



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Karen L. Bowling
Cabinet Secretary

RE: Request for Information (RFI) on State Innovation Model Concepts

Dear Center for Medicare & Medicaid Innovation:

This letter is a response to the request for information released by the Center for Medicare & Medicaid Innovation (CMMI) on September 6, 2016. We, the State of West Virginia and its partners in the State Innovation Model (SIM) process, welcome and thank you for the opportunity to share insights about the future of the SIM program and the health care needs of the state. West Virginia was selected by CMMI in February 2015 as a Round 2 SIM design state, and it was expected to deliver a final State Health System Innovation Plan (SHSIP) by January 31, 2016. CMMI granted the state a six-month no-cost extension, which moved the final submission deadline to July 31, 2016. West Virginia's SHSIP was submitted to CMMI on July 21, 2016. The SHSIP was accepted and approved by CMMI on October 3, 2016.

Although this letter offers extensive detail about West Virginia's health care environment and proposes numerous types of assistance and policy changes that might be pursued, we believe the greatest help that CMMI can provide is by continuing with a SIM Round 3—that is, offering implementation funding to Round 2 design states.

Impact of the SIM Program

A September 2016 brief published by the National Academy for State Health Policy detailed the general successes of the SIM program.¹ We concur with the brief's synopsis of the importance of the SIM program. We also view the stakeholder development aspects of the SIM program as an invaluable outcome just as important as the SHSIP. The SIM process provided a vehicle to convene stakeholders; assure accountability for timelines; benefit from peer learning and benchmarking with other states and technical assistance. This was invaluable to our efforts to develop an approach for health improvement in a manner that meets the needs of West Virginians.

¹ National Academy for State Health Policy. A federal-state discourse on maintaining momentum for payment and delivery system reform. <http://www.nashp.org/wp-content/uploads/202016/09/Discourse-Brief.pdf>. Published September 20, 2016. Accessed October 11, 2016.

West Virginia's Growing Budget Challenges²

As other SIM states noted in the National Academy for State Health Policy brief, West Virginia is concerned about making continued progress toward delivery and payment transformation without ongoing funding to move from SIM planning to testing. This reality, among several contextual considerations, influenced the goals and design of West Virginia's approach to payment reform and health system transformation. First, state and local government agencies are under extraordinary financial pressures due to reliance on the energy industry as a major driver of employment and tax revenue. Energy industries such as coal mining and natural gas drilling have historically been major employers and contributors to the state and local governments through severance taxes. The energy sector in West Virginia has experienced a period of market fluctuation with suppressed demand and prices that may be symptomatic of long-term trends, particularly in certain segments of the coal industry. These market pressures have adversely impacted employment and tax revenues for the state, compounding the challenge of funding innovations in health care delivery and services.

Current budget shortfalls constrain the ability of public payers to sustain continued growth in health care expenditures for the Medicaid program, the state Public Employees Insurance Agency and public health services. Cost pressures also have affected the state's human assets and bandwidth in health services-related agencies—leaving state government, *on its own*, incapable of leading the change necessary to transform the state's health care system. Accordingly, the strategies outlined in our SHSIP rely heavily on a public-private partnership approach. A coalition of likeminded organizations and individuals are prepared to assist the state (and take a leadership role, if desired) in developing the technical expertise and bandwidth to pursue value-based health care transformation. To continue positive momentum from the SIM process, the SHSIP recommends the creation of a public-private partnership, the West Virginia Health Transformation Accelerator (WVHTA), to oversee the execution of the SIM plan and related endeavors. The WVHTA is currently being established as a legal entity, but the conceptual framework for the organization already exists and stakeholders are meeting/strategizing now. In this letter, the WVHTA is proposed as a key organization to act on behalf of West Virginia stakeholders to coordinate health improvement and transformation initiatives.

Ensuring that the state makes the most efficient use of its limited financial resources and moves forward with health care transformation, including the adoption and proliferation of alternative payment models (APMs), it is imperative that West Virginia implement its SHSIP proposals and recommendations. Likewise, it is vital that West Virginia continue to receive financial and technical assistance from CMMI and other federal agencies in these endeavors.

² Information in this section was derived from Section 5 of the SHSIP, which can be found as follows. West Virginia State Innovation Model Grant. West Virginia state health system innovation plan. <http://www.wvhealthcollaborative.wv.gov/Documents/West%20Virginia%20SHSIP%20with%20Cover%20Letter%20and%20Errata.pdf>. Published August 5, 2016. Accessed October 12, 2016.

West Virginia's Many Population Health Problems

West Virginia is beset by numerous population health problems. The state leads the nation in the number of smokers as a percentage of the population; the number of poor physical health days taken in the last month; the amount of heart disease as a percentage of the adult population; the prevalence of high blood pressure in the adult population and the percent of adults with diabetes.³ This state of unhealth creates a cycle that reinforces the population health status quo and further deteriorates the state economically. For instance, worker productivity is significantly lower in West Virginia than in other states, as evidenced by the number of poor health days taken in the last month and other metrics. Lower productivity due to health factors exacerbates the state's economic crisis as people drop out or are intermittently engaged in the workforce. West Virginia, in fact, has one of the worst workforce participation rates in the country, with less than 50% of its noninstitutionalized population age 16 or older working.⁴

The cost of this poor population health is borne predominantly by the state and federal governments and by state-based health care providers. Approximately three-quarters of West Virginia's population is covered by some form of government-supported health insurance, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or the state Public Employees Insurance Agency.⁵ Medicare, in particular, plays a disproportionate role in West Virginia's delivery and payment system. In fact, about 23% of West Virginians are covered by Medicare, tying the state with Maine for the highest proportion of Medicare coverage nationally.⁶ These unique West Virginia characteristics create opportunities for federal partnership and assistance. West Virginia's poor population health status means there are tremendous health care savings opportunities, as well as possibilities to rapidly improve the state's national ranking. Finally, the concentration of public payers within West Virginia makes organizing the health insurance market toward common goals easier than in other states.

How the Centers for Medicare & Medicaid Services (CMS) and CMMI Can Help West Virginia

The aforementioned challenges focus our priorities on a narrow set of health care projects. Generally, West Virginia would benefit most from federal support that:

1. Offers maximum flexibility while operating within defined goals and objectives established by CMS/CMMI (e.g., like the SIM program);

³ United Health Foundation. 2015 annual report: West Virginia. <http://www.americashealthrankings.org/explore/2015-annual-report/state/WV>. Published December 10, 2015. Accessed October 12, 2016.

⁴ Figures from the U.S. Bureau of Labor Statistics peg West Virginia's labor participation rate at 49.4% in 2015. United States Department of Labor Bureau of Labor Statistics. States: Employment status of the civilian noninstitutional population, 1976 to 2015 annual averages. <http://www.bls.gov/lau/rdscnp16.htm>. Published September 20, 2016. Accessed October 18, 2016.

⁵ State of West Virginia Offices of the Insurance Commissioner. Accident and health insurance market report 2016. <http://www.wvinsurance.gov/Portals/0/2016%20A%20%20H%20Report%20Final.pdf>. Published July 20, 2016. Accessed October 12, 2016.

⁶ The Henry J. Kaiser Family Foundation. Medicare beneficiaries as a percent of total population. <http://kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/>. Published March 2016. Accessed October 12, 2016.

2. Permits testing of innovation with willing partners in the state and the scaling up of the most successful models; and
3. Includes technical assistance from CMMI, other relevant subject matter experts and fosters dialogue or facilitates a learning community of SIM states.

Support would be used for projects identified in our SHSIP; these projects (and related endeavors) are detailed in the following section.

SHSIP-Aligned Projects and Policies

Projects and Policies that Create a Culture of Health and Wellness

Try This West Virginia

During the SIM planning process, public health stakeholders identified West Virginians' culture of poor health and sense of fatalism and hopelessness about improving socio-economic status and health outcomes as key roadblocks to the state achieving positive population health.⁷ West Virginia believes it must combat that perception through hundreds of community-based partnerships, media and information campaigns that create a widespread understanding that West Virginia has a rapidly growing healthy community movement and that a healthy West Virginia is possible. Indeed, such a movement is already underway through community-based programs such as Try This West Virginia.

Try This West Virginia advances practice-based, affordable and practical community health improvement projects grounded in the socio-ecological model of health promotion supported by the Centers for Disease Control and Prevention (CDC). As a coalition of more than 20 statewide groups, Try This West Virginia provides mini grants to local grassroots teams to develop projects that expand healthy community choices and build *local leadership*. The program has demonstrated through 153 community projects since its inception in 2014 that people can make changes in their lifestyles more easily if healthy choices are available in their community.

Try This West Virginia projects have received incredible buy-in, as they have leveraged \$8 for every \$1 in grant funding provided for the 153 community projects. Community teams engage each other and network through a large annual conference, considerable social media presences and a well-resourced website, www.trythiswv.com. In the SIM Round 2 Review Cover Letter received from CMMI on October 3, 2016, the CDC remarked that "attempting to address the basic needs of [health care super-utilizers] this vulnerable population by including community partners and providing opportunities for them to explore lifestyle change activities through the Try This West Virginia" is a strong approach.⁸ Given the CDC's embrace of the Try

⁷ The SIM Better Health Workgroup, using a Likert Scale from one (strongly disagree) to 10 (strongly agree), was surveyed using Qualtrics about attitudes toward public health based on comments made by participants in the initial Better Health Workgroup meeting. The culture of poor health statement received an 8.15 score, and the sense of fatalism and hopelessness statement received an 8.09 score. The response rate for the survey was 46%. Workgroup membership at the time (July 2015) was 74 individuals.

⁸ Traylor J. R2D SHSIP review cover letter WV. Received via e-mail. Published October 3, 2016. Accessed October 14, 2016.

This West Virginia model, resources and funding to further scale up the approach in West Virginia and other states is warranted. Additionally, federal partners such as the Appalachian Regional Commission and other state partners, including Kentucky and North Carolina, have expressed interest in replicating the model. The CDC-funded West Virginia Prevention Research Center is currently working with Try This West Virginia to conduct an independent evaluation of the model. This creates an opportunity for collaboration among the states, CDC, the Appalachian Regional Commission and CMMI to explore a grassroots population health intervention model.

Accountable Health Communities (AHC)

We strongly support holistic care models, such as AHC, that help curb unhealthy behaviors, promote healthy lifestyles, address chronic diseases and ultimately progress the state toward value-based health care.⁹ West Virginia health care providers and social service organizations applied for a funding opportunity through CMMI for AHC. Track 2 of this funding opportunity, which is being pursued by a consortium including Charleston Area Medical Center, Partners In Health Network and the West Virginia University Center for Excellence in Disabilities, will provide community navigation services to assist high-risk Medicare and Medicaid beneficiaries with access to social services.

There is a major opportunity for alignment between AHC and Medicaid Affordable Care Act Section 2703 health homes—discussed in greater detail on page 8—that could occur if CMMI made coordination a higher priority and more explicit. States should be able to leverage the staffing resources of the Medicaid health homes for AHC or AHC-like activities and vice versa. Yet, there are three significant hurdles to accomplishing this goal.

1. The population served through Medicaid health homes is, of course, limited to the Medicaid population—unlike AHC which also includes Medicare beneficiaries.
2. The chronic conditions codified in the Affordable Care Act for the health home are narrow and specific and other conditions can only be approved after a lengthy review process.
3. The core staffing structure for the health home is fairly proscriptive—leaving little flexibility to add or change members of the *core care team*.

An additional item requires further clarification by CMMI. The AHC FAQ guidance states that “[AHC] cooperative agreement funds may not be used to provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.”¹⁰ Thus, it is uncertain if health home and AHC resources can be shared to address the needs of the same beneficiaries or those in similar populations. CMS/CMMI can help address

⁹ Alley D, Asomugha, CN, Conway, PH and Sanghavi, DM. Accountable Health Communities – Addressing social needs through Medicare and Medicaid. *N Engl J Med*. 2016; 374(1): 8-11. doi: 10.1056/NEJMp1512532.

¹⁰ Centers for Medicare & Medicaid Services. Accountable Health Communities model - Frequently asked questions. <https://innovation.cms.gov/initiatives/ahcm/faq.html>. Published October 12, 2016. Accessed October 17, 2016.

this issue by promulgating clear rules/cooperative agreements defining when and where health home and AHC resources can be used and/or shared.

Our SHSIP proposes using health homes as a potential way to implement the AHC concept in lieu of receiving a cooperative agreement with CMMI, but this approach is too narrow and shortsighted. We anticipate that the health home and AHC models will need to be complementary and mutually-reinforcing, as they will likely serve many of the same vulnerable populations if not the same Medicaid beneficiaries. Once an effective advanced primary care delivery system has been built to serve Medicaid beneficiaries (i.e., the health home), it should, concurrently, be able to serve other populations of Medicaid beneficiaries, as well as Medicare and CHIP beneficiaries and the commercially insured. Medicare could also support the participating health home primary care practices through an APM to promote sustainability and advance MACRA/MIPS priorities. Medicare's involvement is especially important and timely given the finalization of MACRA/MIPS rules regarding health homes *not qualifying* as an APM.¹¹ We encourage CMS/CMMI to investigate ways of incorporating Medicare beneficiaries into the health home concept, fostering Medicare/Medicaid collaboration as it has done for the AHC cooperative agreement.

Projects and Policies for Health Information Technology and Data

The Need for Medicare and Non-Health Claims Data

West Virginia's Department of Health and Human Resources operates a Medicaid data warehouse that includes all traditional Medicaid, Medicaid managed care and CHIP claims. A logical next step is to utilize the data warehouse and its associated analytics capability for Medicare claims data. The West Virginia Bureau for Medical Services, the state Medicaid agency, has attempted numerous times to acquire Medicare claims data for non-dual eligibles, but it has so far been unsuccessful in securing data from CMS. West Virginia strongly urges CMS to develop a streamlined process for states to request and receive Medicare claims data. Failure to analyze these data creates a large blind spot in any value-based transformation efforts, particularly in our state where Medicare beneficiaries constitute nearly a quarter of the insured population.

CMS has taken a strong leadership and facilitation role in encouraging other federal agencies to provide non-health claims data in an efficient and usable way. We applaud these efforts and hope that these will be continued and expanded. Having access to non-health claims data, such as Supplemental Nutrition Assistance Program data from the U.S. Department of Agriculture, population health data from the CDC and non-CMS data within the U.S. Department of Health & Human Services, helps create a fuller patient profile to address the social determinants of health. We suggest that CMS consider the creation of a data clearinghouse that states could use to request and receive non-health claims data for Medicare and Medicaid beneficiaries.

¹¹ Dickson V. MACRA rule deals blow to docs in Medicaid medical homes.

<http://www.modernhealthcare.com/article/20161017/NEWS/161019916>. Published October 17, 2016. Accessed October 19, 2016.

Streamlining and Achieving Common Quality Measures

Multipayer health care systems often send mixed guiding and incentivizing signals to providers. In the typical environment, including West Virginia, providers collect and report hundreds of different metrics to their payer partners. This creates significant financial, administrative and resource burdens for providers and hinders attempts to improve population health or the delivery system. The alignment of measurement and quality improvement goals will be key to transforming West Virginia's health care system. The SHSIP endorses CMS's Core Quality Measures Collaborative as a starting point for quality measurement alignment.¹² SIM Round 3 funding could support the convening of state stakeholders under the auspices of the WVHTA for the purpose of aligning quality measures that further SHSIP and state public health priorities.

Projects and Policies Related to APMs and Delivery Transformation

Comprehensive Primary Care Plus (CPC+)

CPC+, another CMMI initiative, offered a significant step forward for primary care adoption of APMs. CPC+ was introduced during the final quarter of our SIM planning process, permitting the concept to be presented and to be explained to primary care practitioners and payers in West Virginia. CPC+ received an extremely positive reception; it was considered by many large primary care practices as a viable method of supporting and sustaining meaningful care coordination teams. Nonetheless, the initial plan for CPC+ required private insurance companies to buy-in and prepare APM models in a relatively brief period of time. We propose two key changes to CPC+ recruitment that would encourage wider participation, particularly from regions that most need the financial assistance and practice transformation CPC+ affords.

1. Because West Virginia is dominated by federal payers, as previously noted, implementing a project such as CPC+ in the state would require *full* federal payer participation and a longer timeline for the recruitment of payers and eventually providers due to state staffing deficits/bandwidth and the lack of value-based infrastructure.
2. Potential waivers of CPC+ programmatic requirements (on a case-by-case basis) for the less advanced value-based health care states would also be necessary.

If CPC+ were to accept West Virginia (or part of the state) as a region, it would promote exploration of APMs in different, typically smaller-sized primary care practices. Furthermore, this action would present an important opportunity for the federal government to see how CPC+ works in a rural state with comparatively poor APM adoption. Making programmatic changes that facilitate adoption of CPC+ in rural, medically underserved areas will allow West Virginia to keep pace with advanced value-based states that are better resourced and structured to transform their health care systems.

¹² Centers for Medicare & Medicaid Services. Core measures. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>. Published February 16, 2016. Accessed October 14, 2016.

Medicaid Health Homes

We encourage CMS to use existing authority to improve, expand and make more flexible the Affordable Care Act Section 2703 health homes. West Virginia recently concluded a health home for Medicaid beneficiaries with bipolar disorder and hepatitis B/C or who are at risk of contracting hepatitis B/C. Regrettably, the 90-10 match for the health home, per the law, was capped at eight quarters. For a long-term illness such as hepatitis B/C, this two-year timeline may not demonstrate cost savings or budget neutrality.¹³ Since budget neutrality is required for any Medicaid managed care change and for the state to support a project, especially in this tough fiscal climate, it is unlikely this specific health home will be replicated by managed care organizations or continued by traditional Medicaid. We offer three recommendations to CMS for future approval of health homes.

1. We recommend that CMS allow states to seek a waiver to the eight quarters of 90-10 enhanced match—taking into account the difficulty and clinical nature of the diseases to be addressed and/or the lack of experience in advanced primary care delivery and intensive care coordination that some states face.
2. We recommend that CMS be more flexible in its interpretation of a health home in terms of conditions covered and staffing structure and be better aligned with CMMI projects, as noted on pages 5 and 6 related to AHC.
3. We recommend that CMS be quicker in approving health homes. Back dating the 90-10 match causes confusion for providers, patients and the West Virginia Bureau for Medical Services, the state Medicaid agency, as well as creates an artificial time clock under which services are to be provided to our most vulnerable citizens. CMS should exercise discretion about when to begin the enhanced match period for a health home in consultation with its state partner.

Primary Care - Behavioral Health Considerations and Demonstrations

West Virginia recognizes that behavioral health-related issues are major drivers of healthy or unhealthy choices and have an impact on the burden of illness. Behavioral health conditions are also major contributors to avoidable utilization of health care services and other inefficiencies in the health care system. Moreover, West Virginia—like many rural states—suffers from an inadequate and asymmetric supply of behavioral health professionals. The SIM Project Management Team used a CMMI-approved resource, the Agency for Healthcare Research and Quality's The Academy for Integrating Behavioral Health and Primary Care, to develop a roadmap for integration. In fact, a leadership team member from The Academy was engaged by the SIM Project Management Team to assist in developing a West Virginia-specific integration plan.

¹³ WV DHHR Bureau for Medical Services. West Virginia health homes inaugural year 2014-2015 annual report. <http://www.dhhr.wv.gov/bms/BMSPUB/Documents/HealthHomesAnnualReport%20Final%20Version.pdf>. Published April 2016. Accessed October 16, 2016.

To address behavioral health challenges and strategize for effective behavioral health and primary care integration, the West Virginia SIM Project Management Team formed a specialized *ad hoc* workgroup. The workgroup adopted the following seven principles—devised with the assistance of a The Academy leadership team member—to combat West Virginia’s behavioral health problems and to achieve behavioral health and primary care integration. Note that bolded principles are discussed as areas for CMMI involvement/assistance.

1. Continue to promote collaboration between the primary care and behavioral health communities that fosters integration of behavioral health into primary care and ensures that persons cared for in behavioral health settings are getting optimal primary care support.
2. Broaden support for and remove barriers to using telehealth.
- 3. Implement the Project for Extension for Community Healthcare Outcomes (ECHO) and similar models using telehealth to make specialist expertise more broadly available throughout West Virginia with an initial focus on opioid and other types of substance abuse.**
- 4. Promote the collaborative care/consulting psychiatrist model to improve treatment of common, less serious behavioral health disorders in primary care.**
5. Broaden the use of community health workers, health educators, peer coaches for substance abuse disorders and peer services for mental health; standardize training and certification.
6. Revise academic curricula for health professions to support team-based models that integrate behavioral health and primary care.
- 7. Continue to participate and encourage greater involvement in behavioral health demonstrations and pilots that put the state at the forefront of new types of delivery and payment models.**

Project ECHO is a telehealth application that expands access to specialty care and builds workforce capabilities to address complex chronic conditions. Originally, the project started in New Mexico for hepatitis C treatment, but it has since expanded to include other regions and chronic diseases. Project ECHO uses videoconferencing technology to create knowledge-sharing networks between specialists and primary care providers in rural or underserved communities. Under this model, specialists provide best-practice education to primary care teams, enabling them to provide specialty care services in their own communities. In spring 2016, West Virginia started a Project ECHO for hepatitis C and is developing an ECHO clinic to improve care for those suffering from chronic pain. The chronic pain ECHO is scheduled to launch in January 2017. We encourage CMS/CMMI to adopt and promote the Project ECHO model as a way to expand specialty care and consider funding demonstrations specifically to address systemic and nationwide behavioral health specialist shortages using ECHO.

Another telehealth model worth expanding and pursuing is the Collaborative Care Model as supported by The AIMS Center at the University of Washington. The Collaborative Care Model is based on five core principles: 1. patient-centered team care, 2. population-based care, 3. measurement-based treatment to target, 4. evidence-based care and 5. accountable care.¹⁴ This model uses a core team of primary care providers, behavioral health providers or case managers and psychiatrist consultants working together to treat depression, anxiety and other chronic health and behavioral health conditions. A CMMI- or Patient-Centered Outcomes Research Institute-funded demonstration project for rural states, such as West Virginia, to deploy the Collaborative Care Model would be a welcome opportunity. West Virginia has made major strides to develop its telehealth infrastructure, yet it is comparatively behind in the delivery of behavioral health services via telehealth.

Health Care Payment Learning & Action Network (HCP-LAN) Bundled Payment Demonstrations

In recent months, former SIM Project Management Team members have facilitated exploratory maternal bundled/episodic payment discussions using the materials from HCP-LAN as guidance for the payer and provider stakeholders. Because of West Virginia's budget constraints described previously, when considering incorporating this sort of innovation into Medicaid managed care contracts, our state requires a proven return on investment in terms of quality and cost. SIM Round 3 funding would allow for a systematic study of bundled payments and their effect on health outcomes and cost, as well as provide enhanced access to technical resources and consulting expertise.

Conclusion

To reiterate the theme of this letter and our SHSIP, the absence of SIM Round 3 funding (or some similar vehicle for testing and implementation), will make it difficult for our rural state with an older and sicker population to effectuate the intended system transformation objectives of MACRA/MIPS. This will create additional financial strain on Medicare and Medicaid programs in West Virginia for CMS. But, if SIM Round 3 funding were made available, West Virginia will test the innovations in our SHSIP in alignment with the objectives of CMS for accelerating the movement of hospitals, physicians and other providers to APMs consistent with MACRA/MIPS. Moreover, funding will allow our state to bolster allied initiatives, such as our State Health Plan, which is presently being developed using the SHSIP as a foundational document, to better target and plan West Virginia's health care future.

In West Virginia, Medicare has the most to gain from the savings generated from many of the health innovations in our SHSIP. SIM Round 3 funding would provide support for practice transformation and facilitate efforts with Medicaid managed care organizations and commercial payers to incentivize providers in reducing avoidable hospitalizations, readmissions and emergency department use through expanded patient-centered medical homes and health homes; more effective care transitions; population health management and the use of health information technology and data to risk stratify and prioritize interventions based on health and social determinants data.

¹⁴ Information concerning the Collaborative Care Model is available at <http://aims.uw.edu/collaborative-care>.

Please feel free to contact the former SIM Project Manager Thomas E. Gilpin at (304) 293-6615 or at tegilpin@hsc.wvu.edu should you have questions or require further information concerning this letter. Thank you again for the opportunity to provide our insights, comments and opinion about the future of the SIM program.

This letter is respectfully submitted by the following parties on behalf of their respective organizations.

West Virginia Department of Health and Human Resources



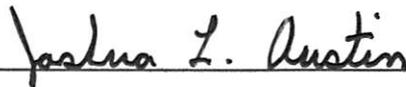
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