

**TITLE XIX ADVISORY COMMITTEE MEETING
Medicaid Purchasing Administration
March 18, 2011**

Face-to-Face Meeting

Courtyard Marriott
Seattle South Center, Tukwila
400 Andover Park West
Tukwila, WA 98188

MINUTES

Members Attending

Claudia St. Clair, Chair
Gerry Yorioka, MD
Eleanor Owen
Thomas Trompeter
Dean Riskedahl, OD
Kyle Yasuda, MD

Staff

Heidi Robbins Brown, Deputy Administrator, HCA/MPA
Jim Stevenson, Communications Director, HCA/MPA
Roger Gantz, Director, Legislative Policy and Analysis, MPA

Diane Getchman, Chief, MACSC, DESD, MPA
Tonda Taylor, Executive Secretary, MPA
Maria Nardella, Maternal and Child Health, DOH

Steve Boruchowitz, Manager, Legislative, Policy and Rules,
Community and Family Health, DOH

Approval of Minutes and Agenda

The agenda was approved.

The January 21 meeting minutes were approved.

Administrator's Report

Merger Legislation

Heidi Robbins Brown attended for Doug Porter.

She spoke briefly on the single state agency legislation that will merge the Health Care Authority and the Medicaid Purchasing Administration. She also discussed Department of Corrections and

Members Not Attending

Lan Nguyen, excused
Joan Brewster, excused
David Gallaher, excused
Mike Hassing

Guests

Bob Perna, WSMA
Molly Firth, CHNW
Christina Peters, Children's
Alliance

Andrew Busz, WSHA
Huy Nguyen, Northwest
Justice Projects

noted that MPA is already working with Corrections on health care purchasing. She also mentioned that Oregon and Washington are talking to each other about cooperative efforts in this same area.

New Chief Financial Officer

Heidi announced Andrew Cherullo was hired as the new Chief Financial Officer, effective May 2. His office will be at the Cherry Street Plaza Building in Olympia. A press release announcing the hiring was scheduled for distribution later that day. Andy grew up in Montana and has been living and working in Massachusetts. He has a strong background in legislative policy and state budgeting. She said he understands Medicaid very well.

March Forecast

The forecast was released a day early, and there is an additional \$80 million shortfall in the 09-11 revenue projections. Heidi said it could have been worse, but that any additional shortfall is still problematic. Other extenuating circumstances have heightened revenue concerns. Those factors include Japan's recent earthquake, the continuing unrest in the Middle East and its effect on oil prices. She said there was discussion from Department of Health and the Department of Agriculture on exports to Japan and the pressure to make relief efforts.

Roger Gantz said the positive side is that caseload is down, reducing projected costs by approximately \$78 million. He said that trend could continue into the new biennium if the recovery holds.

Budget Update

Heidi reviewed the types of budget cuts Medicaid is facing in the new biennium and discussed 2011 priority legislative bills currently in play. She also compared the Governor's supplemental budget recommendations with the bill that actually emerged from the Legislature. The 2011 biennial budget is still a work in progress. There are distinct differences in the House and Senate budget proposals for the biennium, and Heidi told the committee that bipartisanship will be difficult this time around.

There was discussion during the Special Session in December that adult dental care could be restored in the next biennium; however, it looks now as though that may not happen. Heidi reviewed other service reductions, including school-based services, vision/hearing hardware and maternal support services, where funding was cut by 50 percent. Heidi noted that there is separate legislation that would allow eye doctors to purchase frames and lenses from prison industries and then pass them along at cost to Medicaid clients. That bill is still pending in the Legislature, awaiting final budget action.

Dean Riskedahl asked about exemptions for DD adults – a small population. He said he was concerned about this group.

The Children's Health Program will absorb approximately 1,600 children from Basic Health who must be cut from the rolls under terms of the Medicaid bridge waiver. Another several hundred children may lose coverage if the budget eliminates Children's Health Program coverage for families between 200 percent and 300 percent of the Federal Poverty Level.

There was brief discussion on Disability Lifeline and how it stands. For now, the Legislature has not decided its fate. The Governor recommended eliminating the program, but the legislative budget writers have generally hinted they intend to save it by some means. The next biennium budget is still unknown and we are not getting a lot of signals. There are still various strategies to look at such as utilization, prescription drug co-payments, and even waivers.

There is also speculation on de-coupling Medical Care Services (Disability Lifeline), where grant coverage might be eliminated or turned into housing vouchers, even though medical coverage would continue as it does now.

Last night, TVW aired an interview with Senator Zarelli on Basic Health and Managed Care services. The senator would like to retain the underlying structure that is currently in place, especially Medicaid expansion. The Legislature has also indicated it plans to save Basic Health in some form for the next biennium.

There was a question about drug rebate utilization and whether there could be additional savings with better utilization. Heidi said she would follow up on that and suggested it would not generate savings. She said there was a 53-page spreadsheet that subject matter experts were currently reviewing.

A question was asked about medical interpreters. Heidi said there was no state funding for that service. She said a survey would soon go out on this subject.

A question was also asked about physical and occupational therapies and if there are any details on this? Jim Stevenson said they would know more next week (*the answer has since been posted on the MPA budget website at: <http://hrsa.dshs.wa.gov/News/Budget.htm>*).

There was a question on how to help with ICD-10. Heidi said the program is looking to legislators to provide state matching funds.

There was brief discussion on other legislative bills.

Waiver Tools to Change Behavior of Consumers and Providers

Roger discussed the possibility of another waiver request that would provide:

- Flexibility from hard-and-fast federal government requirements
- More effective delivery of services to clients
- Creative ideas to control costs and improve quality of care

Many of these tools would be encouraged under Senator Parlette's legislation, which supports our efforts in innovation (handout on E2SSB 5596). This bill requires the Department of Social and Health Services (DSHS) to submit a demonstration waiver request to revise the current state-federal Medicaid partnership. It would let the state manage the program within a targeted rate for each eligibility category and include cost containment elements in the request, such as modified benefit design, enrollee cost sharing, streamlined eligibility, innovative reimbursement, and enrollment in health insurance exchanges and employer-sponsored insurance.

Other Innovation Pilots

A grant application was submitted, seeking a \$1 million planning grant for dual-eligibles (clients on both Medicare and Medicaid). The state would use the funds to devise a more effective integration of services and improved service delivery between the two types of health coverage.

For children's coverage, the program is studying innovation in reimbursement methods – looking at different payment strategies with CMS.

Other strategies for innovation – payment alternatives, voluntary enrollment in health exchange and efforts to look at employee sponsored coverage.

There was a question on cost-sharing and premiums. Washington State Medicaid currently can impose small cost-sharing (co-payment) requirements, but they are not enforceable and will not change poor behaviors.

Heidi said she would like guidance from committee members on imposing effective premium and co-pay levels. Do co-pays discriminate? Is it realistic to be pressing for better generic utilization?

Medicaid continues to see an increase in emergency room utilization. Some low-income populations use ER care because they can't find a provider, but others overuse those services and some use them regularly in lieu of seeking out available primary care options. Some suggest the state should allow the ER visits to happen, but then follow up with the patients and educate them on the use of a primary provider – more effective, more appropriate and less costly care.

Heidi asked the committee members where they see Medicaid moving and how the program can encourage providers to take Medicaid clients.

Suggestions included working with hospitals and managed care plans, as well as using tax credits for charity care by providers. There was also a suggestion, as a study was done in the Midwest about community health workers being used in a hospital setting to identify outliers and steer them to more appropriate care.

It was suggested that case management must change and a new financial system must be developed. The state needs to look at overall costs in managing the Medicaid population and getting creative by replacing old-style financing and fee-for-service payments.

There was discussion on the use of one electronic database for patients, focusing on age groups, system-wide education to consumers on processes, looking at FQHCs and RHCs if clients can't get in to see private physicians.

Committee members discussed a prescription drug-monitoring project being sponsored by the Department of Health. In it, all prescribers will report into a single database, letting the program react with both patients and prescribers. Currently only 20 percent of prescribers check or input data.

Call Center Update

Diane Getchman, Office Chief, Medical Assistance Customer Service Center (MACSC) within the Division of Eligibility and Service Delivery, provided an update on redefining MACSC. Diane said that answered calls had seen an improvement with the pilot project to decrease staff time on phones. She reviewed the call wait times for providers and clients, as well as the percentage of unanswered calls. Diane shared that, on average, the call center receives about 10,000 calls per day. She said that “Contact Us,” an alternative web/e-mail venue, receives about 260 inquiries per day.

Diane said the average wait time for providers/clients is 20 minutes; however, it could be longer on a Monday or the day after coming back from a furlough day/holiday. She said providers would like a shorter wait time, but there are issues with the different extensions/calls provider need. Some extensions require more research or assistance by staff, creating longer wait times in certain queues.

She said that, currently, via web forms, the wait time to respond is eight days for clients and 30 days for providers. Diane said providers are mainly asking about claims and general provider information.

There was brief discussion on providing continuing communication to providers and clients via listservs, telephone messages while waiting, and online.

Roundtable

Andrew Busz – talked about emergency rooms and the hospital safety net assessment and how hospitals and local community partners could develop a mechanism to prevent emergency room visits or decrease them. He also discussed Healthy Options, noting that people don’t take a proactive approach with selecting plans, rather than being assigned to various plans. He would like to see a workable mechanism or incentive in this area, including outreach contact via education.

Eleanor Owens – Heidi passed around and briefly discussed the recent Seattle Times article on Eleanor Owens – *Eleanor Owen’s tireless battle for mental-health care*. Eleanor provided further details on her 90th birthday party, the article, and formation of NAMI.

Bob Perna – discussed the good exchange on electronic transactions and migrating away from paper claims (e-transactions) and core providers and submission dates.

Gerry Yorioka – said he left Snoqualmie due to layoffs and briefly discussed the percentage of Medicaid clients he saw in private practice (8%) versus at Snoqualmie (40%). He would like to see shorter timeframes for the application process and meeting disabled needs immediately. He wants an effective, efficient process.

Molly Firth – discussed the FQHC cuts, indicating they were significant. She emphasized there will be no infrastructure to cover these populations and staff are trying to preserve care.

Christina Peters – discussed CHIPRA bonuses and Apple Health for Kids. She wanted these programs protected.

Steve Boruchowitz (DOH) – discussed the bills Department of Health was tracking, such as 1311, the cigar bill and 5039.

Maria Nardella (DOH) – briefly discussed the fact that the maternity section in DOH has lost three FTEs – a significant hit. She also discussed neuro-developmental centers across the state.

Dean Riskedahl – discussed medical home legislation and medical eye care and optometrists in rural areas. He said community health clinics are being decimated.

Claudia St. Clair – Molina has a new clinic in South Everett for the TANF population, which has just opened. She said managed care lost 18,000 enrollees, which is a significant drop between February and March. This may be due to caseload, but currently the reason for this large drop is unknown.

The next meeting is a conference call on May 20, 2011.

Meeting adjourned at 11:45 a.m.