

**TITLE XIX ADVISORY COMMITTEE MEETING  
Medicaid Purchasing Administration  
July 22, 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  
Joan Brewster  
Kyle Yasuda, MD  
Michael Hassing  
Christina Peters (for Lan Nguyen), Children's Alliance

**Members Not Attending**

Lan Nguyen, excused  
Thomas Trumpeter, excused  
David Gallaher  
Dean Riskedahl, excused

**Staff**

Doug Porter, Director, HCA  
Jim Stevenson, Communications Director, HCA  
Molly Voris, WASHEP Project Manager, HCP, HCA  
Mary Wood, Chief, OMMEP, DESD, HCA  
Tonda Taylor, Executive Secretary, MPA  
Maria Nardella, Maternal and Child Health, DOH  
Chris Baumgartner, Program Director, DOH  
Melodie Olsen, HIT Program Manager, DSM, HCA

**Guests**

Bob Perna, WSMA  
Molly Firth, CHNW  
Janet Varon, NoHLA

**Approval of Minutes and Agenda**

The agenda was approved.

The March 18 meeting minutes were approved.

**Director's Report**

**Legislation Summary**

Doug reviewed the 2011 Legislative Session impacts on the Health Care Authority. He said we took more than our fair share of reductions. Doug said he put all of the reductions on the table in 2010 and arranged the highest to lowest priorities to OFM – there were no secrets.

If the revenue forecasts continue to go down, Doug said the Legislature would need to revisit the cuts they did not make in 2011 – notably, Basic Health and immigrant children.

There was a question about free clinics and if there has been an increase in their use. Doug said he is not aware of a significant increase in their use; however, he said he foresees fewer free clinics in the future because of the state's funding cutbacks.

There was brief discussion on the Rural Health Clinics (RHCs). Doug said the program is trying to get away from fee-for-service and then might see some savings.

In order to manage chronic care, we must invest in long-term care. Doug said there is the possibility of getting an innovation grant in that area, one that could be implemented in the second half of the biennium.

### **Bills and Budget Provisos**

Doug said the budget was a record breaker. He said there were 27 reductions in benefits – drug co-pays, adult dental, emergency room, and the therapies (physical/occupational/speech) were the big reductions. Doug reviewed that, while some reductions were scheduled for July 1, 2011, it was evident that staff would not be prepared to implement them that quickly and that later dates would be scheduled for implementation. Among them, the Legislature hoped to limit non-emergency visits to Emergency Rooms to three a year beginning July 1, but that it could not be arranged that quickly. Staff now expects the new limit to go into effect on October 1.

Doug also reviewed interpreter services taking a \$6 million reduction, FQHCs taking an \$86 million cut, and Healthy Options cut by \$57 million. Doug said the hospital reductions totaled \$220 million with a General Fund/State savings of \$100 million.

There was brief discussion about interpreter services and collective bargaining for interpreters.

There was brief discussion about the Washington State Hospital Association lawsuit – WSHA is not contesting the state's rate reductions, but is challenging the state's authority to drop a hospital fee arrangement that prevented a rate reduction two years ago.

There was brief discussion on reductions and efficiencies. Doug conceded that the cuts would result in some cases in higher costs down the road. For example, eliminating the therapies might drive up other costs, he said. Our models don't measure whether people will be harmed by these reductions, just how effectively they will result in savings.

There was discussion about a recent study in Oregon that followed that state's lottery for people who were eligible for Medicaid. Because some residents became Medicaid clients and others did not, researchers had a rare opportunity to compare the two groups. The major finding was that Medicaid clients proved to be healthier and happier than those who lost out in the lottery. That clearly refutes a stubborn allegation by some that Medicaid is worse than having no health insurance.

Doug also discussed the merger bill, HB 1738, which moved Medical Assistance out of DSHS and into the Health Care Authority. The new merged agency is still working on a report to legislators on whether and when other services – long-term care, mental health or substance abuse – should be moved over to the Health Care Authority, as well. That report is due December 10. In the meantime, the continuing relationship between HCA and DSHS has been codified in a Cooperative Agreement that will be updated as needed in the months ahead.

Doug said the Joint Select Committee (JSC) meets next week on Health Care Reform and again in September. Both DSHS and HCA will keep the committee up to date on health care reform changes and other activities in health care.

### **Joint Advisory Committee**

Doug is working with MaryAnne Lindeblad, Assistant Secretary for Aging and Disability Services Administration, on getting the advisory committees from Title XIX, Mental Health, Substance Abuse and Long-Term Care together to draw up a stakeholdering plan so advocates' feedback can be part of the Joint Select Committee discussion to discuss chemical dependency and long-term care.

He said they should have a “straw proposal” to send out in two weeks with a final report with three to four options and one recommended option.

There was a question about stakeholder engagement and where it fits in, especially with Medicaid expansion to begin in 2014. Doug said the federal Innovation Center has been asked if they could assist with resources. Doug said he also hopes to have a meeting next week with OFM to discuss the issue.

### **Prescription Monitoring Program (PMP)**

Chris Baumgartner, Program Director, Department of Health (DOH) reviewed the department's new program for prescription drug monitoring. He reviewed 2007 data showing unintentional and undetermined drug overdose death rates by state. Washington State's death rate was 12.3, comparable to Massachusetts at 12.7. New Mexico had the highest death rate of 20.4.

Washington State was also one of the ten states listed as a highest user of non-medical use of pain relievers in ages 12 or older – data 2007 and 2008, with a percentage of users between 6.05 and 6.93.

History of the prescription drug monitoring effort:

- Legislation passed in 2007
- DOH funding obtained in July 2008 for startup and first year operation
- DOH suspended the operation due to budget constraints in December 2008
- Federal funding was obtained in October 2010 to restart implementation

- DOH plans to release an RFP to find an application service provider for data collection and reporting

Chris reviewed the PMP Solution:

- A program designed to deter prescription drug abuse by keeping records of all dispenser transactions.
- Records are stored and evaluated to see if illicit use of prescription drugs has been occurring.
- Reports are generated to aide prescribers, dispensers, law enforcement, and licensing entities in stopping illicit use.

Operational PDMPs are active in over 20 states, and he reviewed the various agencies around the U.S. that operate their state programs – The Department of Health monitors our state’s program. Other agencies involved include the Pharmacy Board/Licensing Agency and Law Enforcement.

The Department’s goals for the program:

- Give practitioners an added tool in patient care
- Allow prescribers and dispensers to have more information at their disposal for making decisions
- Get those who are addicted into proper treatment
- Help stop prescription overdoses
- Educate the population on the dangers of misusing prescription drugs
- Make sure those who do need scheduled prescription drugs receive them
- Curb the illicit use of prescription drugs

Chris reviewed the data submission requirements; who is not required to submit data; who has access, and future enhancements. He noted that the program is voluntary and that DOH is working with minimal resources. The agency would like to expand the current program if they can obtain more resources down the road.

Chris said a letter is going out next week to all pharmacies, as well as to the pharmacy association.

### **Disability Lifeline Program Changes**

Mary Wood discussed HB 2082, which will eliminate the Disability Lifeline program (formerly GA-U) on October 31. The bill establishes three new programs in its place, and clients will continue to receive Medical Care Services coverage, but the current cash grant program will end with the changeover.

Mary reviewed the three program options:

- **Housing Assistance**

- They cannot be eligible for Aged, Blind or Disabled status
- 90-day unemployable due to medical or mental health incapacity
- Housing supports – may be eligible for housing support when the client is homeless or at substantial risk of losing housing
- **Pregnant Women Assistance**
  - Must be pregnant and ineligible for TANF (except for failure to participate)
  - Will qualify for Medical Care Services coverage
  - Supplemental supports in form of cash grant if countable income below payment standard
- **Aged, Blind, Disabled Assistance**
  - Determined to be aged, blind, or likely SSI disabled
  - Medical Coverage – Medical Care Services if does not meet citizenship requirements and Medicaid if meets Medicaid citizenship requirements

Molly Firth said she had heard from participants in meetings around the state they were receiving mixed messages. She said people are panicking and coming to the clinics, afraid they would lose their services. Mary said DSHS was sending out a staggered mailing in late August and into September with a brochure that explains the changes. She said the brochure would be easier to understand than a form letter and that she would be more than happy to share this brochure with Molly and others before it is mailed. Mary said she would also ensure the brochures are available at clinics; however, she acknowledged that clients in a transient status may be difficult to reach and might not receive a brochure.

Janet Varon expressed her concern about two-stop shopping and asked if an insert could be attached to the brochure listing contacts – housing through county agencies and other services at the CSO. Janet said the housing agency could use a web-based interface to see which clients are active. She also asked about how new applicants would be handled, how their eligibility would be verified, and whether county agencies would be handling processes by phone? She said this is the two-step process she would like to avoid.

Mary said she would take those concerns back to the work group.

### **Dual Eligibles**

Doug provided a handout on the Washington State Demonstration to Integrate Care for Dual Eligible Individuals

The handout details the grant overview. Washington is one of 15 states to receive an 18-month planning grant from the Centers for Medicare and Medicaid Services (CMS) to design an innovative integrated care model to improve the quality, coordination, and cost effectiveness of care for dual populations eligible for Medicare and Medicaid. The design plan is due by April 2012 with the last six months of the grant dedicated to working with CMS to determine whether the state will receive approval to implement the design model. The Aging and Disability Services Administration in DSHS will be the lead agency on the grant project.

#### Grant Planning Milestones (April 2011 – March 2012)

- Stakeholder and beneficiary engagement
- Medicare data interface
- Expansion of Predictive Risk Intelligence Modeling System (PRISM)
- Refined population analysis
- Viable delivery/financing models selected including shared savings proposals
- Alignment with ACA/state health reform direction
- Implementation design details
- Legislative requirements identified

Washington Medicaid has about 137,000 dually eligible clients. In 2008, Washington’s Medicaid program spent in excess of \$1.9 billion annually on this population before accounting for Medicare expenditures. Washington is nationally recognized for innovations in its Medicaid program both in acute and primary care, as well as in the provision of home- and community-based service delivery. The grant provides an opportunity for the State and CMS to design a shared savings plan that would align incentives for the right care, for the right person, at the right time.

Doug said staff is looking at utilization data to see where the best savings may be.

Doug said that DSHS and ADSA are taking the initial lead on stakeholdering. There are three FTEs for this effort. Developments are still continuing to get everything in place.

#### **Health Insurance Benefit Exchange**

Molly Voris shared a handout on the Health Insurance Benefit Exchange. The Legislature passed legislation that creates the exchange as a “public-private partnership” governed by an independent board starting on March 15, 2012. A \$23 million federal grant was received to:

- Develop options and recommendations on policy decisions
- Hold Joint Select Committee/stakeholder meetings statewide (first meeting was July 26)
- Build a detailed and comprehensive operational plan to create a structured entity capable of meeting business functions of the exchange
- Develop IT systems that build new features and leverage existing state systems.

Next steps:

- Evaluate and develop options and recommendations on key policy issues, including:
  - Will the state implement a federal Basic Health program
  - How can the exchange work seamlessly with Medicaid
  - Will the exchange be an open marketplace or a selective contractor
  - How can the state ensure a competitive market both inside and outside the exchange, as well as among plans within the exchange
  - What happens to WSHIP (high risk pool) in 2014
  - How will the exchange be financed after 2014

- Will the state choose to pay for benefits beyond what the federal government decides should be in the “essential health benefit package?”
- How can the exchange be an appealing place for small businesses to purchase health insurance?
- How do we educate consumers about what the exchange is and how it might benefit them?

Molly said the process for stakeholding would be very transparent, with statewide meetings as well as asking stakeholders for written comments. There will be an internal workgroup for the Medicaid portion of the project, making policy decisions and addressing a seamless connection.

Molly said the goal is to be up and running in 2014.

There was a question about an Essential Health Benefits package, and Molly said that will not be out until November timeframe.

### **Electronic Health Record Incentive Program**

Melodie Olsen said the Electronic Health Record Incentive Program is underway and will be rolled out in stages. In a nutshell, it will provide incentive payments to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology for up to six years.

Melodie said many organizations have been using EHRs for some time and already have the ability to share this information across their organization. She said the intent is to have common structured information that providers and payers can share outside the boundaries of individual organizations. These advances can result in patient-centered, evidence-based, prevention-oriented, efficient and equitable care.

Today, the program has:

1. Developed the online application (eMIPP)
2. Added Washington to CMS drop down list so providers can begin the registration process
3. Tested the online application and end to end business processes with a cross section of providers
4. Readied instructional materials and webinars.

What's next:

1. MU requirements become more robust over time
2. Washington Medicaid preparing five-year roadmap

There was discussion of grant funds going to regions, but Melodie said that might contribute to conflicting strategies even though the mission would be similar. She said the state is opting to get grant funds out there first.

Mike Hassing said he is writing a proposal for his organization and would this be an opportunity to get everyone together?

Melodie said she will have a communications plan available within the next two weeks.

### **By-Laws and Voting**

Committee Chair Claudia St. Clair reviewed that the committee will be looking at the by-laws within a subcommittee. If anyone is interested in helping, please notify her.

### **Round Table Discussion**

Jim Stevenson shared that Roger Gantz was retiring and there will be a roast in his honor at the end of August. Jim invited members to attend.

Maria Nardella briefly discussed DOH budget reductions and that staff was sorting through them. She said the Tobacco Quit Line was still alive for a limited group. She also said DOH is reorganizing – for example, Immunizations has a new office, and Healthy Communities has merged offices.

Janet Varon asked about Basic Health and Medical Care Services, wondering if they could both become part of the Title XIX Committee. Doug said that is a fair topic to discuss.

Molly Firth briefly discussed Washington State Migrant Workers and the impact the budget cuts had through health centers.

Mike Hassing reviewed a recent announcement concerning Medicaid and pregnant women. He said concerning rural health issues that they used to have good relations with their hospital partners, but find themselves now in fierce competition and not working together. He said they are all battling to keep their doors open.

Kyle Yasuda discussed well-child visits and the Bright Futures program to be implemented in 2014. Provisions change number of visits and screenings, which many insurers have already adopted. He said there are concerns amongst physicians between what is actually covered, and there needs to be consideration on how to provide care for all children.

Joan Brewster said Grays Harbor County is in “financial tatters.” Residents are feeling the impact of the cuts and the impact to her communities. She said it will take a long time to turn health policy changes around and that people are in a crisis now.

The next meeting is a conference call on September 23, 2011.

Meeting adjourned at 11:52 a.m.