



West Virginia Bureau for Medical Services

State Fiscal Year 2014 Annual Report



**STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES**

**Earl Ray Tomblin
Governor**

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**Karen L. Bowling
Cabinet Secretary**

The Bureau for Medical Services (BMS) is dedicated to ensuring West Virginians have access to the best health care services possible.

During the first two quarters of 2014, BMS focused on promoting the expansion of Medicaid and ensuring the supporting systems and structures were in place to enroll individuals. On January 1, 2014, the West Virginia Medicaid program began serving individuals between the ages of 19 and 64 with incomes below 138% of the Federal Poverty Level. This is the first time Medicaid has provided services to adults without children, a demographic that previously received services only due to disability or age. From January 1 to June 28, 2014, this expansion group accounted for 130,334 people. Many of these individuals were either previously uninsured or underinsured.

Once individuals were enrolled, BMS turned its focus to educating members on how Medicaid works and encouraging more cost effective access to medical services through primary care physicians instead of emergency rooms. BMS also began including children's dental services in its managed care program, Mountain Health Trust.

BMS also began to charge co-payments for some services and implemented Hospital-Based Presumptive Eligibility, which allows Medicaid-approved hospitals to determine individuals likely eligible for Medicaid.

On behalf of the West Virginia Department of Health and Human Resources, it is my pleasure to present the State Fiscal Year 2014 Bureau for Medical Services (BMS) Annual Report.

Cynthia Beane
Acting Commissioner

Mission Statement

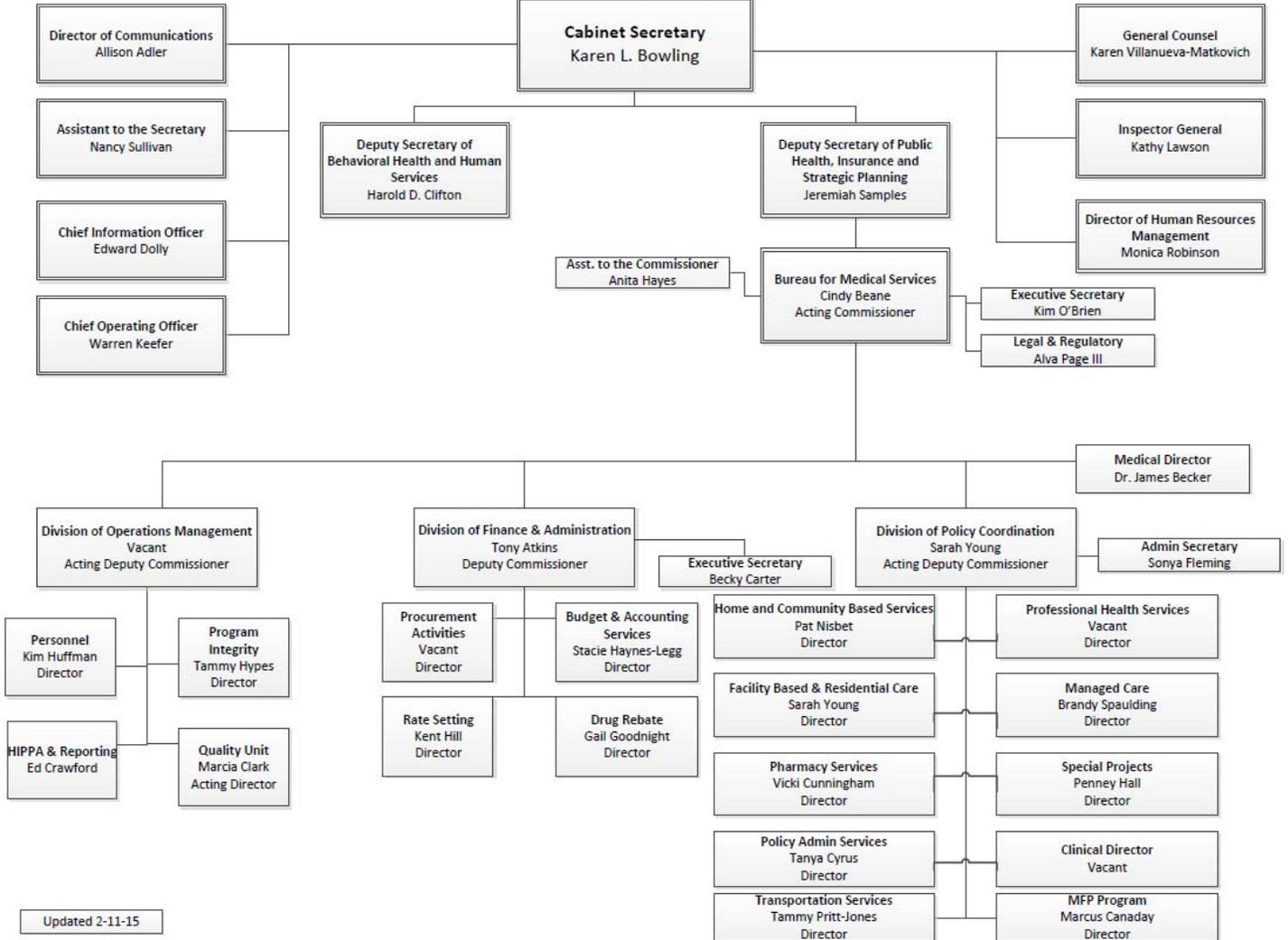
The Bureau for Medical Services (BMS) is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate, medically-necessary, and quality-driven health care services for all members. BMS will provide these services in a user-friendly manner to providers and members alike and will focus on the future by providing preventive care programs.

Goals for State Fiscal Year (SFY) 2015

- Continue to help reduce the uninsured rate in West Virginia.
- Improve the quality of services and promote primary care as a source of health outcome improvement.
- Conduct a thorough review of the Medicaid program to identify cost inefficiencies and work to correct any issues identified.
- Promote the integrity and accountability of the health care delivery system.
- Work with our partners to integrate physical and behavioral health into a single care model and expand the managed care program.
- Streamline waiver programs to be more efficient and beneficial to West Virginians.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Medical Services



Updated 2-11-15

A History of the West Virginia Medicaid Program



In 1965, the United States Congress passed and President Lyndon B. Johnson signed into the law the Medicaid program under Title XIX of the Social Security Act. The Medicaid program was created as a federal-state partnership in which the federal government provides matching grants to states to finance care for children, the aged, blind and/or disabled, and individuals receiving federal income maintenance payments and assistance. Each state operating a Medicaid program must designate a single state agency to administer or supervise the program

according to SSA 1902(a)(5); 42 CFR 431.10. The West Virginia Department of Health and Human Resources' Bureau for Medical Services was appointed as the single state agency responsible for the administration of the Medicaid program.

With the implementation of the Affordable Care Act of 2010, signed by President Barack Obama, states were given the opportunity to expand Medicaid to include individuals between the ages of 19 and 64 that were below 138% of the Federal Poverty Level (FPL). On May 2, 2013, Governor Earl Ray Tomblin announced the expansion of West Virginia's Medicaid program.

In SFY 2014, Medicaid served as the primary health insurance provider for more than 550,000 West Virginia citizens, nearly one-third of the state's population. The Office of Medicaid Management Information System processed over 15 million claims to approximately 23,000 qualified Medicaid providers, including inpatient/outpatient hospital services, physician visits, emergency room services, prescription drugs, and behavioral health services.

Bureau for Medical Services Achievements of Fiscal Year 2014

Medicaid Expansion

The Affordable Care Act (ACA) of 2010 gave states the option to expand their Medicaid programs to include individuals between the ages of 19 and 64 who have incomes at or below 138% of FPL.

Following Governor Tomblin's May 2013 expansion announcement, the Bureau for Medical Services (BMS) and the Department of Health and Human Resources (DHHR) immediately began to prepare for the October 1, 2013 open enrollment period. BMS requested and received several waivers and submitted more than 10 State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS) in late summer 2013.

BMS received a waiver from CMS which streamlined the eligibility process for individuals who were already known by the state to have incomes at or below the 138% FPL threshold. These individuals were either participating in the Supplemental Nutrition Assistance Program (SNAP) or had a child(ren) enrolled in Medicaid. Approximately 70,000 individuals were enrolled through this auto-enrollment process, thus alleviating a burden on the system and staff resources.

Another major change within Medicaid under the ACA was the eligibility determination methodology. For almost all individuals applying for Medicaid, eligibility determinations are now based on an individual's Modified Adjusted Gross Income (MAGI) for a tax household. MAGI is based on federal tax rules for determining adjusted gross income with some modifications. Household size is determined based on who may be claimed as a dependent on the applicant's federal tax return. Through the end of fiscal year 2014, over 130,000 individuals received Medicaid coverage as a result of the Medicaid expansion.

"I don't know what I would've done without the Medicaid Expansion." — Angela White



Angela White, a recently divorced mother of two, was left with legal fees and a loss of health care coverage after 20 years of marriage. As she was preparing for the Christmas holidays, she discovered a small spot under her eye. She knew it was not a typical blemish; however, without health coverage she didn't make a doctor appointment. As the blemish grew larger, a friend told her about Medicaid Expansion. She contacted the local DHHR office to see if she would qualify; Angela was found eligible and immediately made a doctor appointment.

Angela was informed that the blemish was skin cancer. While devastated by the news, the doctor told her that if she had waited longer, it would have been more difficult to treat. She is very grateful that she was able to receive treatment so quickly through Medicaid.

Hospital-Based Presumptive Eligibility

On January 10, 2014, BMS implemented the Hospital-Based Presumptive Eligibility (HBPE) determination program, which permits qualified hospitals to determine certain individuals presumptively eligible for Medicaid. Qualified hospitals are those hospitals which are enrolled as Medicaid providers, agree to follow HBPE policies, and have trained staff to make HBPE determinations. In SFY 2014, 37 hospitals registered to participate in the program. Hospitals must meet two performance measures in order to continue participation in the program:

- 75% of individuals determined presumptively eligible must complete a full Medicaid application; and
- Of those who complete a full Medicaid application, 50% must be approved for Medicaid coverage.

As of June 2014, 3,667 individuals had been determined presumptively eligible for Medicaid and 1,377 of them had become fully eligible for Medicaid. BMS will begin evaluating hospitals for compliance with performance metrics in SFY 2015 once sufficient data has been collected.

WV Starts Health Homes Pilot Program



The ACA of 2010 gave state Medicaid agencies the option of creating Health Homes to provide a comprehensive system of care coordination for Medicaid individuals with chronic conditions. West Virginia chose to participate in the Health Homes program and will receive an enhanced federal match of 90% for eight quarters.

The Health Homes initiative provides a place for individuals to have their health care needs identified and to receive the medical, behavioral health and related social services and supports they need in a coordinated manner that recognizes all of their needs as individuals and as patients. Health Home services include comprehensive care management, care coordination, health promotion and community and social support services.

West Virginia's program focuses on individuals who have a bipolar disorder and have or are at risk of having Hepatitis B or C. The pilot program involves six counties: Cabell, Kanawha, Mercer, Putnam, Raleigh, and Wayne. In May 2014, Medicaid began enrollment of providers in the targeted counties. Eight providers enrolled as a Health Home: Cabin Creek Health Systems, FMRS Health Systems, Marshall University Health, Prestera Center, Process Strategies, Southern Highlands, WV Health Right and WomenCare, Inc. In June 2014, letters were sent to potential Health Home members with services set to start in July 2014.

The goals of the Health Homes program include:

- Helping members experience longer periods of stability of their condition;
- Decreasing the use of medications and increasing compliance;
- Informing patients of their hepatitis risk and status and educating about its spread; and
- Helping identify substance abuse more effectively and reducing ER visits and hospitalizations.

Non-Emergency Medical Transportation

In June 2014, BMS awarded a contract to Medical Transportation Management (MTM) to serve as a broker for Non-Emergency Medical Transportation (NEMT) services for Medicaid members, except for individuals who need stretcher services (transportation by ambulance). MTM will provide statewide brokering services that include, but are not limited to:

- Screening to determine the appropriate mode of transport;
- Verifying member eligibility;
- Verifying the transportation request is for a covered service with an enrolled provider;
- Scheduling the trip with an enrolled transportation provider; and
- Making provider payments.

MTM began providing services in October 2014. As a result of its contract, BMS anticipates seeing improved access to NEMT services, safer transportation for its members, and a reduction in fraud, waste and abuse. Beyond its quality improvement expectations, the contract also serves as a cost savings measure, with projected average program savings over the life of the contract estimated at \$1.5 million per year.

2014 Changes to Mountain Health Trust



On January 1, 2014, BMS integrated children’s dental services into its managed care program. Over the next two years, BMS will work to integrate behavioral health services and other populations into its managed care program to promote quality and reduce costs.

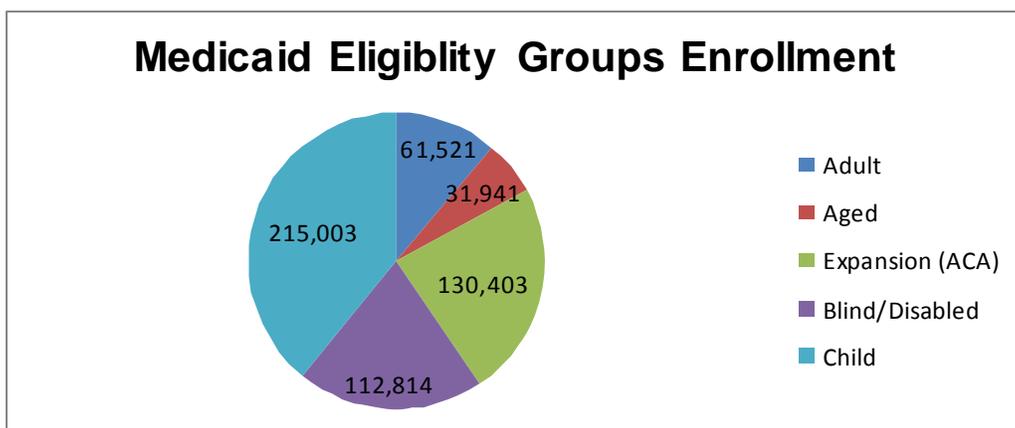
In addition, during 2014, the West Virginia Legislature passed House Bill 4217 requiring Medicaid to report on the performance of its managed care organizations (MCOs). As a result of this legislation, Medicaid will begin to publish an MCO report card on its website using national reporting standards such as:

- Consumer Assessment of Healthcare providers and Systems (CAHPS); and
- Healthcare Effectiveness Data Information Set (HEDIS).

An abbreviated report card will be sent to potential MCO enrollees to assist them in making choices based on quality and performance.

West Virginia Medicaid Program Overview

WV Medicaid served as the primary health insurance provider for more than 550,000 West Virginians, or about 30% of the total population during SFY 2014. In addition to the expansion population, Medicaid continued to provide coverage to the traditional Medicaid population of pregnant women, children, very low income families, aged/blind/disabled and Medically Needy populations. The chart below shows the number of people enrolled in Medicaid by category:



Home and Community Based Services

Home and Community Based Services (HCBS) allow individuals to remain in their own homes and communities with the supports and services they need. There are four basic goals for individuals receiving HCBS:

- To receive quality services that respect personal dignity and choice;
- To decide where and with whom they live;
- To have control over the services they receive and who provides those services; and
- To work, earn money, and have friends and supports to help them participate in community life.

The ten HCBS services include a mixture of optional (waiver services) and mandatory services and one grant program. Below is a brief overview of each of these services.

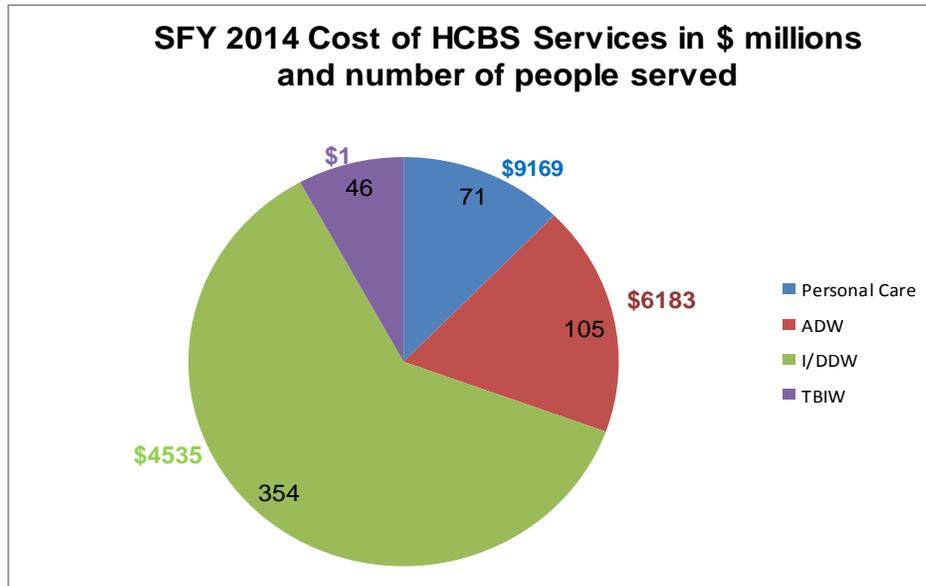
1. Aged and Disabled Waiver (ADW): ADW services are for individuals 18 years of age and older who need a nursing home level of care but choose to stay in their own home. During SFY 2014, 6,183 individuals received services through the ADW program, with 2,079 individuals awaiting services. In SFY 2015, program changes are being made which will accelerate the process of making services available to individuals as soon as a slot becomes available.

2. Intellectual/Developmental Disabilities (I/DD) Waiver: I/DD services are for individuals who have a diagnosis of intellectual and/or developmental disabilities and who have been determined to need Intermediate Care Facility or I/DD Facility levels of care. During fiscal year 2014, the I/DD program served 4,534 individuals, with 1,006 individuals awaiting services. An audit by the Centers for Medicare and Medicaid Services concluded that assurances had been met. In 2014, 82% of providers reviewed had no disallowances, a 17% increase from the previous year.

3. Traumatic Brain Injury (TBI) Waiver: TBI services are provided to individuals at least 22 years of age with a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in the need for a nursing facility level of care. During fiscal year 2014, 46 individuals received TBI services.

4. Personal Care Services: Medically-necessary activities or tasks ordered by a physician, which enable individuals to meet their needs in their homes rather than as a hospital inpatient or nursing home resident. In SFY 2014, 9,169 individuals received services.

The chart on page 6 shows the SFY 2014 costs of these four services.



5. Hospice: Hospice services provide a continuum of home and inpatient care for the terminally ill patient and family and/or significant other during the final stages of life and bereavement. In SFY 2014, 478 individuals received services at a cost of \$27.18 million.

6. Home Health: These services are medically-necessary services such as skilled nursing; home health aides; physical, speech, occupational and other therapeutic services; and nutrition services on a part-time or intermitted basis. Home Health services were provided at a cost of \$45.90 million to 7,652 individuals in SFY 2014.

7. Private Duty Nursing: Services are provided to members under 21 years of age who are in need of face-to-face skilled nursing that is more individualized and continuous than the nursing that is available under the Home Health benefit or routinely provided in hospital or nursing facilities. In SFY 2014, 362 individuals received services at a cost of \$6.33 million.

8. Behavioral Health Services: During SFY 2014, 60,544 members received behavioral health services at a cost of \$195.45 million. Services include behavioral health clinic services, behavioral health rehabilitation, psychiatric services, psychological services, and targeted case management provided in the community.

9. Children with Disabilities Community Services: This program provides services to children with severe disabilities and is an alternative to institutionalization. In 2014, 92 children were served.

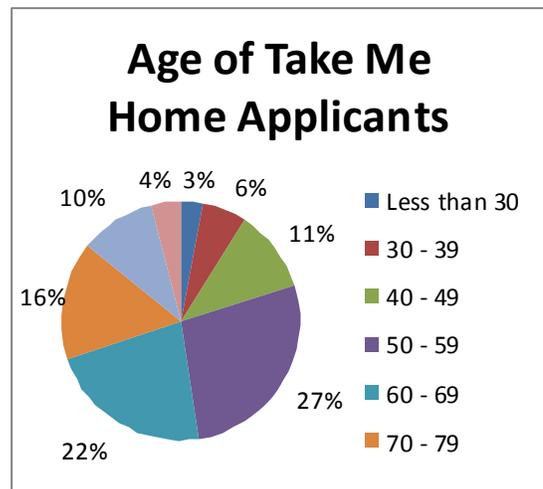
10. Take Me Home, West Virginia: This federally-funded Money Follows the Person Rebalancing Demonstration Grant program assists qualifying individuals with disabilities and the elderly move from a long-term care facility to a home in the community.

Take Me Home participants receive supports from existing HCBS programs or the Supported Housing program operated by the Bureau for Behavioral Health and Health Facilities. Participants also qualify for the following services (see page 7).

- Transition Navigators who work one-on-one with participants and/or legal representatives to develop a transition plan into the community;
- Community Transition Services, a one time service to facilitate the move home, including services such as moving expenses and rental deposits;
- Extended Direct Care Services that allow participants to extend their use of certain waiver and State Plan services, such as requesting additional hours of direct care services;
- *Take Me Home* goods and services are those not provided by Medicaid that address a need within the transition plan, such as assistive technology; and
- Supported Housing which is available only to participants transitioning from an institution for mental disease. This is partnered with community mental health services.

	SFY 2013*	SFY 2014
Number of applicants	122	157
Number found eligible for <i>Take Me Home</i>	110	156
Number found ineligible for <i>Take Me Home</i>	3	5
Number of Transitions Back to the Community	6	47
Pending applications	9	5

*These numbers represent the start of the program in February 2013 to June 30, 2013.



“Being home is the best thing in the world.” — Robin Brown



Sometimes it is the simplest things in life that bring happiness. For Robin Brown, that includes taking a bath whenever she wants. Mother, Treva Wilcoxon, and daughter, Robin, agree the lack of independence and privacy was what they missed the most while living in a long-term care facility.

They learned about *Take Me Home, West Virginia* from the facility’s social worker and began meeting with a *Take Me Home* Transition Navigator to plan a safe transition back into their community.

Treva and Robin were in their new home in time for Robin’s birthday. Treva helps her daughter do the things she cannot do independently and Robin returns the favor to her mother by doing the same. The transition navigator helped them find a place to live and the program provided essential household furnishings and the other supports necessary for them to live independently. They are now a part of their community and are often found at church, shopping or visiting with friends. Perhaps Robin states it best: “Being home is the best thing in the world.”

WV CARES Program: Protecting Members in Long-Term Care

Millions of people in the United States, particularly the elderly and disabled, experience neglect, abuse and exploitation every year by their caregivers whether in the home or in a long-term care facility. The West Virginia Clearance for Access Registry and Employment Screening (WV CARES) is a new program that is helping protect Medicaid members receiving long-term care services.

The Federal Nursing Home Reform Act, under the provision of the Omnibus Budget Reconciliation Act of 1987 (OBRA), set forth new provisions for Medicare and Medicaid to establish new standards for care in long-term care facilities. The purpose of the Act was to bring a measure of quality assurance to the long-term care facility industry to improve the caretaker's role and contribution in a long-term care facility.

The Affordable Care Act (ACA) of 2010 created a structure for a nationwide program to conduct background checks on a statewide basis on all prospective direct patient access employees. The ACA also expanded the definition of long-term care (LTC) to include not only nursing homes but also in-home LTC providers such as home health, personal care, hospice, skilled nursing facilities, Medicaid waiver providers and intermediate care facilities for individuals with intellectual or developmental disabilities.

The Centers for Medicare and Medicaid Services awarded more than \$50 million to 25 states, including West Virginia, to create a comprehensive national background check program for direct patient access employees. The awarded grant funds are used to support an advisory committee, test the automated system with select provider groups, and train providers in the use of the system prior to the program's full implementation.

Before an individual may be employed with any LTC provider, they must be cleared through a fingerprint-based criminal background check (state and federal) and required registry checks. Providers will be able to access the web-based WV CARES system to conduct the required registry checks. Pilot provider testing was scheduled for November 2014, with full system rollout in early 2015.

Implementation of this comprehensive background check system requires the passage of the WV CARES Act, which will be introduced during the 2015 West Virginia Legislative session. This legislation is needed to authorize the WV Department of Health and Human Resources (DHHR) to receive and review the criminal background check results of LTC providers' potential employees. With the anticipated passage of the WV CARES Act, the web-based system will be expanded to allow for automated notification of an individual's employment eligibility based on the fingerprint-based background check results. In addition, a potential employee's fitness determination will be available for a specified number of years, reducing the number of repeat background checks and saving money.

Managed Care

Mountain Health Trust (MHT) is West Virginia’s Medicaid Managed Care program. The Bureau for Medical Services (BMS), Office of Medicaid Managed Care, initiated a risk-based managed care program for certain groups of Medicaid recipients in September 1996. In SFY 2014, the Bureau had contracts with three managed care organizations (MCOs) for the provision of medically-necessary services currently provided by the State, with the exception of behavioral health, long-term care, and non-emergency medical transportation services.

The MCOs under contract with BMS are Coventry Health Care of West Virginia, The Health Plan of the Upper Ohio Valley, and Unicare. In SFY 2015, West Virginia Family Health will enter the market as a fourth participant. As of July 1, 2014, Mountain Health Trust had a total enrollment of 203,157 members. On July 1, 2014, the State also implemented a withhold provision for its managed care rates as a measure to increase quality of services prior to receiving full capitated payment. An evaluation of this measure will be presented in the subsequent annual report.

BMS contracts with Delmarva to develop an annual performance analysis on the State’s MCOs and provides recommendations for improvement projects.

Presented below is an analysis of how West Virginia’s MCOs performed in comparison to 131 ranked plans and an overview of how the analysis was developed. The National Committee for Quality Assurance (NCQA) builds confidence intervals on the difference between plan rates and a measure’s mean.

	Coventry 2013-2014	Health Plan 2013-2014	UniCare 2013-2014
Rank	125	44	76
Total Score (max points = 100)	63.2	80.9	78.8
Accreditation Level (15% of points)	None	Commendable	Commendable
Consumer Satisfaction (25% of points)	3	5	3
Prevention (60% of points)	3	3	3
Treatment* (combined with prevention for points)	I	I	I

- A plan that is significantly higher than the mean and in the top ten percent of plans gets a 5.
- A plan that is significantly higher than the mean and in the top third of plans, but not in the top tenth, gets a 4.
- A plan that is significantly lower than the mean and in the bottom 10 percent of plans gets a 1.
- A plan that is significantly lower than the mean and in the bottom third of plans, but not in the bottom 10 percent, gets a 2.
- A plan that does not fall into any of these groups gets a 3.

Delmarva also conducts an annual compliance review, even though the regulations only require this review every three years. The MCOs are evaluated against standards in the External Quality Review EQR Regulations and their MCO contracts. The four major categories include Enrollee Rights, Grievance Systems, Quality Assessment and Performance Improvement, and Fraud and Abuse. All MCOs had passing compliance scores.

Physician Assured Access System

West Virginia has operated the Physician Assured Access System program under a 1915(b) waiver from the Center for Medicare and Medicaid Services since 1992. Currently, there are approximately 3,017 Medicaid members enrolled in the program.

The design of the program is formulated to enhance access to medical care and to coordinate the health care needs and services of the member, while managing cost and ensuring quality care. Through assigning responsibility for coordination and continuity of care to a primary care provider who accepts the responsibility of directing all aspects of patient care, the patient-provider relationship is formed and a medical home is established. The State hopes to achieve desired levels of access, quality, cost savings, and satisfaction.

Financial Overview

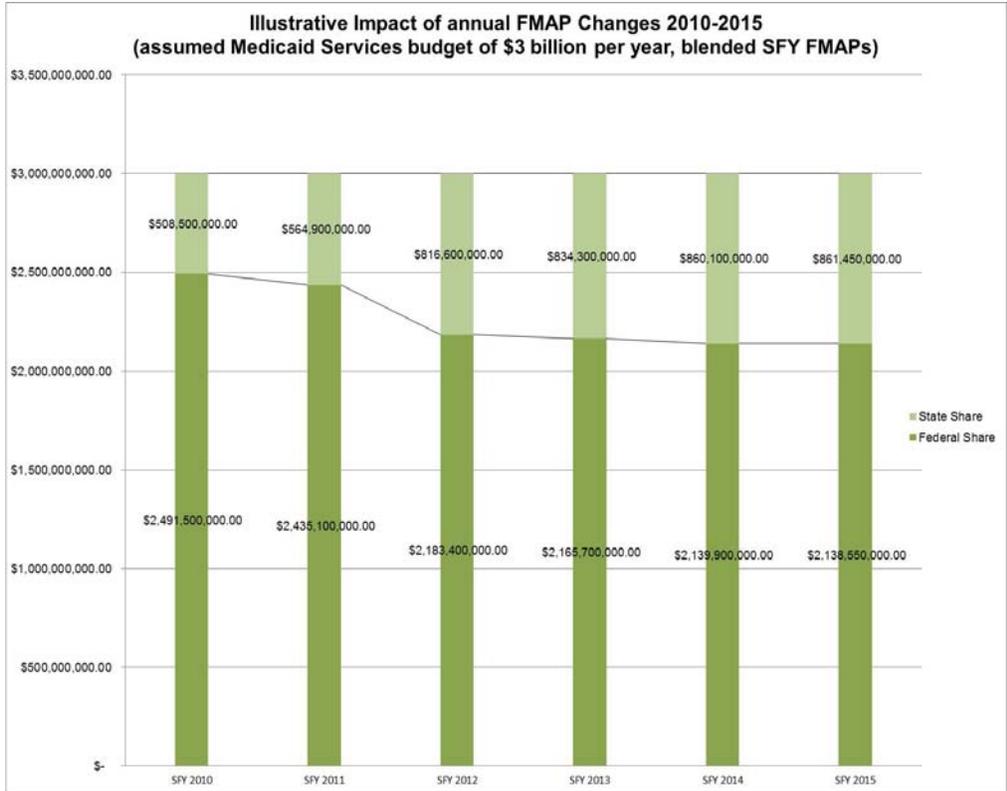
Medicaid Finances

Medicaid is a jointly funded federal and state program. The federal share of funding is based on the Federal Medicaid Assistance Percentage (FMAP), which is updated each federal fiscal year (October 1 to September 30).

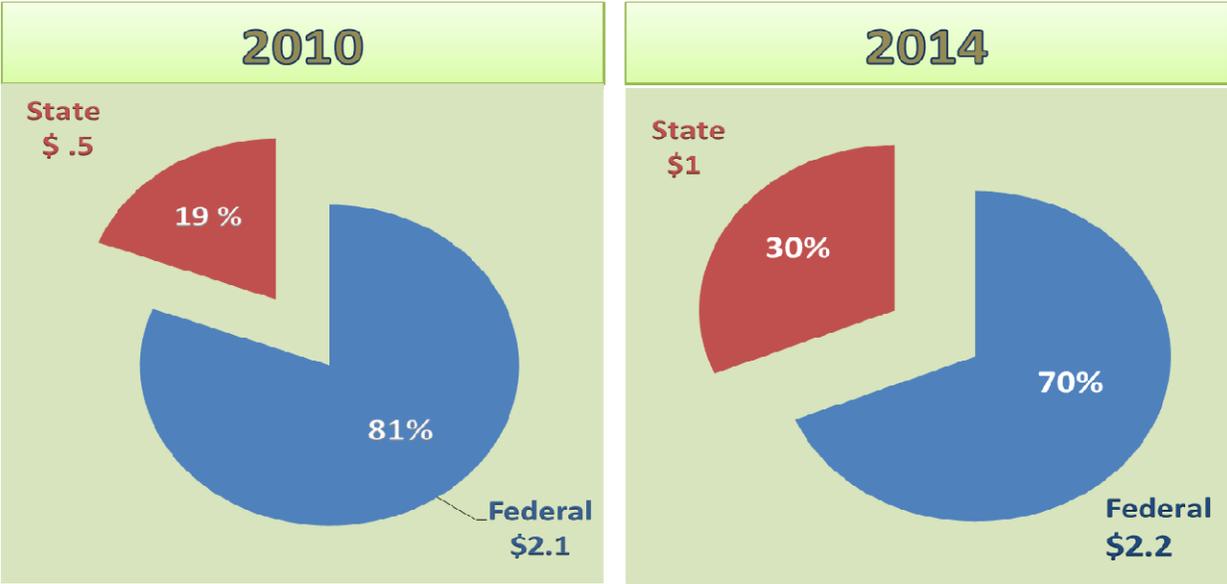
As can be seen in the chart below, West Virginia saw an increase in its FMAP during federal fiscal year 2010 and 2011 when the federal stimulus program was in place. As the federal stimulus program came to an end, the WV FMAP rate decreased.

The FMAP rate for the state's expansion population is 100% for its first three years (2014 to 2016), and then decreases in each subsequent year until reaching 90% in 2020.

The chart on the next page illustrates the impact of FMAP changes to the WV Medicaid budget from 2010 to 2015 (in millions).



Below is a chart which compares the state and federal share of the cost of Medicaid Services (in billions) in 2010 and 2014.



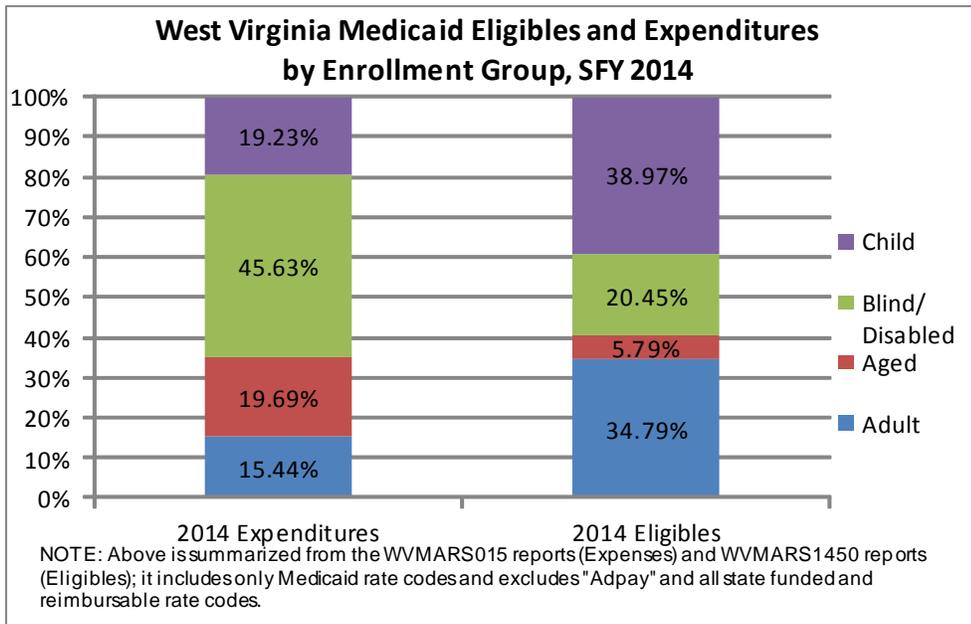
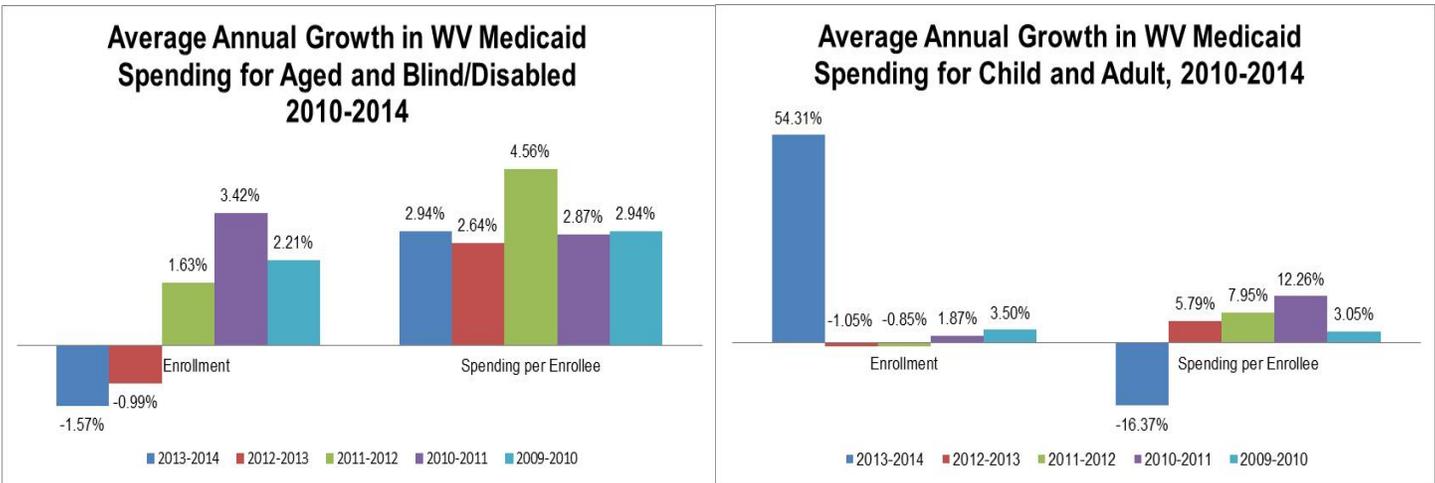
Medicaid Spending by Member Category



During SFY 2014, 551,682 West Virginians received Medicaid services. Approximately 203,000 of them received services through the state's managed care program. Children under the age of 18 and non-disabled adults between 18 and 64 accounted for nearly 74% of enrollees, but only 35% of expenditures. Blind/disabled and aged individuals accounted for 26% of the population and 65% of expenditures.

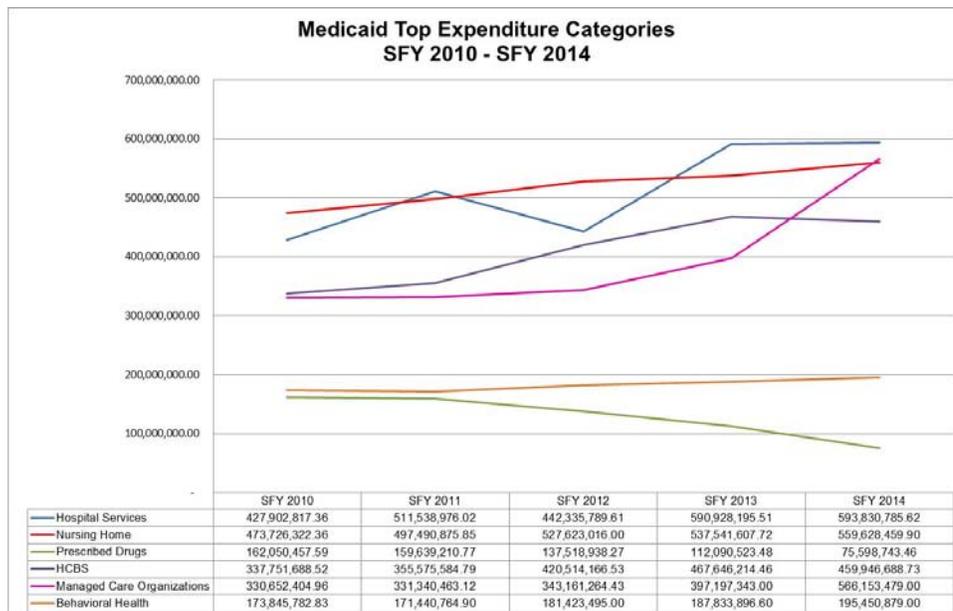
The charts below outline the relationship of enrollees to expenditures. Of note, there

was a decline in 2014 of aged and blind/disabled individuals due to decreased Aged and Disabled Waiver funding.



Expenditure Trends

The chart below shows the top expenditure categories for West Virginia Medicaid over the past five years. Expenditures in the top six categories have increased over the five year period with the exception of prescription drugs. One reason for the decline in the expenditures for prescription drugs is an increased focus on drug rebates. Also, in April 2013, prescription drug services became a part of the managed care program.



During SFY 2011, enhanced federal match provided under the American Recovery and Reinvestment Act (ARRA) increased enhanced supplemental payments. The opposite effect is seen in SFY 2012 when ARRA funds were expiring and the federal match rate was reduced for enhanced supplemental payments. SFY 2013 saw another spike in hospital expenditures (33% over 2012) primarily due to the passage of Senate Bill 492 and a subsequent State Plan Amendment authorizing supplemental upper payment limit (UPL) to qualifying privately-owned and non-state government-owned facilities. Almost two full years of UPL payments were made during SFY 2013. However, during this time period, expenditures for inpatient hospital stays decreased by \$11 million. In SFY 2014, hospital expenditures remained fairly level.

Nursing home and behavioral health services expenditures remained fairly stable over the past five years. The increases in expenditures of these two services were primarily due to annual rate adjustments. Medicaid pays for inpatient and outpatient behavioral health related services and behavioral health professional services. Medicaid does not pay for the cost of members committed to the state mental hospitals.

Since SFY 2011, Home and Community Based Services expenditures have had a steep incline. This incline can be attributed to an increase in state funding for those services and more Medicaid members receiving services through the three Medicaid waiver programs.

Pharmacy Services and Drug Rebates



All Medicaid eligibility groups receive prescription drug coverage. Like the private sector, BMS maintains a preferred drug list and requires prior authorization for high-cost, high-risk drugs. Members are asked to pay a co-payment on certain drugs. The Medicaid program is eligible for drug manufacturer rebates.

During SFY 2014, Medicaid spent over \$287 million for prescription drugs and received rebates of over \$211 million from federal and supplemental programs and managed care organizations, lowering the overall cost of prescription drugs to approximately \$75

million, a savings of almost 74%. Prescription drug expenditures decreased almost 33% or \$36.4 million from SFY 2013 to 2014.

Cost Saving Initiatives

During SFY 2014, the Bureau for Medical Services (BMS) implemented several new initiatives to contain or lower the costs of Medicaid services. As of January 1, 2014, some individuals who receive Medicaid services were expected to pay co-payments for certain services. Select individuals and services are exempt from co-payment requirements by federal regulations. Co-payments are tiered based on income level and may not exceed 5% of the household yearly income. Providers may not deny services to individuals whose household income falls below 100% FPL due to their inability to make a co-payment.

As previously noted, BMS also entered into a contractual agreement for Non-Emergency Medical Transportation to help combat program fraud, waste and abuse. The Bureau anticipates annual savings of \$1.5 million per year. In addition, county staff will have more time available to dedicate to other efforts, which is a secondary, non-calculable cost savings.

BMS will also continue its promotion of managed care, and work to continue to incorporate benefits and populations currently covered under the fee-for-service program. By transitioning populations into a managed care environment, individuals can be better monitored for accessing preventive services, which can lead to significant reductions in medical expenses that may have been incurred in a fee-for-service arrangement.



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