This ability is extremely helpful in ensuring high compliance rates.

Finally, PCG sends monthly compliance reports via email that identify which participants have outstanding moments. Although this information is accessible to district contacts at any time, some contacts find the weekly emails to be very accommodating.

4.1.1.9 –The Vendor shall provide for oversampling moments to ensure sampling objectives are met.

As detailed in *Section 4.1.1.7*, PCG will continue to account for invalid moments and insure a valid sample by completing a 15% oversample of quarterly moments. The Time Study will require an 85% response rate. Moments not returned or not accurately completed and subsequently resubmitted by the LEA will not be included in the database unless the return rate for valid moments is less than 85%. If the return rate of valid moments is less than 85% then all non-returned moments will be included and coded as a non-allowable/non-Medicaid time. The time study questionnaire or survey forms will be kept open no longer than five (5) business days after the end of the time study period to ensure the accuracy of the time. To ensure that enough moments are received to have a statistically valid sample, West Virginia will over sample at a minimum of fifteen percent (15%) more moments than needed for a valid sample size. To ensure that LEAs are properly returning sample moments, the LEA's return percentage for each quarter will be analyzed.

4.1.1.10 – The Vendor shall have procedures to address non-responsiveness to requested moments.

As outlined thoroughly in *Section 4.1.1.8*, PCG utilizes, and will continue to exercise a systematic approach to both notify participants in advance of their selected moments, as well as informing coordinators of any non-response to assigned moments in their district. This process also enables coordinators to run real-time compliance reports, which will apprise key staff to any responded moments.

4.1.1.11 – The Vendor shall create a universal sample pool database of LEA staff members eligible to participate in the time studies. The Vendor's sampling methodology must ensure that the universe of sample units is adequately represented to a 95% confidence level as described in 4.1.1.4 and provide for oversampling as described in 4.1.1.9.

As described in *Section 4.1.1.4*, PCG will continue to utilize our web-based Claiming System to create universal sample pool database of eligible LEA staff members. PCG's random moment time study sampling methodology meets statistical validity at a confidence level of 95% with a precision level of +/- 2%. For West Virginia, we sample 3,000 moments for each of the four cost pools representing Direct Service Providers, Targeted Case Management Providers, Personal Care Providers and Administrative Service Providers**.** These four cost pools are specific to the West Virginia SBHS program, and PCG has configured our web-based application in accordance with the State's approved methodology. The number of moments selected each quarter are monitored based on return rates from previous quarters to meet statistical sampling requirements. The size of the sample for each cost pool could be increased or decreased based on return results. For example, if one of the cost pools has a decrease in the number of working moments, PCG will inform DHHR/BMS so that we can discuss the possibility of increasing the number of sampled moments for that particular cost pool. PCG always discusses these results with DHHR/BMS prior to generating the quarterly sample. Even if there are more completed random moments than needed in a given quarter, all returned moments would still be utilized in the calculation of the time study results.

4.1.1.12 – The Vendor's sampling methodology must include a specification for single source interpretation and coding of all the time study participants' activates. This requirement necessitates a process that participants only describe and report their activity at the sample moment. The Vendor will be responsible for coding all moments.

As described in Section 4.1.1.1, PCG's Claiming System only allows a participant to report activity on their single assigned sample moment. If a participant is selected for more than one moment in a given day or quarter, they are required to independently complete the required questions completely separate from all other moments.

During the course of the quarter, PCG will continue to be responsible for completing a comprehensive centrally coding review of all moments based on the participants reported activities. A breakdown of PCG's four-phase approach to coding moments can be found next in *Section 4.1.1.13.*

4.1.1.13 – The Vendor's methodology must include a specification for primary and secondary review of the sample moment activity descriptions and assigned codes to ensure coding accuracy and consistency, maintaining a tracking system to document all instances of reported errors in coding and ensuring corrective action is taken when errors are identified. The Vendor will be responsible for conducting follow-up as necessary to ensure proper coding and that data can be used.

PCG has a great deal of experience in the Random Moment Time Study and will continue to apply our comprehensive sample moment and coding review methodology to this project. We approach coding in four phases, with phase one and two happening on an ongoing basis throughout the quarter.

- **Phase 1**: During the quarter, sampled participants respond to their moments via the Claiming System web site. Each moment is then coded centrally using approved activity codes by a trained staff member who is familiar with the state-specific methodology, policies, and intricacies. Follow-up is performed when necessary to clarify or gather additional information about a moment response in order to select the correct activity code; PCG's follow-up activity and responses are recorded within the RMTS site.

- **Phase 2:** A second coder quality checks the moment. If the coder and QC staff person disagree, they can discuss the moment amongst themselves, talk to their supervisor, follow-up with the participant for clarification on their response, or pursue other options.

- **Phase 3:** At the end of the quarter, a randomly selected portion of the moments are reviewed again internally for a final quality assurance process. If the review process is completed successfully, the results are submitted to the state for review.

- **Phase 4:** DHHR/BMS will review a sample of moments each quarter for accuracy. This allows an extra set of review and works to reduce the audit risk associated with the coding of moments. Additionally, coders, QC staff, and their supervisor meet frequently to review moments and tracking coding trends and errors. These meetings are an opportunity to discuss the moments, further develop familiarity with the codes and the state methodology, and ensure that moments are being coded accurately and consistently.

4.1.1.14 – The Vendor shall be responsible to maintain each LEA's roster data.

As described previously, PCG will continue the responsibilty in maintaining all RMTS data, including but not limited to LEA roster data, within PCG's Claiming System. This data is maintained permanently within PCG's systems for easy retrieval and review.

4.1.2
Administrative Claiming

4.1.2 Administrative Claiming

4.1.2.1 – The Vendor shall be responsible for using Web-based software to collect accurate LEA staff, salaries, and other information, as required, to calculate aggregate LEA-specific Administrative claim information.

PCG will continue to utilize its Web-based Claiming System in order to collect accurate LEA staff, salaries and other information required to calculate aggregate LEA-specific Administrative claim information. *A comprehensive outline of these processes can be found below in Section 4.1.2.2.*

4.1.2.2 – The Vendor shall be responsible for collecting all allowable expenditure information per the CMS School-Based Administrative Claiming Guide (current version is May 2003; subject to future updates) from participating LEA's Administrative Claims.

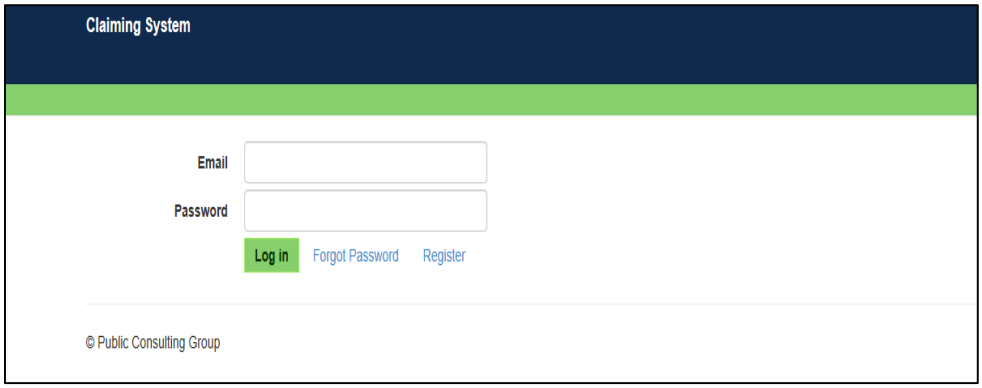
Within this section, PCG outlines our approach and proposed responsibilities for providing a web-based application to support the financial collection process for the calculation of the quarterly Administrative Claim. West Virginia will continue to utilize PCG's Claiming System, a robust web-based application developed to facilitate the collection of financial and statistical information in a streamlined and efficient fashion to support School-Based Administrative Claiming. PCG's Claiming System has the necessary functionality to support the needs of DHHR/BMS and has been successfully deployed on behalf of Medicaid programs across the country at a statewide implementation level, including: Arizona, Colorado, Delaware, Georgia, Indiana, Kansas, Kentucky, Michigan, Pennsylvania, New Jersey, South Dakota, West Virginia, and Wisconsin to support school based Medicaid claiming and cost reporting needs.

PCG has a successful record of accomplishment with West Virginia LEAs, as web-based applications have been successfully implemented and utilized to support Medicaid school based administrative claiming since state fiscal year 2011. PCG's Claiming System is customized and configured to meet the specific needs of West Virginia. By selecting PCG, DHHR/BMS will ensure that there is no disruption in school based service claiming, as our proven application is already deployed, meets, and exceeds the requirements outlined within the scope of work. On the following pages, PCG provides an overview of the Claiming System to demonstrate system capabilities and how West Virginia school district financial contacts will utilize the system to submit the necessary data for Administrative Claiming purposes.

Claiming System Administrative Claiming Functionality

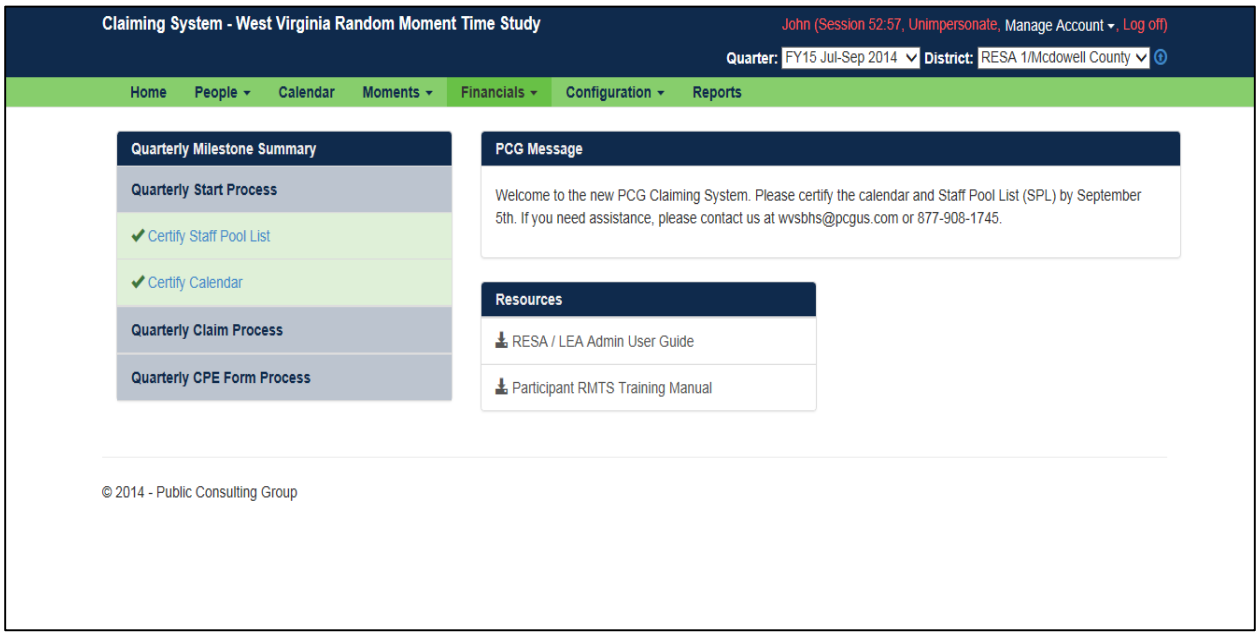
When a district staff person visits the PCG's web-based secure Claiming System, he/she is taken to the login screen as seen in Figure 6. Each district contact receives a unique password upon registering and is prompted to specify his/her login credentials prior to accessing any district specific information.

Figure 6



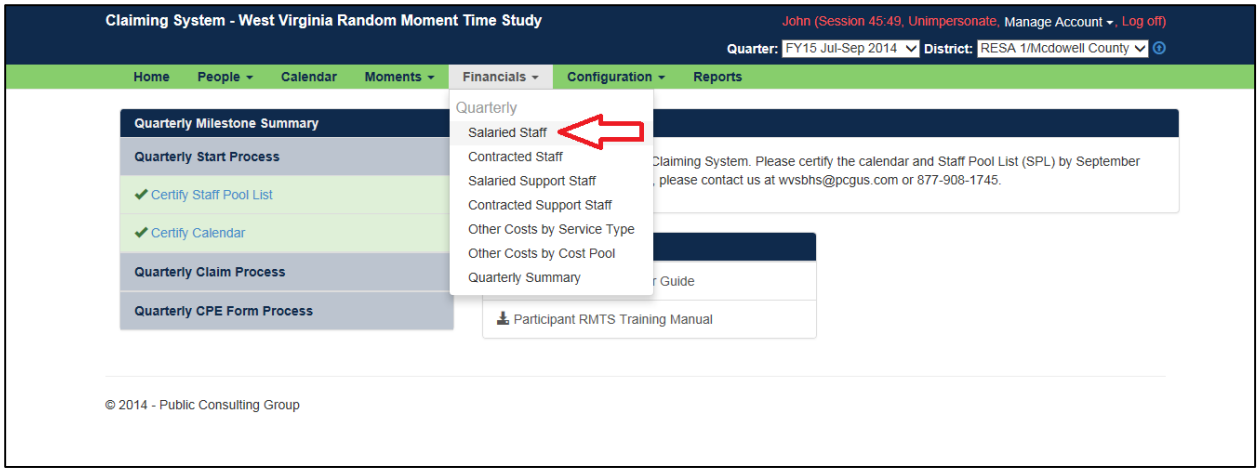
After logging in, the user is directed to the dashboard page seen in Figure 7. The dashboard includes important documents and resources including upcoming due dates, user guides, and training manuals. Any additional helpful resources, guides, manuals, or state plans, could be added upon request. These documents are updated regularly to provide the LEAs with the most current information. LEAs in West Virginia have found these documents helpful.

Figure 7



To submit quarterly financial information, the user clicks the "Financials" tab next to the "Moments" tab and selects the time period in the upper right corner of the page. The user is then presented with separate cost categories in which to submit the district's quarterly financial information. The user begins the process by clicking on the first category "Salaried Staff" as seen in Figure 8.

Figure 8



Each district identifies the eligible participants on their staff pool list prior to the start of each quarter. After the close of the quarter, the *"Financials"* tab allows the user to enter the allowable salary and benefit information eligible participants. Figure 9 is an overview of the process of entering costs for "Salaried Staff".

Figure 9

The fields that are pre-populated prior to the start of the quarter are pulled directly from the certified staff pool list and include Last Name, First Name, Job Category, Cost Pool, Staff Employment Status, District Job Title, and District Employee ID. *The process in which district contacts enter LEA staff rosters, make adjustments to staff rosters, report school calendars, and enter shifts can be found in Section 4.1.1.1.*

This is an automated process that ensures only certified participant specific data is available for the financial district contact entering the quarterly cost data. This process ensures that only eligible participants will appear, saves the district contact from re-entering this information, and ensures proper reporting. PCG

requires LEAs to enter their costs on a per provider basis to ensure that each dollar is accounted for and can easily be traced back in the case of an audit.

To enter data for a participant, the user clicks on the participants name as seen in Figure 10.

Figure 10

									Benefits			Offsets	
Agency	Emp Id	Name	Job Cat	Cost Pool	Title	Job Span	Hours	Salary	Health Insurance	401(k) Plan	Life Insurance	Fed Offset	State Offse
RESA 1/Mcdowell County	960002209	Airplane, Amber	Case Manager	Targeted Case Management	Special Education Teacher								

This allows the user to enter salary and benefit information for an individual participant. Here, Amber Airplane in Figure 11 has a quarterly salary of $10,000, quarterly health insurance costs of $5,000, life insurance costs of $1,000, and 401(k) cost of $1,000. To save this information, the user clicks "Save Changes" on the bottom right of the box.

Figure 11

As shown in Figure 12 payroll information has now been entered for Amber Airplane.

Figure 12

									Benefits			Offsets			
Agency	Emp Id	Name	Job Cat	Cost Pool	Title	Job Span	Hours	Salary	Health Insurance	401(k) Plan	Life Insurance	Fed Offset	State Offset	Gross	Net
RESA 1/Mcdowell County	960002209	Airplane, Amber	Case Manager	Targeted Case Management	Special Education Teacher			$10,000.00	$5,000.00	$1,000.00	$1,000.00	$0.00	$0.00	$17,000.00	$17,000.0

While the ability to enter costs by the individual is advantageous to smaller LEAs with limited numbers of staff, it is not a time efficient process for larger LEAs. For LEAs with a larger number of staff, the system allows them to export the data into a document that can be used in conjunction with the district's accounting system, or the district can use the exported document to enter information for multiple staff at one time in Microsoft Excel. The system has an import/export feature to pull the populated data from the system, allow the user to update the cost fields, and then import the data back into the system. The user scrolls to the bottom of the screen to see the export and import buttons. First, the user clicks "Export" to export a CSV document that can be completed in Microsoft Excel as seen in Figure 13.

Figure 13

An example of the CSV document shown in Figure 14 opened in Microsoft Excel with the corresponding columns from the "Salaried Staff" page.

Figure 14

	A	B	C	D	E	F	G	H	I	J	K	L
1	Agency	EmployeeId	LastNa	FirstNa	JobCategory	HoursPaid	Salary/Contra	Health	401(k) I	Life Ins	Federa	State O
2	RESA 1/Mcdowell County	960002209	Airplane	Amber	Case Manager		10000	5000	1000	1000	0	0
3	RESA 1/Mcdowell County		Apple	Kenneth	Case Manager							
4	RESA 1/Mcdowell County	960000223	Arnold	Lawrence	Case Manager							

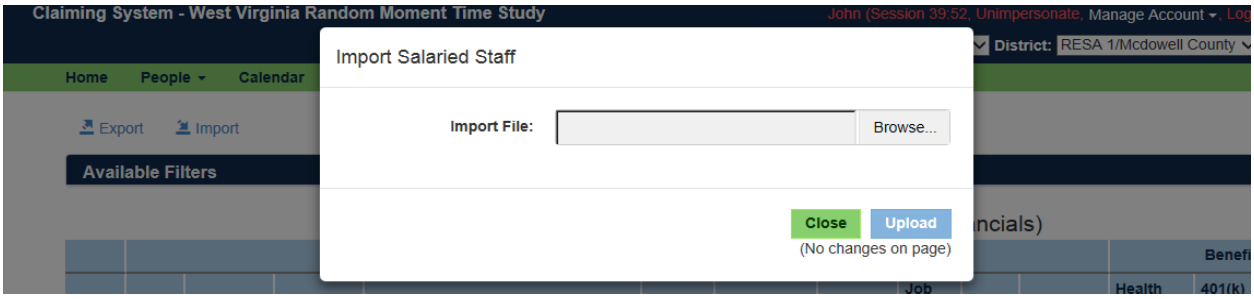
Leveraging this utility, the user can quickly enter all payroll information for every participant in their staff pool list. LEAs can use this file in conjuction with their MUNIS reports, which decreases the burdon on the school district by reducing the overall manual data entry for the user. After completing this spreadsheet as seen in Figure 15, the user can import it back into the PCG financial system.

Figure 15

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Agency	EmployeeId	LastNa	FirstNa	JobCategory	HoursPaid	Salary/Contra	Health	401(k) I	Life Ins	Federa	State O	Notes	Explana
2	RESA 1/Mcdowell County	960002209	Airplane	Amber	Case Manager		10000	5000	1000	1000	0	0		
3	RESA 1/Mcdowell County		Apple	Kenneth	Case Manager		5000	100	25	100				
4	RESA 1/Mcdowell County	960000223	Arnold	Lawrence	Case Manager		2500	100	50	200				

To import this document back into PCG's financial system, the user returns to the "Salaried Staff" screen and selects "Choose File." A dialogue box appears as seen in Figure 16, and the user selects the saved CSV document. Lastly, the user clicks "Upload."

Figure 16



The "Salried Staff" page is now completely updated as seen in Figure 17 with the information which was entered into the CSV document.

Figure 17

Salaried Staff (Quarterly Financials)

									Benefits		
Agency	Emp Id	Name	Job Cat	Cost Pool	Title	Job Span	Hours	Salary	Health Insurance	401(k) Plan	Life Insurance
RESA 1/Mcdowell County	960002209	Airplane, Amber	Case Manager	Targeted Case Management	Special Education Teacher			$10,000.00	$5,000.00	$1,000.00	$1,000.00
RESA 1/Mcdowell County		Apple, Kenneth	Case Manager	Targeted Case Management	Special Education Teacher			$5,000.00	$100.00	$25.00	$100.00
RESA 1/Mcdowell County	960000223	Arnold, Lawrence	Case Manager	Targeted Case Management	Special Education Teacher			$2,500.00	$100.00	$50.00	$200.00

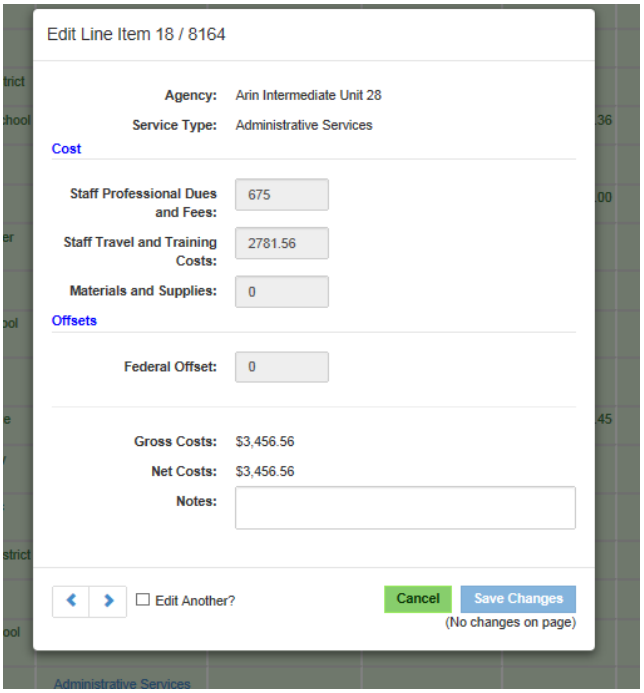
On the "Other Costs by Service Type" screen, the user has the option to enter in other costs associated with the various service types listed in the district's staff pool list as seen in Figure 18. Such "Other Costs" include materials and supplies, staff professional dues and fees, and staff travel and training costs. If the district incurred costs for any of these categories, they were not paid using federal funds, and they can be directly associated with someone listed on the staff pool list, then the district could report them below. If federal funds were used to pay for any of the "Other Costs," they could be reported in the "Federal Revenues" column.

Figure 18

Other Costs by Service Type (Quarterly Financials)

		Cost			Offsets			
Agency	Service Type	Staff Professional Dues and Fees	Staff Travel and Training Costs	Materials and Supplies	Fed Offset	Gross	Net	Clear
Abington Heights School District	Administrative Services							

Figure 19



To enter other costs for each service type as seen in Figure 19, the user clicks on the service type. The West Virginia district contacts have been trained to understand that federal funds are not claimable, but can be listed in the "Federal Revenues" column. The system will subtract these costs from the total reported costs. In addition, contacts have been informed that costs reported in the "Other Costs" section must be able to be tied back to a participant listed on the staff pool list.

PCG's Claiming System has many quality control measures that PCG implemented for West Virginia to ensure accurate data is reported throughout the financial submission process. PCG has developed a number of edit checks to ensure the information submitted by LEAs is reasonable and to catch obvious errors. Each of the edit checks are customizable and configurable to meet the needs of our specific clients. Furthermore, we typically review the list of edit checks with our clients and work to identify additional edits checks in order to improve program compliance. One such edit check we regularly perform is an analysis on the reasonableness of salaries/benefits reported by LEAs. For example, for this specific edit check, calculations are performed by taking the statewide salary and benefits per job category for the previous fiscal year, and then PCG calculates one standard deviation above the mean for each job category. This number is used as the salary and benefit threshold for each job category.

Below is a list of some of the edits that are conducted automatically by this system. The list is not an all-inclusive list of system edits.

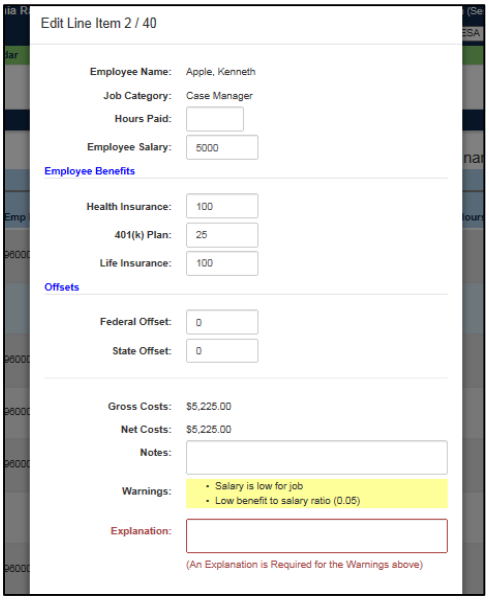
- Contracted staff costs for staff identified as "employees"
- Employee Salary costs for staff identified as "contractors"
- No Cost data reported for an individual
- High Reported Salary Amount
- High Reported Benefits Amount
- High Reported Direct Support Staff Salary Amount
- High Reported Direct Support Staff Benefits Amount
- Reporting Non-compensation costs (ex. Materials and Supplies) in a job category without reported compensation costs
- Federal Revenues Exceeds Total Reported Payroll Costs

There are three levels of edit checks in the system.

- **Level 1**: This type of edit check will not allow information to be saved when entering it directly into the system in an inappropriate field. An error message will appear, describing the error and how to correct it. For example, if a school district tries to enter a negative number in a salary or benefit field, or if they try to enter contracted costs and a salary for the same employee.
- **Level 2**: This type of edit check will flag something unexpected. The system will allow the district to provide an explanation.
- **Level 3**: This type of edit check will not allow the flagged entry to be certified. The entry must be corrected before saving an employee's costs.

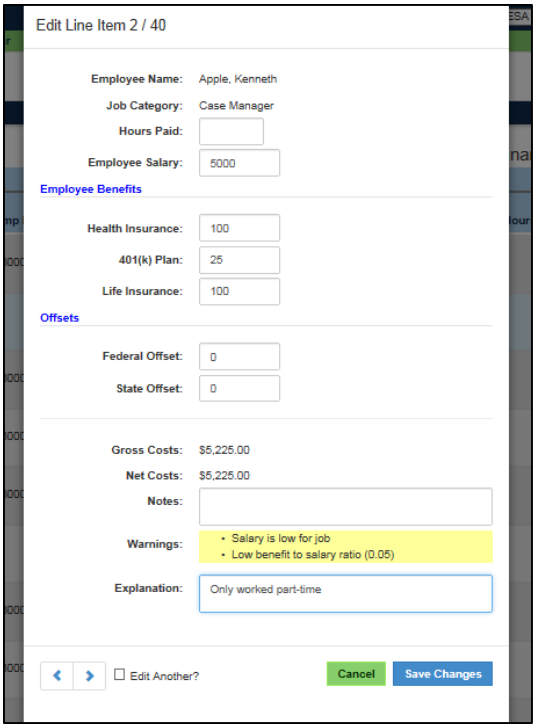
The screen shot seen in Figure 20 notifies the user that there are edits that need to be resolved or explained before submitting a participants financial data (Salary is low for job).

Figure 20



As reflected in Figure 21, once the flagged costs have been corrected, or an explanation has been given, the user is then able to save changes to that participants costs.

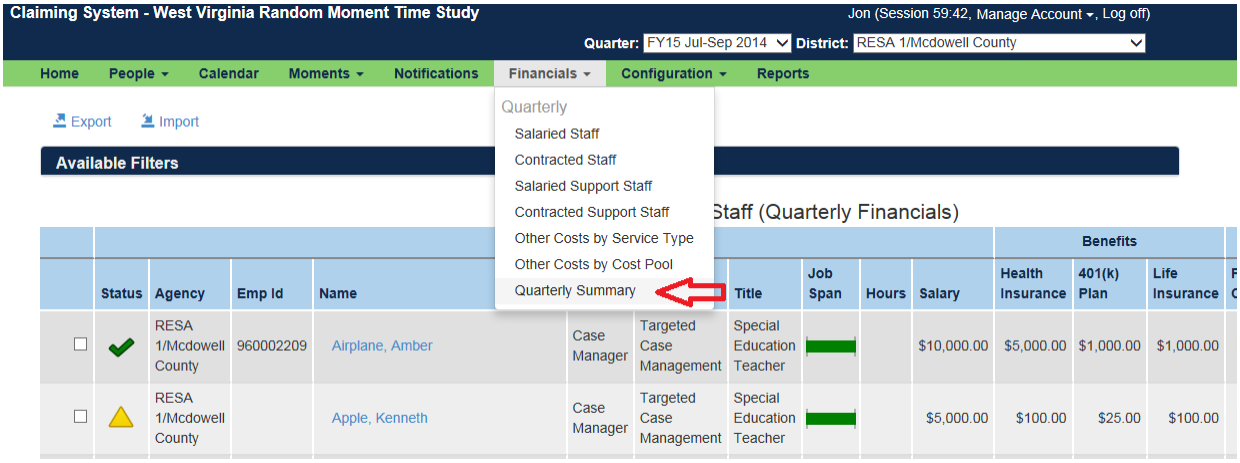
Figure 21



Since the system notifies the district immediately when costs are reported outside of predefined ranges, LEAs are able to correct mistakes either identified through the edit checks or provide further explanation instantly without receiving unnecessary emails requesting follow-up.

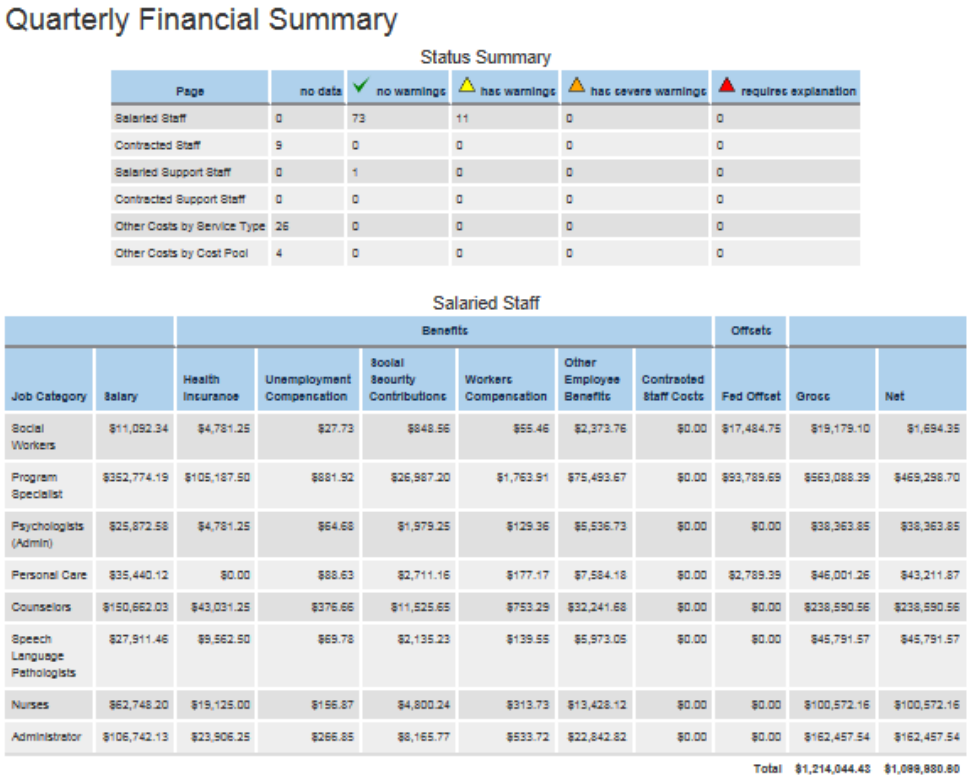
After entering all costs and resolving edit checks, the user returns to the "Financials" tab and proceeds to the last step, "Quarterly Summary" as shown in Figure 22.

Figure 22



The "Quarterly Summary" page shown in Figure 23 reflects the summary of costs reported in the previous steps, as well as a summary of the edit checks that were performed in the financials. The West Virginia district contacts have found this screen helpful as they can see the aggregated costs per job category and confirm that what they entered is accurate.

Figure 23



Quarterly Financial Summary

Status Summary

Page	no data	no warnings	has warnings	has severe warnings	requires explanation
Salaried Staff	0	73	11	0	0
Contracted Staff	9	0	0	0	0
Salaried Support Staff	0	1	0	0	0
Contracted Support Staff	0	0	0	0	0
Other Costs by Service Type	26	0	0	0	0
Other Costs by Cost Pool	4	0	0	0	0

Salaried Staff

		Benefits						Offsets		
Job Category	Salary	Health Insurance	Unemployment Compensation	Social Security Contributions	Workers Compensation	Other Employee Benefits	Contracted Staff Costs	Fed Offset	Gross	Net
Social Workers	$11,092.34	$4,781.25	$27.73	$848.56	$55.46	$2,373.76	$0.00	$17,484.75	$19,179.10	$1,694.35
Program Specialist	$352,774.19	$105,187.50	$881.92	$26,987.20	$1,763.91	$75,493.67	$0.00	$93,789.69	$563,088.39	$469,298.70
Psychologists (Admin)	$25,872.58	$4,781.25	$64.68	$1,979.25	$129.36	$5,536.73	$0.00	$0.00	$38,363.85	$38,363.85
Personal Care	$35,440.12	$0.00	$88.63	$2,711.16	$177.17	$7,584.18	$0.00	$2,789.39	$46,001.26	$43,211.87
Counselors	$150,662.03	$43,031.25	$376.66	$11,525.65	$753.29	$32,241.68	$0.00	$0.00	$238,590.56	$238,590.56
Speech Language Pathologists	$27,911.46	$9,562.50	$69.78	$2,135.23	$139.55	$5,973.05	$0.00	$0.00	$45,791.57	$45,791.57
Nurses	$62,748.20	$19,125.00	$156.87	$4,800.24	$313.73	$13,428.12	$0.00	$0.00	$100,572.16	$100,572.16
Administrator	$106,742.13	$23,906.25	$266.85	$8,165.77	$533.72	$22,842.82	$0.00	$0.00	$162,457.54	$162,457.54
								Total	$1,214,044.43	$1,099,880.80

Costs are totaled by job category, which allows the user to verify total costs prior to certifying. Allowing the district to view the total costs that will be included in the claim prior to submission allows the district to confirm accuracy one final time prior to locking the data.

After reviewing all summaries, the user scrolls to the top left of the screen and clicks the "Certify Quarterly Financial Submission" button seen in Figure 24 to certify the district's financials.

Figure 24

After clicking the "Certify Quarterly Financial Submission," the "Quarterly Financial Submission" tab now shows that the quarter has been successfully certified. The system stores which user in the district certified the data as well as a timestamp of when they certified. This is helpful in the case of an audit to verify exactly who within the district completed the certification.

Once all LEAs have submitted and certified their financial data on the Claiming System, PCG begins its claim generation process.

4.1.2.3 – The Vendor shall be responsible for developing a standardized, Internet-based system for collection of RMTS system information which may include, but not be limited to, collection of LEA staff rosters, adjustments to staff rosters and school calendars.

PCG will fulfill this responsibility by continuing to utilize PCG's Claiming System, an advanced and user friendly RMTS website which is suitable to meet all of the requirements specified in the RFQ, and is currently implemented in West Virginia, as well as an additional 11 states nationally. Within this section, is an overview of the streamlined approach PCG has implemented to ensure that staff rosters are accurate and complete for both RMTS and Administrative Claiming, in addition to making certain that moments are being sampled and assigned correctly based on our school calendar and "Shift" features.

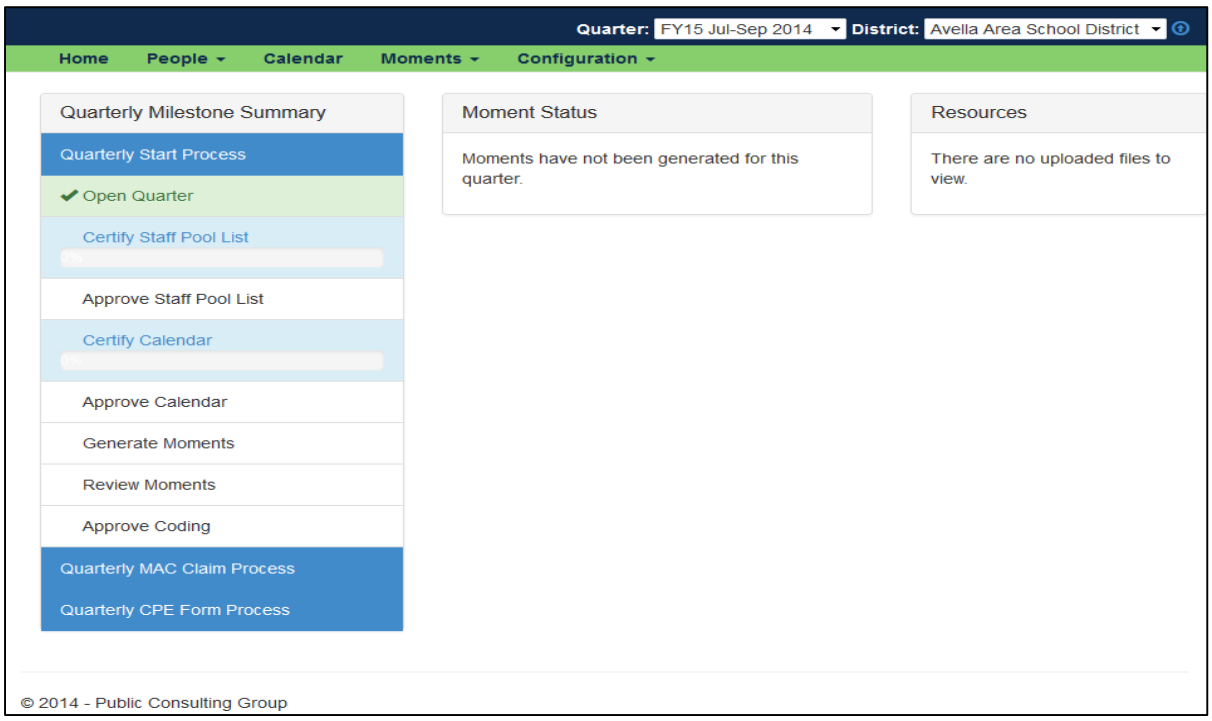
Staff Roster and School Calendar Overview

Once district contacts are added to the PCG Claiming system, district contacts will receive an email with the subject 'New Account Registration' from a 'do not reply' email address. First time users need to click the web link in the email and will then be brought to the page shown in the figure below to enter their password in the 'Password' and 'Confirm Password' fields. Users then click the 'Complete Registration' button and they will be brought back to the main page to enter the email and new password to log into the site.

If the district contact does not have their password, they can select the "Forgot Password" button, which will instantly connect them with instructions on how to enter the system. In addition to the "Forgot Password" button, they can either call our PCG Hotline at 877-908-1745 or email wvsbhs@pcgus.com for assistance. Allowing various methods for the district to contact PCG increases the probability that they will update their staff pool list on time, feel comfortable asking questions, and confirm their participant's compliance

Below is the home screen available after logging into the Web site. The home screen contains links to all of the functionality within the system, including links to People, Calendars, Moments and Configuration. Users navigate through the system using links to each of the sections. The home screen navigation links are circled in Figure 25 below. The home screen also contains data fields known as widgets that display information regarding quarterly milestone summaries, moment status and resources uploaded by PCG. Users click on the 'Home' link at any time to return to the home screen shown in Figure 25 below. The desired quarter needs to be selected by clicking on the 'Quarter' dropdown at the top of the home screen to edit or monitor information pertaining to that quarter**.** The 'Quarterly Milestone Summary' on the left of the home screen displays the status of the claiming process for each quarter. LEAs are only responsible for tasks that appearing in light blue hyperlink text. State administrators or PCG staff complete tasks that are green, blue or white.

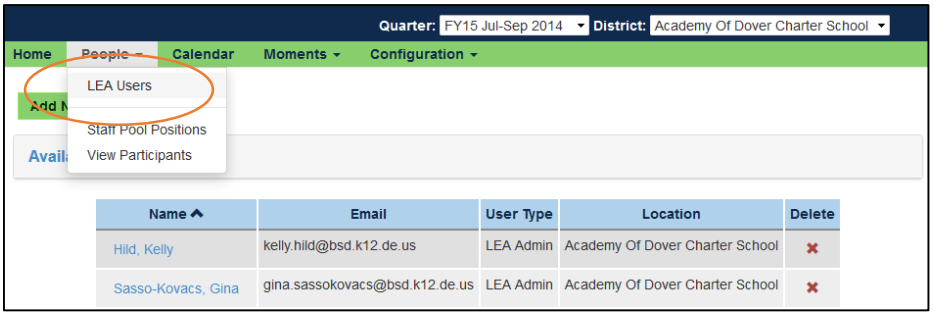
Figure 25



Updating Users

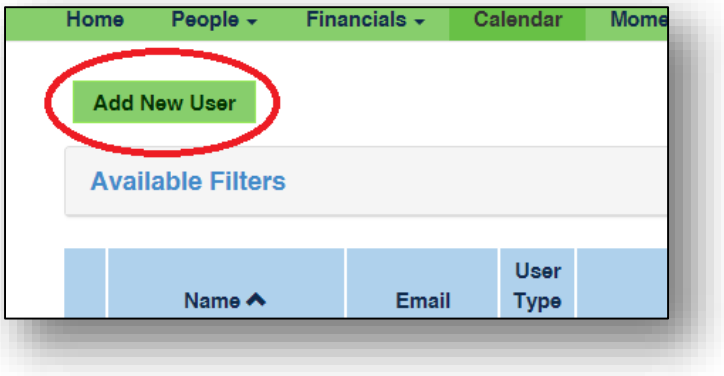
Figure 26 shows the 'People' dropdown where Coordinators can add users (LEA Admin users can add or update LEA Users) by selecting the identifying menu (LEA Users).

Figure 26



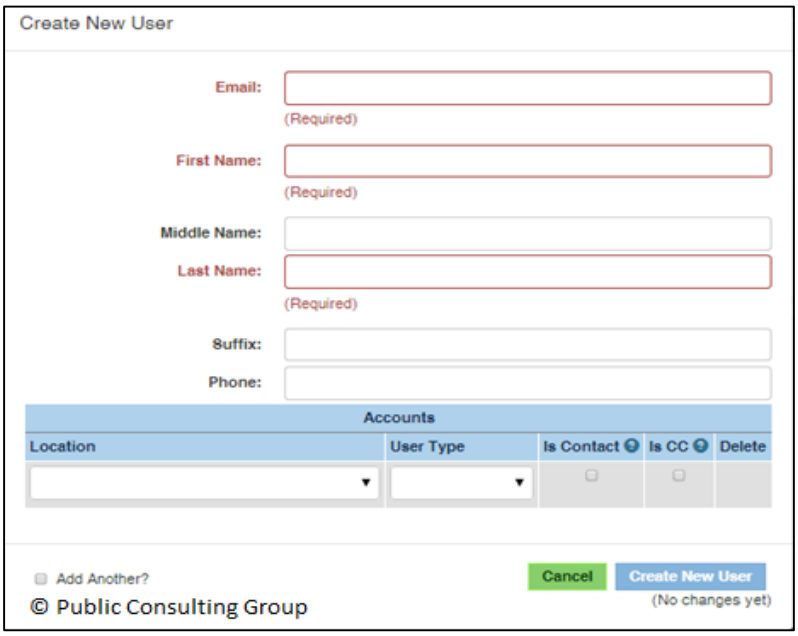
Users select the green button 'Add New User' and a fill in screen will appear to add the user's information as seen in Figure 27.

Figure 27



Users enter all of the required contact information, the location the contact will have access to (only locations the user has access to will appear) and user type. They then select the check box for 'Is Contact' if the user should receive program and system information and 'Is CC' if the user should receive RMTS late notifications for participants at the assigned location. Once all of the information has been entered, users click 'Create New User' to save the information in the site. Figure 28 shows the available fields for creating new users. The site then sends the user an email with instructions to access the system.

Figure 28



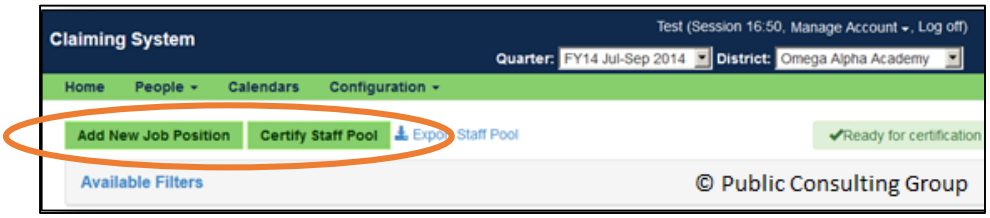
Updating & Certifying the Staff Pool Lists (SPL)

In the previous RMTS system utilized by West Virginia, the Staff Pool List (SPL) was made up of "participants;" however, in the new system, the staff pool list consists of "positions" which can be filled with a participant.

It is important for LEAs to have an accurate SPL, as the information will be used to claim the costs associated with the staff on this list. In order to verify the information included in the SPL, it is important for coordinators to routinely work with LEA staff responsible for the financial duties. Coordinators update their SPLs at the beginning of each quarter using the Web-based PCG Claiming System.

To view, create and/or update the SPL, district contacts click on the 'People' tab on the home screen and select 'Staff Pool Positions.' The two main components of the 'Staff Pool' page are the 'Add New Job Position' and 'Certify Staff Pool' buttons. These are shown in Figure 29 below. The 'Add New Job Position' button is how users can add new job positions to their staff pool list. The 'Certify Staff Pool' button is the button that users click to certify and lock their staff pool in the Claiming System.

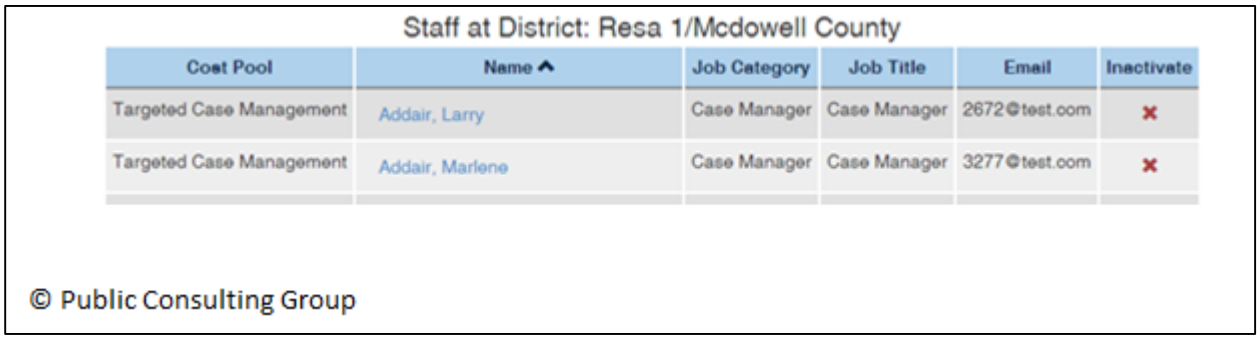
Figure 29



After clicking 'Staff Pool Positions' under the 'People' dropdown, all current active staff members in the particular school district will appear with the following information also seen in Figure 30 below:

- Agency (the District or LEA)
- Cost Pool (Targeted Case Management, Direct Service, Admin, Personal Care)
- Job Category
- Job Title
- Full Name
- Email
- Indication of Inactive Status (a red X in the 'inactivate column means that the positions are currently active but can be inactivated by clicking the red X)

Figure 30



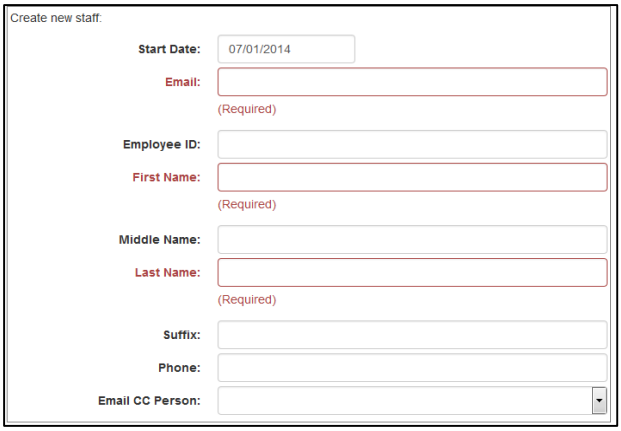
Adding a New Job Position

1. To add a user, district contacts select the green button 'Add New Job Position' and a fill in screen will appear to add the user's information. Figures 31, 32 and 33 below show fields that should be filled in to add participants to new job positions.

Figure 31

Figure 32

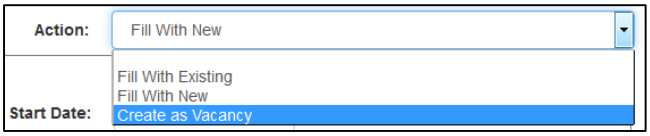
Figure 33



2. Users enter in all of the required information (noted with "Required" text below each required field). When adding a new staff person, users select 'Fill With New' from the 'Action' dropdown and are careful to select one of the names in the 'Email CC Person' dropdown who will receive notifications regarding pending moment submissions. Once all of the information has been entered, users click 'Create New Job Position' to save the information on the site.

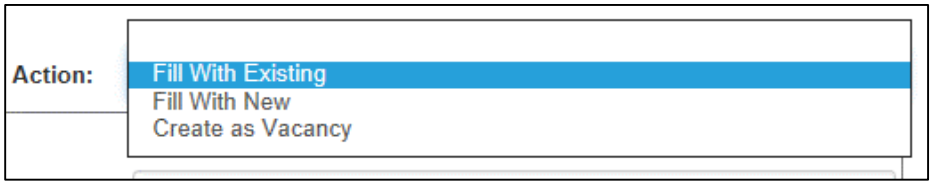
***Adding a New Vacancy Position*:** Users can add a position as a 'vacancy' if they expect to fill the position during the quarter. When adding a vacancy, users select the 'Create as Vacancy' option from the 'Action' dropdown shown in Figure 34.

Figure 34



Filling a New Position with an Existing Staff Member: When selecting an existing staff, users select the 'Fill with Existing' option seen in Figure 35.

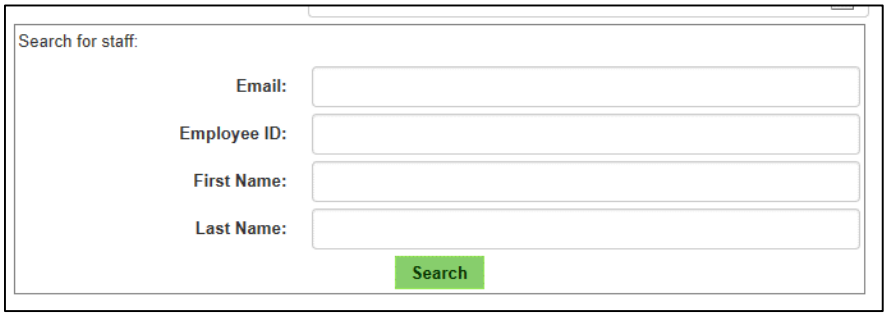
Figure 35



Note: Only staff that are inactive and not assigned to another position can be selected to fill a position. If changing a staff person from one cost pool to another, users delete the position in the current cost pool then add a position in the correct cost pool and select 'Fill With Existing' to choose an existing staff person.

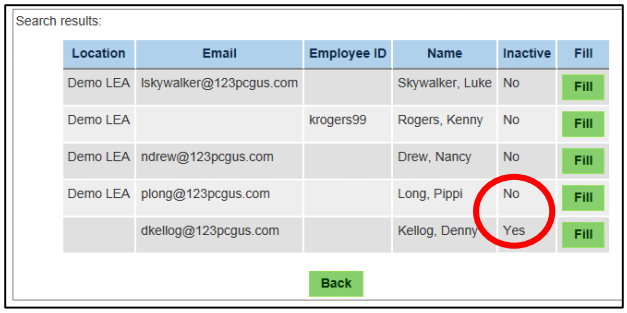
The PCG Claiming System makes searching for the staff person by entering specific criteria in the search fields simple. Figure 36 shows these search options.

Figure 36



All staff, both inactive and active, will appear in the search results based on the criteria selected. 'Yes' under the column header 'Inactive' means the participant is inactive and can be selected to fill the position. 'No' in the 'inactive' column indicates the staff is active in the district as shown in Figure 37. Only a participant that is not assigned to a current position (having a 'Yes' in the column 'Inactive') can be selected. Select the 'Back' button to redo search criteria or to return to the adding participant screen.

Figure 37



A users clicks the 'Fill' button once the desired staff is located to populate the job position.

Figure 38

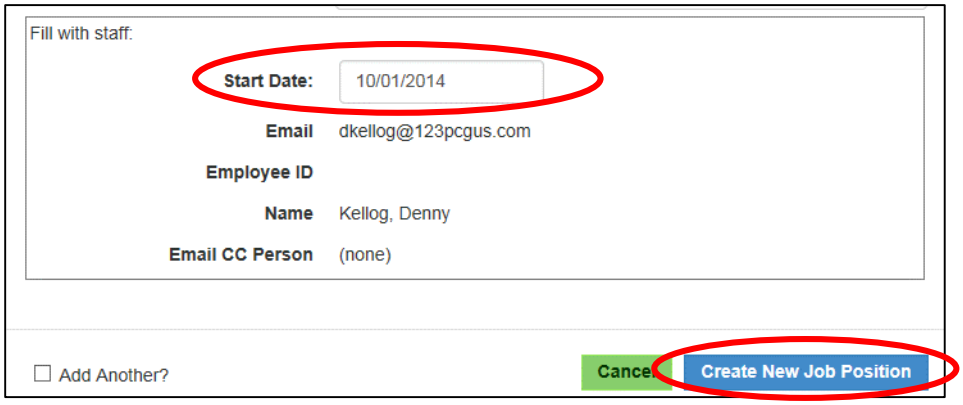


Figure 38 above shows how users can enter the start date that the existing staff person is beginning the new position. The system will default to the first day of the quarter. Users then select 'Create New Job Position' to save it.

Delete & Edit a Staff Member: To edit a contact's information, district contacts simply click on desired name highlighted in blue. To inactivate a participant, simply click on the red 'X' mark shown in Figure 39 below.

Figure 39

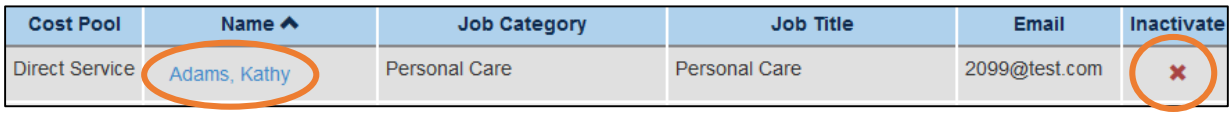
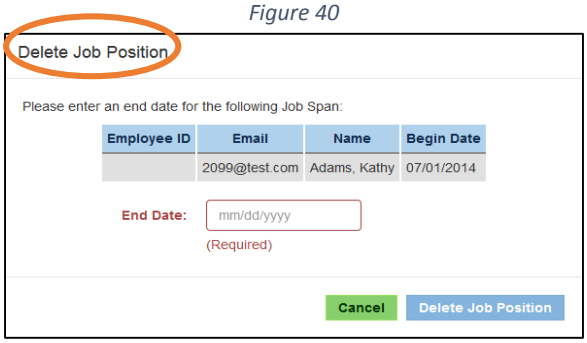


Figure 40



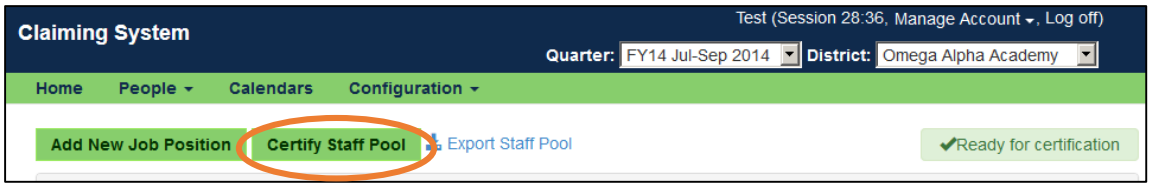
A 'Delete Job Position' form will display like the one shown in Figure 40 with an 'End Date' required field. Users enter the staff member's last day if it remains within the current quarter. If the staff member's last day falls outside of the current quarter and the participant no longer wishes to receive moments following the current quarter, enter the last day of the quarter as the end date.

Certifying the Staff Pool

Once all staff members' contact details have been updated and verified, the LEA must certify the Staff Pool List. Before certifying the SPL, please be sure the list is accurate and complete.

1. Users click on the 'Staff Pool Positions' link from the 'People' dropdown on the 'Home' screen.
2. The staff pool will display. Users will select the 'Certify Staff Pool' box to certify the staff pool as shown in Figure 41.

Figure 41

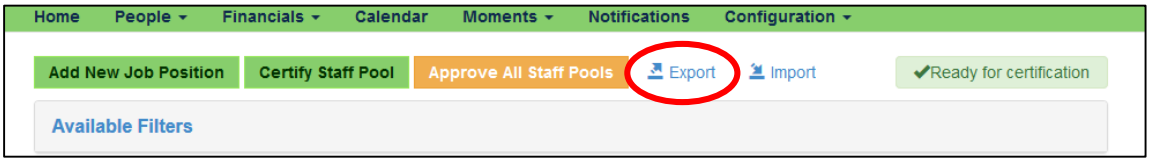


The system will display the message that the list has been certified successfully.

Exporting and importing the Staff Pool List

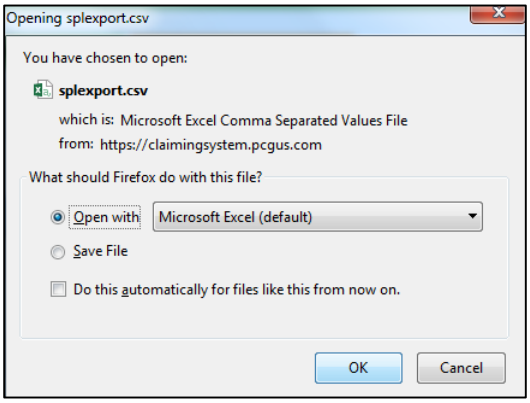
As an additional option, staff can export the SPL, make updates and then import the file into the site. To export the file users will go to the 'People' tab and choose 'Staff Pool Positions' where you will see 'Export' on the top of the screen as shown in Figure 42.

Figure 42



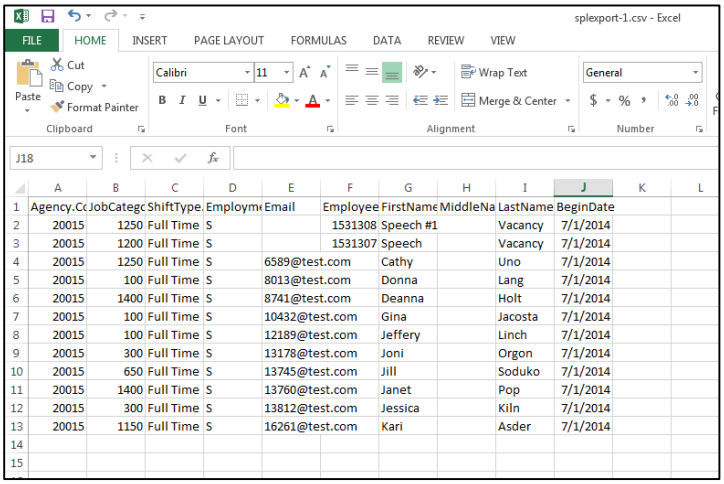
A pop up box will appear. Users will click 'OK' as shown in Figure 43.

Figure 43



This will allow the file to open, it will open in .CSV format and the user will need to save this file in Excel format as shown in Figure 44.

Figure 44



	A	B	C	D	E	F	G	H	I	J	K	L
1	Agency.Co	JobCategc	ShiftType.	Employm	Email	Employee	FirstName	MiddleNa	LastName	BeginDate		
2	20015	1250	Full Time	S		1531308	Speech #1		Vacancy	7/1/2014		
3	20015	1200	Full Time	S		1531307	Speech		Vacancy	7/1/2014		
4	20015	1250	Full Time	S	6589@test.com		Cathy		Uno	7/1/2014		
5	20015	100	Full Time	S	8013@test.com		Donna		Lang	7/1/2014		
6	20015	1400	Full Time	S	8741@test.com		Deanna		Holt	7/1/2014		
7	20015	100	Full Time	S	10432@test.com		Gina		Jacosta	7/1/2014		
8	20015	100	Full Time	S	12189@test.com		Jeffery		Linch	7/1/2014		
9	20015	300	Full Time	S	13178@test.com		Joni		Orgon	7/1/2014		
10	20015	650	Full Time	S	13745@test.com		Jill		Soduko	7/1/2014		
11	20015	1400	Full Time	S	13760@test.com		Janet		Pop	7/1/2014		
12	20015	300	Full Time	S	13812@test.com		Jessica		Kiln	7/1/2014		
13	20015	1150	Full Time	S	16261@test.com		Kari		Asder	7/1/2014		
14												
15												

Calendar Completion

Staff included on the SPL are eligible to receive Random Moment Time Study (RMTS) surveys throughout each quarter. Because each LEA has a different schedule, we need a way to ensure that staff members have a high likelihood of receiving a moment during hours when they will be at work. To do this, we collect calendar information for each participating LEA. At the beginning of each quarter, LEAs are notified that their SPL is open to be updated for the upcoming quarter. Roughly one month before each quarter begins, non-work days must be selected on the calendar (e.g. enter non-work days in December for January – March quarter) and the calendar must be certified. The RMTS system uses this information when assigning moments to ensure they are distributed during working hours. This is important to guarantee that a large enough sample of working moments is gathered.

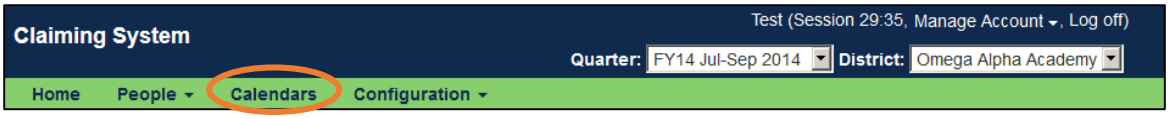
The calendar collection process has been made simple in the new system being utilized by West Virginia. Instead of collecting hundreds of Excel documents, proofing them, aggregating them, importing them into the system, and then manually entering in start/end times, the LEA Admin enters the information directly into the system. LEAs enter non-work days directly into the PCG Claiming System to prevent staff from being selected for a moment on days that they will not be at work. After entering all dates, the LEA certifies the calendar.

LEAs must certify the calendar first, and then State Administrators will be able to approve the calendar. Each LEA must certify the calendar before EACH quarter in order for the non-working days to be excluded from being selected for moments.

To enter staff days off:

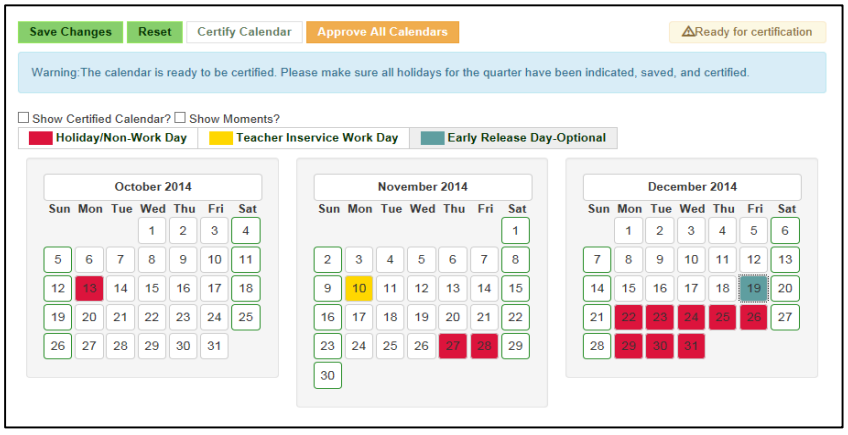
1. Users will click the 'Calendars' link at the top of the home page as seen in Figure 45.

Figure 45



2. **Holiday/Non-Work Day is the only selection that indicates non work days for staff.** The Teacher In-service Work Day and Early Release Day-Optional selections can both be used if the LEA wishes to indicate them on the calendar, but they will not be days that are removed from the time study. As shown in Figure 46, users select Holiday/Non-Work Day and then click on the days on the calendar that correspond to the days off for the district. If a day is selected in error, users simply click it again to refresh.

Figure 46

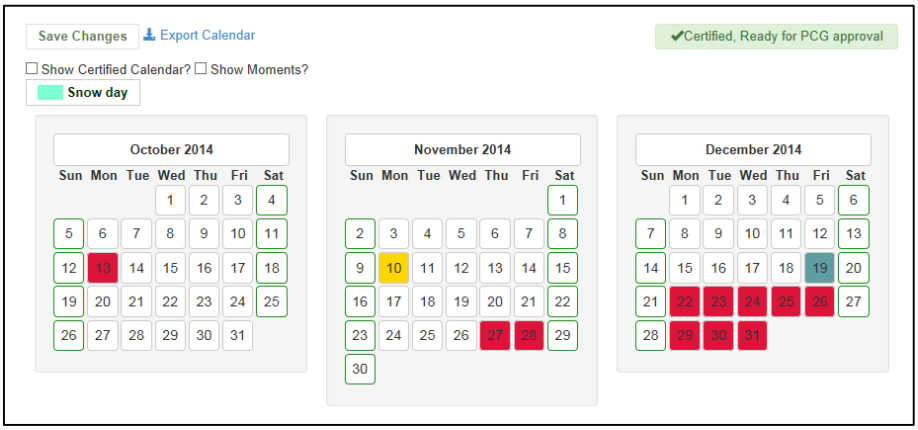


3. As shown in Figure 47, users click 'Save Changes' to lock in the non-work days and then click 'certify calendar.' Contact PCG to make changes to the calendar if certification is selected prematurely. Only PCG can unlock a district calendar.

Figure 47

Once a calendar is certified, it locks and the snow day selection is displayed as shown in Figure 48. Users can utilize this throughout the quarter to identify any days off that the district schedules unexpectedly. PCG will use this information to assist in completing moments.

Figure 48



Show Certified Calendar?

Checking this box will refresh the calendar and show the calendar that was originally certified. It will hide the changes made since certification.

Show Moments?

Checking this box will refresh the calendar, and instead of days of the month, the calendar will display how many moments are generated on each day. You can use this feature to make sure that moments were not generated on holidays. You can also use this feature to get a sense of the distribution of the moments.

Entering Shifts

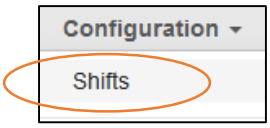
PCG recognizes that not every LEA or school on the staff pool list begins and ends their workday at the same time. The creation of shifts in the new system allows for differences in schedules per LEA or school to be created within each LEA to capture the truest working time for each participant. An LEA can create multiple shifts for staff that have set schedules. If an LEA has a part time staff person, but their schedule is flexible, that participant must be assigned the full time shift. At a minimum, an LEA must have a full time shift that encompasses the contracted work time. Other examples of shifts the LEA may set are:

- Shift for high schools
- Shift for elementary schools
- Shift for administrators contract time
- Shift for part time staff members with a set schedule (M-F 8-12 or MWF 1:00pm-3:00pm, etc.)

To enter shifts:

1. As shown in Figure 49, users go to the 'Configuration' drop down on the home screen and select 'Shift.'

Figure 49



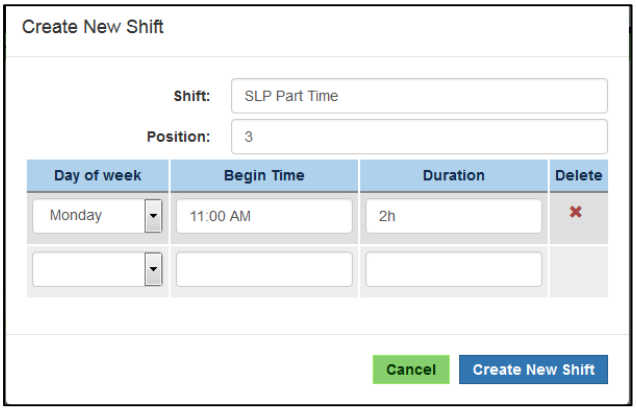
2. As shown in Figure 50, users click on 'Add New Shift.'

Figure 50

Users should type in a Name for the shift being created as shown in Figure 51. Naming conventions should be easy to identify so that a correct shift can be selected for a staff person. Naming convention examples:

- M-F 8-12
- T, W, TH 8-3
- Full Time HS 8-3:30
- Full Time Toyon Elementary school

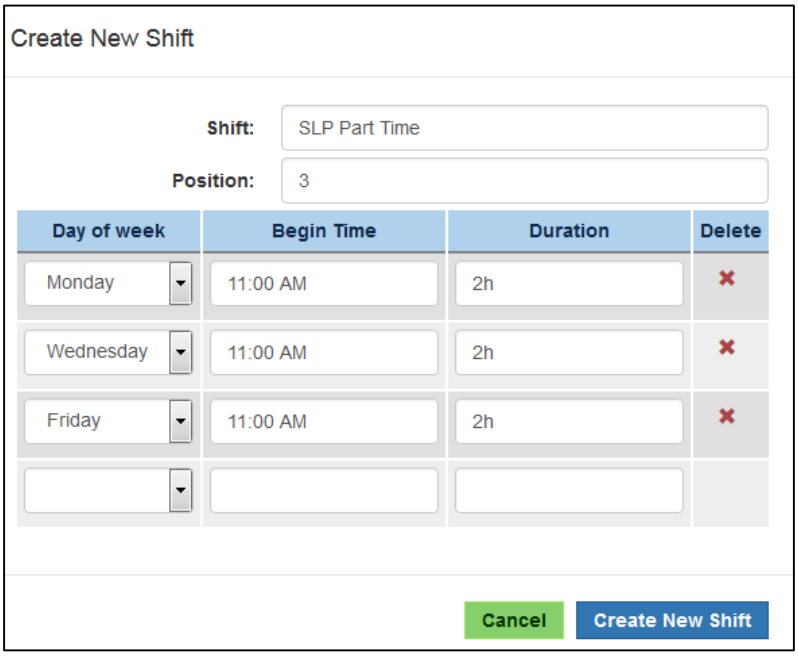
Figure 51



4. The Position is there to indicate the order you want your shifts to appear in the drop down for your staff pool (Positions.)
5. Choose the day of the week for your shift from the drop down. Each day must be added to the shift separately. If the shift is 2 or more days, steps 5-7 will be repeated until the full shift has been identified.

6. Enter the starting time in the following format 8:00 AM/PM or military time (13:00 = 1:00 PM.) Note: LEAs will enter the duration time instead of an end time.
7. Enter the duration of the shift in the following format #h #m (substituting # for the actual duration of hours and/or minutes e.g. 2h 30min) – This is not the ending time, but instead is the length of the shift. The system will determine the ending time based on the start time entered in step 6 and the duration of the shift entered in this step.
8. Repeat steps 5 – 7 for each of the days, which are associated with this shift and click 'Create New Shift' to save it in the system.

Figure 52



9. The shift will then be saved in the system and can be assigned to job positions as shown in Figure 52.

4.1.2.4 – The Vendor shall ensure that the Web-based system is populated with all required LEA information for RMTS activities that is necessary to calculate LEA-specific Administrative Claims. The Vendor shall be responsible for implementing the Administrative Claiming Process.

As described throughout this proposal, PCG will ensure that the Claiming System implemented in West Virginia will continue to contain all information necessary for both implementing the RMTS and calculating quarterly Administrative Claims. One of the major benefits of PCG's web-based Claiming System is that the staff that are certified by the district prior to each quarter are the same staff members that the district's business/finance director sees when logging into PCG's financial reporting site. This allows the LEAs to ensure that the participants match up properly, increasing compliance and decreasing the audit risk of claiming costs for unallowable participants.

Once LEAs have certified staff pool lists, adjusted school calendars, and created correct working shifts, PCG has all of the components necessary to implement the RMTS, code and monitor responses, and use those results to implement the Administrative Claiming Process based on district reported allowable costs. *Information on the Administrative Claiming process is detailed in Section 4.1.2.8.*

4.1.2.5 – The Vendor shall ensure that its data stores, process and calculation methodologies include the capacity to adjust any prior period or current period data necessary for claim adjustment and/or recalculation.

Once a quarter has been certified by financial contacts in the Claiming System, the district cannot edit any financial information without contacting PCG. This limitation enables PCG to control when LEAs are making changes to their certified financials. In certain situations, the district may realize that they incorrectly reported costs for a previous quarter. If they realize their error before the quarterly claim has been generated, PCG has the capability to roll-back the quarter and allow the district contact to make his/her changes and certify again. However, in other cases, the district may want to make changes to their costs after the claim has been paid. PCG's quarterly amendment process allows the district to make changes while still capturing the originally certified data. This is important to track the originally claimed data in the case of an audit. All historical data is captured and stored securely for accurate claiming and to ensure a clean audit trail. In addition, the newly amended data is captured to keep a trail of the most recently processed claim data.

West Virginia school district contacts also have view access to their previously submitted financial data and amended data dating back to July 2012. The historical data is securely stored within PCG's previous Medicaid Cost Reporting system MCRCS which offers easy access for the LEAs to view the previous data that they reported. Storing this historical data will become very useful to the district in the case of an audit.

4.1.2.6 – The Vendor shall maintain LEA-specific information for the Administrative Claim, including, but not limited to, quarterly claim summaries, staffing information supplied by the LEAs, and other pertinent information that the Vendor utilized in calculating the claim align with relevant documentation, concerning the Administrative Claim, for access by the respective LEA.

PCG is currently providing Administrative Claiming support services on a statewide, consortium or district level in over 15 states. This experience allows us to provide extensive reporting and analysis around Administrative Claiming reimbursement levels by LEAs. Our experience not only allows us to draw comparisons within a state, but against other states and LEAs throughout the country. Several factors can affect the level of Administrative Claiming reimbursement: expenditure data, non-restricted indirect cost rates, Medicaid eligibility rates, time study results, staff listed on the staff pool and the use of federal funds to name a few. We provide quarterly reports that are designed to look at all of those factors independently as well as their cumulative effect. This is a critical factor in determining whether or not a district is optimizing their Administrative Claiming revenue. Should a district add more staff to their staff pool list? The answer to that question depends on the expenditure level associated with those staff and the amount of

time they spend on reimbursable activities. PCG looks at this data to provide LEAs insight into the creation and maintenance of their quarterly staff list. Our reporting is another factor that distinguishes PCG from others in the marketplace.

4.1.2.7 – The Vendor will be responsible for coordinating with assisting DHHR/BMS the collection and editing of all data from State agencies including, but not limited to total enrollment and enrollment of special education students, that is necessary to carry out this program and meet CMS requirements based on the relevant regulations and CMS guidance. The Vendor will evaluate the collection methods to ensure that all necessary data is collected and stored within timeframes to meet applicable CMS requirements and comply with the WV State Plan.

As the current WV SBHS vendor, PCG will continue to facilitate the process with DHHR/BMS of capturing all required data collection needed in order to submit judicious quarterly Administrative Claims. PCG understands that this practice needs to be in ordinance with all CMS and WV regulations and guidelines.

4.1.2.8 – The Vendor will be responsible for preparation of financial information used for MAC claiming.

Calculating a valid quarterly administrative claim requires a proven cost-allocation method. The cost-allocation method is a combination of complex computations and an automated integrated system. PCG has developed an approved cost-allocation model that has been utilized for other clients to obtain reimbursement for administrative activities performed. In particular, this model focuses on the following areas:

- Reimbursable Costs: The first step of our cost-allocation methodology is to ensure that all items of allowable costs are identified and included in the trial balance of expenses. These costs are aggregated into cost pools. PCG's claiming mechanism takes each cost pool and applies the appropriate time study information and/or other methodologies in order to calculate the reimbursable cost. As previously mentioned, PCG will utilize our Medicaid Cost Reporting (EasyMAC) web-based tool in WV to streamline cost capture and compliance.

- Time Study Results: The time study results are entered into our claiming model and applied against the expenditures (e.g. salary, fringe benefits, materials, supplies, and capital) of participating groups in the time study.

- Eligibility Ratios: A key component of the claim is the calculation of the Medicaid eligibility rate, the special education Medicaid eligibility rate, and the general administration overhead factor. PCG will determine these percentages on a quarterly basis and use them in determining the reimbursable amount of each cost pool.

- Federal Match Rate: Each area of reimbursable cost will be applied against the appropriate federal financial participation rate.

The final step is to prepare, perform quality assurance checks, and submit the actual claim. Claims will be submitted in the required format. All administrative claims prepared on behalf of divisions will be consistent with Office of Management and Budget Circular A-87 (OMB A-87) federal cost allocation guidelines. We will use our knowledge of these regulations to ensure the full compliance with all federal requirements. It is important that the claim contain all supporting documentation in the event of audit.

- Check Claim: PCG is committed to submitting all claims accurately. We've built into our claim preparation process both automated and manual quality assurance procedures. Our claim program contains many automated checks that ensure that the integrity of equations and data is maintained. In addition, after a claim is prepared, various elements of the claim are compared to past quarter results to see if there are any conspicuous differences.

- Supporting Documentation: All costs must be identified, organized, and easy to trace to the various cost centers. PCG maintains computerized versions of the claims in addition to meticulous hardcopy files of all backup documentation arranged by quarter. The documentation is securely stored and can be easily accessed in the event of an audit.
- Claim Certification: As required by the State Medicaid Agency, a claim certification statement must be signed by a financial representative of the school or city prior to submission of the claim. PCG will generate this claim certification and obtain the appropriate signature.

- Claim Submission: Finally, PCG will furnish DHHR/BMS with all claims (including adjustments) to be submitted on the CMS-64 by the end of the month following the end of the quarter.

4.1.2.9 – The Vendor is responsible for any component not previously communicated that is required to support MAC claiming.

PCG understands and will continue the responsibility of fully supporting all aspects of MAC claiming. PCG also recognizes that components of MAC claiming for which have not been previously communicated are the full responsibility of the vendor.

4.1.3
Direct Service Claiming – Cost Reporting Requirements

4.1.3 Direct Service Claiming – Cost Reporting Requirements

4.1.3.1 The Vendor shall be responsible for development and implementation of a CMS approved, web-based cost reporting system that will be based on the State Fiscal Year End (June 30). The cost reporting system must be operational within ninety (90) days of contract award.

PCG features technologies that simplify, streamline, and satisfy state and federal requirements for a successful cost settlement program. PCG will deploy our proprietary web-based Claiming System that incorporates both time study and financial reporting capabilities to support LEA claiming, with extensive and proven track records in jurisdictions across the country. PCG's Claiming System is a robust, automated, web-based time study and cost reporting software solution specifically designed with LEAs in mind, to assist them with the complexity of the time study, administrative claiming and cost reporting processes for Medicaid reimbursement.

This solution is unlike other solutions offered by competing firms in that the financial reporting component of the system requires discrete cost reporting that enables our analysts to conduct tailored desk reviews to ensure compliance and avoid reporting errors. PCG's Claiming System provides a simple step-by-step process to direct the end user through the cost reporting process. There are a number of comprehensive edit and error checks in order to ensure information is reported accurately, which will provide DHHR/BMS and CMS with the confidence that the Medicaid cost settlement results will withstand federal scrutiny. *Our financial reporting system currently supports statewide school-based claiming programs for administrative claiming, direct services cost settlement or the combination of both in twelve states.*

PCG's Claiming System

Participating LEAs will submit annual Medicaid cost reports and complete quarterly financial data through PCG's web-based Claiming System. PCG's Claiming System is an automated, web-based software solution which is used nationally to assist states and LEAs with CPE reimbursement implementation. The Claiming System is designed specifically to assist LEAs with reporting necessary financial and statistical data and may be customized to address the specific reporting requirements of DHHR/BMS and the CPE reimbursement methodology recently approved by CMS. PCG is fully responsible for hosting and maintaining the Claiming System on PCG servers. Also, PCG's Claiming System does not require any installation on local hardware and can be accessed by any LEA or DHHR/BMS through an internet connection.

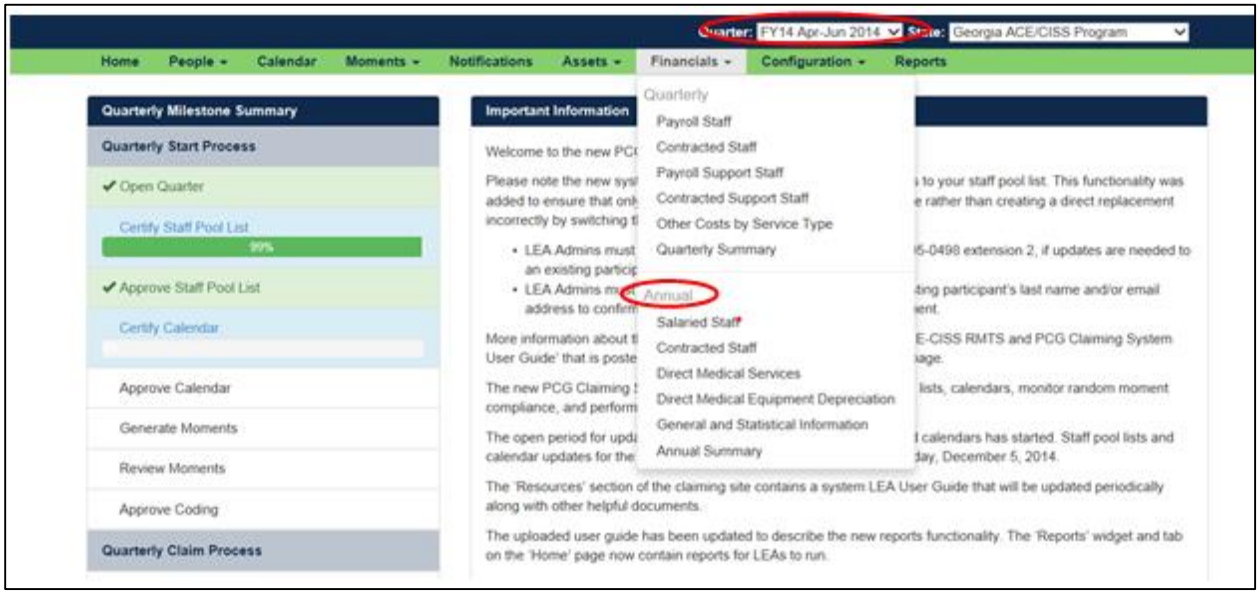
PCG's Claiming System reduces the amount of time LEAs spend to complete the cost report while enhancing understanding of the cost settlement process through a simple step by step process directing the end user. Each quarter and annually, PCG's Claiming System will contain the necessary data to facilitate cost reconciliation and settlement such as: salary and wage expenses, unrestricted indirect cost rates, the time percentage pertaining to direct care derived from time study results, Medicaid eligibility rates, and any additional operating costs permitted by CMS and approved in the West Virginia State Plan.

PCG's Claiming System simplifies the cost reporting process by populating certain fields within the cost reporting form to reduce the administrative burden to LEAs to the greatest extent possible. PCG will work with DHHR/BMS and other stakeholders to identify data elements during the design and development phases that could be pre-populated in the Claiming System. These data elements typically include district Medicaid provider numbers, national provider identifier (NPI) numbers, the direct medical services time study percentage from the RMTS, LEA specific indirect cost rates, and the total Medicaid reimbursement received through the interim payment process from the state Medicaid Management Information System (MMIS).

The screen shots on the following pages are examples of the annual Medicaid cost report pages from our current web-based claiming system for LEAs across a number of states, which can be customized easily for West Virginia.

LEAs are able to navigate through the Medicaid cost report process following the easy to use drop down screens, demonstrated on the graphic below. In addition, if an LEA has questions on allowable financial data or requires additional assistance, PCG provides comprehensive support throughout the cost report preparation process. This support is offered through our WV specific toll free hotline, as well as by a dedicated email account which is constantly monitored by PCG staff. PCG strives to provide the necessary resources to ensure LEAs have the proper support throughout the submission process.

Figure 53



Each link available on the Direct Medical Services Cost Report contains pertinent information on the completion of the report by the LEA user. LEAs are encouraged to complete each link in a sequential manner, beginning with the "Salaried Staff" tab. The screen shot in Figure 53 outlines what the user will see once this tab is selected.

Annual Salaried Staff

This page will include the direct medical services payroll information reported by job category and employment status, e.g., total number of full-time speech language pathologists. This data will automatically calculate and generate cost settlement results based upon the information entered. Much of the information on this page will be pulled from the three Quarterly staff pool lists, to help reduce the administrative burden to LEAs. Figure 54 below shows an example of the Annual Salaried Staff page.

Figure 54

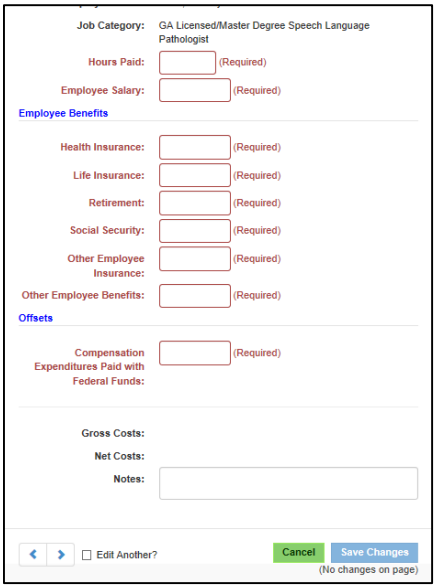
A new feature to the PCG Claiming System is the addition of the status column which is used to prompt the user when edit checks are triggered. These edit triggers have been put in place to flag any disparities or questionable costs reported – for example, if a reported salary appears to be too high for a reported job category. This mechanism has repeatedly proved successful in catching erroneous costs reported before certification of the report.

While completing the annual payroll page, the following icons may appear:

- A green check will appear if no edits were triggered and no further action is needed.
- A yellow yield sign will appear if edit checks were triggered which exceed the statewide threshold by one deviation of the average and an explanation will need to be entered before certifying.
- An orange yield sign will appear if edit checks were triggered which exceed the statewide threshold by two deviations of the average which exceed the statewide threshold an explanation will need to be entered before certifying.

The LEA user has two options for completing the Annual Payroll Information and may use whichever method is easiest for them. The first option is to enter data by line item, as exhibited in Figure 55, where information for each individual may be completed on a line-by-line basis. This option may be useful for users of small LEAs with few employees on the SPL, or to make edits to a single employee's payroll information.

Figure 55

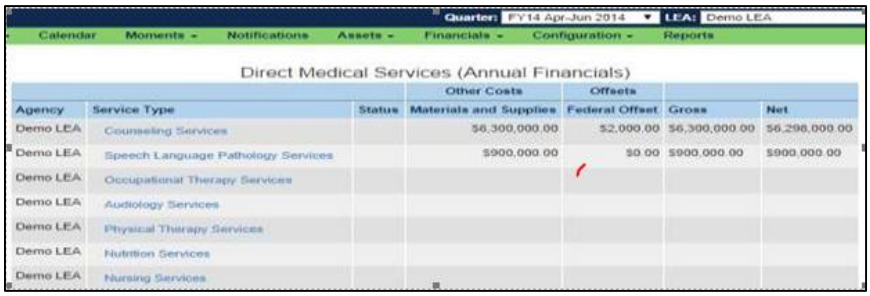


The second option is for users to export and import information using an Excel file. By exporting the file, the user is provided with an easy-to-edit spreadsheet where the necessary information may be entered. Once the information is entered, this file may be imported back into the system and the fields are updated instantaneously.

Direct Medical Services Other Costs

The following image illustrates the Direct Medical Services Materials and Supplies in an example cost report:

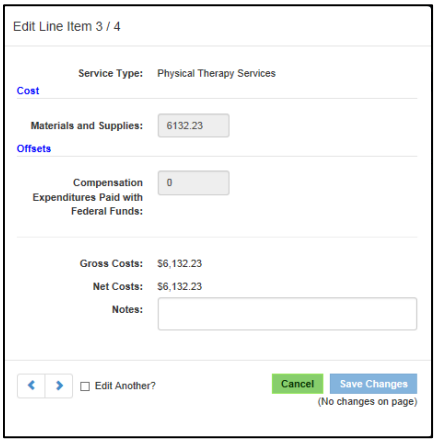
Figure 56



LEAs are allowed to enter the cost of any materials and supplies purchased for the provision of direct medical services for the use of Special Education students. These items must be listed on the CMS list of approved materials and supplies and cost less than $5,000.

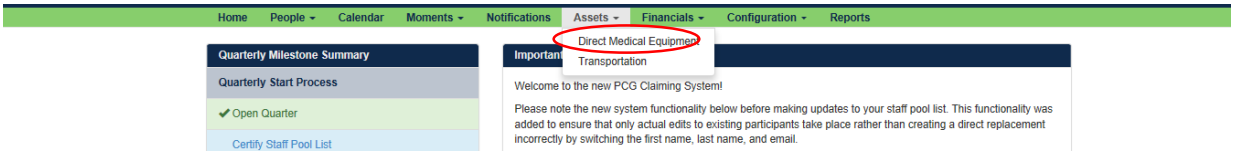
As illustrated in Figure 57, to input costs for these items users would simply click 'Service Type' on the relevant direct medical service type and enter the amount of materials and supplies purchased, and the portion of these costs were paid by federal funds, if applicable.

Figure 57



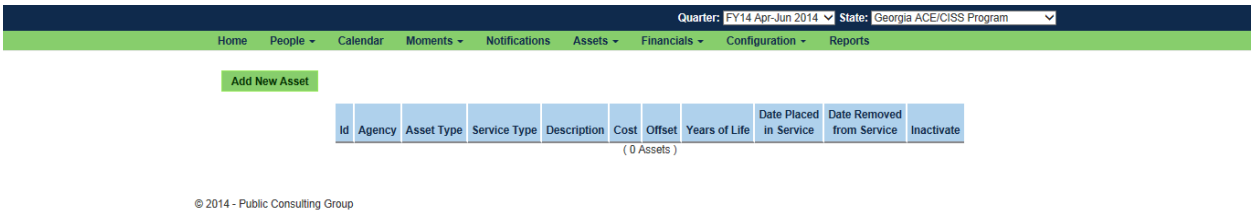
Once an LEA completes this section, they have the option to report "Direct Medical Services Equipment Depreciation" (if applicable) on the page shown in Figure 58.

Figure 58



The screen in Figure 59 below will appear after clicking on the 'Direct Medical Equipment' link on the 'Assets' dropdown.

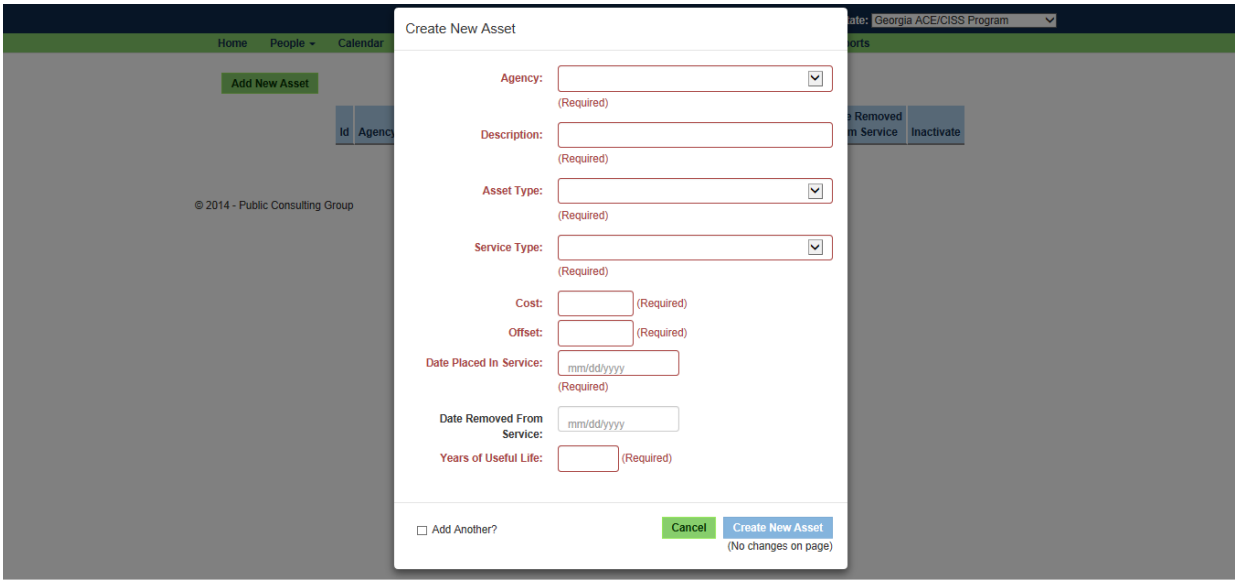
Figure 59



On this page, the LEA has the option of reporting any "Direct Medical Services Equipment Depreciation" for items on the approved CMS list that individually cost more than $5,000.

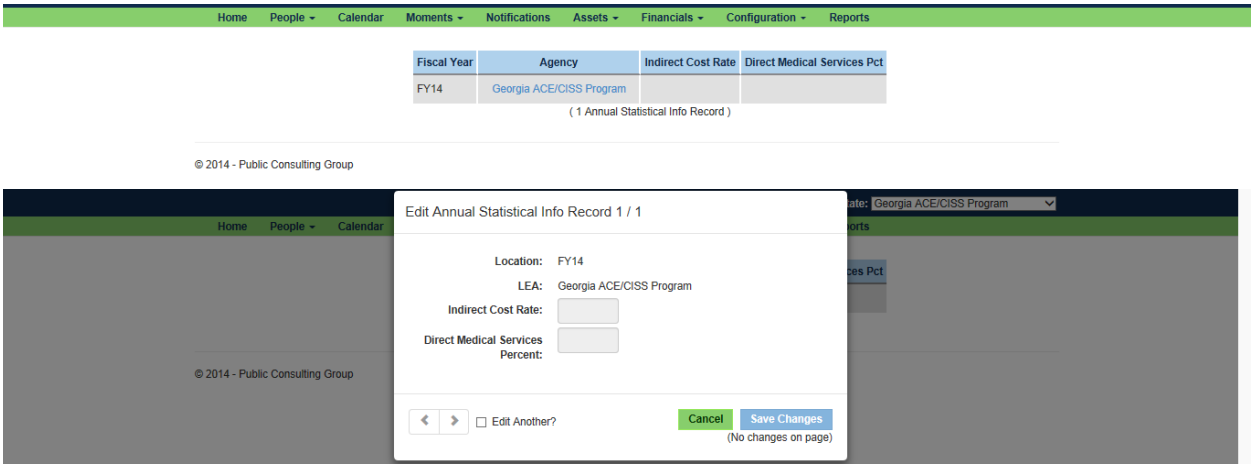
These assets must be depreciated according to a straight-line depreciation method. This method assumes that the asset depreciates an equal amount of value from one year to another during the useful life defined for the asset. The annual depreciation is calculated by dividing the purchase price by the estimated useful life of the asset. To further ease district burden, this calculation automatically occurs within PCG's Claiming System once the required fields are entered as indicated in Figure 60.

Figure 60



General and Statistical Information

Figure 61



Several sections of the "General and Statistical Information" page may be pre-populated by PCG with information coming directly from DHHR/BMS. Some of these items may include: the National Provider Identification (NPI) number, the Medicaid Provider ID, and the Unrestricted Indirect Cost Rate.

Certain information for the following categories also may be required to be entered by the LEAs (or pre-populated per DHHR/BMSs request): Individualized Education Program (IEP) Ratio, and, if applicable, ratios pertaining to specialized transportation costs. In this case, the transportation ratios are only required when the district reports transportation costs.

Transportation

Since CMS has approved Specialized Transportation as an approved service type in West Virginia, PCG will work to develop the schedules necessary for LEAs to report this data. This will include a Transportation Payroll page, where LEAs will report payroll information for bus drivers, bus aides, mechanics, and substitute drivers who work on modified vehicles for special education students. These individuals may be categorized as "only specialized transportation" if they only work on special education transportation vehicles, or "not only specialized transportation" if they work on both special education and general education transportation vehicles.

A Transportation Other Costs page will be developed to allow LEAs the opportunity to report the following costs relating to the provision of special education transportation: lease/rental, insurance, maintenance and repairs, fuel and oil, purchased professional services-transportation services, and purchased professional services-transportation equipment and other related costs. These costs can be reported as "only specialized transportation" if LEAs are able to discretely break out their special education transportation costs from their general education transportation costs. If an LEA is unable to separate these costs from their total transportation costs, they may report the total costs for each cost category under "not only specialized transportation."

PCG will also develop a Transportation Equipment Depreciation page so that LEAs may report any transportation purchases in excess of $5,000. LEAs will record pertinent information on this page, such as the cost of the asset, whether the asset is considered "not only specialized transportation" or "specialized transportation only," and the month and year placed in service and removed from service (if applicable). Through this information, PCG's claiming system will calculate for the user the total claimable amount of depreciation for these assets for the fiscal year.

The PCG Claiming System will apply ratios to all transportation costs, as appropriate, based on the LEA's categorization of these expenses. For those costs listed at "not only specialized transportation," the Specialized Transportation Ratio will be applied to determine which portion of the total transportation costs can be attributed to special education transportation. The One Way Trip Ratio would then be applied to determine which portion of these costs are Medicaid Allowable. For those costs categorized as "only specialized transportation," only the One Way Trip Ratio will be applied. The application of these ratios and the calculation of Medicaid allowable costs can be viewed in the Cost Summary Report.

Cost Summary Report

The Cost Summary Report is the most comprehensive of all of the pages on the Annual Medicaid Cost Report as it details and aggregates all financial cost reported, along with the application of key ratios, resulting in the total Medicaid Allowable Costs reported for the district.

Figure 62

Once the LEA reviews the summarized data and deems it correct, the LEA can click on the 'Certify Financials' button. Only the District Administrator user profile type, as identified in the PCG Claiming System by the LEA, can certify the Annual Cost Report. Once the cost report has been certified by a user, the report is locked and no further edits can be made. If a report has been submitted in error, an LEA can contact PCG to roll back the certification of the report for further edits to be made. Once the cost report has been certified, PCG will begin the desk review process, which is outlined further in section 4.1.3.3.

As the current vendor, PCG has already created reporting functionality for West Virginia LEAs to complete their quarterly Medicaid Administrative Reporting in our new PCG Claiming System. The annual cost reporting system will be created utilizing this platform, and would be fully operational within ninety days of contract award.

4.1.3.2 The Vendor shall be responsible for conducting interim LEA annual cost reconciliation of actual incurred costs to interim Medicaid payments and completing final cost settlement of the difference between actual incurred costs and interim payments. Providers are required to submit an annual cost report on or before December 31st of the same year following the end of the cost reporting period. Interim settlement shall occur within six to twelve months following the submission of the annual cost report. Final cost settlement will occur within twenty-four months following the submission of the annual cost report.

PCG will conduct an interim LEA annual cost reconciliation of actual incurred costs to interim Medicaid payments, and will also complete a final cost settlement of the difference between actual incurred costs and interim payments.

PCG is a proven leader and understands the responsibilities needed to successfully facilitate the development of Direct Medical Services Cost Reports and Settlements. Our firm has wide ranging nationwide experience collecting LEA data related to all facets of reporting, along with the calculation of Cost Settlements throughout the country. LEAs utilize PCGs dynamic online system, PCG Claiming

System, in order to report all data. The PCG Claiming System calculates the settlement information through a robust and comprehensive process. The PCG Claiming System seamlessly completes all components of the Medicaid cost settlement calculation and the resulting information is accessible and can be viewed by each individual LEA. All of this data, including the settlement figures is thoroughly crosschecked by PCG staff in order to ensure accuracy.

The Medicaid cost settlement process is a function of comparing Medicaid costs to Medicaid fee for-service interim payments billed and received by LEAs throughout the applicable school year. PCG will work hand in hand with DHHR/BMS to obtain the necessary Medicaid interim payment financial information to complete the Medicaid cost settlement calculations. PCG has a comprehensive understanding of the intricacies of Medicaid MMIS data. Our team has the ability to accurately and appropriately aggregate paid claims data to ensure Medicaid cost settlements are calculated and processed correctly. Upon completion of the aggregation of the Medicaid paid claims data, we load the results into our web-based PCG Claiming System platform to seamlessly calculate and process Medicaid cost settlements. To ensure continued compliance, prior to the loading of the data into the PCG Claiming System, PCG will offer West Virginia a series of validation checks including verifying interim payments tie back to the CMS 64 for programmatic compliance. We will work with DHHR/BMS to develop additional quality assurance processes to ensure the proper control mechanisms are implemented to produce accurate Medicaid cost settlement calculations.

In order to facilitate the processing of the Medicaid cost settlement calculations, all LEAS are required to view and electronically approve cost settlement amounts in the PCG Claiming System. These amounts flow directly from costs reported. Additionally, LEAs are required to sign a Certification of Public Expenditures (CPE) form, which is also easily accessed via the PCG Claiming System. Prior to payments being made, this form must be signed by the appropriate representative at the LEA and received by PCG.PCG is able to track and manages the collection of the cost reporting forms on behalf of DHHR/BMS and the LEAs. Only those LEAs in which a CPE form has been properly completed and submitted are able to proceed with the processing of the Medicaid cost settlement.

LEAS will have the opportunity to review and approve their final cost settlement in the PCG Claiming System. All final LEA Medicaid cost settlement detail will be shared with DHHR/BMS upon LEA approval.

PCG has customized and configured our PCG Claiming System to calculate Medicaid cost settlements and will ensure that this interim settlement occurs within six to twelve months following the submission of the annual cost report, and that final cost settlement will occur within twenty-four months following the submission of the annual cost report.

4.1.3.3 The Vendor shall be responsible for reviewing data submission by LEA's and comparing to anticipated results (e.g. based on prior period data submissions and any other available data) to determine data accuracy and reasonableness and to follow-up with LEA's and amending specific cost calculations when necessary.

Following the submission of the annual cost report, PCG will conduct desk reviews during which we will review the data submissions of the LEA's and compare these submissions to anticipated results. When questions arise regarding data accuracy and the reasonableness of included costs, PCG will reach out to LEAs to address concerns and request revisions to the cost report, if necessary.

Once cost reports are submitted by LEAs within our PCG Claiming System application and before the processing of cost settlement payments, the PCG will perform desk reviews on all LEA cost reports to ensure the financial data submitted was done so accurately. Unlike other vendors offering similar school based management services, one differentiating factor of PCG's services is our specific experience and comprehensive approach in performing desk reviews. There are existing firms that provide software solutions with built in edit checks but the quality assurance and desk review process stops there. PCG has developed a comprehensive desk review process to facilitate and promote program compliance with LEAs across the country.

Our desk review process includes reviewing each and every financial and statistical data element submitted by LEAs for reporting outliers and errors. PCG is willing to work with DHHR/BMS to develop desk review processes and procedures to ensure that all parties understand the areas we target for review and the breadth of the review process. PCG"s experience performing a consistent review process and is outlined in detail on the following pages.

Prior to cost settlement payments being processed PCG leverages our national best practices to perform desk review audit policies and procedures. Desk reviews will be conducted on every LEA submitting a Direct Medical Services Cost Report. This is a comprehensive process aimed entirely at maintaining program integrity and compliance along with verifying LEAs avoided reporting errors.

Once Direct Medical Services Cost Reports are submitted by each LEA, PCG begins the desk review process. These reviews are done annually and completed within established timelines based on State policy. PCG performs a number of edit checks throughout the desk review process to ensure the cost report is completed correctly prior to settlement. Our services also include thorough communication with all LEAs via email and phone throughout the duration of desk reviews.

PCG uses industry experience to review particular components of each cost report. This involves a comprehensive list of edit checks and procedural review. The following is a list of desk review protocols that PCG typically performs:

1. ***Review salary and benefit data for reasonableness.*** PCG will examines salary and benefit data and validates against peers and DHHR/BMS guidance.

2. Review LEA explanations to edits flagged. PCG reviews all explanations from LEAs for why costs exceeding thresholds should be permissible.

3. Review salary and benefit costs by service type to total time study count. PCG verifies that only costs of clinicians‟ participating in the time study are included in the cost settlement.

4. Compare employee benefit to salary ratios for reasonableness. PCG calculates the statewide average benefit to salaries ratio and uses it as a benchmark for reasonableness.

5. Test the reasonableness of other costs. The West Virginia state plan will potentially allow for the reporting of other direct medical materials and supplies. PCG will test the expenditure data reported and identifies outliers with unusually high other costs relative to salary and benefits.

6. Review of Medicaid eligibility ratio for direct medical services. The individual education program (IEP) ratio is the statistic used to apportion costs to the Medicaid program. PCG will compare the ratio to statewide statistical information for reasonability purposes. PCG will work with the State to obtain the total special education population by LEA and verify this number against what is reported in the Medicaid cost report.

7. Evaluate reasonableness of Medicaid eligibility for transportation services. PCG verifies the number of one way trips reported in the numerator and denominator for reasonableness.

8. Review of Allowable Transportation Costs. PCG reviews all allowable specialized transportation costs to ensure reasonableness and that the costs reported are eligible for reimbursement.

Upon receipt of their desk review findings via email, LEAs are provided with a pre-defined amount of time to respond to the desk review process. If PCG receives feedback from the LEA on the identified issues, PCG will review supporting documentation or explanations to determine whether any adjustments or actions are required. If adjustments are required, PCG opens up the LEAs report in the PCG Claiming System, and works with them to adjust appropriate costs and recertify. If a response is not received in a timely manner, PCG proceeds with continuous customer service outreach including phone calls and emails. In the event that a district is completely unresponsive, PCG will provide a draft letter to DHHR/BMS This letter is typically signed by the appropriate program liaison and sent to all LEAs warning of recoupment of all Medicaid funds if a response is not forthcoming.

If any potential policy or programmatic issues are identified during the desk review process,
PCG will involve DHHR/BMS as appropriate and necessary. Historically, PCG is proactive in bringing issues to the attention of our clients in order to facilitate statewide memorandums on policy issues. Additionally, PCG maintains all audit documentation and work papers as an audit trail in case the desk review process is reviewed prospectively by CMS, OIG, or any other auditing body.

4.1.3.4 The Vendor shall be responsible for obtaining an annual certification from each LEA of actual, incurred allowable costs, including the federal and non-federal share of each expenditure.

PCG will be responsible for obtaining an annual certification from each LEA of their actual, incurred allowable costs. These will include the federal and non-federal share of each expenditure.

Upon PCG completion of the LEAs desk review, the LEA is responsible for printing out the "Certification of Public Expenditures Form." The final step for LEAs is to sign the certification of public expenditures (CPE) form. The CPE form is accessible within the PCG Claiming System. This is another feature that allows for a more efficient process for LEAs to complete and collect the CPE forms. LEAs are not required to search their email for these forms; instead the distribution of the form will occur within the PCG Claiming System application. Upon certification of the cost report, the CPE form becomes available. By clicking on the link, the CPE form opens in a .PDF format. PCG will work with DHHR/BMS to format the CPE form for West Virginia. Typically, this form must be signed by the CFO, Superintendent, Business Officer, or other appropriate representative, as indicated on the form.

4.1.3.5 The Vendor will be responsible for providing DHHR/BMS with information needed for payment or recoupment of interim and final cost settlement amounts.

PCG commits to providing DHHR/BMS with any information required for payment or recoupment of interim and final cost settlement amounts. This information may include any cost reporting data as submitting in the PCG Claiming System, and any documentation including emails and backup data collected throughout the desk review and/or in-depth monitoring review process.

As the national leader in providing school based health service cost settlement services, PCG has extensive experience in providing state Medicaid agencies with various reports to present interim and final cost settlement calculations. PCG will be able to provide DHHR/BMS with multiple report format options in order to determine the structure and the content of the reports for cost settlement results.

4.1.3.6 The Vendor will be responsible for calculating and providing DHHR/BMS with interim payment rates which will be paid by the WV Medicaid program for each SBHS service for each LEA on an annual basis following cost report reconciliation.

PCG will assume responsibility for calculating and providing DHHR/BMS with interim payment rates on an annual basis following cost report reconciliation and will specifically work with West Virginia staff to develop interim rates for use in Fiscal Year 2016.

It is vital that interim rates are closely aligned with provider costs, and PCG recognizes that this is a delicate balance to maintain. Rates should not be over inflated as this would result in providers owing money back to the Medicaid program after the cost settlement and cost reconciliation process; however, it is equally important to ensure rates are maximized so providers do not experience a loss in revenue streams.

In order to equate interim rates closely to provider costs, PCG will extract data from MMIS and the PCG Claiming System to establish provider specific interim rates on an annual basis by service type. PCG will develop a comprehensive Excel workbook, which will automate the rate setting process. The Excel workbook will automatically calculate provider specific rates once essential data is extracted into the application, including Medicaid eligibility rates, provider costs, provider specific unrestricted indirect cost rates, and aggregate time study data. The results will then be diligently reviewed by PCG staff to ensure rates are accurate and maximized in comparison to provider costs. PCG has experience in multiple states successfully implementing interim rate setting under our school based health service contracts with the District of Columbia, Colorado, Louisiana, New Jersey, Texas, and Wisconsin.

4.1.3.7 The Vendor will be responsible for obtaining on a quarterly basis, Certification of Public Expenditure (CPE) from each LEA. Certification forms must be submitted to DHHR/BMS no later than the 15th of the month following quarter end.

PCG will collect a Certification of Public Expenditure (CPE) from each LEA for their Medicaid Administrative Claiming on a quarterly basis; PCG will collect the Certification of Public Expenditure (CPE) for Direct Service Claiming from each LEA on an annual basis. LEAs will be able to print their CPE form directly from the PCG Claiming System, sign the document, and send to PCG for processing and retention.

4.1.3.8 The Vendor will be responsible for collection of an annual Non-Restricted indirect cost rate (ICR) from each LEA.

PCG will assume responsibility for collecting an annual Non-Restricted indirect cost rate (ICR) from each LEA. To encourage consistency and ease administrative burden, PCG will leverage current relationships with the West Virginia Department of Education (WVDE) to compile the indirect cost rate for all LEAs. As the cognizant agency responsible for calculating the indirect cost rates on behalf of all LEA in the state WVDE can be called upon to facilitate the collection of the indirect cost rates for all LEAs. These Non-Restricted indirect cost rates will be loaded into PCG's Claiming System so that indirect costs may be captured in the cost report.

4.1.3.9 The Vendor will be responsible for the collection of any item that was not included in the Vendor's cost report or other data collection tools that subsequently us identified as required to complete cost settlement. The Vendor will be responsible for any such omissions and ensuring that any and all information that is required to comply with the WV State Plan, CMS guidance and applicable regulations has been collected and is documented accordingly.

Following cost report submission, PCG will complete a desk review process where we will review LEA cost reports for any missing data required to complete cost settlement. PCG will reach out to any LEAs who may be missing this data in their initial cost report submission and request its inclusion. During this process, PCG will also ensure that all included information complies with the WV State Plan, CMS

guidance and applicable regulations and that this information has been collected and is documented accordingly.

4.1.3.10 The Vendor will be responsible for assisting DHHR/BMS in monitoring of the time study and MAC program to ensure compliance with federal requirements. The areas of review include, but are not limited to: Participant List/Roster to ensure only eligible categories of staff are reported on the participant list based on the approved RMTS categories in the implementation plan; RMTS which includes sampling methodology, actual sample and time study results; RMTS Central Coding – review at a minimum 5% sample per quarter of the completed coding; Compliance with Training requirements and Financial Reporting to ensure that costs are only reported for eligible cost categories and meet reporting requirements.

PCG agrees to assist DHHR/BMS in the monitoring of the time study and MAC program to ensure compliance with federal requirements. With more than fifteen years of experience working with school-based Medicaid programs, PCG has extensive knowledge of State and Federal Medicaid billing and claiming requirements, surrounding both MAC and Medicaid cost settlement programs. As a national leader in this particular arena, PCG has legal and regulatory staff review at our disposal that are constantly monitoring the Office of Inspector General (OIG) and other national school based service programmatic audits. We use these reports to inform our staff, as well as aid in establishing national best practices for constructing highly compliant school based programs.

PCG understands the utmost importance and necessity to work with DHHR/BMS and other agency divisions and units to support fraud detection and pursuit activities. PCG will serve as a trusted partner to support all participating LEAs in appropriately claiming for services available under the Medicaid Administrative Claiming and Medicaid cost settlement program. We have established processes, as well as built in edit checks within our automated financial reporting systems to aid in these efforts. We will work with DHHR/BMS to customize and configure our program integrity efforts to meet the specific needs and expectations of DHHR/BMS.

Areas of review will include, but will not be limited to:

- Participant List/Roster to ensure only eligible categories of staff are reported on the participant list based on the approved RMTS categories in the implementation plan;
- RMTS which includes sampling methodology, actual sample and time study results;
- RMTS Central Coding – review at a minimum 5% sample per quarter of the completed coding;
- Compliance with Training requirements and Financial Reporting to ensure that costs are only reported for eligible cost categories and meet reporting requirements.
- And any other areas of review as determined by DHHR/BMS and agreed by PCG.

4.1.3.11 The Vendor will assist DHHR/BMS with monitoring of all LEA's at least once every three years. Monitoring will consist of either on-site or, desk review, or a combination of both. The goal of the monitoring will be to ensure that the LEA;s are maintaining appropriate documentation as required by CMS (e.g. in the event of CMS audit the LEA's would be able to provide documentation to support data submitted and utilized in the RMTS, cost report and administrative claiming).

PCG appreciates the value of a comprehensive oversight and monitoring program to ensure that the school-based health services program is implemented and operated in compliance with all state and federal regulations. PCG will implement, in conjunction with DHHR/BMS, a comprehensive program oversight and monitoring program for the school-based direct services program that will include comprehensive desk reviews and on-site audits of LEAs. PCG agrees to assist DHHR/BMS with in-depth cost report reviews of all LEA's at least once every three years, either through on-site meetings, by desk review, or a combination of both. PCG proposes reviewing one third of West Virginia LEAs each fiscal year, with the expectation that each LEA would be reviewed once in a three year cycle.

Through these in-depth reviews, PCG would request appropriate documentation to substantiate the inclusion of reported costs on the cost report. LEA will be notified with ample time before the desk review begins to collect the required backup. PCG will then review this information and discuss any questions that arise with the LEA. Once all questions have been answered and the desk review has been completed, PCG will compile a summary with the results of the desk review to the LEA and to DHHR/BMS. A revision of the cost report may be requested if an LEA's documentation is insufficient. This review would ensure that appropriate documentation as required by CMS is being maintained by the LEA, and that in the event of CMS audit the LEA would be able to provide adequate documentation as requested by CMS.

4.1.4
Training

4.1.4 Training

PCG will continue to utilize our in-depth knowledge of the SBHS program to develop comprehensive training programs to focus on all aspects of School-Based Medicaid. PCG will draft training presentations and instruction manuals as resources for state and school district staff in order to assist them through the required processes. We know that the training of LEAs is essential to the success of this project. PCG will identify the appropriate staff by title and obtain contact information within each LEA to participate in training. For example, it is essential that school business officers participate in the quarterly financial and annual Medicaid cost report training sessions. DHHR/BMS will review and approve our recommendations on the staff that should be trained.

By participating in our detailed training program, staff will clearly understand the goals and structure of PCG's solution, their responsibilities, and the importance of complete and accurate data and documentation. PCG's training program not only covers the specific RMTS and financial requirements of staff, but also reviews the complete process of generating claims and completing the annual Medicaid cost report. In our experience, this level of training leads to fewer errors. We will provide ongoing support for all school district staff involved in cost settlement and reconciliation processes through a toll-free hotline. The hotline will be operational immediately upon the approval of this project.

PCG will continue to provide training to West Virginia staff and LEA coordinators on both the RMTS and cost reporting components of our comprehensive Web-based Cost Reporting site. PCG will coordinate training dates with LEAs and identify opportunities to consolidate travel to the greatest extent possible. Additionally, we offer "Web-ex" or computer based conference call training sessions. Web-ex is an online training tool that allows staff to view the training presentation locally from their office as if they were in a live training. We use a toll-free dial-in number that allows users to participate actively through the ability to ask questions or for the trainer to solicit feedback from the participants. In addition, PCG records each training session and will make these accessible via the web for staff to review on their own time. Web-ex trainings have been favorably received and save time and travel expenses for LEA staff.

The PCG project team is comprised of staff with the specific Medicaid claiming experience needed to perform all required trainings. The following components are essential in providing successful training:

- **West Virginia Specific Terminology**: PCG takes special care to use West Virginia specific examples in the training process. By working directly with LEA staff, we will leverage understanding and examples from one division that may be directly applicable to how another division does business.

- **Consistency of Message:** PCG maintains a database of frequently asked questions and uses it to enhance trainings in an effort to address questions before they are asked. These questions and answers are posted to our web based tools for future access. PCG staff also meets regularly to ensure a consistent message is being communicated during trainings and all unique examples are vetted throughout the team for a consistent message.

- **Adult Learning Techniques:** PCG staff understands best practices techniques for adult education and learning and applies them in all of our training environments. We also know that not all school level participants will respond to training in the same way. PCG takes special care to ensure all LEA staff feel confident at the end of the training and if not we can provide one on one support.

- **Subject Matter Expertise:** You can be assured our team will understand the broader scope of RMTS, Administrative Claiming, and Medicaid cost settlement and use that understanding as it relates to training LEA personnel.

- **Active Participation:** We have found that active participation leads to better program results. One example is post-training quizzes which can increase the level of training involvement, understanding and ultimately the accuracy of the data that is used in claim development.
- **Questions and Answers:** Staff often have fundamental questions regarding the RMTS process, PCG's Claiming System, or the Medicaid cost settlement process. We often send follow up emails to trainees outlining key points that need further emphasis based on these questions. In addition, all training materials will be posted on our web sites as resources for staff to access.

4.1.4.1 – Training for RMTS: The Vendor shall create, distribute, and present a complete RMTS training program to LEA's, which must be prior approved by DHHR/BMS. This training is necessary for the initial and ongoing implementation of the statewide RMTS. In addition, telephone training, as requested, and Web-based training modules shall be developed and provided by the Vendor. Any aspects of the RMTS that are not covered in the Vendor's training program and which are requested by the LEA or DHHR/BMS, shall also be made available to LEA staff. The initial training must be provided on-site at a minimum of four (4) agreed upon state-wide sites selected by DHHR/BMS or when a significant change in procedure is identified.

Comprehensive Random Moment Time Study (RMTS) on-site trainings will continue to be held each year, spanning at least four of the DHHR/BMS selected locations across the West Virginia and various day and time options, ensuring accessibility for all LEAs. These on-site trainings incorporate a PowerPoint presentation, comprised of reinforcing visuals and examples, as well as references to other helpful materials online such as step-by-step guides, memos, and handouts. Appropriate participatory activities are also incorporated in the trainings to address different learning styles of district staff.
Upon receiving content approval from DHHR/BMS, the comprehensive on-site training curriculum will cover all facets of the RMTS program and include, at a minimum, the following components: Random Moment Time Study (RMTS) Staff Pool List preparation and RMTS process Details for each component of the training are described below. This level of organization ensures LEAs understand not only the process but also the purpose of the SBHS program.

- **RMTS Staff Pool List (SPL) Preparation**: The Staff Pool List is the foundation of both programs, updated three times per year with each district's "list" of staff employees and contractors eligible to undergo the RMTS survey. PCG trains LEAs how to both update and closely review the SPL, as the quality of such directly correlates to a district's Medicaid reimbursement. LEAs are educated

to analyze each potential individual listed, not only on their job title but also on their involvement in completing activities considered reimbursable under the Medicaid program. They are also taught which staff should be included in which cost pool. LEAs leave the training with an in depth understanding of the implications of completing the SPL correctly or incorrectly.

- **RMTS Process**: The RMTS is the survey process used to identify the amount of time spent performing reimbursable activities under the Medicaid program, both from a Medicaid administrative claiming and direct medical services standpoint. Based on statistically valid and approved methods, the results of RMTS are used to apportion costs reported by LEAs. In trainings, PCG emphasizes the purpose of the RMTS and its web-based process. The RMTS District Coordinators are of particular interest in this section of the training. LEA coordinators are presented with instruction and tips on how to educate their own providers listed on the SPL on the requirements for proper participation. These tips and examples include providing adequate detail when answering Random Moments and increasing district-specific and state-wide compliance.

PCG recognizes that RMTS questions may arise during the course of the year that may not have been covered during these trainings. PCG will continue to provide our toll-free hotline, upon request ad hoc telephone training, as well as providing Web-based training manuals on the dashboard of our Claiming System site. In the event that the RMTS program under goes a procedural change, PCG understands that additional trainings than the frequency described will be needed.

4.1.4.2 – Training for Administrative Claim: The Vendor will create, distribute, and present a complete Administrative Claim training program, which must be prior approved by DHHR/BMS. This training is necessary for the initial and ongoing implementation of Administrative Claiming based on results of the statewide RMTS. In addition, telephone training, as requested, and Web-based training modules shall be developed and provided by the Vendor. Additional training, as requested, by the LEA or DHHR/BMS, shall be made available to the LEA staff. The initial training must be provided on-site at a minimum of four agreed upon state-wide sites selected by DHHR/BMS.

Comprehensive Administrative Claiming on-site trainings will continue to be held each year, spanning at least four of the DHHR/BMS selected locations across the West Virginia and various day and time options, ensuring accessibility for all LEAs. These Administrative Claiming on-site trainings incorporate a PowerPoint presentation, comprised of reinforcing visuals and examples, as well as references to other helpful materials online such as step-by-step guides to entering financials, memos, and handouts. Appropriate participatory activities are also incorporated in the trainings to address different learning styles of district staff.

Upon receiving content approval from DHHR/BMS, the comprehensive on-site training curriculum will covers all facets of the Administrative Claiming program and include, at a minimum, the following components: Staff Pool List preparation, utilizing our Claiming System cost edit checking process, and the completion/certification of financials. Specific details for the completion of the financials segment of the

training is below. This level of organization ensures LEAs understand not only the process but also the purpose of the Administrative Claiming program.

PCG provides the background, purpose and technical instructions for completing the quarterly Administrative Claiming financials. PCG presents the details behind approved methodologies for reporting payroll information and costs for eligible staff travel and training, professional dues and fees, and administrative materials and supplies. Additionally, LEAs are provided instructions on how to take the financial information and report it using the Web-based system. PCG links concepts behind RMTS results and reported costs; teaching LEAs that the results of the survey process directly affect the Medicaid claim.

PCG understands that Administrative Claiming questions may arise during the course of the year, that may not have been covered during these trainings. PCG will continue to provide upon request ad hoc telephone training, telephone hotline support, as well as continue to provide Web-based training manuals on the dashboard of our Claiming System site.

4.1.4.3 – Training for Direct Service Program and Cost Reporting: The Vendor shall provide training and technical assistance to the LEAs on DHHR/BMS program policies and regulations relative to Cost Reporting requirements. The training shall include, at a minimum, covered services, cost reporting submission and certification procedures. After the initial training, which must be provided on-site, the Vendor shall provide training either on-site, via telephone and/or through Web-based training program no than on an annual basis, as developed by the Vendor and prior approved by DHHR/BMS. The initial training must be provided on-site at minimum of four state-wide sites as selected by DHHR/BMS.

Comprehensive Direct Service Program and Cost Reporting on-site trainings will continue to be held each year, spanning at least four of the DHHR/BMS selected locations across the West Virginia and various day and time options, ensuring accessibility for all LEAs.

PCG has conducted Direct Service Program and Cost Reporting trainings for thousands of school-based personnel and has a finely honed approach to training. This approach is comprised of five components: Materials, Attendees, Schedule, Content, and Delivery. PCG will utilize our in-depth knowledge of Medicaid cost settlement and reconciliation processes to develop a comprehensive training program that encompasses all aspects of the cost reporting and settlement process in a format that is easy to understand and implement.

- **Materials -** PCG will draft training presentations and instruction manuals that will be shared with DHHR/BMS for review and approval prior to conducting training sessions. These documents will be made available as resources for state and school district staff in order to assist them through the required processes.

- **Content -** PCG's training program not only covers the specific financial requirements of staff, but also reviews the Medicaid covered services and the entire process of generating claims and completing the annual Medicaid cost report. PCG will provide training on our Web-based Claiming

System. We will provide ongoing support for school district staff involved in cost settlement and reconciliation processes through a toll-free hotline and email address. The hotline and email will be operational immediately upon the approval of this project. By participating in our detailed training program, staff will clearly understand the goals and structure of PCG's solution, their responsibilities, and the importance of complete and accurate data and documentation. This detailed training approach will lead to fewer errors.

- **Attendees –** The training of school district coordinators is essential to the success of this project, as is participation by school business officials. PCG will identify the appropriate staff by title, obtain contact information for identified personnel within each school district and solicit DHHR/BMS approval of the recommended list of staff that should be trained.

- **Schedule -** PCG will coordinate training dates with LEAs and identify opportunities to consolidate travel to the greatest extent possible. PCG understands and will provide at minimum the required four state-wide initial trainings.

- **Delivery -** In order to reach the greatest audience, PCG intends to offer trainings both in-person and via "web-ex", a Cisco System online training tool that allows staff to view the training presentation locally as if they were in a live training. A toll-free dial-in number allows interactive participation (users can ask questions and trainers can solicit feedback). In addition, PCG records each training session and will make these accessible via the web for staff to review on their own time. Web-ex trainings are increasingly common as a means of saving time and travel expenses.

Once all training sessions have been completed, PCG will provide DHHR/BMS with a report of the LEAs and staff that participated. PCG will also conduct outreach activities to arrange additional training opportunities for those LEAs that did not participate in the scheduled training sessions to promote compliance with requirements of the revised reimbursement methodology.

Throughout the training and cost reporting process, PCG will operate the cost report help desk to receive and respond to communications from district providers regarding cost reports, via telephone and e-mail. PCG shall have voicemail capability to receive calls when the help desk is not staffed.

The cost report help desk will be staffed to receive and respond to calls, at a minimum, between 8:30 am and 5:30 pm Eastern Time, every business day.

PCG will track call volume per hour during all times that the cost report help desk is available to receive and respond to calls. For each call received, PCG will document all of the following:

- The name of the provider;
- The District in which the provider practices;
- The general nature of the call; and
- The resolution to the call.

PCG understands that questions may arise during the course of the year, that may not have been covered during these trainings. PCG will continue to provide upon request ad hoc telephone training, as well as continue to provide Web-based training manuals on the dashboard of our Claiming System site.

4.1.4.4 – The Vendor shall provide training to DHHR/BMS regarding all components of the SBHS and rate setting services provided under the scope of this procurement and will assist in development of policy and procedure manuals regarding tasks.

PCG is not only an expert in school based health services, but also in terms of rate setting. Once cost settlement is implemented throughout the State, PCG will be able to assist the State with rate setting services. Our team has expertise with Medicaid and Medicare rate-setting. The PCG team's rate setting and reimbursement consulting knowledge and experience is grounded in a core set of principles, including:

- ✓ Knowledge and understanding of all costs, utilization, productivity standards, and/or efficiency factors which affect specific rate calculations;
- ✓ Experience assisting county and state agencies to defend rate setting methodologies to legislative bodies, the provider community, media, and other relevant stakeholders;
- ✓ Experience helping public sector agencies to reform payment methodologies to change provider behavior and promote higher quality of care;
- ✓ Knowledge of reimbursement best practices; and
- ✓ A comprehensive understanding of the Medicare principles of reimbursement established in Provider Reimbursement Manual (PRM).

PCG will train DHHR/BMS staff on the SBHS program and demonstrate how the program relates to establishing rates for services throughout the State. PCG will also provide thorough trainings to DHHR/BMS on our rate setting methodologies and document the process of rate setting for each service so that rates can be updated on an as needed basis. Documentation will include developing policy and procedures manuals with a clear set of tasks outlining the rate setting process.

4.1.4.5 – The Vendor shall provide DHHR/BMS a training plan that fully describes the training approach for each of the above referenced tasks in 4.1.4.1 - 4.1.4.3.

As stated above PCG will continue to conduct comprehensive on-site trainings at a minimum of four approved locations across the West Virginia. PCG will make sure that the trainings are offered on various days and times so LEAs have access to attend. We will continue to work closely with DHHR/BMS to identify the locations of the regional trainings so that the locations are convenient for the LEAs and do not require the district staff to travel extensively to be able to attend. Even though multiple days, times and locations may be offered, that may not always work with the contacts at every district. PCG offers WebEx trainings on additional days and times as well. This is done to ensure that every district in West Virginia has options to receive the training. We want to be as flexible as possible because we realize this is only one of the many job responsibilities the district contacts have each day. The more we can reduce the

administrative burden on a district, the more willing the district is to participate fully in the other aspects of the program.

PCG has placed particular emphasis on comprehensive training to ensure staff members are fully informed about the entire school-based Medicaid program throughout West Virginia. Training is a critical program component to ensure program compliance. It is a process that PCG takes seriously and we work with our clients and other stakeholders to continuously improve our training efforts to enhance program comprehension. PCG has developed a comprehensive and detailed training program which includes the development and distribution of in-depth training materials, facilitation of informative training sessions, and provides a toll-free support line for staff questions following trainings. Our training program includes both in-person and online webinar sessions rendered several times throughout the fiscal year. Furthermore, all trainings are also recorded and posted to the dashboard of our web based application in order to allow LEAs to access and review the training materials at their convenience prospectively on an as needed basis.

In each training, PCG takes special care to use school-based terminology and relevant examples to ensure that staff members are trained appropriately. Through best practices for adult education and learning techniques, PCG engages district staff to understand the broader scope of the school-based program. PCG trainers are experts in school based Medicaid and are well-equipped in promoting the most current industry practices in training, supporting active participation and enhanced learning.
Once trainings are completed, PCG follows up with a series of post-training tasks. These post-training tasks wrap up the event and are an additional attempt to resolve any outstanding questions or needed clarification. The post-training process includes the:

- Development and distribution of a Frequently Asked Questions document;
- Recording and posting of training sessions so LEAs can easily access them at their convenience, multiple times if needed; and,
- Publishing of training materials on the Dashboard of PCG's Claiming System website for ease of use for existing and new program participants.

PCG has proven to be an established industry leader in the comprehensive trainings of LEAs in West Virginia on the school-based Medicaid program. West Virginia specific knowledge and experience has allowed our team of experts, over the last several years, to properly train schools LEAs on Medicaid school based services. There is no other firm that has this type of experience working cooperatively with LEAs in West Virginia.

4.1.5
Other Administrative Functions

4.1.5 Other Administrative Functions

4.1.5.1 – Toll-Free Telephone Line: The Vendor must maintain a toll-free telephone number to provide customer service and technical assistance as needed for both Administrative and Direct Service Claiming. The Vendor shall ensure that a statewide, toll-free telephone system is installed with an automated answering system. The call volume on a daily basis shall be handled so that any calls not answered at the time of the call and for which a message is left shall be returned within one (1) business day. The toll free number shall be answered by Vendor staff between the hours of 8:30 a.m. to 5:00 p.m. eastern standard time, Monday through Friday, except for the federally observed holidays (New Year's Day; Birthday of Martin Luther King, Jr.; Washington's Birthday; Memorial Day; Veterans Day; Thanksgiving Holiday; Christmas Holiday).

- PCG support staff are accessible by email or phone and can be reached during all regular business hours, including Monday-Friday, 8:00 a.m. to 5:00 p.m. eastern standard time, except for federally observed holidays (New Year's Day; Birthday of Martin Luther King, Jr.; Washington's Birthday; Memorial Day; Veterans Day; Thanksgiving Holiday; Christmas Holiday).

- Statewide Toll-Free Customer Support Line: PCG's toll-free phone line provides convenient, easily accessible customer service and technical assistance for all program areas, including Administrative and Direct Service Claiming assistance. The toll-free phone line is supported by the same experienced PCG staff that conduct the training sessions. All support staff members are available to answer incoming calls. During regular business hours, when all staff members are assisting customers any incoming calls automatically go to voicemail, where customers can leave a detailed message for the support team. Also, outside of regular business hours, incoming customer calls are immediately directed to voicemail.

- PCG staff are also accessible via email customer support email box. Customers may submit emails to this email box, 24 hours per day, 365 days per year. Customer responses are provided within 48 hours (two business days).

- Regional and District level support: PCG staff will provide on-site, customized assistance to all participating LEAs as needed.

4.1.5.2 – The Vendor must maintain an automated answering system that will allow the caller to leave a message after 5:00 p.m., Monday through Friday and on weekends. The Vendor's staff must contact the LEAs leaving messages within one (1) business day of the Vendor's receipt of the message.

PCG's Statewide Toll-Free Customer Support Line provides an automated answering system that allows customers to leave a detailed message. During regular business hours, when all staff members are assisting customers any incoming calls automatically go to voicemail, where customers can leave a detailed message

for the support team. Also, outside of regular business hours, incoming customer calls are immediately directed to voicemail.

The Customer Support Line voicemail box is checked regularly during regular business hours. Return calls are typically made to customers on the same day the call was received, but in all cases customers receive return calls within one (1) business day.

4.1.5.3 – The Vendor shall have the ability to communicate with all individuals on its toll-free lines, which must be able to accommodate such issues as hearing impairment, or other communication barriers, or physical or mental disabilities.

PCG has the ability to support TTY/TDD services on the toll-free hotlines dedicated to West Virginia users and contacts.

4.1.5.4 – Web site: The Vendor shall be responsible for the development and maintenance of a Web site. All materials on the Web site must be prior approved by DHHR/BMS before appearing on website. The Web site must be kept current. The Web site shall be compliant with readability requirements as set forth in the Americans with Disabilities Act standards.

PCG will continue to utilize and maintain a Web site specifically to provide information for the statewide school based health services program. PCG's Claiming System site includes important documents and resources including upcoming due dates, user guides, recorded WebEx trainings, links to the DHHR/BMS website, and PowerPoint presentations of the training material. Any additional DHHR/BMS approved resources, including user guides, manuals, or state plans, could be added upon request. These documents are updated regularly to provide the LEAs with the most current information. LEAs in West Virginia have found the Claiming System site is a helpful SBHS resource. PCG's Claiming Site is compliant with readability requirements as set forth in the Americans with Disabilities Act (ADA) standards.

4.1.5.5 – The website shall include all training modules related to RMTS, Administrative and Direct Service Claiming, training manuals, frequently asked questions, important dates or approaching deadlines and links to relevant Web site materials such as CMS, BMS or other State programs.

As mentioned above, PCG will continue to maintain a website specifically to provide information for the statewide school based health services program. Program information will include: links to all training modules related to RMTS, Administrative and Direct Service Claiming, training manuals, frequently asked questions, important program dates and deadlines, as well as links to relevant websites such as CMS, BMS or other state programs. In all states where PCG has provided Medicaid claims services, the program website has included training schedules and registration links, selected state agency-created memoranda and information sheets, presentation slides and handouts from statewide training events, video links to statewide training events, and document library.

4.1.5.6 – The Data Systems: The Vendor shall have a reporting system in place to facilitate access to and receipt of all information necessary for RMTS, Administrative and Direct Service Cost Reporting.

As cited throughout the proposal, PCG will continue to provide a Web-based comprehensive reporting system to facilitate access to and receipt of all information necessary for RMTS, Administrative and Direct Service Cost Reporting.

4.1.5.7 – The Vendor shall assist DHHR/BMS in development of State Plan Amendments regarding SBHS program or any reimbursement methodologies. This requirement also includes drafting responses to any CMS inquiry whether designated as informal or formal request for additional information.

PCG will assist DHHR/BMS in the development of the necessary State Plan Amendment (SPA) language to support proposed changes to the School-Based Direct Services Program. Our services are comprehensive and our team has the necessary experience and skill set to assist DHHR/BMS with this important process. PCG's qualifications are evident that PCG recently assisted DHHR/BMS to obtain approval of their Medicaid cost settlement and reconciliation SBHS state plan.

PCG will prepare draft SPA language and work closely with DHHR/BMS staff to review and provide feedback on the coverage and reimbursement sections to ensure that they meet the goals for this project and the overall needs of the agency. In addition to drafting SPA language, PCG will prepare the supporting materials commonly requested by CMS specific to SBHS program. This includes developing implementation plans to support RMTS processes, developing supportive manuals that describe the policies and procedures that will be implemented by DHHR/BMS, such as cost reporting procedure manuals, developing accounting crosswalks to ensure consistent reporting processes are established for LEAs, to name a few.

Upon the submission of SPA and other materials to CMS, PCG will guide DHHR/BMS throughout the approval process. PCG will assist DHHR/BMS in responding to any Requests for Additional Information (RAI), both formal and informal by preparing draft responses to questions raised by CMS for DHHR/BMS consideration. *PCG understands the urgency to respond to CMS inquiries in a timely fashion in order to expedite the approval process* and therefore PCG will draft responses to formal CMS inquiries the following business day, when feasible. If PCG determines additional time is needed to prepare a proper response, PCG will alert DHHR/BMS and provide an alternative timeline. As needed, PCG will also assist DHHR/BMS in addressing and drafting responses to all informal questions or comments from CMS related to the SPA. Furthermore, PCG will support DHHR/BMS by participating in conference calls with CMS as requested and provide any additional support processes to ensure SPAs and related documents are approved in a timely fashion.

4.1.5.8 – The Vendor shall submit a Project Implementation plan with their proposal that demonstrates overall understanding of SBHS requirements and establishes key requirements and time frames for implementing RMTS, Administrative and direct Service Claiming and Cost Reporting activities.

	Task or Event	Completion Day	Assigned Personnel
Development and Start-up Requirements			
1.0	The contractor shall be fully operational (which shall include providing the required personnel and full implementation of all required services pursuant to the requirements of this document	45	PCG
1.1	Assign a liaison staff person to coordinate communication, deliverables, and progression between the state agency and the contractor. The liaison shall be a key position that must have advanced communication (oral and written), organizational and time management skills	Ongoing	PCG
1.2	Provide the state agency with a draft of all required correspondence templates, training material, and reporting templates for review and approval by the state agency	75	PCG / DHHR/BMS
1.3	Incorporate and implement any revisions identified by the state agency to correspondence templates, training material and reporting templates within the time frame specified.	105	PCG / DHHR/BMS
1.4	Submit any modifications, alterations, or changes to the correspondence templates, training material, and reporting templates to the state agency for review and approval	105	PCG / DHHR/BMS
Random Moment Time Study Administration			
1.5	Train LEAs on all elements of the School District Administrative Claiming program	175	PCG / DHHR/BMS
1.6	Administer a statistically valid Random Moment Sample process	75	PCG
1.7	Implement a centralized coding process	75	PCG
1.8	Implement required School District Administrative Claiming performance monitoring activities and report all activities to the state agency.	365 (ongoing)	PCG
School District Administrative Claiming Training			
1.9	Train all participating school district cost pool staff on the School District Administrative Claiming program requirements including: a) Cost pool criteria; b) RMS process and form completion; c) Total expenditure certification; d) Invoicing process; and e) Appropriate documentation requirements.	175	PCG
2.0	Assure all participating school district cost pool staff are trained in accordance with the time frames listed below: a. Initially when the School District Administrative Claiming Program begins in the district; b. At least annually (at least one hour each year); c. Prior to the time a new staff is to be sampled; and d. When the results of the time study indicate that one or more school district cost pool staff in the sample pool may not be responding correctly.	365 (ongoing)	PCG

	Task or Event	Completion Day	Assigned Personnel
School District Administrative Claiming RMTS Development & Administration:			
2.1	Develop and submit to the state agency for approval a statistically valid process for all of the LEAs participating in School District Administrative Claiming	75	PCG
2.2	Administer the quarterly RMTS process using PCG's Web-based Claiming System	Ongoing	PCG
2.3	Implement a process to ensure that the appropriate school staff are assigned to the cost pool	75	PCG
School District Administrative Claiming RMTS Centralized Coding Requirements:			
2.4	Develop and submit to the state agency for approval a RMTS centralized coding process	30	PCG
2.5	Administer the approved RMTS centralized coding process simultaneously with the approved RMTS process as approved by the state agency.	Ongoing	PCG
School District Administrative Claiming Monitoring and Reporting Requirements:			
2.6	Open web-based cost reporting system for use by LEAs	Quarterly	PCG
2.7	Review and conduct edits checks on reported costs by LEAs to ensure compliance	Quarterly	PCG
2.8	Provide performance monitoring activities to assure that the participating LEAs are appropriately claiming for services provided	Quarterly	PCG
2.9	Calculate Administrative Claims based on reported allowable costs and results of the Random Moment Time Study	Quarterly	PCG
3.0	Provide LEAs with Certification of Public Expenditure (CPE) for signature, along with required summary report detailing elements used to calculate the claim	Quarterly	PCG
3.1	Randomly select one percent of LEAs participating in the April-June quarter and October-December quarter and verify the provider participation rate was calculated accurately and appropriately	On a semi-annual basis	PCG
3.2	Select a sample of participating LEAs to verify the appropriate staff costs are being included and that all federal funding sources are removed	On a quarterly basis	PCG
3.3	Verify accuracy and maintenance of the School District Administrative Claiming program documentation by conducting desk audits, interviews and periodic site visits with the LEAs	As requested	PCG
3.4	Maintain documentation of all School District Administrative Claiming requirements contained in this section and provide the information quarterly to the state agency in the format specified	Ongoing, quarterly	PCG
3.5	Provide the state agency with a quarterly report including, but not limited to, the information outlined in this section of the RFP.	Quarterly	PCG

	Task or Event	Completion Day	Assigned Personnel
School-Based Direct Service Functions			
3.6	Train the appropriate state agency and school district staff on the approved School-Based Direct Services Medicaid Cost Settlement Process	250	Cost Reporting Team
3.7	Develop and implement school district cost reporting procedures including but not limited to collection of expenditure data, calculation of costs, and submission of certifications of expenditures by school districts	365 (ongoing)	Cost Reporting Team
3.8	Report quarterly all audit activities to the state agency; reports shall include those elements outlined in this section of the RFP	365 (ongoing)	Cost Reporting Team
3.9	Develop, implement and administer a Compliance Review program, in accordance with the requirements outlined in this section of the RFP, to ensure that the participating school districts are appropriately claiming School-Based Direct Services.	75 and ongoing	Regulation Team
4.0	On a quarterly basis, provide the state agency with a report including, but not limited to, the information outlined in this section of the RFP	365 (ongoing)	Regulation Team

4.1.5.9 – The Vendor must provide all services within the scope of this contract per the approved Medicaid State Plan and meet all CMS requirements.

PCG will continue to provide all services within the scope of this contract per the approved Medicaid State Plan and meet all CMS requirements. Details of PCG's approach on all services described within this procurement are cited throughout the proposal.

4.1.5.10 – The Vendor must participate in all levels of provider appeals or audits initiated by State or Federal entities. Participation includes, but is not limited to, providing all supporting documentation, preparation of written responses and providing subject matter experts, as needed, to testify in person during appeal or audit.

PCG will participate in all levels of provider appeals or audits initiated by State or Federal entities. Participation would include, but not limited to, providing all supporting documentation, preparation of written responses and providing subject matter experts, as needed, to testify in person during appeal or audit.

PCG is the largest provider of Medicaid services to states and LEAs in the nation. No other vendor matches the number of implementations, revenues generated or number of qualified staff that PCG brings to this engagement. As such, it would make intuitive sense that we also have the broadest experience with Medicaid audits. In total, financial findings in federal and state audits combined have accounted for less than 1% of the revenue generated by PCG over our entire 25 year period of Medicaid claiming, this includes both Fee-for-Service and Administrative Claiming audits. In continuing with PCG, West Virginia would have full access to this unparalleled audit support.

4.1.5.11 – The Vendor shall provide a Turn-Over Plan that provides for transfer of process to DHHR/BMS or subsequently awarded Vendor to ensure continuity of program. The Turn-Over Plan must be submitted and approved by DHHR/BMS within six (6) months of the expiration of the contract.

In the event DHHR/BMS requires a transition after a non-renewal or termination by either party, PCG shall transition our responsibilities back to DHHR/BMS. PCG will be responsible for the orderly transition of work and the accuracy of data in coordination with any Contractor(s). PCG assures DHHR/BMS of our cooperation with the new Contractor to facilitate a smooth transition. Within ten calendar days after written notification by DHHR/BMS of the initiation of transition, PCG will provide a Transition Document. Upon receipt of the detailed Transition Document by DHHR/BMS, DHHR/BMS shall review the document within fourteen calendar days and provide written instructions to PCG as to the packaging, documentation, delivery location and delivery date of all records, as needed to provide orderly transition. If DHHR/BMS determines upon review the Transition Document is missing necessary information, DHHR/BMS shall provide PCG written instructions as to the information that is still needed, and PCG shall amend the Transition Document with the necessary information.

PCG will deliver a full and complete accounting and report as of the date of termination on the status Cost Reporting and Rate Setting services. This report will be provided to DHHR/BMS within twenty one days of the effective date of termination. PCG will transfer all documents and records of every kind, including electronic, microfilm, paper, or otherwise, in our possession which pertain to this contract, including but not limited to all those listed in the contract, within twenty days of the effective date of termination. All documents shall be in MS Word or MS Excel format. All project plans shall be submitted in MS Project format. PCG will provide reasonable and appropriate assistance to DHHR/BMS and its designees regarding the contents of such documents and records, and shall provide reasonable and appropriate reference materials, including data files and file documentation. Both parties shall retain copies of all such files and records for a period of two years. PCG shall pay any and all additional costs incurred by the State that are the result of PCG's failure to provide the requested records, documents, data or materials within the time frames agreed to in the Transition Document. In the event of transition, a formal Turn-Over Plan will be submitted to DHHR/BMS for approval within six (6) months of the expiration of the contract.

4.1.6
Reports

4.1.6 Reports

4.1.6.1 – Administrative Claim Reports: The Vendor shall design and provide reports related to the quarterly SBHS Administrative claims for each LEA that contain detail data that the Vendor utilized to calculate the Administrative claim by the LEA. The Vendor shall propose the design of the report and data to be included; the format and final data elements included shall be approved by DHHR/BMS. These reports are due to DHHR/BMS by the 15th of the month following the quarter end.

PCG will produce quarterly reports related to the Administrative Claiming process. Quarterly reports will be submitted to DHHR/BMS no later than the 15th of the month following the quarter end. Due to the quarterly nature of the SBHS program, district coordinators see only pieces of the program at a time. The program contact updates the staff pool list at the beginning of the quarter, monitors compliance of the random moment time studies during the middle of the quarter, and the business officer submits financial information at the end of the quarter. To help West Virginia LEAs gain a holistic, comprehensive view of their participant in the SBHS program, PCG created a claim analysis report that is electronically distributed to each district after all certification forms are signed and returned to DHHR/BMS.

4.1.6.2 – The Vendor shall produce quarterly claim reports that summarize the information required for the DHHR/BMS to receive Federal Financial Participation (FFP) from the Centers for Medicare & Medicaid Services (CMS). The Vendor shall propose the design of the report and data to be included; the format and final data elements included shall be approved by DHHR/BMS. These reports are due to DHHR/BMS by the 15th of the month following the quarter end.

PCG will produce quarterly claim reports that summarize the information required for DHHR/BMS to receive Federal Financial Participation (FFP) from the Centers for Medicare & Medicaid Services (CMS). Specifically, PCG will develop and design summary or detailed reports according to DHHR/BMS specifications, and will provide these documents by the 15th of the month following the quarter end. PCG will submit to DHHR/BMS a comprehensive document detailing each LEAs quarterly claim with a breakdown of both the state and district shares. PCG will work with DHHR/BMS to understand the specific reporting needs and necessary in West Virginia to ensure complete FFP.

4.1.6.3 The Vendor shall produce annual reports related to the cost calculation process, including LEA-specific information submitted. Annual Reports are due no later than the 15th of the month following year end.

PCG will produce annual reports related to the cost calculation process. Annual reports will be submitted no later than the 15th of the month following year end. Upon the completion of cost settlement results for all LEAs, PCG submits our clients an approved comprehensive cost settlement file detailing the settlement and recoupment amounts for each district, breaking down both the state and federal shares. PCG will work with DHHR/BMS to understand the specific reporting needs and Medicaid cost settlement analysis necessary in West Virginia. Frequently, Medicaid agencies we work with will want to use Medicaid cost

reporting results to update interim Medicaid rates, particularly if rates are too low or too high. Medicaid cost report data provides Medicaid programs with the necessary information to make informed decisions on whether interim rate adjustments are necessary.

Other common reporting requested of PCG is a listing of cost settlement amount by LEA and cost settlement amount by LEA and service type (e.g. speech therapy, PT, OT). This type of information provides our clients with the appropriate information to make informed program decisions. Finally, PCG will work with DHHR/BMS to ensure Medicaid cost settlements are calculated and processed in a timely fashion. We will work with DHHR/BMS to make sure all West Virginia timelines are met in a timely fashion.

4.1.6.4 Additional Reports: DHHR/BMS will require additional reports of the Vendor. Such report formats are to be developed by the Vendor and must be approved by DHHR/BMS prior to implementation. Such required reports shall include, but not be limited to, the following: Quality Assurance and Improvement Measures such as quarterly data collected from the Vendor's phone system and monitoring activities; Annual Report of Web Site Improvements, including updates to the Vendor's Web site training materials; Annual Summary Log of Training Activities, including the name of LEAs training technical assistance provided and log of outstanding questions with responses provided by the Vendors; Issues Log if Outstanding Issues and Resolution and Plan of Action, including areas of concern expressed by LEAs or identified by the Vendor; Ad hoc reporting as requested by DHHR/BMS, which would be limited to data already contained in the system. Each report identified must be available within thirty calendar days of identification.

PCG will develop draft reports for approval by DHHR/BMS before creating and implementing the final requested reports.

PCG will be able to produce the following required reports as indicated by DHHR/BMS in this RFQ:

- Quality Assurance and Improvement Measures such as quarterly data collected from the Vendor's phone system and monitoring activities;
- Annual Report of Web Site Improvements, including updates to the Vendor's Web site training materials; Annual Summary Log of Training Activities, including the name of LEAs training technical assistance provided and log of outstanding questions with responses provided by the Vendors;
- Issues Log if Outstanding Issues and Resolution and Plan of Action, including areas of concern expressed by LEAs or identified by the Vendor;

If requested by DHHR/BMS, PCG will be able to produce supplementary reports based on data contained in our PCG Claiming System. With our experience as the largest national Medicaid vendor for school-based services, we understand the need for providing the information requested in a timely fashion while recognizing that flexibility and innovation regarding the information being provided is just as important. PCG will submit all reports and deliverables within thirty calendar days of the initial report request in an

electronic format that is widely used such as Microsoft Excel, Word, PowerPoint, and PDF and also deemed acceptable by DHHR/BMS.

4.1.6.5 DHHR/BMS/Vendor Meetings: The Vendor and DHHR/BMS shall meet regularly throughout the term of the Contract. Such meetings shall be held at least monthly for the first year of the Contract and not less often than quarterly thereafter at the discretion of DHHR/BMS. Meetings may be conducted in person, by teleconference or by videoconference as directed by DHHR/BMS. The initial contract kick off meeting shall occur within ten business days of the award of the contract and shall be held on-site at the DHHR/BMS location.

PCG and DHHR/BMS will meet regularly throughout the term of the Contract. Regular status meetings are a key component of PCG's overall project management approach. PCG will adhere to DHHR/BMS in terms of meeting frequency, but will be ready to schedule regular status meetings held daily, weekly, bi-weekly or monthly, depending on the project's needs. Before each status meeting, PCG will provide DHHR/BMS with a status report detailing project status, recent accomplishments, current activities, project issues and next steps. PCG will conduct meetings with DHHR/BMS either in-person, by teleconference, or videoconference. PCG has the capabilities and resources to conduct meetings at the discretion of DHHR/BMS. PCG agrees to meet with DHHR/BMS for the initial contract kick-off meeting within ten business days of the award of contract on site at the DHHR/BMS location.

4.1.7
Key Staff Requirements

4.1.7 Key Staff Requirements

4.1.7.1 The Vendor shall employ a full-time Project Manager who shall have day-to-day authority to manage all aspects of administering the SBHS program. The Project Manager must have at least three years professional experience in School-Based Administrative Claiming, Cost Reporting and RMTS on a statewide basis. The Project Manager shall be available Monday-Friday, 8:30am – 5:00 p.m. EST, excluding federal holidays as indicated in Section 4.1.5.1.

Joseph Weber, a Senior Consultant located in the Albany, New York office, will serve as the **Project Manager** for this engagement. As the Project Manager, Mr. Weber will be responsible for overseeing the day-to-day operations of the project and communicating project status or issues to DHHR/BMS.

Mr. Weber has over ***nine years of experience*** in assisting Medicaid state agencies, healthcare providers, and LEAs with a variety of financial management services. Mr. Weber's experience includes administrative claiming and RMTS services, as well as assisting state Medicaid agencies in developing and implementing cost based reimbursement methodologies for school based health service programs. In fact, Mr. Weber has successfully served as the Project Manager for the State of West Virginia SBHS program since July 2011, thus exceeding the three year minimum experience requirement and demonstrating the necessary skill sets and experience to serve this important role into the future. Mr. Weber has assisted with all facets pertaining to school based service programs, from program design and obtaining of CMS approval, to program implementation, including managing RMTS processes, calculation of MAC claims, and performing Medicaid cost settlement and reconciliation calculations. Mr. Weber brings national SBHS experience and expertise, as he currently plays a key role in assisting the State of New York and New Jersey in the operation of their SBHS programs.

Mr. Weber understands the extensive amount of details and work steps required to successfully manage SBHS projects. In leading these efforts, Mr. Weber leverages and applies best practices surrounding project management to ensure project goals and milestones are successfully completed and more importantly in a timely manner. Mr. Weber will be available Monday through Friday, 8:30 am to 5:00 pm EST, excluding any federal holidays as identified by DHHR/BMS.

4.1.7.2 The Vendor shall employ staff with demonstrated experience (and provide the necessary staff training) to perform the following services required in this solicitation: Software development, policy and program planning and execution, LEA relations and training, data systems support and data entry staff to enter information necessary to support the development and creation of Administrative Claim records for all participating LEAs. The Vendor shall employ and assign to this project sufficient staff to ensure that timeframes approved in the Project Implementation Plan are achieved.

PCG's team for this engagement brings to bear exceptional experience in the fields of school based services, RMTS services, Medicaid Administrative Claiming (MAC), and Medicaid cost settlement. Our team possesses the necessary qualifications and has the proven track record to perform the scope of services required by DHHR/BMS. Furthermore, our respective teams have unparalleled familiarity with the specific operations of these programs, as demonstrated through our prior success in performing these services on behalf of DHHR/BMS for the past three plus years. PCG has assembled this team, who is uniquely qualified to perform the requested services.

The professionals assembled within this project team understand all facets and best practices in operating successful Medicaid school based services programs. This includes developing and implementing software to support SBHS programs, policy and program planning and execution, RMTS processes, LEA training, and the necessary expertise to develop and calculate Medicaid administrative claims and process Medicaid cost settlements. Our team's expertise and experience includes the following:

- ✓ A comprehensive understanding of Medicaid reimbursement programs, established for school based service providers;
- ✓ Knowledge of the Medicaid State Plan amendment development and approval processes;
- ✓ National experience of operating RMTS systems, including coding processes;
- ✓ Knowledge of Medicaid Administrative Claiming, as well as established best practices to accurately calculate and document MAC claims;
- ✓ Knowledge of Annual Medicaid Cost Settlement and Reconciliation calculations;
- ✓ Knowledge of school based Medicaid fee-for-service MMIS Claims Data;
- ✓ Experience in implementing comprehensive training programs for school based service providers;
- ✓ Experience in providing in depth customer service to school based service providers through the usage of a toll free hotline and comprehensive email support; and
- ✓ Experience assisting States in implementing and operating SBS initiatives.

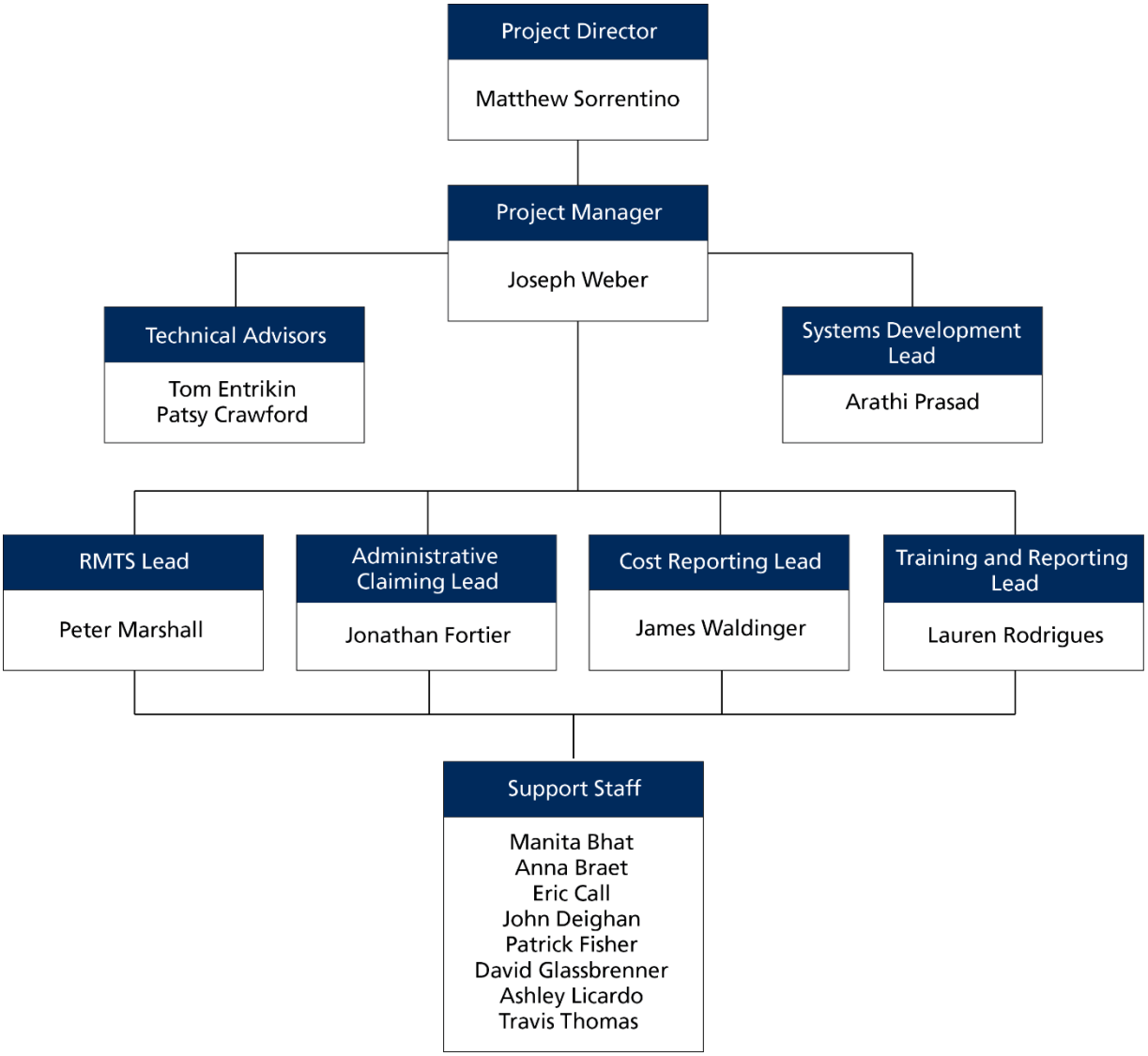
PCG's staff members have demonstrated experience performing the specific services required in this RFP, as shown in the chart below:

Staff Member	Software Development Experience	RMTS Experience	Policy and Program Planning & Execution Experience	LEA Relations and Training Experience	MAC Claims & Medicaid Cost Settlement Calculation Experience
Matthew Sorrentino	✓	✓	✓	✓	✓
Joseph Weber	✓	✓	✓	✓	✓
Peter Marshall	✓	✓	✓	✓	✓
Jonathan Fortier		✓		✓	✓
James Waldinger		✓	✓	✓	✓
Lauren Rodrigues	✓	✓	✓	✓	✓
Thomas Entrikin			✓		
Patsy Crawford			✓		
Arathi Prasad	✓				
Manita Bhat	✓				
Anna Braet				✓	✓
Eric Call		✓		✓	✓
John Deighan	✓				
Patrick Fisher				✓	
David Glassbrenner	✓				
Ashley Licardo				✓	
Travis Thomas	✓				

As a leading national vendor of SBHS programs and more importantly, as the incumbent, our staffing levels reflect what our prior experience has taught us – administrative claiming and cost settlement projects can require intense staffing needs for the initial development and operation of a successful school based health services program. Our team has been sufficiently staffed to perform the necessary services required by this RFP.

4.1.7.3 The Vendor shall provide a staffing organizational chart indicating the Vendor's key staff assignment and their role for each of the following: RMTS, Cost Reporting, Administrative Claiming, Training and Reporting. Key staff in leadership roles on the project, as well as those with subject matter expertise that are considered essential to the successful achievement of the project in this RFP.

Following is an organizational chart indicating PCG's key staff for this engagement. Each key staff member's role is identified. PCG also included the names of the support staff team members who will provide support to the key staff members throughout this project.



PCG's Project Manager, Joseph Weber's biography is included in section 4.1.7.1. Below are biographies for all other proposed key staff members.

Project Director

Matthew Sorrentino, a Manager located in PCG's Austin office, will serve as the Project Director for this project. Mr. Sorrentino has twelve plus years of experience in assisting Medicaid state agencies, healthcare providers, and LEAs in performing financial management services. Mr. Sorrentino has an in depth understanding of Medicaid, CHIP, Medicare, and other publicly funded health care programs. Mr. Sorrentino is a Medicaid reimbursement expert and has worked with states across the country to implement Medicaid claiming and cost settlement programs, including designing programs, successfully assisting States to navigate through the Centers for Medicare and Medicaid Services (CMS) approval processes,

designing web based applications to automate and streamline financial reporting requirements, and developing program review processes to promote compliant program participation.

Furthermore, Mr. Sorrentino is a reimbursement expert in regards to Medicaid payment methodologies. Mr. Sorrentino has led numerous studies and evaluations of Medicaid reimbursement rates for community based services, such as: physician services, school based services, mental health services, substance abuse services, and long term care services, among others. Mr. Sorrentino understands the extensive amount of details and work steps required to perform and assist rate setting activities and projects. In leading these efforts, Mr. Sorrentino leverages and applies best practices surrounding project management to ensure project goals and milestones are successfully completed and more importantly in a timely manner. Other projects Mr. Sorrentino has lead and has been involved with include projects such as: supplemental payment programs, cost reporting and settlements, cost allocation plans, and other revenue maximization efforts. Mr. Sorrentino will serve as a technical resource to the Project Manager and work to ensure the project stays on track throughout the life of the contract.

RMTS Lead

Peter Marshall is a Manager with PCG. Mr. Marshall has 19 years of experience with implementing school-based projects. He also has extensive experience with the implementation, training, and support of EasyIEP™ for over 30 LEAs. Mr. Marshall works with various districts who submit claims under the Fee-For-Service methodology including Boston Public Schools and Providence Public Schools. In addition, Mr. Marshall led the implementation of a multi-faceted Medicaid reimbursement project in the Commonwealth of Pennsylvania. This project included RMTS, Medicaid Administrative Claiming, cost settlement, and fee-for-service billing with project start-up coinciding with CMS-mandated program changes, including many significant changes to processes and procedures. He has led over 200 training/information sessions, weekly webinars, an extensive communications plan, and a case management system implementation in 683 school districts, charter schools, intermediate units and private schools. Mr. Marshall's experience and understanding of SBHS programs will allow him to play a key role in this project. He will lead the RMTS work and be responsible for managing the development and implementation of the quarterly, statewide time study. He'll also ensure all RMTS results are reported to DHHR/BMS in a timely manner.

Administrative Claiming Lead

Jonathan Fortier, a Schools Specialist located in our Boston office, has a background in legislative research and analysis as well as business general management. Prior to joining PCG, Mr. Fortier worked as a legislative aide within the Connecticut General Assembly as well as a General Manager of several Boston restaurants. Currently, Mr. Fortier handles Administrative Medicaid Claiming and Cost Reporting for fourteen Massachusetts School Districts, as well as statewide Medicaid Administrative Claiming for the Commonwealth of Pennsylvania. Mr. Fortier will serve as the Administrative Claiming lead for this project. He will be responsible for all components regarding Administrative Claiming, including managing the collection of LEA information and calculating aggregate LEA-specific Administrative Claiming

information. Mr. Fortier will work with DHHR/BMS to ensure all data and information is accurate and collected on time.

Cost Reporting Lead

James Waldinger, an Associate Manager in our Boston office, focuses on using data to measure outcomes and aid in the development of Medicaid reimbursement policies. His specific areas of focus are using data to assist in the implementation of behavioral health integration and movement of outcomes driven reimbursement policy. Mr. Waldinger is responsible for PCG team's performing school-based and Emergency Medical Services (EMS) cost reporting and cost settlement projects nationally. Additionally, over the past few years Mr. Waldinger has also played a primary role in PCG's health care reform efforts in New Mexico, Arkansas, and North Carolina, also working with the Medicaid agency to implement the numerous Affordable Care Act (ACA) provisions. He has led PCG's health homes and care management efforts, assisting in the identification of high-cost utilizers and policy discussions about appropriate interventions.

Mr. Waldinger served as the VP of Finance and Chief Financial Officer of the Massachusetts Behavioral Health Partnership. While there, Mr. Waldinger assisted the MBHP in forecasting and managing $350 million medical claims budget while re-vamping and monitoring the IBNR model, management of $28 million administrative budget, he achieved administrative budget surpluses and exceeded EBITDA budgets, and the implementation of Pay-for-Performance Strategy among Inpatient Hospital providers. For this project, Mr. Waldinger will be the Cost Reporting lead. He will work with DHHR/BMS to manage the LEA cost reporting process, the desk review process, and cost settlement process throughout this engagement.

Training and Reporting Lead

Lauren Rodrigues, a Consultant in the Health division at Public Consulting Group, has worked on healthcare finance projects ranging from cost reporting and rate setting to healthcare auditing. Ms. Rodrigues is currently assisting the states of West Virginia, New Jersey, and Pennsylvania in developing and implementing cost based reimbursement methodologies for school based health service programs. She has created and conducted trainings regarding the completion of the annual cost report and cost settlement for all three states, and has assisted LEAs with questions about the cost reporting process. She has also assisted with the completion of school-based health services cost reports for public schools in Washington, D.C. and Delaware.

Ms. Rodrigues has been working with the Massachusetts Executive Office of Health and Human Services to obtain CMS approval for the MassHealth Supplemental Payment Program and assisting with its subsequent implementation. In addition to this work, Ms. Rodrigues has completed Medicaid cost reports for state psychiatric facilities in Massachusetts and has assisted Massachusetts state psychiatric facilities with Medicaid rate setting on a biannual basis. Ms. Rodrigues has also completed reviews of applications for the Colorado Department of Health Care Policy and Financing's Nursing Facility Pay-for-Performance

program and has worked on teams auditing the Health Safety Net in Massachusetts. She will be the Training and Reporting lead for this engagement. Ms. Rodrigues will be responsible for coordinating and conducting trainings for the LEAs on all aspects of the SBHS Program. She will also be responsible for ensuring all reports related to SBHS activities will be accurate and generated on time.

Technical Advisors

Thomas Entrikin has over 40 years of experience with the Medicaid and Medicare programs. From 1972 to 1979 he was a Medicare program specialist with the Social Security Administration, Bureau of Health Insurance. From 1981 to 1992, he was a Medicaid law, regulations, and policy specialist with the Health Care Financing Administration (HCFA), now CMS, providing technical assistance to the States of Vermont, Connecticut, and Massachusetts on Medicaid eligibility, coverage, and reimbursement; provider certification and enrollment; program integrity; recovery of third party liabilities; Medicaid Management Information System (MMIS) performance specifications and operations; interagency agreements; contracts with managed care organizations; and Medicaid waiver programs. While at HCFA, he assisted the State of Vermont in developing its first home and community-based services waiver for individuals with developmental disabilities, and he received a HCFA Administrator's Citation for his work achieving savings in Medicaid prescription drug reimbursement systems.

Since coming to PCG in 1992, he has assisted in the design, development, and implementation of revenue projects for school based health services; hospital-based and municipal projects for pregnant women, infants, and children; state services offered through youth services, child welfare, mental health, substance abuse, and public health agencies; and reimbursement systems for hospitals, long term care facilities, and community-based waiver programs. He has made presentations at national conferences on Medicaid waiver programs and participated in the development of a manual on consumer self-determination under waiver programs for the Robert Wood Johnson Foundation. Mr. Entrikin will support the project team as a Technical Advisor and provide guidance on Medicaid statutes and policy.

Patsy Crawford is a Subject Matter Expert and the Director of Legal Services for PCG Education. She is an attorney with over 30 years of legal experience. She is responsible for providing legal and regulatory compliance support to the PCG Education Management Team. Since joining PCG in 1997, she has worked closely with school districts and/or PCG Project Managers in coordinating with state and federal Medicaid agencies to protect and improve billing programs for school districts. She has provided direct legal support to PCG Education projects in a number of states, including Illinois, Minnesota, Michigan, Massachusetts, Georgia, California, New Jersey, North Carolina, Tennessee, Texas, Pennsylvania, and the District of Columbia. For approximately six years, beginning in 1997, Ms. Crawford served as the Project Operations Manager for the Chicago Public Schools Health Services Management Program. She also served as the Project Manager for Saint Paul Public Schools for two years. Ms. Crawford, with extensive experience in market research and development and contract negotiation, has been instrumental in expanding PCG Education's client base in Illinois. She will serve as a Technical Advisor for this project, providing any legal support and Medicaid policy guidance to the project team.

Systems Development

Arathi Prasad, is our Software Development Manager for EasyIEP, EdPlan, EasyTrac, Behavior Plus products at Public Consulting Group (PCG). Ms. Prasad provides leadership and direction for the software team in developing quality software for the Company's Education product Line. Ms. Prasad is responsible for managing the design, implementation, testing, and documentation of software for multiple products and improving an automated web-based system Easy IEP®. Ms. Prasad was responsible for implementing the Process Wizard which allows customers to specify a process driven interface that matched the customer's IEP creation process. She designed and developed the Flexible Interface which allows customers to have custom specific interfaces where the user interface matched the customer's IEP document. She implemented the Gifted Education Program feature to keep track of Education Plan events for gifted children in EasyIEP®. She has designed and implemented the EDplan/RTI a solution for early intervention services. Ms. Prasad implemented compliance tracking for schools and users over time. She setup, several Service Level Management Process, for the software development and hosting support of Easy IEP®. She has experience rolling out large customers like TN, NJ, Miami and DC.

Prior to joining PCG, she worked with Apogee Networks where she helped the company build the NetCountant Billing Product, which analyzed network packets and generated an invoice based on a specific rate plan chosen by the customer. Prior to that she worked at Lucent Technologies implementing several products. She Implemented the Jini Lookup service using Sun's Jini Lookup Service specifications. The lookup service provides a central registry of services and is a primary means for programs to find services within the distributed system. She designed and developed a man machine language (MML) translator using C++ and the AT&T standard components Library which was used to test the lines in an international 5ESS switch. She also worked at Indian Institute of Science designing and developing an "Automatic Simulation of Queuing Network Models", which was used for evaluating the results on processor performance, memory allocation, process scheduling and many other performance measures. Ms. Prasad will serve as the lead of systems development. She be responsible for managing all aspects of the web-based systems for Administrative Claiming and Cost Reporting and leading the development, implementation, and operational functionality of the systems.

Support Staff

In addition, PCG will provide a team of staff members to support the key staff and project leads. This group has demonstrated experience working on PCG's past school based services projects and will be able to provide support to the project leads and successfully perform and complete the required services for this project.

4.1.7.4 The Vendor shall provide with the proposal resumes for each key staff included on the organizational chart, which includes prior work experience for similar projects.

On the following pages, we have provided resumes for each of the key staff members identified in our proposed organizational chart.

MATTHEW SORRENTINO
Public Consulting Group, Inc.
Manager

RELEVANT PROJECT EXPERIENCE

State of Wisconsin
Department of Health Services
School Based Services Cost Reporting / Reconciliation Initiative: Lead the development and implementation of a Medicaid cost settlement process under new Medicaid State Plan. Assumed management responsibility of the integrated random moment time study process for both direct services as well as administrative claiming. Compiled time study rosters, trained school district staff on revised procedures and are implementing a web-based cost reporting and Medicaid reconciliation system. Managed the processing of over 400 school district desk audits and processing of Medicaid cost settlements. Worked with the DHS to develop district and service specific rates.

State of Kansas
Kansas Department of Health and Environment
Medicaid Cost Reimbursement for School Based Services: KHDE contracted with PCG to develop a cost reimbursement methodology for the services provided by school districts and covered under the Medicaid program. Lead the development of the public notice and Medicaid state plan amendment. Assisted KHPA in responding to CMS questions and requests for additional information. Designed web based cost reporting application to facilitate Medicaid cost settlement process. Managed trainings to school districts on the new annual cost reporting process. Directed the processing of Medicaid cost settlements. Developing onsite field audits of LEAs to validate cost reports and supporting documentation.

State of Georgia
Department of Community Health
Medicaid Cost Reimbursement for School Based Services: DCH has contracted with PCG to implement a Medicaid cost settlement program. Lead the development and assisted DCH to obtain approval of the Medicaid state plan amendment to implement a cost settlement methodology. Developed cost reporting form and instructions, implemented the Medicaid Cost Reporting and Claiming System to automate the submission of the Medicaid cost reports, trained providers on how to complete cost reports, and calculated Medicaid cost settlements. Responsible for the development of onsite and remote audit program to validate cost reports.

State of Arizona
Arizona Health Care Cost Containment System
Medicaid Cost Reimbursement for School Based Services: AHCCCS contracted with PCG to implement a Medicaid cost settlement and reconciliation process. Lead the development and assisted AHCCCS to obtain approval of the Medicaid state plan amendment to implement a cost settlement methodology. Developed cost reporting form and instructions, implemented the Medicaid Cost Reporting and Claiming System to automate the submission of the Medicaid cost reports, trained providers on how to complete cost reports, and calculated Medicaid cost settlements. Responsible for the development of onsite and remote audit program to validate cost reports.

Commonwealth of Pennsylvania
Department of Education & Department of Public Welfare

Medicaid Cost Reimbursement for School Based Services: PDE & PDW contracted with PCG to implement a Medicaid cost settlement and reconciliation process. Lead the development and design process to implement a cost settlement methodology. Developed cost reporting form and instructions, implemented the Medicaid Cost Reporting and Claiming System to automate the submission of the Medicaid cost reports, trained providers on how to complete cost reports, and calculated Medicaid cost settlements. Responsible for the oversight and project management of all program functions.

State of Wisconsin
Department of Health Services
Wisconsin Medicaid Cost Reporting (WIMCR) Settlement Project: Manage the review and submission of county Medicaid cost reports for eligible Medicaid services. The services subject to cost settlement include mental health, developmental disabilities, and long term supports. Cost reports are used to develop interim payment rates for Medicaid purposes.

State of New York
Department of Health
Pre-School and School Supportive Health Services Program Design and Implementation: Project director of this effort to assist the State in designing and implementing a cost based reimbursement methodology for the school based health services program known as SSHSP. Oversaw the development of the SPA document outlining the new methodology and all accompanying documents including the cost report and cost reporting guide. Managed the preparation of responses to CMS' Requests for Additional Information pertaining to the SPA and other related documents. Conducted trainings for school districts across the state to introduce the new methodology and all of the new program requirements. Conducting financial trainings to assist the LEAs in completing the annual cost report.

EDUCATION

Clark University
Master's in Business Administration
June 2006

Bentley College
Bachelor of Science, Finance
May 2002

SOFTWARE PROFICIENCY

Microsoft Access, Excel, Word, PowerPoint
KPMG CMS 2552 Cost Reporting Software
KPMG CMS 2540 Cost Reporting Software
KPMG CMS 287 Cost Reporting Software
KPMG CMS 288 Cost Reporting Software

PROFESSIONAL ASSOCIATIONS
Healthcare Financial Management Association (HFMA),
Financial Management Association Honor's Society (FMA)
National Alliance

JOSEPH WEBER
Public Consulting Group, Inc.
Senior Consultant

RELEVANT PROJECT EXPERIENCE

State of New York
Department of Health
Pre-School and School Supportive Health Services Program Design and Implementation: Project Manager for PCG's efforts assisting the state in designing and implementing a cost based reimbursement methodology for the school based health services program known as SSHSP. Assisted in developing the SPA document outlining the new methodology and all accompanying documents including the cost report and cost reporting guide. Prepared responses to CMS' Requests for Additional Information pertaining to the SPA and other related documents. Conducted trainings for school districts across the state to introduce the new methodology and all of the new program requirements. Conducting financial trainings to assist the LEAs in completing the annual cost report.

State of West Virginia
Department of Health and Human Resources
Bureau for Medical Services
School Based Health Services Program Design and Implementation: Serving as PCG's Project Manager for our efforts assisting the state in designing and implementing a cost based reimbursement methodology for the school based health services program. Assisted in developing the SPA document outlining the new methodology and all accompanying documents including the cost report and cost reporting guide. Working with the Department of Education to develop consistent practices for the reporting of indirect costs across the state's 57 LEAs. Conducted trainings to introduce the new methodology and all new program requirements to the LEA and RESA staff.

State of New Jersey
Division of Medical Assistance and Health Services
Special Education Medicaid Initiative Program Design and Implementation: Project Manager for PCG's cost settlement team that is assisting the state in designing and implementing a cost based reimbursement methodology for the school based health services program known as SEMI. Assisted in developing the SPA document outlining the new methodology and all accompanying documents including the cost report and cost reporting guide. Prepared responses to CMS' Requests for Additional Information pertaining to the SPA and other related documents. Conducting financial trainings to assist the LEAs in completing the annual cost report.

Commonwealth of Pennsylvania
Department of Public Welfare Pennsylvania Department of Education
School Based Access Program Cost Settlement Implementation: PCG's Project Manager for the cost settlement team responsible for assisting the Commonwealth in implementing a cost based reimbursement methodology for the school based health services program known as SBAP. Conducted a review of the recently approved SPA to identify implementation requirements. Worked with DPW and PDE to conduct trainings on cost settlement requirements. Developed the web-based cost reporting template and cost report instructions for the LEAs. Implemented a comprehensive desk review and auditing protocol to support DPW audit efforts.

State of Georgia
Department of Community Health
School Based Health Services Program Design and Implementation: Assisting the state in designing and implementing a cost based reimbursement methodology for the school based health services program known as CISS. Developed the SPA document outlining the new methodology and all accompanying documents including the cost report and cost reporting guide. Prepared responses to CMS' Requests for Additional Information pertaining to the SPA and other related documents. Conducting financial trainings to assist the LEAs in completing the annual cost report.

District of Columbia
District of Columbia Public Schools
Medicaid Cost Settlement Reports: Prepared and submitted the Special Education Medicaid Cost Settlement Report on behalf of the District of Columbia Public Schools for fiscal years 2004 through 2009. Conducted an analysis of all costs incurred by the District of Columbia Public Schools in the provision of special education services to Medicaid eligible students. Identified the Medicaid allowable and non-allowable costs for school based health services.

District of Columbia
Department of Health Care Finance
School Based Health Services Program Design and Implementation: Assisted DHCF in developing and implementing a cost based reimbursement methodology for the school based health services program. Prepared the SPA document as well as the cost report template and instructions. Prepared responses to CMS questions to gain approval of the SPA. Conducted cost reporting trainings for DC Public Schools and DC Public Charter Schools to inform the schools of the new methodology and cost reporting requirements.

State of Missouri
Department of Mental Health
Physician Billing Conversion Analysis: Provided consulting services related to the implementation of a cost based physician reimbursement system in 4 state owned and operated teaching hospitals. This methodology will switch these providers from the fee for service system to a cost based reimbursement system under the Medicare program. PCG assisted DMH with submission of patient logs and provider negotiations with the intermediary.

Medicare Billing Review: Conducted a review of patient medical records and claims to determine if current billing practices at Missouri DMH facilities are maximizing reimbursement during the transition from TEFRA to PPS. Analyzed coding procedures to ensure that all comorbid conditions were properly coded to appropriately capture the full PPS adjustments.

Federal and State Cost Reporting: Prepared the CMS-2552 cost reports for Medicare and Medicaid on behalf of the 9 state operated psychiatric facilities. Obtained specific information from the facilities in order to properly analyze detailed charges, revenue, and expenditures. Completed a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports. Conducted an analysis of the current rates set for Medicaid services and the current Disproportionate Share Hospital (DSH) calculation for the state facilities.

State of Missouri
Department of Social Services
MO HealthNet Division

Title XIX Funding for University of Missouri Health Systems Affiliated Program: Conducted an analysis of Medicaid funding for the University of Missouri Health System (UMHS) and UMHS Programs. Reviewed multiple initiatives geared towards increasing the Medicaid funding for UMHS and UMHS programs including Medicaid Disproportionate Share Hospital (DSH) claiming, Provider Tax, Hospital, EMS, and Physician Upper Payment Limit (UPL). Provided a detailed assessment of current Medicaid funding and opportunities for increased Medicaid funding and the work steps for implementing the initiative.

State of Colorado
Department of Human Services, Office of Behavioral Health

Standardized Coding, Unit Costing, Reimbursement Rate & Web Solution for Substance Use Disorder: Assisted the State in completing a review of current coding standards for substance use disorder (SUD) providers and in developing a new, standardized coding manual for SUD services. Reviewed the existing cost reporting methodology for SUD providers and developed revised cost reporting guidelines and template to more accurately capture the actual cost of providing SUD services. Developing a web-based cost reporting form and user guide to be used by all SUD providers in the state for completing the annual cost reports that will be used to inform rate setting efforts.

Commonwealth of Massachusetts
Executive Office of Health and Human Services

Supplemental Payment Program for EMS Providers: Worked with EOHHS on CMS approval for, and the implementation of a MassHealth Supplemental Payment Program to generate incremental federal Medicaid revenue for local governmental providers of ambulance/emergency medical services (EMS) to MassHealth beneficiaries. Facilitated the creation of a Medicaid State Plan Amendment and its submission to CMS. Organized a workgroup with 6 EMS providers to understand financial and reporting capabilities and finalize reporting methodologies. Developed cost report and cost reporting guide utilizing feedback from the workgroup.

EDUCATION

College of the Holy Cross
Bachelor of Arts, Economics
May 2005

Clark University
Master's in Business Administration
May 2009

PROFESSIONAL ASSOCIATIONS

Healthcare Financial Management Association (HFMA)

PETER MARSHALL
Public Consulting Group, Inc.
Manager

RELEVANT PROJECT EXPERIENCE

PCG Education Northeast and Mid-Atlantic Regional Manager
Responsible for the oversight, management and client engagement for the PCG Education Northeast and Mid-Atlantic regions. This geography includes New England, Pennsylvania, Virginia, West Virginia, Delaware and the District of Columbia.

Special Education Data Management System, Office of the State Superintendent of Education (OSSE), Washington DC
Led the implementation of SPED data system. Implementation included data migration, training, development, project management, ongoing support, reporting and hosting of the application. Engagement included coordination of 50+ Charter Schools and DCPS. Stakeholder buy-in was critical to project success and involved multi-agency coordination.

Pennsylvania Department of Education (PDE)
School-Based Access Program (SBAP)
Led the implementation of a multi-faceted Medicaid reimbursement project. Project included Medicaid Administrative claiming, Cost settlement and fee-for-service billing. Project start-up coincided with CMS-mandated program changes, including many significant changes to process and procedures. Led over 200 training/information sessions, weekly webinars, and an extensive communications plan. Project included implementing a case management system in 683 school districts, charter schools, intermediate units and private schools.

Massachusetts Municipal Medicaid Revenue Maximization Project
Project manager overseeing tens of millions of dollars in reimbursement annually. Generate Medicaid billings for Medicaid eligible Special Education students. Used PCG resources and school data files to track attendance information for students enrolled in SPED. Tracked remittances from Medicaid and presented timely status reports to client. Assisted in the implementation of Administrative Activity Claiming. Developed training material and time-survey forms to be used in conjunction with the training of clinicians. Training of therapists, psychologists, nurses and administrative staff covered the proper procedures in filling out time survey forms.

Provided programmatic oversight to all Massachusetts municipal clients. Frequently meet with State Medicaid agency regarding regulation changes and program updates.
City of Boston, Boston, Massachusetts
City of Brockton, Brockton, Massachusetts
City of Cambridge, Cambridge, Massachusetts
City of Chelsea, Chelsea, Massachusetts
City of Fitchburg, Fitchburg, Massachusetts
City of Lowell, Lowell, Massachusetts
City of Lynn, Lynn, Massachusetts
City of Quincy, Quincy, Massachusetts
City of Springfield, Springfield, Massachusetts
City of Watertown, Watertown, Massachusetts

Special Education Data Management System
Led the implementation of SPED data system. Implementation included data migration, training, development, project management, ongoing support, reporting and hosting of the application.

City of Cambridge, Cambridge, Massachusetts
City of Lowell, Lowell, Massachusetts

City of Lynn, Lynn, Massachusetts
City of Quincy, Quincy, Massachusetts
City of Somerville, Somerville Massachusetts
City of Springfield, Springfield, Massachusetts
City of Watertown, Watertown, Massachusetts

EDUCATION

Emmanuel College
BS, Business Administration (BSBA)

JONATHAN N. FORTIER
Public Consulting Group, Inc.
Schools Specialist II

RELEVANT PROJECT EXPERIENCE

Municipal Medicaid Revenue Optimization Project
Gather and process attendance, enrollment and individual education plans for Municipal Health Care providers to recover reimbursable funds from the MA State Medicaid program. Generate Medicaid claims for Medicaid-eligible Special Education students in Lowell, Lynn, Pentucket Regional, Quincy, Somerville, and Springfield school districts.

Municipal Medicaid Services Optimization Project
Preparation of Administrative Activity Claims (AOC) on behalf of Massachusetts public school systems; Collect and analyze financial data, apply AOC time study results, and input data into claiming tool used to calculate federal Medicaid reimbursement for EPSDT and health related services performed in school districts.

Commonwealth of Pennsylvania
Statewide Medicaid Services Optimization Project
Preparation of school-based Medicaid Administrative Claims (MAC) on behalf of the Commonwealth of Pennsylvania; Collect and analyze financial data, apply statewide time study results, and input data into claiming tool used to calculate federal Medicaid reimbursement for EPSDT and health related services performed in school districts.

PROFESSIONAL BACKGROUND

Vox Populi, Boston, Massachusetts
General Manager of restaurant grossing $12 million in annual sales. Leader in all aspects of the company including but not limited to staffing, terminating, profit and loss write-ups, purchasing and product development. Delegated to oversee a team of managers in addition to the restaurant's 75 employees.

Connecticut General Assembly, Hartford, Connecticut
Legislative Aide
Researched and presented analysis to State Senator's office, e.g. State recidivism, pardons and paroles, State Judicial appointments. Assisted in legislative bill tracking and entrusted to perform District constituent work. Collaborated with local leaders to help create annual function commemorating Connecticut small business owners.

EDUCATION

University of Hartford
Bachelor of Arts: Political Science, 2004
Minor: Law Studies

Software proficiency

Microsoft Word, Access, Excel, PowerPoint, EasyIEP™, EasyRMTS™, MCRCS™

JAMES WALDINGER
Public Consulting Group, Inc.
Associate Manager

State of New Jersey
Division of Medical Assistance and Health Services
Special Education Medicaid Initiative Program Design and Implementation: Project Manager for PCG's cost settlement team that is assisting the state in designing and implementing a cost based reimbursement methodology for the school based health services program known as SEMI. Oversees day to day operation of the cost reporting and cost settlement portion of the SEMI program.

State of Delaware
Department of Education
Medicaid School-Based Services and Cost Reconciliation and Reporting: Program Manager for Medicaid Cost Reconciliation and Reporting on behalf of the Delaware Department of Education. Oversaw the completion and review of Medicaid cost reports and cost settlement calculations for 36 school districts for fiscal years 2009, 2010, 2011, 2012, 2013, and 2014 to support cost reconciliation and recovery processes.

State of Colorado
Division of Behavioral Health
Cost Report Training:
Assisted in the review of the Accounting and Auditing Guidelines for Community Mental Health Centers of Colorado. Worked with DBH and HCPF to develop and deliver on-site provider trainings for the new supplementary cost report.

State of New Mexico
New Mexico Health Insurance Exchange
State-Based Exchange Project Management:
Client executive in charge of PMO activities related to the implementation of the state-based SHOP in 2013 and development and implementation of the state-based individual marketplace in 2014. Managed all PMO and professional services activities, including plan management, consumer assistance, and financial management.

State of North Carolina
Department of Health and Human Services
Affordable Care Act Consulting and Work Plan Development:
Led PCG's efforts to help organize and provide technical expertise to DHHS in planning, implementing, and managing all relevant facets of health care reform. Project accomplishments included: 1) creation of centralized work plans for all Affordable Care Act (ACA) initiatives; 2) developed DHHS communication and oversight plan; 3) develop IT gap analysis; 4) assisted in drafting NC Division of Insurance's Health Benefit Exchange Level I Cooperative Agreement Application.

Commonwealth of Massachusetts
Commonwealth Care Customer Service Center
Financial and Reporting/Training and QA:
The Customer Service Center serves as the premium billing and call center entity for the Massachusetts CommCare products. As Reporting Manager, documented all contractual reports, improving accuracy and client satisfaction. Reporting has changed from a contractual obligation to a management tool. Financial Manager reviews and reports on daily, weekly, and monthly financial metrics related to bank account balances, member invoices, and related day-to-day fiscal issues. Documented financial internal controls for all premium billing processes.

City of San Francisco, California
Department of Public Health
Finance Lead – Primary Care-Behavioral Health Integration Initiative:
PCG was hired to assess and implement a PC-BH Integration project within the city-owned primary care centers. As the Finance Lead worked with City Staff to identify existing financial, utilization, and quality metrics that could be used to develop a pre- and post-implementation cost and revenue analysis.

Northeast Behavioral Health; Peabody, Massachusetts
Billing Process Review:
Assessed NBH's Medicaid contracting processes to proactively identify any issues that could have financial impact (an example is approved site location requirements); Assessed NBH's billing practices to proactively identify problems that could result in payment issues, as well as the interface with and the practices of their 3rd party vendor.
Billing Process Standardization and Training:
Based on findings from the Billing Process Review, was contracted to develop and document a standardized in-take process across multiple sites, and provide training, as needed.
In process
Management Reporting Consulting:
Also based on findings and work during the Billing Process Review, was contracted to work with their data vendor to create reports for Leadership and Site Managers.

State of New Mexico
Human Services Department
Behavioral Health Provider Claims Audits:
Led intensive 4 month audit of 15 behavioral health statewide providers. Organized and led 6 on-site data collection teams, managed clinical and administrative audit, and edited 400+ page final report. Findings amounted to $36 million in extrapolated overpayments over a 2.5-year period.

Commonwealth of Massachusetts
Division of Health Care Finance and Policy
Health Safety Net Audits:
Conducted provider compliance field reviews of Health Safety Net (HSN) claims (formerly uncompensated care pool). The objective of this review was to ensure hospital compliance with the HSN regulations. Conducted reviews of 20 hospitals and 5 community health centers, identifying findings that resulted in recommended recoveries. Prepared a final report detailing HSN billing error trends and made recommendations for tightening regulations.

Commonwealth of Virginia
Division of Medical Assistance Services (DMAS)
Community Behavioral Health Provider Auditing:
As a subcontractor, PCG is supplying audit process and clinical auditing expertise. Assisted with organizational set-up of audit protocols and development of audit tools. Manage the clinical auditors, whose reviews have produced 15%-20% in recovery opportunities.

State of Colorado
Division of Health Care Policy and Financing
Benefits Design Assistance:
Leading team assisting state in designing and implementing Medicaid programs for expansion populations, including buy-in programs for the disabled, adults without dependent children, and dually eligible. Performed research on state options, drafted recommendation memos to Medicaid leadership, led consumer and provider stakeholder meetings, drafted state plan

amendment language, calculated cost models, and provided general consulting services.

EDUCATION

Northeastern University, Boston, Massachusetts
Master of Public Administration (MPA), 2002

University of Connecticut, Storrs, Connecticut
Bachelor of Arts, Communications, 1994

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

- Publications: *Models to Manage Quality and Costs of Individuals with Multiple Chronic Conditions: US Experience*, 2011
- Trainings for Person Centered Medical Home NCQA Recognition Process

LAUREN E. RODRIGUES
Public Consulting Group, Inc.
Consultant

RELEVANT PROJECT EXPERIENCE

State of West Virginia
Bureau of Medical Services
School Based Health Services Program Design and Implementation**:** Assisting the state in designing and implementing a cost based reimbursement methodology for the school based health services program. Revised the State Plan Amendment to outline the new methodology as well as accompanying documents including the cost report and cost reporting guide. Created presentations and conducted financial trainings to assist the LEAs in completing the annual cost report and participating in the Random Moment Time Study.

State of New Jersey
Department of Education
NJ SEMI Program: Creates and presents trainings to districts to facilitate their understanding of the cost reporting and cost settlement process. Reviews data submitted by districts through the annual cost report for reasonability. Assists districts with questions regarding the annual cost report through the phone hotline and by email.

District of Columbia
District of Columbia Public Schools
Medicaid Cost Settlement Reports: Prepared and submitted the fiscal year 2010 Special Education Medicaid Cost Settlement Report on behalf of the District of Columbia Public Schools. Identified the Medicaid allowable and non-allowable costs for school based health services and analyzed all costs incurred by the District of Columbia Public Schools regarding special education services to Medicaid eligible students.

Commonwealth of Pennsylvania
Department of Public Welfare Pennsylvania Department of Education
School Based Access Program Cost Settlement Implementation: Assisting the Commonwealth in implementing a cost based reimbursement methodology for the school based health services program known as SBAP. Conduct trainings on cost settlement requirements to assist the LEAs in completing the annual cost report.

State of Delaware
Department of Education
Medicaid School-Based Services and Cost Reconciliation and Reporting: Assisting the state with the completion and review of Medicaid cost reports and cost settlement calculations for 36 school districts for fiscal years 2009, 2010, 2011, 2012, 2013, and 2014 to support cost reconciliation and recovery processes.

Commonwealth of Massachusetts
Executive Office of Health and Human Services (EOHHS)
Office of Medicaid
Supplemental Payment Program for EMS Providers: Worked with EOHHS on CMS approval for, and the implementation of a MassHealth Supplemental Payment Program to generate incremental federal Medicaid revenue for local governmental providers of ambulance/emergency medical services (EMS) to MassHealth beneficiaries. Facilitated the creation of a Medicaid State Plan Amendment and its submission to CMS. Organized a workgroup with 6 EMS providers to understand financial and reporting capabilities and finalize reporting methodologies. Developed cost report and cost reporting guide utilizing feedback from the workgroup.

State of Colorado

Office of Behavioral Health
Standardized Coding, Unit Cost, Reimbursement Rates & Web Solution:
Assisted with the creation of uniform service coding standards for substance use disorder (SUD); Created a uniform cost calculation to improve the accuracy and consistency for determining the cost of SUD treatment services; Currently developing a substance use disorder treatment service valuation methodology and modifiers to set up reimbursement rates; Facilitating the production of a web based cost report application incorporating all of the requirements of the other project phases.

EDUCATION

Bentley University
Masters of Business Administration (MBA)
May 2010

Bentley University
Bachelor of Science in Finance
May 2008

THOMAS ENTRIKIN
Public Consulting Group, Inc.
Manager

RELEVANT PROJECT EXPERIENCE

Chicago Public Schools, State of Illinois
School Based Services
Technical Advisor
Project: Provided legal and regulatory support for Medicaid administrative and Medicaid services claiming, time studies, state plan amendments, and cost allocation procedures.
Mr. Entrikin: Provided recommendations on legal and regulatory compliance under federal and state plan requirements. Performed data analysis and legal, regulatory, and policy research in support of increased federal reimbursement of early intervention services.

Tennessee Bureau of TennCare
State of Tennessee
Medicaid Administrative Claiming
Advisor
Project: Assisted in developing Medicaid administrative claiming practices and documentation.
Mr. Entrikin: Provided analysis and recommendations to update interdepartmental service agreements between the Bureau of TennCare and eight sister state agencies and state universities.

North Carolina Department of Health and Human Services, State of North Carolina
Advisory Services
Advisor
Project: Developed state Medicaid plan amendment for upper payment limit (UPL) adjustments for public health and behavioral health clinics. Identified FFP revenue maximization opportunities in disproportionate share hospital (DSH) payment adjustments for mental health facilities and in State services for children, the elderly, and disabled groups. Developed Medicaid State plan amendment for State psychiatric hospital DSH reimbursement. Identified additional DSH eligible facilities and allowable costs. Recommended improvements in cost allocation methods. Recommended new procedures on certifications of public expenditures. Evaluated compliance with certification requirements for inpatient psychiatric residential treatment facilities. Performed legal and regulatory research.
Mr. Entrikin: Advised on all project processes.

New Hampshire Department of Health and Human Services, State of New Hampshire
Revenue Maximization
Advisor
Project: Provided recommendations on upper payment limit (UPL) adjustments for county operated nursing facilities, intergovernmental transfers of funds (IGTs), development of waiver programs, payment reform, and disproportionate share hospital (DSH) payment adjustments.
Mr. Entrikin: Developed Section 1115 research and demonstration waiver proposal to expand Medicaid eligibility for low income children and to provide capitated mental health care. Analyzed community mental health center utilization and expenditure data. Developed recommendations to re-design state contracting and oversight of community mental health centers. Participated in public meetings on the re-design process with provider and consumer representatives. Provided recommendations on incorporating evidence-based practices in Medicaid coverage and reimbursement instructions. Evaluated provider-related tax requirements applicable to community based providers. Identified opportunities to obtain revenue for mental health services provided in residential programs for

delinquent youth. Evaluated compliance with certification requirements for inpatient psychiatric residential facilities. Performed legal, regulatory, and policy research.

Massachusetts Department of Public Health, Department of Mental Health, Commonwealth of Massachusetts
Revenue Maximization
Advisor
Project: Established FFP claiming process for early intervention services provided to EPSDT children by developmental educators.
Mr. Entrikin: Designed and implemented FFP claiming process. Recommended improvements in intergovernmental transfers of funds (IGT) procedures. Provided recommendations for improvements in annual caseload and expenditure projections for state budget purposes. Evaluated commercial insurance and HMO coverage and billing requirements for services provided by developmental educators and recommended improvements in third party collections. Performed legal, regulatory, and policy research in support of Medicaid FFP and TANF claiming activities.

Massachusetts Department of Mental Health, Commonwealth of Massachusetts
Community-Based Services Rate Setting
Advisor
Project: Developed enhanced encounter rate for hospital and community-based crisis intervention and crisis stabilization services offered through managed care and fee-for-service arrangements. Developed Medicaid State plan amendment and calculated Medicaid payment rates for the services.
Mr. Entrikin: Designed and implemented encounter rate for crisis intervention and crisis stabilization services. Performed analysis of the federal Olmstead decision and other case law on home and community-based services. Drafted planning APD for a DMH management information system integrated with the Medicaid agency's MMIS.

Delaware Department of Alcohol, Drug Abuse, and Mental Health, State of Delaware
Strategy Implementation
Advisor
Project: Assisted the agency in developing a strategy to revise its Medicaid administrative claiming process and to develop a managed care plan and a section 1915(b) waiver application for individuals with persistent mental illness.
Mr. Entrikin: Developed section 1915(b) waiver application. Performed legal research on disproportionate share hospital (DSH) payment adjustments.

West Virginia Bureau of Medical Assistance, State of West Virginia
Medicaid Revenue Projects
Advisor
Project: Assisted in the development of projects to increase FFP revenues and to improve coordination of benefits practices.
Mr. Entrikin: Assisted in developing Medicaid third party liability action plan and Medicaid revenue projects. Developed legal and financial justification for retroactive corrections to rate calculations. Legal research on disproportionate share hospital (DSH) payment adjustments.

Kentucky Department of Medicaid Services, State of Kentucky
Medicare Part B Premiums
Advisor
Project: Assisted in ensuring compliance with federal Medicaid requirements.
Mr. Entrikin: Analyzed buy-in agreements, state plan, systems specification and operations, and Medicaid payment procedures for Medicare Part

B premiums. Legal research on provider-related taxes.

Washington Department of Social and Health Services, State of Washington
Management Information System Implementation APD
Advisor
Project: Assisted in ensuring compliance with federal Medicaid requirements on MMIS APDs and FFP claiming practices.
Mr. Entrikin: Performed legal, regulatory, and Medicaid policy research on MMIS APD issues. Assisted in the development of a compliance evaluation tool for inpatient psychiatric residential treatment facilities and other institutions for mental diseases. Performed legal, regulatory, and policy research on Medicaid eligibility, coverage, and reimbursement issues

PROFESSIONAL BACKGROUND

Public Consulting Group, Inc., *Boston, MA*
August 1992 – Present

EDUCATION

Harvard University, *Cambridge, MA*
Master of Public Administration, June 1980

University of Massachusetts, Amherst, Massachusetts
Bachelor of Arts, May 1971

Certifications / Publications / Special Skills

- Managed Care in Medicaid Program, Tom Entrikin, June 1994
- Beyond Managed Care: An Owner's Manual for Self-Determination.
  T. Nerney, D. Shumway, M. Fenton, T. Entrikin, S. Morrill, G. Marburg, published by Robert Wood Johnson Foundation, 1997.

PATSY K. CRAWFORD
Public Consulting Group, Inc.
Subject Matter Expert

RELEVANT PROJECT EXPERIENCE

PCG Education

Director of Legal Services: Current activities: Provides direction, based on legal research and analyses, to the PCG Education Management Team to ensure that all Education projects are in compliance with State and Federal Medicaid billing rules for direct service, administrative claiming, and targeted case management programs; Monitors and analyzes state and DHHS OIG audit reports pertaining to school-based Medicaid billing programs, including Medicaid administrative claiming, to identify best practices, as well as any potential or actual changes in the Medicaid billing/claiming rules; Monitors and analyzes changes and potential changes in Federal Medicaid rules regarding school-based billing and Education rules regarding IDEA, NCLB/ESEA and FERPA; Facilitates negotiations with State and Federal Medicaid agencies to eliminate actual or to preclude proposed restrictions on school-based Medicaid billing; Responds to requests from PCG Education staff and clients for guidance regarding compliance with Medicaid and Education laws and rules; Addresses issues related to HIPAA and FERPA compliance, including parental consent and electronic signatures; and Provides guidance regarding PCG clients' compliance with Medicaid and Education laws and regulations including ESEA/NCLB, IDEA, and FERPA (parental consent). Provide, upon request, guidance to government officials and national organizations such as the **National Association of School Nurses** in developing or enhancing strategies to support school-based Medicaid billing; Prepares the PCG Education Legal Brief newsletters with legal and regulatory updates on Medicaid and education issues for distribution to PCG staff, clients and potential clients nationally. Prepared an article regarding school-based Medicaid billing published in NASN's national magazine. Assisted with the Medicaid research for an article on school nursing services published by the Robert Woods Johnson Foundation.

PCG Education Resource Center: As Subject Matter Expert, led the development of an online interactive "library" of legal and regulatory resources in the areas of Medicaid, education and special education. The website is open to the public and includes breaking news of general interest to PCG staff and the education community.

Project Manager for Development of a State Plan Amendment for Ohio: Served as the Project Manager of a project to provide legal consulting services to school districts and Ohio State agencies to develop a new State plan for school-based Medicaid billing. Researched State and federal Medicaid laws and regulations to support the design the proposed new program. Negotiated with State and federal Medicaid officials to obtain support for the new program.

Legal and Regulatory Advisor for the District of Columbia Administrative Organization (DC ASO) Project: Assisted the team to identify Medicaid and Education requirements to facilitate compliance monitoring of school-based Medicaid direct service billing.

Legal and Regulatory Advisor for the Start-Up of New Jersey Special Education Medicaid Initiative (SEMI): In conjunction with the PCG team, consulted with State officials to develop a

new SEMI Handbook for school-based service providers. Assisted the State to address findings in a DHHS OIG Medicaid audit report. Assisted the State to address Medicaid provider qualifications with school-based staff.

Project Operations Manager for Chicago Public Schools (CPS): As Project Manager for six years, managed operations of CPS's Health Services Management Program, which includes Medicaid billing for fee-for-service and administrative outreach claims resulting in more than $200 million in revenue to CPS between 1997 and 2003. Researched and facilitated implementation of opportunities to optimize FFS and AOC Medicaid and other federal revenue. Assisted in the development and analyses of appropriate management reports. Researched various statewide regulatory changes affecting the school-based billing program to achieve optimum outcomes for school districts. Created the initial concept and design of a "decision tree" process to facilitate easier and more accurate documentation for the Medicaid administrative claiming program.

Project Operations Manager Saint Paul Public Schools: Provided project management of the school-based Medicaid billing program, including implementation of a web-based service fee-for-service documentation program, including a process for automatically creating encounter notes, required by Medicaid, during the documentation process. Assisted in the design and development of appropriate management reports for SPPS.

Legal Advisor for the TennCare School-Based Health Services Program: Reviewed Tennessee laws, regulations, and State plan amendment to draft the Medicaid Provider Manual for school-based health services. Provided support to TennCare administrators to achieve optimum reimbursement opportunities for health services provided to Tennessee students.

Chicago-based Marketing Lead: Served as the Chicago-based marketing lead for PCG Education products in Illinois including EasyIEP™, EDplan™, and Medicaid billing services. Her efforts resulted in the creation of large consortium of Illinois cooperatives and districts (ICAD) for the joint purchase of PCG Education products serving approximately 40,000 special education students and generating over $500,000 in annual revenue.

Member of the Marketing Team and Legal Advisor for Michigan Intermediate School Districts Project Start-Up: Participated in oral presentations and facilitated the initial project start up, including review of Medicaid billing and administrative claiming rules and various contracts associated with the project.

PROFESSIONAL BACKGROUND

Community Health Care of Illinois, Inc.
As Executive Director/CEO, directed the establishment of a unique statewide provider network for Medicaid recipients, using Community Health Centers as the basis for primary health care. Coordinated with the Board of Directors and the Illinois Departments of Public Aid and Insurance to secure HMO certification.

Health Care Compare Corp. (now called First Health)
As a Manager and Senior Negotiator, directed the development of managed care provider networks across the country for various clients. Drafted and negotiated contracts with hospital

administrators. Trained staff to negotiate contracts and develop market areas. Designed and implemented new managed care products, including a national prescription drug management program.

California Medical Assistance Commission
As General Counsel and Senior Negotiator, participated in the development and implementation of a statewide managed care program for Medicaid recipients in California. Negotiated contracts and advised the Board with regard to legal and regulatory matters.

California State Teacher's Retirement Board
Provided legal counsel to the Board on matters of investments. Represented the Board in administrative hearings pertaining to teachers' benefits. Represented the Board at stockholder meetings.

Office of Statewide Health Planning and Development
As Staff Attorney, directed a program for improving California hospital compliance with the Hill-Burton Act requirement to provide inpatient services to indigents residing in the communities they serve. Represented the Office in Certificate of Need Hearings regarding the acquisition of hospital equipment.

State of California Department of Health Services
Provided legal counsel to the Director regarding matters of regulatory compliance by health facilities. Prepared legal opinions and analyses of proposed legislations. Drafted regulations to implement new laws.

EDUCATION

University of California, Davis
School of Law
Juris Doctorate degree

University of California, Riverside
Bachelor of Science degree in Economics

PROFESSIONAL AFFILIATIONS

Registered, Illinois Attorney Registration and Disciplinary Commission of the Supreme Court

Member, California State Bar Association

Member, National Alliance of Medicaid in Education
- Governmental Affairs Committee

ARATHI GOWDA PRASAD
Public Consulting Group, Inc.
Senior Programmer Analyst

RELEVANT PROJECT EXPERIENCE

Software Development
Provide leadership and direction for the software team in developing quality software for the Company's Education product Line (EasyIEP, EdPlan, BehaviorPlus, EasyTrac, 504). Responsible for managing the design, implementation, testing, and documentation of software for multiple products and improving an automated web-based system

EDplan/RTI
Designed and implemented RTI, a web based solution for early intervening services. RTI provides school districts with a method to identify students with academic challenges, provide interventions and monitor progress.

Flexible Interface
Designed and developed the Flexible Interface to allow customers to have custom specific interfaces. Flexible Interface helps in delivering the customer needs faster, reduces number of features implemented and improves performance. New Jersey school system and Broward School System are using the Flexible Interface.

Gifted Program
Designed and developed the ability to capture EP (educational plan) events in EasyIEP® for gifted children being tracked in EasyIEP. This feature was generically written to accommodate Gifted Programs for any state.

Process Wizard
Designed and developed a framework for EasyIEP® to allow customers to specify a process driven interface. The process wizard had the capability to match the customer's IEP creation process. Customers were able to specify custom rules, custom process, custom pages and custom look and feel. The feature was specifically developed for Philadelphia. Process Wizard is now being used by California and New Hampshire.

Hosting EasyIEP®
Responsible for the EasyIEP® hosting environment, server emergencies, software releases, responding to all pager alerts from customer reps and automatic monitoring tools. Ensure that EasyIEP® was available to customers 24 by 7.

Service Level Management
Responsible for establishing processes and documentation for Change Management, Incident Response and Monitoring for the EasyIEP® hosting environment.

Large implementation experience.
Rolled out EasyIEP product line for NJ, DC, and Miami. Rolled out EdPlan for VA, FL, and TN. Experience with rolling out state and federal reports.

PROFESSIONAL BACKGROUND

Apogee Networks, Laurence Harbor, NJ

Product: Net Countant Billing (NCB)
Designed and developed OnNet OffNet manager, to keep track of the onnet and off net traffic for Inktomi's Content Data Network Settlement. Implemented Oracle tables to maintain relationships between domains and access partners. The module dynamically determined onnet/offnet usage record and rated the usage appropriately. Designed and developed an

invoice process, to read the rated icdr's and produce an end of term billing records, which would be used to produce a customer's bill. Designed and developed Database Change Notification Manager, to get dynamic updates from passive components. The module was able to send the updates to all interested parties, registered with the manager. This module replaced the polling mechanism to reflect changes in data.

Lucent Technologies, Murray Hill, NJ
Product: Distributed Object Based Operations System (DOBOS)
Implemented the Jini Lookup service. The lookup service provides a central registry of services. Lookup service is a primary means for programs to find services within the distributed system, and is the foundation for providing user interfaces through which users and administrators can discover and interact with services in the distributed network. The Lookup Service was implemented using Sun's Jini Lookup Service specifications.

Product: Mechanized Loop Test System (MLT)
Man Machine Language Translator (MMLT) for International 5ESS
Designed and developed a man machine language (MML) translator using C++ and the AT&T standard components Library. The TEP-6 software uses MML commands to control the access and testing of lines in an International 5ESS Switch using the Subscriber Line Measurement unit (SLIM) and other 5ESS testing resources. The translator receives requests from the users, maps it into a sequence of MML commands and sends the commands to the International 5ESS Switch. The switch sends back a report and the translator analyzes the report and sends testing status to the users, hence eliminating manual testing of the lines.

Database Interface for Mechanized Loop Testing-4)
Converted the legacy MLT flat file database to relational database using Oracle. Designed and developed a library in Proc C and Pro C++, to insert/update/delete/retrieve data from Oracle database for the MLT application. Generic routines were designed to facilitate a common access by various MLT processes
Indian Institute of Science, Bangalore Automatic Simulation of Queuing Network Models
Designed and developed an "Automatic Simulation of Queuing Network Models" using C/Unix, which was used for evaluating the performance of Queuing Network Models. The software is used to obtain results on processor performance, memory allocation, process scheduling and many other performance measures.

EDUCATION

Duke University, Durham, NC
MBA

University of New Haven, West Haven, CT
Masters in Computer Science

U.V.C.E, Bangalore, India
Bachelor of Engineering, Computer Engineering

SOFTWARE PROFICIENCY

- Languages: Java (RMI, Servlets, AWT,
- Swing, Networking, JDBC), JNI, C++,
- C, Perl, JavaScript, HTML, ProC++, Pro

- C, SQL, PL SQL, DBI (Sun
- Microsystems, training in Java
- Programming, JDBC, Java GUI Design
- and Development)
- Distributed Systems: Jini, RMI
- Middleware: JMS
- Databases: Oracle, Microsoft SQL
- Server
- Operating Systems: UNIX, Windows
- NT, Windows 2000
- Debugging Tools: Purify, Softbench,
- JBuilder
- Design Tools : Rational Rose

4.1.7.5 The Vendor shall agree that DHHR/BMS has right of refusal for any key staff.

Public Consulting Group agrees that DHHR/BMS has the right of refusal for any key staff proposed.

4.1.7.6 The Vendor shall provide DHHR/BMS written notification within seven (7) calendar days of any proposed changes to key staff as identified in the organizational chart throughout the term of the Contract.

Public Consulting Group agrees to provide written notification to DHHR/BMS within seven (7) calendar days of any proposed changes to key staff as identified in the organizational chart throughout the term of the Contract.

4.1.8
Deliverables

4.1.8 Deliverables

4.1.8.1 – The Vendor shall have a DHHR/BMS approved finalized staffing plan within thirty (30) calendar days of the contract award date.

In this proposal PCG has included proposed staffing for key staff and positions for this important project. Our team is comprised of school-based cost reporting, cost settlement, and RMTS professionals that have the right balance of experience and expertise necessary to perform the scope of services required and outlined within the RFQ. We commit to finalizing our staffing plan with DHHR/BMS within thirty (30) calendar days of the contract award. PCG will work with DHHR/BMS to determine the level of detail and content that should be captured in the staffing plan to ensure it meets and exceeds DHHR/BMS expectations. At a minimum, the staffing plan will formally document the roles of responsibilities of each team member, as well as confirm key staff, and include contact information for all PCG staff. PCG will maintain the staffing plan throughout the life of the project and make updates as necessary each contract year or period.

4.1.8.2 – The Vendor shall submit the Operations and Procedure Manual within thirty (30) calendar days of the contract award, including staff training materials. The Vendor is required to submit all updates to such manual within seven (7) calendar days of a change occurring. The Manual shall include, but not be limited to, the policy and procedures of DHHR/BMS and the Vendor relative to the SBHS Program. The Operations and Procedures Manual shall be given to all Vendor staff assigned to this program and incorporated in the training of all new employees assigned to this program. The Operations and Procedures Manual shall include, but not be limited to, the following: Vendor policies and procedures regarding customer service; call center protocols/standards; RMTS process; collection and verification of financial data; web-based software and training modules; regional, face-to-face and telephone training (for both Administrative Claiming and Direct Service Claiming); and follow-up reporting to LEAs.

PCG agrees to submit a comprehensive Operations and Procedure Manual within thirty (30) calendar days of the contract award, including staff training materials. PCG understands the importance of having formal documented policies and procedures. Our procedures will include all aspects of our program operations, as well as internal training processes. This rigorous documentation process is necessary to ensure PCG staff are performing operational tasks in a consistent manner that adheres to the Medicaid State Plan, Medicaid administrative claiming Implementation Plan, and any other formal policies established by DHHR/BMS and approved by CMS. Furthermore, the Operations and Procedure Manual will ensure there is clear guidance given to LEAs, particularly through the completion of in person and online training processes. PCG will develop the content of the manual in collaboration with DHHR/BMS, however at a minimum the Operations and Procedures Manual will included but not be limited to the following.

- ***PCG's customer service policies and procedures*** – PCG will outline our standard customer service processes. PCG strives to provide excellent and informative customer service to LEAs, as we understand that a program's success is founded on the LEAs overall comprehension of SBHS program requirements. We will establish standardized documentation processes to ensure all calls

from LEAs are formally documented and consistently addressed. This will allow our staff to be successful in providing excellent customer service, as well as position our employees to identify issues and trends that need to be raised to the Project Manager and program leads.

- ***PCG's all center protocols/standards –*** PCG will have standard protocols on how calls are handled upon intake, as well as standards for responsiveness for other methods of outreach such as emails. PCG staff assigned to this project will undergo a training program before being assigned to this important project. PCG will define our protocols and standards and review these in depth with DHHR/BMS to ensure our processes meet or exceed expectations.

  Furthermore, PCG will develop standards in terms of call center availability, reports on call center statistics, as well responsiveness to emails consistent with the contract requirements.

- ***PCG's RMTS processes –*** As the market leader in provided RMTS processes, PCG has established best practices in all aspects of RMTS processes. This includes training coders on how to properly code moments, to establishing quality assurance and peer review processes on coding processes, to defining state come behind review processes. Furthermore, PCG has standardized sampling process, moment generation and follow up procedures, etc. PCG will work with DHHR/BMS to determine the processes that must be established to ensure compliance with the CMS approved RMTS processes outlined in the implementation plan.

- ***PCG's process for the collection and verification of financial data –*** PCG will establish validation edits within our cost collection software, as well as develop standards on our financial desk review processes for both Medicaid administrative claims and Medicaid cost reports. The edits within our web based financial collection system can be customized to meet West Virginia specific thresholds and updated throughout the life of the project. Furthermore, when our team is completing reviews of financial data, we will establish comprehensive desk review processes go beyond system edit capabilities. This includes processes for reviewing explanations provided by LEAs for records flagged, as well as asking for supporting documentation for expenditures and statistical information.

- ***PCG's web-based software and training modules, both regional face-to-face and telephone trainings –*** A comprehensive training program is critical to the success of any SBHS program. PCG will develop web based training modules within our software tools, as well as hold regular in person trainings each contract year. We will develop a training curriculum that encompasses all components of the SBHS program, from RMTS processes, to the submission of financial data to support MAC claims and Medicaid cost settlements. We have developed numerous training modules and processes and we will work to determine the best and most appropriate model for DHHR/BMS and West Virginia LEAs.

These are just some of the elements of the Operations and Procedures Manual. We will work with DHHR/BMS to outline all of the components to ensure the manual is appropriately comprehensive and addresses all of the intricacies of the operational components of the SBHS program.

4.1.8.3 – The Vendor shall have a DHHR/BMS approved Training Plan within thirty (30) calendar days of the contract award.

PCG commits to producing a DHHR/BMS approved Training Plan within thirty (30) calendar days of the contract award. PCG's training plan is a compilation of best practice trainings that PCG has learned and developed over its many years of school-based cost reporting, cost settlement, and RMTS management services. We have outlined our training program in detail in our response to Section 4.1.4 of our proposal response. PCG will work with DHHR to be certain this training module meets and exceeds the needs of the agency. However, our training plan will include web based training programs, development of supplemental training materials, such as frequently asked questions (FAQs) as well as more detailed policy briefs on issues requiring clarification, perform annual in person trainings, execute planned online trainings on focus areas, to name a few. PCG is a firm believer that training is a critical to the success of the SBHS program and, as a result, we will ensure our training efforts are sufficient to promote compliant and informed participation by the LEAs.

4.1.8.4 – The Vendor shall have a DHHR/BMS approved Turn-Over Plan ninety (90) calendar days prior to the contract end date.

PCG commits to producing a DHHR/BMS approved Turn-Over Plan at least ninety (90) calendar days prior to the contract end date. The organization and content of this Plan will be discussed with DHHR/BMS at the necessary time. However, PCG understands the importance of working with our clients to transition processes both to our clients, as well as new partners.

4.1.8.5 – The Vendor shall demonstrate a fully operational Web site, with capacity to accept LEA inquiries, and shall post its training schedule within sixty (60) calendar days of contract award.

PCG will be able to demonstrate its fully operational West Virginia school-based services Web site within sixty (60) calendar days of contract award. As the incumbent vendor, PCG will be able to deploy our RMTS and financial reporting web tool immediately upon contract execution. Furthermore, our web based application will include all upcoming trainings and the specific schedule in which trainings will occur, as well as identify the location of the trainings if conducted in person. It is critical that LEAs have access and understand when upcoming trainings will occur to ensure active participation.

4.1.8.6 – The Vendor shall demonstrate a fully operational, user friendly, Web-based training system with a training manual available for download by each LEA, within sixty (60) calendar days of contract award.

PCG will develop all-encompassing training manuals and make these materials available to LEAs within sixty (60) days of contract award. The training materials will include all facets of the SBHS program, such

as RMTS, MAC, and Medicaid cost reporting requirements. These manuals will be made available on our web based tool. As the incumbent vendor, PCG has developed comprehensive materials already and these training documents will be updated based upon recent CMS guidance and approval.

4.1.8.7 – The Vendor shall ensure that the Web-based training module is DHHR/BMS approved and operational within ninety (90) calendar days of contract award.

PCG commits to producing Web-based training modules approved by DHHR/BMS within ninety (90) calendar days of contract award. For more information on our proposed web-based training modules, please refer to Section 4.1.4 of the training program.

4.1.8.8 – The Vendor shall ensure that all LEAs have received training, including RMTS, Administrative Claiming, and Cost Reporting prior to the implementation of each task.

PCG will ensure that all LEAs receive PCG's training on RMTS, Administrative Claiming, and Cost Reporting prior to the implementation of each task. For more information on PCG's training please see Section 4.1.4 of our proposal response.

4.1.8.9 – The Vendor shall have and maintain a statewide toll-free telephone system capable of handling and addressing LEA calls within thirty (30) calendar days of contract award.

PCG will maintain a statewide toll-free telephone system capable of handling and addressing LEA calls within thirty (30) calendar days of contract award. PCG has established call centers for each of the dozen SBHS programs we operate on behalf of Medicaid agencies across the country, including DHHR/BMS. We will ensure our call center is available in accordance with the timeframes and workdays established by DHHR/BMS.

4.1.9
Additional Services

4.1.9 Additional Services

4.1.9.1 – Upon request from DHHR/BMS, the Vendor shall submit a Statement of Work (SOW) including a cost estimate, to provide assistance in development of requested reimbursement strategy(ies).

PCG is eager to assist West Virginia with reimbursement reform throughout the term of this engagement. We will be proactive in discussing reimbursement strategy opportunities with DHHR/BMS and will follow the statement of work protocol identified in this RFP.

PCG provides Medicaid rate setting and reimbursement services for an array of healthcare services and provider types. It is core competency borne of 28 years of experience. PCG is nationally-known for evaluating and assessing historical payment methodologies and working with states to identify and recommend alternative payment methodologies to more appropriately align reimbursement to services provided and/or outcomes, as Medicaid moves towards value-based purchasing. We compare predictive models to outcomes, communicate complex reimbursement issues to the provider community, conduct peer state analyses, and implement pay-for-performance measures to improve quality of care and ensure Medicaid programs receive value for services rendered and reimbursed.

We take a great deal of pride in the fact that PCG has unmatched expertise assessing payment options and developing rate structures across such a broad range of health and human services programs. PCG has assisted agencies to think through the various internal and external factors that impact the successful implementation of new reimbursement methodologies. This includes the obstacles and barriers that may impede or prohibit certain strategies for certain services.

Reimbursement strategy is much more than just developing a rate for a service. Considerations included, but are not limited to, the following:

- **Payment Types** – PCG's team has experienced developing and updating all sorts of payment types, from grants, to Fee-For-Service, to Per Diems, to Bundled Payments, to Episodes of Care, to Condition Specific Capitation (commonly referred to as "Global"), to capitation rates.

- **Costs of Care** – Throughout PCG's history we have been cost report experts. We understand federal guidance surrounding allowable costs versus non-allowable costs, and we understand how to identify all costs, at both the institutional and community-based provider levels.

- **Adjustments** – PCG understands the various adjustments that need to be accounted for during the rate-setting process, including metrics associated with case mix, provider geography, level of staff effort required for a service, etc.

- **Reimbursement and Risk** – The health care system's shift to paying for outcomes means that risk is being shifted from the payers to the providers. PCG's experience provides us with in-depth knowledge of how best to analyze and discuss risk with provider and states.

This is, by no means, an exhaustive list, but is meant to highlight PCGs relative expertise in a wide range of rate-setting strategies. PCG knows there is no one "right" answer to which approach is "best." Each rate setting project is unique. Not only does each population, program, and provider community have variation in cost, utilization, and other statistics, but the exact structure and interactions of these systems will always vary from location to location. These differences require a customized approach to rate setting and that is what PCG brings to our clients.

Reimbursement strategy is not just about setting rates. This is not an exercise performed in a vacuum. During any reimbursement strategy discussion, PCG will be sure to discuss the following topics:

- **Budget Constraints**: Often an afterthought of the provider community, the PCG team understands the financial constraints that states encounter when administering their health and human service programs. Our consulting services will consider the availability of funding when developing the pros and cons of the various rate setting methodologies. The PCG team understands that rates need to provide equity to the provider community but we also recognize that each program must live within the funding levels approved by the legislature.

- **Quality:** PCG will examine each methodology to determine if the reimbursement method considers quality measurements and benchmarks. Quality can be evaluated through the review of established criteria for credentialing staff, through outcome measures, incident reporting, and through program audits. While quality benchmarks may be difficult to establish initially, the overall impact of this issue cannot be ignored and should be at least a long term goal for public sector payers to build measures of quality into reimbursement rates.

- **Simplicity**: The PCG team will assess the administrative burden and process requirements of each viable rate setting method it proposes. Simplicity will be considered with regard to the required changes to the claims processing system and any additional state staff will have to undertake to calculate rates under the methodology outlined in our recommendations. We will also consider how potential changes may impact the requirements of providers. It is important that providers do not realize an interruption in reimbursement as a result of any changes that will be required of the claims processing systems when adjudicating claims under a new rate setting methodology.

- **Access**: West Virginia needs to ensure that any changes to the rate setting methodology do not reduce or hinder access to services for recipients. The PCG team will evaluate the potential effects on access associated with each rate setting methodology in order to determine whether it is viable.

- **Build upon Existing Processes:** PCG understands the importance of building upon the foundation of rate setting processes already established. The unique network of providers and unique needs of the clients West Virginia must be seriously considered in our recommendations as we evaluate the impacts of our proposed rate structure.

The rate methodology recommendations that the PCG team will produce will be consistent with the requirements of this procurement. The PCG team can assist in the development of brand new rate setting methodologies or build upon the current rate structure and the intended service delivery system, and update the rates based upon available data and if needed, supplemental data resources.
We can apply the lessons learned and best practices from our hospital, behavioral health, school-based health centers, and other area rate setting and cost report collection. We have worked with rehabilitation service agencies to collect costs, analyze fees, and make payment recommendations. CSF will benefit from our qualified staff as well as a breadth of related project work in behavioral health, substance abuse treatment and throughout the health and human services sector.

4.1.9.2 – The Statement of Work shall include at a minimum: Scope of Work, Project Assumptions/Constraints/Risks, Deliverables, Schedule, Cost, and a place to indicate Acceptance.

When Statements of Work are drafted, PCG will include all of the requirements listed above. West Virginia will certainly benefit from PCG's national experience. In addition to simply providing DHHR/BMS with a list of project Assumptions, Constraints, and Risks, PCG will also provide you with solutions to the potential obstacles.

4.1.9.3 – The Vendor shall also assist the DHHR/BMS with any State Plan or waiver requirements including submissions of any CMS required demonstrations regarding reimbursement services provided under the scope of an approved SOW.

PCG's team is comprised of individuals who have written and co-written numerous state plans and waivers, both as a consultant and as Medicaid state employees. We as a team feel comfortable with all facets of Medicaid and will ably assist DHHR/BMS with any Medicaid State Plan or waiver requirements, including submissions of any CMS required demonstrations about the reimbursement services provided under the approved SOW. We have proven this expertise, as demonstrated by successfully assisting DHHR/BMS to recently obtain approval of the SBHS Medicaid cost settlement and reconciliation SPA. PCG will assist with all facets of SPA and waiver requirements, from state plan development, to preparing responses to requests for additional information (RAIs), to performing budget neutrality analyses, to evaluating waiver program components. PCG is prepared to assist DHHS/BMS as requested and has the necessary programmatic expertise to be successful.

4.1.10
Prior Year Settlement

4.1.10 Prior Year Settlement

PCG will assist DHHR/BMS will all prior year Medicaid cost settlements and reconciliations. As the incumbent vendor, PCG understands the Medicaid cost settlement process is approved retroactively to July 1, 2014. SBHS Medicaid cost reports for the cost reporting period 2015 will be due on or before 12/31/2015 by LEAs. Furthermore, interim cost settlements are to be calculated six to twelve months from cost reporting filing with final reconciliations to be performed within twenty four months or 6/30/2017. PCG has all of the necessary RMTS and financial data to complete the calculated retroactive settlements in a streamlined manner. PCG will work with DHHR/BMS through the establishment of an implementation plan to successfully complete Medicaid cost settlements. PCG is cognizant that DHHR/BMS is anxious to start processing Medicaid cost settlements given the considerable CMS negotiation process to obtain CMS approval. PCG will complete all prior settlements in accordance with the cost settlement and reconciliation processes established in partnership with DHHR/BMS.

5. Forms

a. Contract Manager
b. Addendum Acknowledgement Form
c. HIPPA Business Associate Addendum
d. Purchasing Affidavit

PUBLIC CONSULTING GROUP

a. Contract Manager

6a. Forms – Contract Manager

During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract.

PCG designates Matthew Sorrentino as the Contract Manager for this engagement. Mr. Sorrentino may be contacted to address any contract related issues that may arise throughout the duration of this contract.

Matthew Sorrentino
Telephone Number: 512-287-4663
Fax Number: 512-407-9249
Email Address: MSorrentino@pcgus.com

b. Addendum Acknowledgement Form

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1500000001

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[ ]	Addendum No. 6
[✓]	Addendum No. 2	[ ]	Addendum No. 7
[✓]	Addendum No. 3	[ ]	Addendum No. 8
[✓]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Public Consulting Group, Inc

Company

Authorized Signature

December 18th, 2014

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

c. HIPPA Business Associate Addendum

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures**. Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED: West Virginia Department of Health and Human Resources, Bureau for Medical Services

Name of Agency:_____

Signature:_____

Title:_____

Date:_____

Name of Associate: Public Consulting Group, Inc.

Signature: _____

Title: Principal

Date: December 18th, 2014

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY Of Jan 20 15
Patrick Morrisey
Attorney General
BY _____

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: West Virginia Department of Health and Human Resources
Bureau for Medical Services

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

All [types of PHI listed on App. A] in paper, electronic, verbal or any other form.
Including, but not limited to:
Paid claim data including Medicaid Member ID and Name.

d. Purchasing Affidavit

RFQ No. CRFQ 0511 BMS 1500000001

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Public Consulting Group, Inc

Authorized Signature: _____ Date: December 18th, 2014

State of Massachusetts

County of Suffolk, to-wit:

Taken, subscribed, and sworn to before me this 18 day of DECEMBER, 2014.

My Commission expires 3-11-16, 20___.

AFFIX SEAL HERE

STUART A. KAUFMAN
MY COMMISSION EXPIRES MAR. 11, 2016
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS

NOTARY PUBLIC _____