

Summary of Medical Services Fund Advisory Council Meeting
April 7, 2006
1:30 p.m.
Kanawha Valley Senior Services

Members Present

Violet Burdette, Chairperson, Primary Care Representative
Mike Robbins, Alternate, Hospital Representative
Scott McClanahan, Aging Program Representative
Cathy Taylor, Alternate Ex-Officio, Bureau for Public Health
Richard Stevens, Alternate, Pharmacist Representative
Sue Buster, Alternate Ex-Officio, Bureau for Children and Families
Larry Robertson, Hospice Representative

Bureau for Medical Services Staff Present

Nancy Atkins
Shelley Baston
Sandra Joseph
Vicki Cunningham

Interested Parties

Christy Thomas, Unisys
LuAnn Summers, WVDRS
Karen Keaton, WVMI
Benita Workman, Self

I. Welcome and Opening Remarks

Violet Burdette welcomed everyone to the meeting. Nancy Atkins had no opening remarks.

II. Approval of Minutes of the MSFAC Meeting of January 13, 2006

After looking over the minutes of the January 13, 2006 meeting, Richard Stevens had a correction, which is found on page 5, fifth paragraph down. This should read,

He said that 340b clinics, Federally Qualified Health Clinics, obtain pharmaceutical products at very substantial discounts, as much as 51% off of average wholesale price, and if they are in a buying group, it is as much as ~~(50%)~~ 60% off of average wholesale price.

- ◆ Mike Robbins moved they be accepted with correction. Larry Robertson seconded the motion. All in favor.

NEW BUSINESS

III. Unisys Update

The Unisys Update was provided by Christy Thomas, Manager of Provider Relations, for Unisys. She addressed the following topics:

Provider Workshops

Christy indicated that Unisys has scheduled the Provider Workshops, which will start in June 2006, and if anyone would like this information to send to their associations, she will provide them with a list indicating the dates and locations. Because the Wheeling Hotel has closed, it is assumed that PEIA will be moving the workshop to another location.

Timely Filing Guidelines

Regarding the timely filing guidelines extension, Christy stated that this ended as of March 31, 2006; therefore, the timely filing goes back to normal. For crossovers, timely filing is one year from the EOMB from Medicare, and for the commercial insurance, timely filing is one year from the date of service.

Claims with No Prior Authorization

Recently, Unisys has denied about 16,000 claims for services that required prior authorization. Christy would like the MSFAC members to make their providers aware of the prior authorization rules. Outpatient surgery was implemented in February, 2006, Radiology was in October 2005, and DME was in March 2006. Christy stated that many of the denied claims were focused around the Behavioral Health Providers, more so than on the medical side.

Cross-Over Payments on the Reprocessing Schedule

Christy indicated that it was planned for Unisys to do a mass adjudication of the crossover payments. It has been decided that Unisys will not be doing a mass adjudication, and the physicians will either need to reverse or replace those claims.

Expired License

Christy indicated that last October, 2005, Unisys started a new process with expired licenses. Unisys is expected to maintain a current license on file for providers. After running a report, they discovered about 4,000 providers in their system had expired licenses. Unisys is in the process of working with the physicians, and terminating physicians from West Virginia Medicaid. The providers now will receive a letter sixty days prior to their license expiration date, stating that Unisys needs their current license. Thirty days prior to the expiration date, Unisys will place that provider on pay-hold, indicating their current license has not yet been received. If the current license has not been received by their expiration date, then Unisys will proceed with the termination.

Richard Stevens suggested that the timeline is a little stringent. He explained that different types of providers licenses are renewed at different times, dentists in February, pharmacies in June, etc. and those providers have to obtain so many hours of continuing education before their licenses are renewed. Sometimes providers tend to procrastinate, and wait until the last 30 days before the renewal of their license, to get their required CE. Therefore, they will not be receiving their renewal license from the licensing agency until around the due date. Richard indicated that it is a little restrictive to put a pay-hold on a provider thirty days prior to the expiration date. He also indicated that the boards, which have several hundred licenses to issue, may not get the licenses out in an expedient fashion.

Christy stated they are taking into consideration that the boards may be behind in issuing the licenses, and that contact has been made with the licensing boards.

Shelley Baston asked for a suggestion from Richard Stevens for a process that would be reasonable.

Richard's suggestion is that the sixty day notice is appropriate. Then after sixty days, on the date the license is due, send a notice that we are holding the provider's payment until we get their license renewal. Richard would like a statement put in the sixty day notice that states **no services will be paid after the provider's license expires, whatever date that is**. Then the final notice would be sent, stating that the provider is on payment hold until we receive the provider's renewed license.

Shelley Baston clarified Richard's suggestion, that we send the sixty day notice to the provider, and say January 31 is the last day of your licensure. If we do not receive your updated renewal by February 1st,

we are putting you on pay hold. If by February 28th we still have not received anything, then we will terminate you from the system. Nothing will be paid to this provider after February 1.

Richard had a question regarding the Bureau terminating the provider from the system. Shelley informed Richard that if the provider's licensure is not received, we take the contract off, and if the provider bills anything, there is no contract to pay off of.

Christy brought up the point that if the provider is six months behind in billing, and it is after February 1, and we put a pay hold on this provider, then this will pend everything and put everything on pay hold. Shelley stated that we would have to look at the system.

Because of the results of the single audit, Nancy Atkins stated that payment for those with expired licenses is no longer acceptable.

Christy informed the Council that Unisys is terminating providers with expired licenses. They have terminated around 1,300 providers, and need to terminate around 2,000 more.

Richard asked that, once Unisys has cleaned up the files, and completed the terminations that they are working on, if the Council could get some information on counts of numbers of providers participating in the program.

Shelley said she has recently reviewed and approved that report, and have the number of providers by county also.

Christy said that in addition to the expired licenses, Unisys has about 2,700 physicians that have no expiration dates in our system. Unisys is contacting the licensing boards and verifying the expiration dates, pulling down their license and getting that put in the system. Unisys has completed about 1,800 so far, so these providers are still active with WV Medicaid. However, Unisys has not been able to locate a license for eighty-eight providers, so they will be terminated.

Call Center

Christy Thomas said that Unisys has decreased the hold time through the call center, and hopefully providers are experiencing a lesser time on hold. Metrics have been installed for each of the call reps. Average wait time is 2.5 minutes. Behavioral Health Association meetings are now phone calls by-weekly instead of weekly. The Hospital Association call is every other Wednesday. Nursing Home conference calls are now on a monthly basis.

Christy said that Unisys recently visited the top Behavioral Health providers. They also participated in board meetings and discussed the issues that were found.

IV. Financial Report

Shelley Baston announced that neither Tina Bailes nor Leonard Kelley could attend the meeting to do the financial report, as they are working on a project for the Secretary. Therefore, Nancy Atkins is going to substitute the Proposal for Cost Containment that the Council had previously requested.

Proposal for Cost Containment

Nancy Atkins stated that there is a lot going on in Medicaid right now, and that while Unisys has been a struggle, it does have the technology to allow us to do some of the things to clean up the program, that we have not had management tools to do before. Nancy stated that there are several major projects going on right now: 1) Redesign, plan to roll it out July 1, 2006; 2) certification of the Unisys system, and hope to have it certified by September; 3) and most importantly the Deficit Reduction Act of 2005

(DRA05) the President signed into law in February, which has changed the face of Medicaid dramatically. You will see from the national perspective, as well as from the statewide perspective, a great deal of change in the way that Medicaid is managed. A lot of the redesign will be able to be done through State Plan Amendments. A waiver will not be needed.

Regarding the Cost Containment Timeline, Nancy Atkins indicated she had reviewed this with the Council last year, and today she gave the council those things that we have put forth and the status.

Nancy also brought up the public works initiative, which is the consultants who come in to help streamline and simplify the administration of the State. So we also, in addition to what we are doing, have requirements upon us from those consultants in cost containment, and one of those is prior authorization, which was figured into our budget.

There was a question presented from a non-member who was present at the meeting, regarding how many additional AD Waiver slots have been requested. Nancy Atkins stated that these have not been requested. Nancy said that we have the budget document and now we have to do everything in a cross-walk to make sure that they really appropriated all the money. If they have then we will request those additional slots.

Another question was presented regarding the Deficit Reduction Act. The question was, how will this be done? Will the plan be put out for a comment period or brought to this committee?

Nancy said that this will be through state plans, and we'll probably do the 30 day public comment period. It will be done in pieces as opposed to a waiver. Nancy said that we are looking at July 1, 2006 to start with the first population.

V. Managed Care Quality Strategy

Shelley Baston stated that with every managed care 1915b waiver that we do, we have to update our managed care quality strategy. This waiver is due to CMS, and has probably already been sent to them. If not, it will be sent by early next week. With every waiver renewal period, we have to do this quality strategy for the Managed Care Program. This is for the upcoming waiver period that begins July 1, 2006 – June 30, 2008. As a requirement from the feds, we have to get approval from the Advisory Council that this would meet what you would think we would need as a quality strategy.

Shelley indicated that this was sent out in advance to the Council, so that they could read it prior to the meeting, and that basically she just needs any comments, or anything the Council thinks might not look appropriate, or the Council's approval.

Mike Robbins has the following requests that could be added:

- ▶ Page 7, at the top, first paragraph, where it says that the insurance commission goes through their review of the MCO's, he wants to add financial solvency.
- ▶ Attachment B, page B-4, under Focused Case Review, at the bottom of the page there is a series of bullet points, regarding the second bullet at the bottom of the page, which says 'Readmission to an inpatient care facility within seven days of discharge.' Mike would like this clarified to say, 'Readmission to an inpatient care facility within seven days of discharge for same or related DRG.'

Shelley informed Mike that we review all of them, whether or not it is for the same or related diagnosis. If we find that the diagnoses are not related, a formal review will not be requested.

- ◆ Richard Stevens moved that the Managed Care Quality Strategy Report be accepted. Mike Robbins seconded the motion. All were in Favor

OLD BUSINESS

VI. Review Terms of Council Members

Shelley Baston indicated that we had discussed the Bylaws, specific members, and the terms of members, at the last meeting of the Council. She also informed that Council that 4 members' terms are about to expire in August 2006. These members are: Scott McClanahan, Larry Robertson, Michael KilKenny, M.D., and Mark B. Ayoubi, M.D.

Violet Burdette announced that we will find out in the July 2006 meeting, whether these four members, whose terms are ending in August 2006, want to continue to serve, or whether they want to be replaced.

Shelly stated that she has a couple of issues to bring to the Council:

- 1) Pharmacy representative. Richard Stevens said that he had given Peggy King the name of Dennis R. Lewis from Chapmanville.
- 2) Consumer representative. As we have been unable to reach the current Consumer Representative, Shelley asked the membership if they had any recommendations for appointing another consumer representative.

Violet Burdette mentioned that she would be glad to contact either the Health Department or the Community Health Centers to see if they had a client that they feel would be a good consumer representative.

There was also a suggestion from Mike Robbins that we contact Sonja Chambers at the Health Care Authority, regarding the Affordable Insurance Workgroup. He indicated that there are consumer representatives in that workgroup, and if they are not interested, maybe they could recommend someone who would be interested. Violet advised that this should be a Medicaid recipient.

It was also brought up that there needs to be an alternate appointed for the following members: 1) Consumer Representative, 2) John Russell, Behavioral Health Representative, 3) Scott McClanahan, Aging Program Representative, and 4) Mark Ayoubi, M.D., Physician Representative.

VII. Volume of ER Visits Report

As Pat Miller was not able to attend, Shelley Baston gave the report. She said that after we started the diagnostic radiology prior authorization process in October 2005, there was here-say that the ER visits were increasing based upon, "we can't get it done so we are just going to send everybody to the ER."

So far we have looked at the total number of claims that we have received with ER visits, going back six months. We are going to keep going forward, so we will be updating this report because there is always a claims lag. The chart in your packet is based upon dates of service, so they are bucketed into this report based on the date of service. These should increase as the lag time goes out, and then we will be able to see if what we are hearing is actually true.

Mike Robbins asked if we are just looking at fee-for-service visits. He wanted to know if this chart picks up ER visits for claims paid by the managed care organization. The answer is no.

Mike is concerned that theoretically as we expand through the population in managed care, we could see this go down, and it would not be because there has been a decline in the ER visits, it's just more than we are being paid by the managed care organization.

Shelley stated that we have only expanded into one county since implementing diagnostic radiology review.

VIII. Changes to the Remittance Advice

Christy Thomas said that Unisys has made several changes to the remittance advice.

- ▶ The new HIPAA Adjustment Reason Codes have been put on the remittance advice
- ▶ If a claim denies as a duplicate, Unisys has indicated what claim originally paid
- ▶ If there is other insurance, it has been added that the payment adjusted because the charges have been paid by another payer, and the claim is paying zero

IX. Prescription Drug Reimbursement

Richard Stevens requested that this be put on the agenda. He said that he has served with the Pharmacist's Association since 1979, and has witnessed various third parties, including Medicaid and PEIA, develop and undertake cost containment strategies and measure among health care practitioners. He said that these same third parties have had to come back to the table a couple of years later after a reduction in reimbursement through this or that practitioner or institution, and make additional cuts.

Richard suggests that a different approach to contain cost be undertaken, rather than cutting reimbursement. Medicaid has taken innovative steps in reducing cost in its prescription drug program. The Rational Drug Therapy Program is an excellent example, for which Pharmacist's Association encouraged and supported.

Richard respectfully suggests to Medicaid that the recent concurrent cuts in reimbursement to pharmacies are severe, and will result in more adverse consequences than just financial impact on pharmacies. There will be employees laid off, along with curtailed services to the public as a whole, and some pharmacies will close their doors. These cuts could not have come at a more inappropriate time. Medicare Part D is also a contributor to these economic consequences. While pharmacies are witnessing reimbursement below their cost for some products for Medicare Part D, they are also witnessing delayed payments.

Medicaid's recent and current cuts in reimbursement of pharmacies fall squarely on those pharmacies' shoulders. Not the first drug manufacturer, brand or generic, will witness any reductions in their prices. For the most part generic products are the targets of these cuts. Medicaid pays an average of \$24.84 for a generic in mid 2005, and \$97.14 per brand. State Maximum Allowable Cost (SMAC) was implemented on more than 500 generic products on July 1, 2005, capping the price Medicaid would pay pharmacies for these products. SMAC was expanded 30 days later on August 1, 2005, capping another 150 products. SMAC was again expanded on April 1, 2006, adding or adjusting the cap prices of over 500 products. The SMAC is in addition to the federal MAC, which has been in place for several years.

Medicaid, now beginning on April 17, 2006, pharmacies will witness reduction in reimbursement for any generic that is not in the federal MAC or the state MAC, a discount of average wholesale price minus 30%. This will result in all generics having a maximum price to be paid by Medicaid.

Richard respectfully suggests that SMAC, in the forthcoming draconian reduction, AWP minus 30 for disincentives for pharmacies to dispense low cost generics. He understands that Medicaid tracks the rate of generic dispensing every quarter to see how this measure is working. Reduced expenditures for generics cannot stand alone. To demonstrate that SMAC and AWP minus 30 are a saving cost, the way

the brand products being dispensed must also be tracked, to see if there is a shift from fewer generics and more brands.

Richard also suggests, given the forthcoming increase in dispensing fee to the 340b clinics, that prices paid to 340b clinics be compared to the reimbursement paid to retail pharmacies, to see if a lower cost is being paid for those same prescriptions.

Vicki Cunningham said that we will require the 340b pharmacies, when that enhanced dispensing fee is put into effect, to certify that those are the prices for which the drugs were purchased, and they do know that they will be subject to a random audit.

Vicki said that the enhanced dispensing fee for generics is \$5.30, so we hope that will encourage dispensing of generics, and it is only \$2.50 for brand. Most of the generics cap anyway, so we think that generics will continue to be dispensed at the same rate and increase, in fact, by the enhanced dispensing fee of \$5.30 for the generics, and lesser dispensing fee for brand.

Mike Robbins asked Richard Stevens if there was any way to get information on the impact on the enrollees in terms of access to the drugs that they need, or access geographically, because of this change.

Richard said he intends to monitor this by county. He will target the rural counties to find out the financial impact on these pharmacies, and the consequences that the Medicaid and the Medicare Program have on these pharmacies.

Richard stated that when Medicaid tracks the generic dispensing rate, that will tell if there is a shift, if more brands are being dispensed than generics.

Richard requested the agency compare claims submitted by 340b pharmacies with that submitted by retail pharmacies, to see if the product cost at these clinics is much less than a retail pharmacy. Pharmacists have told Richard that they buy some products at the same price that the clinic buys them, and are concerned that they are paying the same product cost and not getting \$8.25 dispensing fee.

X. Other

Larry Robertson stated that at the last meeting Leonard Kelley told him that he was still looking at nursing home / hospice Medicaid benefit.

Nancy Atkins confirmed that Leonard is looking at this, and stated that they were having conversations with CMS.

XI. Next Meeting

The next meeting of the Medical Services Fund Advisory Council will be July 14, 2006, at 1:30 p.m.

Respectfully submitted by,

Pat Johnson
Secretary