

Summary of Medical Services Fund Advisory Council Meeting
April 22, 2005
1:30 p.m.
Kanawha Valley Senior Services

Members Present

Violet Burdette, Chairperson, Primary Care Representative
Charlie Young, Alternate, Bureau for Children and Families
Charles Covert, Hospital Representative
Jesse Samples, Nursing Home Representative
John Mullins, Alternate, Nursing Home Representative
Scott McClanahan, Aging Program Representative
Larry Robertson, Hospice Representative
John Russell, MH/BH Representative
Chuck Smith, Dental Representative
Cathy Taylor, Alternate, Bureau for Public Health
Mark B. Ayoubi, Physician Representative

Bureau for Medical Services Staff Present

Nancy Atkins, Commissioner
Peggy King
Randy Myers
Jim Shedd
Shelley Baston
Tina Bailes
Shannon Riley
Auburn Cooper
Sandra Joseph
Pat Miller
Steve Mullins

Interested Parties

LuAnn Summers, DRS
John Marks, WVMI
Brian Cunningham, WV Primary Care Assoc.
Charlotte Pulliam, WVSOM
Bob Whittler, CAMC

I. Welcome and Opening Remarks

Nancy Atkins welcomed everyone and informed them that she, Auburn Cooper, Shannon Riley, and Shelley Baston would be leaving the meeting early and that Randy Myers, Deputy Commissioner, would answer any questions.

II. Approval of Minutes for the MSFAC Meeting of January 14, 2005

Jesse Samples made the motion to accept the minutes as written, John Russell 2nd the motion. All were in favor.

III. Medicaid Cost Containment Initiatives

Nancy did a walk-through and explained the materials that we have put together regarding reductions. She stated that Medicaid received an additional \$70 million in funding this year; however, that does not put us where we need to be to maintain the Program as it is. Based on that, we have about \$156 million that we have to take out of the system, based on the appropriations we're going to receive July 1, 2005. A big portion of that is our match rate has dropped from 74.65 to 72.99, \$36 million we're not going to receive in federal match. We've lost about \$32 million in provider tax. The rest of it is pretty much growth of the program and utilization. Based on what we have been appropriated, we are going to be looking at taking this money out of the system.

Nancy said that we also don't know what will happen at the federal level, so we have no choice but to move forward.

Nancy Atkins explained how they came to the decision of what to cut. She stated that there are only about three places you can look at to cut, and that is reimbursement, eligibility, or services. We looked at this from a legal perspective of what the federal rules and regulations require us to do, what are some of those things that are optional that we can cut, and that's how we came up with the list. She explained that we didn't single out any particular provider group, but we looked at what we can do within the confines of the rules and regulations under which we have to operate. Nancy explained that we have the federal mandated services that we have to pay for, and also some federal/state mandatory services. Those are things by state statute Medicaid is required to pay for.

Nancy then discussed federal/state optional services. She explained that they could not just cut all the optional services.

Nancy Atkins stated that starting the first of the next week, we will be putting out public notices on the State Plan Amendments that we have to get approved from the feds. She said that part of our dilemma is that our new appropriation begins July 1, 2005. It takes us 3 to 6 months, and even longer, to get some of these changes approved by the federal government. So we have to move forward.

Charles Covert said that the Hospital Association won't support any cuts. He said what we will start seeing is a lot of talk from the commercial payers, because they are getting tired of carrying the load for the governmental payers. The commercial payers pay about 2.5 times what the State does.

Nancy Atkins said that we have been given appropriations, and that's what we have.

Jesse Samples asked, "What is your appropriation for SFY 2006. Do you understand that your budget right now is \$1.9 billion? What is the 2006 amount as far as what Medicaid understands its budget is right now?"

Tina Bailes said she has an estimate of \$2.18 billion. What is appropriated or budgeted to fund is a little over \$2 billion.

Nancy Atkins said that we have about 37,000 more recipients than we had in 2001. We are seeing those rolls continue to grow each year, and it's primarily the aged and disabled population, not our children. The aged and disabled population is our most expensive population. Our growth is about 7% to 9% over the last 3 or 4 years, which is pretty phenomenal compared to what it is nationally. Most Medicaid's are in double digits.

Violet Burdette asked the Council if they want Nancy to go through each of the changes that are being proposed and discuss them.

There was some discussion concerning co-pay for non-emergency ER use. Nancy Atkins said that the Governor is committed to personal responsibility. They are looking now at doing a pilot for Medicaid in West Virginia allowing for some new and innovative policies, such as reasonable and enforceable co-pay. Nancy said that what we really want to do is to craft something that helps people take some responsibility for their health care and their health behaviors, so that we actually are rewarding those folks who are doing the right thing. Perhaps maybe a higher co-pay or a higher premium for the folks who continue to smoke, or don't follow their regime, or don't take their medications. It's very conceptual at this point. Nancy stated that when we start drafting that and putting it together, we'll have to negotiate that with the feds, but we will be coming back to this group to get some feedback.

Charles Covert said that if you're going to have a co-pay, it needs to be a co-pay - - period. We don't want to have to decide whether to charge it or not. If you come to the ER, it's a co-pay - - period, whether it's an emergency or not.

Nancy said that the most difficult thing she sees is that our kids don't have a choice, so if a parent chooses not to bring them in because they don't have the money, or they don't want to pay the money, a child may indeed be in an emergency situation. Part of it is that dilemma of taking some of those kids in really dire poverty stricken situations and making sure they are getting what they need and they are getting their immunizations, looking at how we might be able to structure that.

Nancy said that there is only a couple of co-pays that we can enforce, one of them is inappropriate use of the ER, and the other one is the first day of hospitalization. You can

do up to 50% of the total cost of the first day of hospitalization. That's a fair amount. We did 50% because we knew that it would probably be hard for people to come up with \$500.00 for that first days stay.

Nancy stated that we are open to any suggestions or any ways that the providers can think of that we can do things more efficiently.

Jesse Samples said he could not vote in the affirmative to implement any of these cuts. He stated that he thought we should make the administration and Legislature aware that this Council is very concerned about any cuts done to the Medicaid Program arbitrarily in this nature. At the same time every health care provider group willing to come to the table should be invited to look for those efficiencies in ways to work the program.

Nancy Atkins said that one of the things in West Virginia that is to our disadvantage is that we have not expanded our coverage in eligibility. A lot of folks are covering the parents of CHIP children. They've expanded for the uninsured. Utah has what they call a basic package, primary care for adults. In West Virginia we don't have any eligibility categories that are above the federal minimum. We're at rock bottom.

Gerry Stover stated that he would like to see the entire budget for DHHR. Nancy said that we would have to set up a meeting with Secretary Walker to do that, as that is not in her area of authority.

Violet Burdette said she heard that there are possibly other monies available that could have been used for this program, the Lottery for example. Violet wants to know what other options there are to help assist the Medicaid Program. Nancy said that we have to live with what has been appropriated to us.

Dr. Ayoubi stated that it is becoming harder and harder for pediatricians to provide services to the children. He would like to relay pediatricians' concerns about their ability to continue to provide services. Some will be going out of business because they are having difficulty making ends meet. He would like to make a motion for this Council to express grave concern about any cutting in reimbursement for children's services and other services provided by Medicaid.

Nancy said that part of our problem is that we lost \$32 million this year in provider tax from physicians.

Jesse Samples 2nd Dr. Ayoubi's motion. He asked if we could write a letter from this Council to the Governor incorporating that fact that we don't think there should be any reductions made at this point-in-time for the reasons that money is there, i.e. Lottery monies, traffic account that sits there designed specifically to take care of reductions within federal matching dollars. Can we do some research that actually puts into that letter that we don't recommend any cuts to the Medicaid Program and the Governor and

Legislature find monies in these particular areas to eliminate this particular cut, with the caveat that we are going to have to come back to the table and negotiate some reductions going forward in the program, because the program can't sustain its growth.

Violet Burdette stated that we have a motion, 2nd, and beginning of a discussion. She asked if there is further discussion.

Violet said that an interested party, Brian Cunningham with the Primary Care Association, would like to speak.

Brian Cunningham said he had heard a lot of talk about cutting provider reimbursements, etc., but he hasn't heard a lot of talk about cutting some of the waste, for example, the eligibility determination side of the system.

Violet Burdette asked that by bringing this before the Council, if the Bureau is bound by the Council's recommendations, or if this is just for the Council's information, whether there is agreement or disagreement.

Auburn Cooper said that federal regulations require that Medicaid put these things in front of the Council, whether or not the Council agrees with what we propose to do. By virtue of having this meeting, your comments are on the record. If you want to go beyond that to make a formal recommendation to the Governor, the Legislative Leadership, or whatever, that is within the purview of the Council.

Violet said that the motion says that the group does want to make a formal letter to the Governor noting the concerns and proposed changes.

Gerry Stover said we need to look at alternative revenue streams.

Violet asked if the Bureau has a Grant Writer. Nancy said no, we do not. We usually work with the Bureau for Public Health and other Bureaus within DHHR, they have Grant Writers.

Violet said we have the motion and 2nd, and called for a vote. All were in favor.

Violet stated that as this committee only meets every quarter, that this issue would not be able to wait until July if there is any kind of response from the Governor's office or if there is a core group that would like to meet to make recommendations.

Auburn Cooper said the By-Laws permit the Commissioner or MSFAC can call a meeting at any time.

IV. DME Plan Proposed Amendment (Needs motion and vote)

Auburn Cooper discussed the Public Notice, West Virginia Medicaid Program, Reimbursement Methodology, Durable Medical Equipment (DME). He said this just cleans up the language in our State Plan about how we reimburse for Durable Medical Equipment. The current State Plan simply says we reimburse a discount off Medicare, and this one specifically says we reimbursement Medicare minus 20%. We need the Medical Services Fund Advisory Council to give us a motion on this. Auburn Cooper said that this particular notice would not result in a change, it's just clarifying what is already out there. However, there are some things in your packets that talk about reductions which relate to DME.

Charles Smith asked whether the things in the packet that talk about reduction in DME negatively affect the statement that this Public Notice makes. Auburn Cooper said no. This is general enough that it will cover whatever needs to be done with that issue.

Jesse Samples made the motion to accept the Public Notice as presented. Charles Smith 2nd the motion. All were in favor.

V. MMIS Implementation (Unisys) Update

Pat Miller said that Secretary Walker held a Public Forum on March 2nd and asked Unisys to give the "completion date" for having all the problems cleaned up. At that time Unisys gave the date of April 30, which is next week. So they actually updated the handout that was given out at that forum to contract some of the progress that they have made. Some of the main things of note are that all of the Medicare crossover claims are now processing. Last weekend they actually processed the outpatient hospital crossovers, and the inpatient hospital crossovers will be processed tonight. That is just all the paper crossover claims. They are very close to having the intermediaries get their connections made, they have been testing their files, and that should occur very soon. The system change is in process right now for processing of the Third Party (TPL) claims. We expect that to be working in the next week or two also. Regarding the PAAS Management Fees and Rosters, the passwords are now being generated. Pat said that we also have been working with RAPIDS to try to improve the information that prints on the monthly cards, and to assure that people who want to make changes to their PCP, either their HMO or PAAS provider, can actually take place for the future month. We have had some problems with that working, and we are working out some changes for RAPIDS that should take place for the coming month's file. We also met the other day with our Pharmacy Stakeholders to discuss the re-implementation of the Pharmacy Point-of-Sale System, which is scheduled to take place the week of May 16, and that is contingent upon what we're calling the "clean bill process", which Peggy and her group will get the feedback on that.

Violet Burdette asked what is not done.

Pat Miller said that the biggest thing is getting the TPL to work properly. Finalizing the intermediary, the crossover claims come electronically. They did just this week determine that providers who have access to the web portal, but have been getting paper remittances, didn't have access to what they call the "in process report", the "in process summary", which tells you all of the claims that are in the system that haven't made it into accounts payable. So at least you can have a report that shows you that the claims have been received and that they are in the process somewhere. They did just add that this week that you can pick up that "in process report" off the web portal even if you get a paper remittance. The PAAS Management Fee Rosters and payments were one of the outstanding items in those RV process being worked on right now. Pat said she knows there are still some pockets of concerns that they have been working on. The Behavioral Health Group still has a few outstanding issues. The reprocessing of all of the old errors has been taking place, and is about 90% complete. They did make a change so that if your claims were being reprocessed, there was a problem with the reversal going straight through and taking the money back, but the claim that got reprocessed had to age through the accounts payable process, so now they have got tied together so that those reprocessed claims look like your oldest claims so that they go through fairly well together.

Violet Burdette said that with the budgetary problems that Medicaid is currently experiencing, one of the biggest concerns was how much money is out there that Medicaid owes. Do you now know that with any comfort level?

Pat Miller turned that one over to Tina Bailes. Tina said that we still have many issues on the table. We have experience where we have paid claims multiple times, the Nursing Homes are not withholding the resource amount, but not on every single claim. We have issues with the hospital claims, although I think that has pretty much been fixed with outlier claims. We have so many things going on. We are getting a daily report from Unisys that gives us the activities and that is how we are monitoring at this point. We are hoping that once we get through all the reprocessing we can sit down and look at what we have and go back and focus on those claims that we have paid in error. So the reporting piece, in my opinion, is still an issue with Unisys, but we are working on it and we have billed the core reporting, so now we just have to bill the peripheral reports around that. By that I mean what we report to the federal government, CMS, for our expenditures. We still have a lot of work to do on the financial reporting. In any given week something can happen, and that's been the experience, if something was working right then all of a sudden it didn't work, it causes the reprocessing, we're still day-by-day, week-by-week.

Pat Miller said that we feel there has been progress made on the eligibility file itself in reflecting correct eligibility. They built what they call a "reconciliation system" that took all of the converted information from ACS, took all the additional daily updated files, and

does a compare on a daily basis with the core system to make sure that the information in the core system reflects the correct eligibility coverage. So there are still a few issues that they are working on that affect 70,000 members that may have in the last year a piece of eligibility that needs correction. For the most part we do have more confidence in the fact that they are capturing the eligibility correctly and loading instructions.

Charles Covert questioned 98% of crossover claims has been processed. Pat said that was paper claims. Pat said that if providers are waiting for the electronic claims to start working, that is the piece that they are working on right now, getting those claims in from the intermediaries. They do have the plan to take in all the way back to last June.

Charles Covert asked what percent of the total crossover claims does this make up?

Pat said we don't really have an idea, because we don't know how many providers have actually submitted paper or how many providers are waiting for the electronic end of the year.

There was some discussion about Unisys, and that Unisys would be around for another 2 years. The Secretary has to make that decision as to whether to bring in another Vendor.

Peggy King asked to say something about the Pharmacy system just for the Council's information. She said that the pharmacy architecture is quite different than it was a year ago, as it is an independent system, and they have been testing it every day since early in December. We are quite confident that the system has been remediated. Peggy said that the area of concern that we have is the eligibility glitches that still exist. We had a meeting with Unisys yesterday and they said that on any given day there may be 250 people that visit the pharmacy that their eligibility is not correct, so we are working on a process to deal with this. Peggy said she was told within 30 days that should be cut in half. Peggy said she is hopeful that the eligibility issues will be fixed, because that is what hurts Pharmacy, other than the architecture not being able to handle the volume of claims. Peggy said they had a Stakeholder's meeting this week with the Pharmacy Representative, and they told us in no uncertain terms that three days is all they can stand. If we have the same issues in three days, we will certainly be at the Secretary's office asking her to let us revert back to ACS. It went on for 10 days last year. We do not want a repeat of that.

Jesse Samples commended everyone in the Department for their hard work in this issue.

VI. MR/DD Waiver Renewal / AD Waiver Renewal

Steve Mullins stated that these waiver programs are only approved in 5 year increments by the federal government. We were on a schedule to submit renewal applications by

the end of March, hoping to have federal approval back by July 1, so that we could start another 5 year cycle right on the heels of the expiration of the previous 5 year period. We began taking public input through forums and sent letters to all of the families and participants of both waivers. That started last fall and concluded in February, and based on all the stakeholder, family and provider input we received, we tweaked the applications and had hoped to bring them before you before we submitted them for final approval. In the meantime a new administration took office. We were unsure what they wanted to do with these programs. We knew we were probably going to have the budget deficit to address, but didn't know at that point what role these waivers would play in addressing any of the budget problems that we have. The Aged and Disabled Waiver is contributing about \$10 million to the reductions that are proposed. The MR/DD waiver will be undergoing changes also, the financial consequences of which are not known at this time. Because we were asked to look at them in that light, and because the Secretary felt we should accelerate the implementation of some changes that we had planned to phase in later, we asked for and received an extension of the current waivers through the end of September to give ourselves more time to revise the applications and put them back out for public comment. We will issue a revised application for each of these two programs in mid-May and will take public for other stakeholder and provider input probably until about the middle of June and then apply for the renewals by sending those to CMS at the end of June. In the AD Waiver we will be reducing the number of slots significantly, and that's how we are going to save money that's illustrated on the spreadsheet you have in your packet. We receive indirectly an appropriation of Lottery Funds to fund that program. Right now it is \$13 million in Lottery Funds, which yields about a \$51 million program, if you add the federal match on it. It has been \$13 million for the last 3 or 4 years, but we have been spending more money than the \$51 million that \$13 million yields, so we have decided to live within the lottery appropriation, and the only way to realistically do that is to reduce the number of people served in the program. That will not mean kicking people off of the program, but rather just stopping intake for a significant period of time and letting attrition bring us down to this affordable number. This affordable number is not known exactly, but it will probably be something around 3,100 people. We currently have almost 4,000 people participating in the program. There are usually about 900 or 1000 departures for various reasons during the year, so we will probably continue the program and serve the 4,000 folks who will be on there at the beginning of waiver year one. By the beginning of waiver year two, if we don't add any people to the program, we will be down to something that we can manage within the appropriation of Lottery Funds. What was put out for public comment earlier envisioned keeping the number of slots the same as it has been for the past few years, so there has been no public comment yet on reducing the number of slots, so that will definitely require another round of comment, which will begin around the middle of May. The other change that may be in there is a positive change. We are introducing a self-directed piece into that waiver where participants can become the employer of their own waiver staff, and we will be using some Robert Wood Johnson Grant Funds to develop the infrastructure. Basically some entity will be an intermediary to handle the payroll responsibilities of the waiver participant. It will give them more

control over who they get their services from and allow them to do the hiring and firing. That was envisioned to be rolled in sometime probably within the first year of this renewal cycle. But now that we are delaying the submission of the application, we were hoping to include self direction in the application. The new waiver will start sometime around October 1 or no later than the end of December.

The MR/DD Waiver will also go out for further comment in mid-May. Some changes that we had originally proposed will not be made. Instead we will be proposing to move directly to a system of levels of care in that waiver. Right now that waiver is a one size fits all, but we believe that we can create four or maybe even more service levels and associate a budget with each level that will help determine what services participants receive. Whether that saves us any money or not is not known at this time, but it will address a lot of comments we have been receiving from participants and their families who feel they are being asked to accept more services than they really need and they don't have the flexibility to get what they want within the services that they do receive. We are trying to introduce a more person centered planning process where they or those who make decisions for them have more input into who gives them the service and what service they get within a specific budget. It will be based on an assessment instrument, probably the ICAP or a similar assessment instrument that would place them in a specific level. We had planned to phase this in sometime in year one of the five year renewal, but our Secretary believes we should go to that immediately now and the implementation of that, because we had an intermediate plan. The Secretary pointed out that she didn't want to put providers, consumers, and advocates through two changes.

Steve said that if the committee is going to have another meeting, he would like to bring the final versions of these applications before the Committee at that time. He said he would like to put this on the agenda.

There was discussion of using hours instead of slots.

Meeting was adjourned.

Respectfully Submitted By:

Pat Johnson
Secretary