

Summary of Medical Services Fund Advisory Council Meeting
July 14, 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
Gerry Stover, Alternate, Physician Representative
Dennis Lewis, Pharmacy Representative
Charles Smith, Dental Representative
Jesse Samples, Nursing Home Representative
Charles Young, Alternate Ex-Officio, Bureau for Children and Families
Michael Kilkenny, M.D., Physician Representative
Mark B. Ayoubi, M.D., Physician Representative
Charles Covert, Hospital Representative

Bureau for Medical Services Staff Present

Nancy Atkins
Shelley Baston
Leonard Kelley
Sandra Joseph
Vicki Cunningham
Pat Miller
Nora Antlake
Pat Johnson
Ed Altizer

Interested Parties

LuAnn Summers, WVDRS
Karen Keaton, WVMI
Benita Whitman, Self
Fred Hinds, Unisys
Perry Bryant, WVAHC
John Mullins, WVHCA
Terri Bliziots, WVPCA
John Marks, WVMI

I. Welcome and Opening Remarks

Nancy Atkins welcomed everyone to the meeting. As she had no opening remarks, we proceeded with the meeting.

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

After reviewing the minutes of the April 7, 2006 meeting, Mike Robbins made a motion to accept the minutes as written, Charlie Young seconded the motion. All were in favor.

NEW BUSINESS

III. Unisys Update

Fred Hinds, Deputy Project Director, from Unisys presented the Unisys update as follows:

- ▶ The provider workshops were completed over the early summer. He indicated that Christy Thomas is working on summarizing the survey response sheets.
- ▶ Provider license update was completed June 30, 2006.
- ▶ Unisys brought the Summary of Providers by County report to the MSFAC, as was requested at the April meeting.
- ▶ Nursing Home Association calls that were held monthly are now almost obsolete.
- ▶ Regarding the report card that Unisys generally prepares with BMS and the Unisys Quality Assurance staff, Unisys is 95% compliant.
- ▶ In the area of claims, there is a 24 hour turnaround time in the mailroom. Unisys is looking at a 4 to 5 day processing time to get the claims into the system.
- ▶ Unisys is seeing a high volume of Medicare crossover claims.
- ▶ Regarding provider enrollment, the application processing time range is within the 5 day requirement.
- ▶ The call center time is within the 3 minute average speed answer.
- ▶ Unisys continues to work with WVMI, APS, and BMS on prior authorizations.
- ▶ 89% of all claims are electronic.

Pat Miller stated that one of the things that just started in July is that all Medicare cross-over claims now come through one coordinated billing agent, the COB clearing house. She stated that if providers are having new problems with Medicare cross-overs that they were not having before, they may want to call Unisys to see if it was impacted by the clearinghouse.

IV. State Plan Report

Nora Antlake said there are two state plans in the packet.

1) The first one is the Approved Medicaid Redesign. She indicated that the body of the plan is the preprint check-off. The details are in the attachments, which include the groups, the basic and the enhanced, benefit package and the member agreement.

2) The second plan is the ICF/MR. Nora indicated that this was brought to the attention of the MSFAC in the April meeting. The plan will go to the Center for Medicare and Medicaid Services (CMS) in the middle of this month. This is a phase in of the capital cost, which will start in October 2006. Nora also included a copy of the Public Notice so the council can see the fiscal impact.

V. Medicaid Redesign

Nancy Atkins stated that West Virginia and Kentucky are the first states to redesign their Medicaid Program through State Plan Amendment (SPA). Nancy then gave the Council a brief overview, with slideshow presentation, of what we are planning to do and how Medicaid Redesign is moving forward. The presentation included the following topics:

- ▶ SPA Approved
- ▶ Goals of West Virginia Medicaid Redesign
- ▶ Key Components of Redesign
- ▶ Development of the West Virginia Medicaid Redesign
- ▶ Streamlining Administration
- ▶ Eligibility
- ▶ Flexible Benefits
- ▶ Electronic Health Information
- ▶ Medical Home
- ▶ Member Agreements
- ▶ Outcomes and Measurements
- ▶ Implementation
- ▶ Contacts

Nancy stated that CMS approved West Virginia's SPA on May 3, 2006. The purpose of Medicaid Redesign is to provide alternative benefit packages. In the state plan there are several different ways of doing this. Ours is called Secretary approved. Medicaid Redesign is starting out with Healthy Adults with Children and Children, which are AFDC and TANF children. The administration will be streamlined, going from 29 different eligibility categories down to 4 eligibility categories.

The key components that Medicaid is focusing on are prevention and health education. Personal responsibility is a big piece of this. This is what our member agreement is about. The importance of establishment of a Medical Home was also stressed.

There will also be a Healthy Rewards Account. The Bureau is doing some market analysis to look at what is valuable to our members and what will help them.

Nancy emphasized that we are not kicking anyone off Medicaid because of Redesign. Everyone who is now on Medicaid will continue to be on Medicaid. We have just changed the benefit packages around these groups. The four eligibility categories are: 1) Children, 2) Adults 65 and older, 3) Adults with Children, and 4) Special Needs Groups. We have created benefit packages around 2 of these groups right now, Children and Adults with Children. The other two eligibility groups have not changed, their services have not changed and what we cover has not changed. At this point we are not proposing any expansions.

Our charge in the Medicaid Commission is to determine what we are going to recommend to Secretary Levitt and President Bush about how Medicaid should look going forward. There has been a lot of conversation regarding universal health care coverage, and also regarding expansion of Medicaid.

In this first phase of the Redesign concept, we are not considering expansions. We need to see what we have created and how well it is going to work before we move on to something else.

Nancy then spoke regarding Flexible Benefits, which is to ensure that participants receive the right care at the right place, at the right time, by the right provider through care coordination. She stated that we are using evidence-based medicine to try to determine our services by scope of severity, so that we can put some parameters around the care based on what evidence-based research tells us. Also, we want to move towards an Electronic Health Record. This will save us all a lot of time and money.

She also spoke regarding the Medical Home, and gave the definition from Senate Bill 4021: A team approach to providing health care and care management. Whether involving a primary care provider, specialist or sub-specialist, care management includes the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, provision of follow-up and support for achieving the identified outcomes. The medical home maintains a centralized comprehensive record of all health related services to provide continuity of care.

The Member Agreement has been the one thing that is so very different in West Virginia than from any other state. The Member Agreement outlines member rights and responsibilities, and if they want to be a part of this plan, then they have to agree to certain things. For example:

- ▶ do their best to stay healthy
- ▶ go to health improvement programs as directed by their Medical Home, i.e. smoking cessation, diabetes education, nutritional counseling
- ▶ read the booklets and papers given by Medical Home and ask questions
- ▶ go to Medical Home when sick
- ▶ take their children to their Medical Home when they are sick
- ▶ go to Medical Home for check-ups
- ▶ take children to their Medical Home for check-ups
- ▶ take the medicines that are prescribed
- ▶ show up on time for appointment
- ▶ bring children on time
- ▶ call Medical Home when they can't keep appointment
- ▶ let them know if there is a change of address or phone number
- ▶ use the hospital emergency room for emergencies

Nancy stated that this plan was not put together for cost containment. We did this because we want to improve the outcomes and coordinate the care better. We do have a four year implementation plan, but right now we are starting with our healthy children and adults with children. Nancy did a walk-through of how this might work. For example, someone goes in to determine eligibility, and they get on Medicaid. They will be sent information which managed care organization they might want. Then they get a choice of which Medical Home they want. If they don't choose an MCO, we choose it for them. If they don't choose a Medical Home, we choose it for them. This is where the member agreement gets signed.

If you are able to meet your health goals, then there is a healthy rewards account. That is how we reward people for being able to stick with their health plan. We are still in negotiation with the feds regarding how that is going to look, as we have to be very careful not to give them money that would knock them out of their food stamps. Each quarter the member will get points deposited into their account to buy services that normally would not be covered on Medicaid.

If someone chooses not to sign the member agreement, and that is their choice, they would get Basic Services. For children the difference between Basic Services and Traditional Medicaid is two things, podiatry care and chiropractic care. We have not seen any medical evidence that says that chiropractic care and podiatry care are appropriate for children. That's what they lose in basic services. If they sign an agreement and get enhanced services, some of the things they will get are additional educational training, nutritional counseling, weight management, and unlimited prescriptions.

We are trying to encourage people and change health behaviors and give people rewards for moving in the right direction. This is why we are starting with our healthy children and adults with children, to try to find out if we can move in that direction. We will probably not see cost savings immediately, but maybe down the road. However, this was not the intent. The intent was to change the direction to get some more personal responsibility into the Program.

Nancy stated that we are starting in three counties, Clay, Upshur and Lincoln.

Gerry Stover asked a question regarding a report called Process for Regress for Medicaid Patient in the New Plan. Gerry's question is, if we are going to move someone from the Traditional Model down to the Basic Pan, and the recipient wishes to challenge this, would there be a process for those individuals? The answer is that there is an appeal process.

There were numerous questions regarding the Medicaid Design Program.

Violet Burdette asked if there was any more new business. Jesse Samples wants the topic of Citizenship addressed, which deals with Medicaid recipients under the Deficit Reduction Act (DRA). Nancy said we have been working on this diligently. The guidelines came out the first week of June, and will be implemented July 1, 2006.

OLD BUSINESS

Financial Report

Leonard Kelley said that Unisys delivered the MARS files June 22, 2006, and we are in the process of reconciling. A series of reports have been run, and these are being reconciled to make sure everything in the system balances, and to make sure that the data in the system is reliable. We are hoping to provide some new reports for the July interims. This can be made available once we get these produced.

Jesse Samples asked if the reports can be e-mailed to the Committee.

Leonard stated that we are in the black, and appears we are going to carry monies forward.

Nancy said that one of the issues we may need to bring up is another initiative by the federal government on provider taxes. They are looking at reducing provider taxes to a ceiling of 3%. We have some nursing homes that are close to 6%, but that would be 1% per year over the next three years. Nancy stated that this is pretty much our dedicated revenue source, so if it does get reduced there will be a huge crisis. Leonard Kelley said that the provider tax is somewhere between 35 to 45% of the total general revenue appropriation to Medicaid.

E R Visits

Because of prior authorizations for outpatient surgeries, there was a concern that there may have been a rise in people being sent to the ER to avoid the prior authorization process. Therefore, Pat Miller said there was a report run based on dates of service for ER Visits. Pat said that in looking at the report, it looks fairly consistent. There were 18,581 in October, but if you look back to July 2005, there were 18,609.

There was then a discussion regarding ER visits. The following comments were made:

- ▶ Mike Robbins inquired if these ER visits are for just the fee-for-service population. Pat said this is correct, that it does not include any managed care. Mike then said that what has happened over this period of time, there has been an increase in the number of people covered under the managed care programs. If in your fee-for-service population the ER volume is remaining fairly constant, however the number of enrollees has gone down, because more are now in managed care. In fact the number of visits for each of the remaining fee-for-service patients has gone up. He said that is the concern he was expressing, and this would confirm it.
- ▶ Mike then requested to see the Managed Care enrollees in June 2005 versus June 2006. He said his sense is that we have added thousands to the managed care enrollees, particularly with the expansion of Unicare, but yet the ER visit volume hasn't gone down.
- ▶ Dr. Ayoubi added that the other alternative is to provide the Committee with the number of enrollees for fee-for-service, as well as the number of the visits and extract the percentage.
- ▶ Mike commented that he gets annual data that goes to the Health Care Authority, and ER volume is not going down. It continues to grow with the Medicaid population, which would be both in the traditional plan as well as the managed care combined.

In conclusion, Pat Miller said that the concern was that there would be an increase of ER visits because of the authorizations that were put in place in October 2005. Basically, in looking at this data, we don't see any unusual spikes in ER visits.

Outpatient Prior Authorization

John Marks circulated a summary report to the Committee. This gives a general update on some of the approval / denial rates by service area, related to the prior authorization work performed by WVMi. There is a particular interest in taking a look at some of the outpatient services, given the fact that over the last six to nine months a couple of significant events have occurred:

- 1) Change in review criteria that has been adopted by the Bureau, and
- 2) Some additional services covered under the Medicaid Program that previously did not require prior authorization.

Material that John is presenting conveys two periods of time. Information is presented for calendar year 2005, including information that reviews the numbers of reviews deducted and the approval / denial rates for the six months ending June 2006. One of the events that has occurred this past 12 months was the Bureau's decision to proceed with the use of the InterQual review criteria as the basis for conducting review. WVMI started utilizing InterQual for inpatient review activity in September. Imaging, which is a new service area, which previously had not required prior authorization, went on line in October of 2005. WVMI began reviews for various outpatient surgical procedures in February, and we expanded the review work for DME related items in March 2006.

The third sheet of the report identified service area, and compares approval / denial rates for those two periods of time, 12 months 2005 versus 6 months 2006. John indicated that there were some increases in the denial rates for inpatient review volume. There has also been a noticeable decline in the numbers of requests received for inpatient hospitalization services. All of this deals with the Medicaid fee-for-service population.

Items entitled Imaging and Outpatient Surgical, represent two of the new service areas that require prior authorization. John indicated that it was reported early on in the implementation of the imaging review that a couple of events surprised us:

- 1) The volume of imaging reviews was significantly higher than they had projected or the Bureau had anticipated.
- 2) There is also a significant denial rate for those imaging procedures.

Regarding Outpatient Surgical, John indicated that we have not seen a significantly high denial rate in the numbers of outpatient surgical procedures that WVMI has reviewed.

There was a question as to whether the increase on the inpatient denials has to do with a learning curve related to using the InterQual. John stated that the InterQual criteria is stricter than the previous criteria utilized by WVMI, so there will be some tendency to deny. Shelley Baston explained that the first couple of months after we implemented InterQual, the denial rate more than doubled, just in the first two months, however, now we are starting to see a decline in the denial rate.

John stated that on the fourth sheet, because Imaging and Outpatient Surgical represented new service areas, there are some very high denial rates, particularly on Imaging. What he has identified here are the particular procedures where there is a significantly high, between 35% and 50% of the request that come in for those particular scans, not meeting medical necessity review. John said they understood that the Imaging review activity was going to be very new for the provider community. A couple of steps have been taken that would help inform providers about what basic information was necessary in order to complete a review. Reference was made to smart sheets, which are documents that will essentially identify the clinical information required in conducting the review.

NH / Hospice Services

Leonard Kelley stated that in researching what other states are doing and how they are paying hospice for nursing home services, we discovered that there are some variations in what CMS approved in different regions around the country and different states. We decided to send our draft policy to CMS to review, so we have their blessing before a policy manual is released.

Appointment / Reappointment of Council Members

Shelley Baston stated that there are four members of the Advisory Council who need alternates: Scott McClanahan, Mark Ayoubi, M.D., John Russell, and the Consumer Representative.

Scott McClanahan's said his alternate is Dinah Mills, Executive Director from Lewis County Senior Citizens Center, Inc.

Mark Ayoubi, M.D. – Shelley indicated that we should be fine the way it is, because we have Michael KilKenny and his alternate, which is Gerry Stover, who are Physician Representatives.

John Russell was not in attendance.

Shelley advised that our past Consumer Representative notified us that she did not want to continue as a member. We contacted the Health Care Authority, and Violet Burdette contacted the Primary Care Association, however, no response as of yet. Shelley said that she would appreciate any suggestions on how to get a member representative.

Also, we have four members whose terms are about to expire on August 31, 2006, and we need to know if they would like to continue. Scott McClanahan and Dr. KilKenny indicated they would continue as members, Shelley said that we would get their reappointment letters to them. Also, we will contact Mark Ayoubi, M.D. and Larry Robertson, and if they desire to continue their membership, we will get reappointment letters to them also.

Next Meeting

The next meeting of the Medical Services Fund Advisory Council will be held on October 13, 2006, at 1:30 p.m., at Kanawha Valley Senior Services.

Minutes Respectfully Submitted By:

Pat Johnson
Secretary