

**Summary of Medical Services Fund Advisory Council Meeting
August 12, 2005
1:30 p.m.
Kanawha Valley Senior Services**

Members Present

Violet Burdette, Chairperson, Primary Care Representative
Charles Covert, Hospital Representative
Jesse Samples, Nursing Home Representative
John Mullins, Alternate, Nursing Home Representative
Michael Kilkenny, Physician Representative
Mike Robbins, Alternate, Hospital Representative
Ron Forren, Alternate, Bureau for Public Health
Larry Robertson, Hospice Representative
Richard Stevens, Alternate, Dental/Pharmacist Representative

Bureau for Medical Services Staff Present

Randy Myers
Shelley Baston
Nora Antlake
Jim Shedd

Interested Parties

Nancy Daugherty, DRS
Karen Keaton, WVMI
Bob Whitler, CAMC
Benita Whitman, Legal Aid of West Virginia

I. Welcome and Opening Remarks

The meeting of the Medical Services Fund Advisory Council was called to order at 1:30 p.m., August 12, 2005 by Violet Burdette, Chairperson. Violet then turned the meeting over to Nora Antlake.

Nora Antlake thanked the Council for coming on such short notice and stated that the reason for calling the emergency meeting is that the Plan Amendments must be submitted before the end of the quarter.

II. Hospital Transfer Payments

In reference to State Plan Amendment 4.19 Payments for Remedial Care and Services, Attachment 4.19-A, Pages 24, 24a, 24b, and 24c, Nora Antlake stated that this Plan Amendment has two different parts. It gives a special payment to the acute care hospitals and a special payment to the tertiary and safety net hospitals. A similar plan has been in effect for three years. We have revised the plan since the new plan expired, to give broad authority, so we don't have to change the plan with every change. It gives special payments to rural and urban hospitals based on certain criteria, which is provided in the plan. This plan has a do not exceed amount, so that in future years if we

receive less money we can adjust the payments based on appropriations from the legislature for these special payments.

Mike Robbins stated that he wanted to make sure that it is clear for the minutes that as a matter of process, before items of this nature hit the State Register, the State agency should discuss it with affected parties. As to the Plan itself, there are a number of items where, if we had that prior discussion, we could have avoided the conflict which will occur and the disagreement over the substance of this change. Mike stated that the most minor point is the language that is used for referring or defining urban versus rural hospitals, on the first page of State Plan Amendment 4.19, Payments for Remedial Care and Services, Attachment 4.19-A, Page 24, which talks about metropolitan statistical areas. In fact, now the terminology is core based statistical areas for purposes of defining hospitals as being urban or rural. Mike doesn't know what that language means, since it's a language that is no longer used by CMS in its Medicare or Medicaid Programs.

Mike drew attention to the third page of State Plan Amendment 4.19, Payments for Remedial Care and Services, Attachment 4.19-A, Page 24b, Item D, and stated that in terms of the eligibility criteria for these tertiary and rural safety net providers, this talks about a hospital's qualifying status changing during the period. Mike stated that in his opinion we have never had language in there that talked about making a hospital, when it comes into this program, eligible at the start of the next State Fiscal Year. Mike stated that he wants to go back and verify that because this is an issue that at least two of the tertiary level 2 trauma centers have had since day one of this program; and if we had seen that language clearly in this, we would have given that to them to define why they would have had to wait until the start of the next fiscal year to become eligible. Mike stated that the Department, to his knowledge, for at least the last 2 quarters of the 2005 fiscal year, made a payment out of the pool to the 2 new level 2 trauma centers. So even if this language was in there, the Department itself has not followed that language as it relates to the tertiary safety net pool. If, in fact, it is new language, that's an eligibility change that, at the very least, should have been indicated in the State Register Public Notice.

Nora Antlake explained that the language about the hospitals that drop out of the pool is not new, the language about waiting until the next fiscal year is new.

Mike Robbins stated that this is an eligibility change which should have at least been noted in the State Register Public Notice. Because when you read the State Register Notice, all it says is that we are changing the renewal date and that we are changing this to a not to exceed amount.

Mike Robbins commented to the Bureau for Medical Services that first, in terms of the amount that you have in the State Notice, and the amounts that you have in the very last page of this amendment, the not to exceed amounts of \$11.6 million for the tertiary and \$5 million for rural safety net providers, does not reflect the legislative intent. In the 2005 session \$1 million was added to each of those pools by the 2005 legislature. So at the

very least, if we are going to agree to set a not to exceed amount, it should be \$1 million added to each of those pools. But more importantly, and this is our major concern with this entire action, this program was hinged and in part funded, and linked to a reduction in inpatient payments that the hospitals took from the Public Employees Insurance Program. Essentially, by giving you the authority through a not to exceed amount, you could at any point in time lower, reduce, eliminate those payments without seeking any increase in reimbursement from PEIA for the hospitals, because they are two separate programs. But more importantly, irregardless of whether or not the legislature earmarks specific funds for this program or not, once you have that authority in hand the linkage goes away. You could say, we don't have enough money to make all of our Medicaid payments, so we are going to cut this special payment program as well, and can do that without any further public review and comment once this change is put into effect. Mike wants to make it very clear in the minutes of this meeting that the Hospital Association and its members absolutely reject this Plan Amendment while we support the renewal of this program, because the legislature has renewed it at least through 2008. The Hospital Association and its members object to the use of a not to exceed amount, and expect that this Plan Amendment will, at the very least, be revised to reflect the increased amounts approved by the legislature. Mike stated that, if you are going to require hospitals to lose payments and their eligibility on the day that they immediately lose that status, at any point during the year, that equally should be the case for hospitals that become eligible for the pool, as a matter of consistency in the plan and basic fairness.

Discussion ensued about Mike's comments.

- Richard Stevens made a motion that the Council not support the proposed State Plan Amendment as reflected in the four page handout identified as pages 24, 24a, 24b, and 24c.

Michael KilKenny seconded the motion.

All were in favor.

Mike Robbins wanted clarified for the record that at no point has anyone said here that the Agency has no money. I think we have to be very careful here about what is being reflected, because in fact in the State Register Notice there is no indication given here that the reason for this flexibility is because of any concerns over funding. If in fact that is a concern, it should be stated in a Notice. The State Register simply says the rationale for this amendment is to renew the pools and to clarify that these payments will not have a not to exceed amount. It doesn't say, a not to exceed amount because we are running out of money.

- Mike Robbins made a motion that the Council support renewal of the Enhanced Inpatient Hospital Reimbursement Methodology for the year beginning July 1, 2005, and request that the Bureau come back to the Council with a more specific and revised Plan Amendment authorizing that change, as well as including, at a

minimum, the amounts authorized by the Legislature in the 2005 session for the year beginning July 1, 2005.

Dr. Ayoubi seconded the motion.

All were in favor.

III. Medicare Modernization Act (MMA)

Regarding State Plan Under Title XIX of the Social Security Act, Attachment 2.2-A, Page 27, Requirements Relating to Determining Eligibility for Medicare Prescription Drug Low-Income Subsidies, Nora Antlake stated this amendment is mandated by CMS. It involves the Medicare Drug Benefit, and all it basically says is that the Medicaid Agency will continue to make determinations based on eligibility of people who are Medicare and Medicaid, and will forward those names to CMS for the low income subsidy. In essence, when a person is Medicare and Medicaid, and they come to the local office and apply, their application will be taken. Once it is approved, those lists will go to CMS for the Medicare Drug Benefit part of the plan.

- Richard Stevens made a motion that the Council approve and support the proposed State Plan Amendment as contained on the single sheet identified as page 27.

Mike Robbins seconded the motion.

All were in favor.

IV. Medicare as a Condition of Medicaid Eligibility

Nora Antlake stated that the federal regulations on whether you can require someone who is Medicare eligible, who is applying for Medicaid, to take Medicare are rather obtuse, to put it mildly. If they are on Medicaid, they won't be able to get their drugs through Medicaid, so they have to be on Medicare to get their drugs. What this will do is allow us, when they come in to apply, to tell them that they must apply for Medicare as a condition of getting Medicaid. This only relates for those which we pay premiums, co-insurance and deductibles. If they are found to be eligible for Medicare, they must apply before receiving Medicaid.

Mike Robbins wants to clarify on number 11 of State Plan Amendment, Attachment 2.6-A, Page 3c, that it is an "and/or" meaning. They don't have to sign up for Part A and Part B, they can simply sign up for Medicare Part D, which is simply the prescription drug coverage, in order to get Medicaid eligibility.

Nora Antlake stated that Part A is automatic. They don't have to pay any premiums for that. We want them to sign up for Part B and Part D both.

Although there was a concern regarding increasing enrollment or increasing cost, Nora stated that it is actually going to save us money, because if we can get them to sign up for Medicare, Medicare will be the primary payer. The reason we're doing this at this particular time is that CMS reviewed a 1973 case that reversed their previous decision. The second reason is, if they are Medicare eligible and they don't sign up, they won't get their prescription drugs, because Medicaid is precluded from paying for those once Part D goes into effect. So they have to get both to make sure they get full coverage.

After a lengthy discussion regarding number 11 and the "and/or" clause, it was determined to be written correctly, as it is CMS' language.

There was some discussion regarding Item 10 of State Plan Amendment, Attachment 2.6-A, Page 3c. Nora said that Item 10 is not new. It has been there for years. If it is available for them, we pay the premiums. You can offer to pay their premiums, but you can't require them to do it. If they want to drop it there is not much we can do about it. They have an option.

- Mike Robbins makes a motion to accept these changes to the State Plan with regard to Medicaid eligibility as indicated on page 3c.

Dr. Ayoubi seconded the motion.

All were in favor.

Motion was made and seconded to adjourn the meeting. All were in favor. Meeting was adjourned.

Respectfully Submitted By:

Pat Johnson
Secretary