MINUTES
MEDICAL SERVICES FUND ADVISORY COUNCIL MEETING
OCTOBER 25, 2013

Members and Alternates Present
Nancy V. Atkins, Bureau for Medical Services
Charles Covert, Chairman, Hospital Representative
Carol Haugen, Hospital Alternate
Marshall C. Long, Vice Chairman, Physician Representative
Thom Stevens, Physician Alternate
Mark Drennan, MH/BH Representative
Patrick D. Kelley, Nursing Home Representative
Ralph Daniel Adkins, Consumer Representative
Cassie Long, Alternate for Ron Stollings, Senate LOCCHRA Chair
Louise Reese, Primary Care Representative
Charles L. Smith, Dental Representative
Richard Stevens, Dental / Pharmacist Representative

Bureau for Medical Services Employees Present
Alva Page III, General Counsel
Tina Bailes, Deputy Commissioner, Finance
Cindy Beane, Deputy Commissioner, Policy
Penney Hall, Communications Manager
Emily McCoy, Director, MMIS Operations
Julia Caton, Legal Secretary II, Bureau for Medical Services
Susan Harman, Legal Counsel

Interested Parties Present
M. J. Pickens, Spilman / HMO Association
Helen Snyder, APS Healthcare
Benita Whitman, LAWV
Donna Sand, Highmark WV
Todd White, Aetna
Tim Smallridge, Aetna / Coventry
Nancy Tonkin, WV Phys. Ther. Assn.
John D. Law, Rain Maker
Nicole Becnel, Berry Dunn
Amanda Hiser, Molina
Evan Falks, WVSMA
Renate Pore, WVAHC
Megan Roskoveasky, Law office of Phil Reale
Brian Cunningham, Lewin
Phil Shimer, TSG
Perry Bryant, WVAHC

Welcome and Opening Remarks
Nancy Atkins, Commissioner, Bureau for Medical Services welcomed everyone to the meeting and then turned it over to Chairman Charles Covert.

Approval of Minutes
There are three sets of minutes to approve: July 12, 2013, which was our regular meeting; and two special meetings which are August 2, 2013 and September 13, 2013.

- A motion was made and seconded to approve all three sets of minutes. All were in favor.

Health Care Reform
Commissioner Atkins gave an update on Health Care Reform.

Early Enrollment: In the middle of August we sent letters to all of the SNAP food stamp recipients, to the parents of children on Medicaid and CHIP. 118,000 letters were sent out, and we have received back about 60,000 of those letters, and are enrolling them into Medicaid. A second mailing is planned in a couple of weeks.

Commissioner Atkins also advised that if people are having problems with this process, to go to their county office to get assistance with this process.

Policy Update
Deputy Commissioner Cindy Beane presented the policy update:

- The Personal Care Chapter policy manual will be going on our website next week. The trainings are already scheduled and the personal care providers have been notified when the trainings will be held. The effective date will be 1/1/2014.

- There will be policy announcements and training around hospital based presumptive eligibility. BMS has been working closely with Hospital Association.

- An internal workgroup has been working on our Behavioral Health Rehab Manual Policy chapter, and it is in the final stages.

- Deputy Commissioner Beane informed the group of the Three Branch Initiative, which is focusing on our foster care children and our kids in custody.

Communication Update
Penney Hall, BMS Communication Manager, stated there was nothing to report. BMS is trying to keep the website up to date and launching our face book page

Finance Update
Deputy Commissioner of Finance, Tina Bailes, presented the financial update.

Eligibility Enrollment
- SFY 13 our membership decreased about 4,200 members, roughly 1% decrease over the previous fiscal year
- Current average monthly trend through September is approximately .2% higher than where we were this time last year

- There are some increases in the children category and aged groups and slight decrease in the disabled population. Overall we are pretty much flat in terms of the comparison of where we are today currently verses where we were this time last year.

Current Medicaid Report

- Current expenditures are trending below our budget estimate, but we expect to close that gap. We are reprocessing related to the primary care enhanced payment. Our budget estimate included those payments being in effect in July and August. We are starting the reprocessing there so we expect that to show up in future months, as well as some of the timing of the payments, and how we estimated those, so we are making some adjustments on those.
- To give some comparison to SFY 13, we were within 1.8% of our budget estimate in terms of our actual expenditures.
- The YTD medical expenses are trending 10% higher than we were last year.
- Seeing decrease in pharmacy expenditures and rebate collection, which are due to an increase in our generic verses dispensing rates over this year.
- Seeing an increase in MCO payments.

Updated six year Medicaid Projection

- In the approved budget Medicaid received $142 million dollars in additional funding to support the program this FY. Due to some legislative technical issues and some state overall budgetary, we are going to have to ask for some additional supplemental funding.
- There was $50 million lottery surplus funding that was approved in the budget. We will receive about $21 million of that and the remainder we will have to receive under supplemental appropriation.
- Through executive order there was $17.7 million that was used for the state in terms of reduction in the Medicaid budget.
- We are projecting a $20 - $21 million dollar deficit. We have requested supplemental funding to bring us back to zero.
- We are able to use our surplus money that was carried over from previous FY and our trust fund balance, so there has been no impact in terms of the operation of the program or on provider payments at this point.
- Effective October 1, 2013 our Federal Match Rate declined from 72.04% to 71.09%, which is almost a 1% drop in our federal match rate. That means we will need an additional $30 million in state monies to offset that loss in federal funds. The good news is that preliminary match for 2015 is showing we will increase. It is projected now to increase to 7.35%.

Information Technology Update

Deputy Commissioner Ed Dolly presented the Information Technology Update.

- Data Warehouse Initiative is still on track to go live in the first quarter of next year
- Regarding the new contract of the MMIS Operations which began in January, we are still on the design development implementation phase of that and it is going very well. There has been no slippage in the schedule.
- Our partner for the eligibility system is Deloitte, and they did a very good job of insuring that WV responsibility for the Affordable Care Act was where it needed to be. Federal participation not withstanding West Virginia has been recognized by CMS as a leader in that and a success story.

State Plan Amendments

Alva Page III presented the state plan amendments. He suggested that after each SPA is presented, that we take any comments at that point.

- Special Payments to Prospective Payment System (PPS) Hospitals
  In this SPA the language never changes, just the amounts. Distribution amount per SFY for these PPS hospitals is $15,652,629. Last year that amount was $16,135,179, so it went down about $500,000. For the rural hospitals it is $8,063,475, and the year before it was $8.3 million. On the last page 24C, distribution amounts for each SFY 2013 for these safety net hospitals will not exceed $22,167,582 for tertiary and $9,053,972 million for rural. For last year the tertiary was $22,850,000 and the rural hospital last year was $9,300,000.

  There was a motion and a second to approve this one. All were in favor.

- Cardiac Rehabilitation / Pulmonary Rehabilitation
  Cardiac Rehabilitation and Pulmonary Rehab are only found in our benchmark plan. When we submit our ABP SPA, we have to remove the benchmark plan, which means these services go away, so we have to submit these state plans to have these services provided. The definition in here is what is in our manuals currently.

  There was a motion and a second to approve these plans. All were in favor.

- Cost Sharing Charges
  Alva Page III reviewed Attachment 418-F which is a preprint from CMS and broken down in the following groups: A) For groups of individuals with family income at or below 100 percent of the FPL, B) For groups of individuals with family income above 100 percent but at or below 150 percent of the FPL, C) For groups of individuals with family income above 150 percent of the FPL, D) Period of determining 5 percent aggregate family limit for premiums and cost sharing, E) Method of tracking beneficiaries' liability for premiums and cost-sharing, F) Public Notice Requirements. He also reviewed Attachment 4.18-A, which is for the categorically needy and Attachment 4.18-C, which is for the medically needy. BMS is having weekly calls with CMS on how to deal with this.

  Commissioner Atkins clarified that there are some people who are exempt from this. You can find the exemptions on Attachment 4.18-A, under D) The procedures for implementing and enforcing the exclusions from cost sharing contained in 1916(a)(2) and (j) of the Social Security Act 42 C.F.R. 447.53(b).

  Mr. Dolly explained that we are working on a web portal so that when the provider would look for a member, it would say what the tier would be and what co-pay the member would have.

  Much discussion ensued regarding co-pays.

  A motion was made to table this until the next meeting, so that physicians and patients can be polled about this. Motion was seconded.

Commissioner Atkins stated we will be putting this up for comment on Monday, and encouraged everyone to comment. She needs to know what information the Council needs in order to help make this decision. We will have to have a special meeting as this has to be submitted between now and January 1, 2014.

A motion was made that we table this for two weeks and then have a special meeting regarding co-pays. Motion was seconded and all were in favor.

A conference call will be set up for November 8, 2013 for the Special Meeting. People may also attend the meeting in person if they choose.

A question was asked if we could put the co-pays in for 100% and above FPL, and not below 100% FPL. Commissioner Atkins said it could be crafted that way, but they would have to have conversations with CMS. The decision was made to wait for two weeks until the special meeting to make any decisions.

- FMAP
  Deputy Commissioner Bailes reviewed the SPA and clarified that what this state plan amendment does is it allows us to draw down the enhanced federal match for the new expansion population. We are currently waiting on the MAGI Conversion Plan Phase II, and it is about our disability groups and how they currently qualify.

  Children aged 19 and 20, the reason it is indicated as not covered is those individuals today would have to qualify in one of the adult categories, whether it be the parent, caretaker, relative groups or one of the disability groups. So basically there is just assertions that says that the state's not going to apply the additional standard in determining how to do that. We are not a state that has elected to cover this group early under a demonstration waiver, so we are just certifying that we don't currently serve this group, and that we have no special circumstances, and that we do not have an 1115, so therefore we would not be considered an expansion state.

  A motion was made and seconded to approve this. All were in favor.

- Presumptive Eligibility by Hospitals
  Alva Page III, reviewed this SPA with the council. There was a question about the second 75%, which reads, "The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period".

  Deputy Commissioner Beane said we are still taking the second 75% into consideration. We have asked the Hospital Association to give us some comments on that second standard on that 75%. We have talked with CMS, and while they do say that it is more option, the likelyhood of zero percent being in there and approval is probably not going to happen. We are going to ask the Hospital Association to comment on that second standard and give us additional feedback.

  A motion was made and seconded to approve this SPA. All were in favor.

- Alternative Benefit Plan Draft
  Alva Page III reviewed this with the council. Included in the draft were these SPA's:

  - Alternative Benefit Plan Populations – ABP1
  - Voluntary Benefit Package Selection Assurances – ABP2a
    Deputy Commissioner Beane clarified what the ABP2a says is that if you are medically frail, you can attest, and there has to be capability for you to opt to the traditional plan verses the alternative benefits
  - Enrollment Assurances – Mandatory Participants – ABP2c
  - Selection of Benchmark Benefit Package for Benchmark-Equivalent Benefit Package – ABP3
  - Alternative Benefit Plan Cost-Sharing – ABP4
  - Benefits Description – ABP5
  - Benefits Assurances – ABP7
  - Service Delivery Systems – ABP8
  - General Assurances – ABP10
  - Payment Methodology – ABP11

  The comment period will be a short one. It will go up on Monday and be up until November 15, 2013.

  - There was a motion made and seconded to approve the Alternative Benefit Plan Draft. All were in favor.

The Council will have a special meeting on November 8, 2013. Meeting adjourned.

Minutes submitted by:

Pat Johnson, Secretary II
Bureau for Medical Services