Washington State Health Care Authority

TITLE XIX ADVISORY COMMITTEE
MINUTES – 3/22/2019

Meeting Title:	Title XIX Advisory Committee	
Minutes	Meeting Date: 3/22/19	Meeting Time: 8:30 am – 12:00
Meeting Location:	Emerald Queen Conference Center | 5580 Pacific Hwy E Fife, WA 98424 | Chinook Ballroom	
Meeting Called By:	Janice Tufte, Acting | Claudia St. Clair, Chair (Absent)	
Minutes:	Catherine Georg | Meetings may be recorded for transcription RCW 9.73.040 (3)	

Title XIX Advisory Committee Online:
https://www.hca.wa.gov/about-hca/apple-health-medicaid/medicaid-title-xix-advisory-committee

Attendees:

Members:								
☐	Christian, Ann	1	☐	Marsalli, Bob	7	☐	Sawyckyj, Kristina	13
☐	Delecki, Chris	2	☐	Milliren, Heather	8	☐		14
☐	Gil, Sylvia	3	☐	Morrison, Cynthia	9	☐		15
☒	Hannemann, Barbara	4	☐	St. Clair, Claudia	10	☐		16
☐	Hendrickson, Wes	5	☒	Tufte, Janice	11	☐		17
☐	Lester, Litonya	6	☒	Yorioka, Gerald 'Gerry'	12	☐		18
HCA Staff:								
☐	Dotson, Steve		☐	Linke, Taylor		☒	Kreiger, Gail	
☒	Georg, Catherine		☒	Brown, Michael		☐		
☒	Kramer, Karin		☒	Dean, Jessie		☐		
☒	Lindeblad, MaryAnne		☒	Fotinos, Dr. Charissa		☐		
Please Review & Bring								
Please Review/discuss:	☒ Current agenda and minutes from 11/16/18, 1/18/19 meeting ☒ Please email any changes on the minutes to: catherine.georg@hca.wa.gov							

This public meeting may be recorded in order to produce a transitory audio record for transcription purposes.

RCW 9.73.030 (3) Intercepting, recording, or divulging private communication *(3) Where consent by all parties is needed… consent shall be considered obtained whenever one party has announced to all other parties engaged in the communication or conversation, in any reasonably effective manner, that such communication or conversation is about to be recorded or transmitted: PROVIDED, That if the conversation is to be recorded that said announcement shall also be recorded.*

Date	Time	Call or In-Person	
January 18, 2019	8:30-9:30 am	Conference Call	Telephone
March 22, 2019	8:30-12:00 pm	In-Person	Emerald Queen Conference Center - Fife
May 17, 2019	8:30-9:30 am	Conference Call	Telephone
July 12, 2019	8:30-12:00 pm	In-Person	Emerald Queen Conference Center - Fife
September 20, 2019	8:30-9:30 am	Conference Call	Telephone
November 15, 2019	8:30-12:00 pm	In-Person	Emerald Queen Conference Center - Fife

AGENDA

Allotted Time	Agenda Items	Lead	Approach
8:30-8:50 *20 min*	1. Call to Order 2. Announcement *This public meeting may be recorded in order to produce a transitory audio record for transcription purposes.* 3. Introductions 4. Approval of Agenda - Action Items (Members Only) 5. Approval of Minutes - Action Items (Members Only) 6. Review Action Items	Janice Tufte	Informational
8:50-9:20 30 min	7. Tele-medicine	Dr. Charissa Fotinos	Informational
9:20-9:50 30 min	8. Applied Behavior Analysis Services	Gail Kreiger	Informational
9:50-10:20 30 min	9. Tribal Update	Jessie Dean	Informational
10:20-10:35 15 min	10. Break	All	Informational
10:35-10:50 15 min	11. Trueblood Update	Michael Brown MaryAnne Lindeblad	
10:50-11:00 10 min	12. Legislative Update	MaryAnne Lindeblad	Informational
11:00-11:10 10 min	13. Organizational Update – Appointments	MaryAnne Lindeblad	Informational
11:10-11:30 20 min	14. Potential Future Agenda items	All	Decision
11:30-12:00 30 min	15. Around the Room	All	Informational
12:00	16. Closing	Janice Tufte	

ACTION ITEMS & DECISIONS

Item	Action Items / Decisions	Completed
1.	**Eligibility:** Is there a mechanism where HCA could send something to last known primary care provider (PCP)? Check with operations folks to see if possible. [Preston Cody – lead] Note: Kim Robbins states the PIP workgroup is working with MCO on add/drop list; let's see where that goes before launching another work group [3/20/18 Keep or remove; discussion/decision/status 3/23/18] [3/23/18 Get update; Complicated, no progress; future item; check in July for update] [9/21/18] Get update from Preston [11/16/18] Preston Cody new position; Re-visit with Taylor Linke or remove [1/14/19] Recommend removal due to org changes and recruitment. [1/18/19] Taylor Linke and Steve Dotson will work together and follow up [MAL – 3/22/19] Not as easy as it might sound; not a lot of definition what the issue was, as it is, recommendation would be to move it; Think it was Kristine Sawyckyj; Bob – best guess, think people should be relying on PCP to determine next; HCA doesn't move people from one PCP to another; still need further understanding (MAL); Move to remove; other activities occurring that address	Complete: ☐ Date:

2.	**Title XIX Membership & Bylaws Refresh:** In progress; recommend pause while Claudia is on leave.	Complete: ☐ Date:

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8:30-8:50 *20 min*	1. Call to Order 2. Announcement *This public meeting may be recorded in order to produce a transitory audio record for transcription purposes.* 3. Introductions 4. Approval of Agenda - Action Items (Members Only) 5. Approval of Minutes - Action Items (Members Only) 6. Review Action Items	Janice Tufte	Informational
• 8:33 Call to order for Janice Tufte on behalf of Claudia St. Clair (out) • Agenda: Motion to approve; Barbara Hannemann first motion; Geri Yorioka second • Minutes: Always welcome feedback to Catherine • Minutes: Approval motion - Geri Yorioka first motion; Barbara Hannemann second			
8:50-9:20 30 min	7. Tele-medicine	Dr. Charissa Fotinos	Informational
• Current landscape: From a Medicaid perspective, have been paying the same as in person visits; helps in prescribing OUD; filling in for physicians around the state • Pilots in Olympic region; doing consults • Few bills Senator Becker; used tele-health/tele-medicine; do not include phone consultations as part of billing; improve schools ability to identify kids at risk of SUD, behavioral Health challenges, mental health, screening; consultations can occur with a physician at a distant location; how it occurs now is with the US Echo program; working with schools • Do not have enough child psychiatrists in the state • Require (bill) reimbursement rates to be same as in-person; does not affect Medicaid • Complicated issues could be a challenge • Find we may need additional capacity at the agency to wrap our arms around it • Studies have shown that it helps SUD and other areas; we can direct energy where needed • Personal monitoring; distant monitoring shows promise; chronic disease; can make improvements and improve outcomes • Technology is a concern: Can video conferencing be encrypted? Individual counseling sessions, etc.; BH visits; criteria, what does that look like and how do we keep records? There a lot of details to consider • Consider mental health: Health interventions by smart devices; partnering with UW (FOCUS) which is an application that allows people to check in every day; cognitively thinking, how can we support technologies; potential is there and we will do our best to stay with it • Gerry Yorioka: Gave examples of programs that worked well; need to institute treatment changes as you go; not a one-time deal, need to check back in few weeks, continue with follow up; on rise of opioid crisis could help; fundamental problem is reimbursement; preservation of privacy, takes the work of practitioner managing the case; require that the patient be in the room; kills the whole function of UW programs in some cases; its being underutilized due to technicalities • Charisa Fotinos: Good to think about it in a couple ways; the UW tele Echo programs (provider support); specialty consultation (biopsy); from a distant site, could have some kind of tele-medicine encounter that can bill; part of Becker's bill allows for billing going forward; continuity with EHR; there is a tele-med collaborative formed at the state level; ran by Scott that piloted the UW Echo • Bob Perna: Wider variety of patients with different scenarios; who has ownership within HCA; why isn't HCA part of the collaborative? CF – We weren't invited to the table, although we tried		

- Charisa Fotinos: There may be some block grant dollars from SUD funds that we may be able to use; we have one person with ten other jobs that is the go-to person; we are largely reactive
- MaryAnne Lindeblad: As we look to serve more people in rural areas, looking at hospitals that are willing to take longer term patients; if we can take care of people closer to home, they recover quicker; ready access is positive
- Bob Perna: You are meeting the patient where they are
- Charisa Fotinos: a good move for us, or to investigate, would be methadone clinics; spent $14M dollars on sending people to Methadone clinics, traveling hundreds of miles away; in rural areas this can create a hardship, as the person has to be established first; with tele-medicine, we could potentially prescribe etc.
- Gerry Yorioka: With Opioid crisis, would help having HCA at the table; PCP find face to face visits are longer than normal, not able to spend enough time with patients
- Janet Tufte: Kansas, SAMSA has contracted with organizations to track individuals; if person is suddenly off radar, can reach out to check on them, etc.
- Charisa Fotinos: Technology can provide access to people that don't normally have it; it's the new or complicated issues that are areas of concern and present potential legal issues
- Michael Brown: It becomes a standard of care issue; there are some conditions doctors are not comfortable treating without having eyes on

9:20-9:50 30 min	8. Applied Behavior Analysis Services	Gail Kreiger	Informational

- Applied Behavior Analysis Services (ABA) is a behavior treatment approach covered by Apple Health for children ages two through twenty; the benefit was implemented in 2012 as a result of a lawsuit, in result of providing care to children with autism
- HCA developed the program in partnership with Seattle Children's (SC), Mary Bridge, etc., developing a report on recommendations to the legislature; individuals continued to meet, solve issues and help solve our problems
- Board certified at a national level, there were certain challenges in implementing the benefit, including TRICARE, Microsoft, and Aetna
- Everywhere else had nothing; our challenge was pulling at those places, to provide care in other places
- Requirements: Child must have a Center of Excellence recommendation; diagnosis needs to be accurate; children were being misdiagnosed, because people were not trained; have been building those centers
- There has been money for training and have contract with SC for training, and building centers in more rural areas (Wenatchee, Yakima, Bellingham, King County), and diagnostic centers around state
- Difficult in Southwest Washington; was going to partner with OHSU; they had their own population to manage, so we are working on Clark County Center of Excellence
- ABA is a benefit that provides services where the child is, whether that is home, school, etc.
- Unique program: Went to UCLA and learned about day program(s); children receive intensive services 4-5 days a week; working with SC and other ABA providers, we are able to render services 6 months of age on up; there does need to be a peer (school) setting model
- One challenge we faced in providing services is that there were only 14K board certified professionals in the world; profession needs to grow to expand treatment services; we had to add more testing dates to license
- Capacity has been building for us, moved from FFS in 2015; data shows that we have about 10K; there about 13K kids in our system that have autism; 7K kids have been participating in treatment this last year
- Increase on spending = Increased programs
- Working with SC and talking about training providers in rural communities; two day training to build confidence in diagnosing; this is supported through ECHO
- Washington was asked to participate in building codes; developed temp codes; as of 2019 there are official codes, we are recognizing codes as being valued

- MaryAnne Lindeblad: Services for children; unfortunately do not provide services for adults; as kids age out, what kind of services can we provide for those moving out of pediatric services; there is not an effective system for ages after 20
- Charissa Fotinos: Is it packaged, is it intermittent?
- Gail Kreiger: There may be achievements, there may be changes and need to re-engage
- Their board has determined that the Board Certified Behavior Analyst (BCBA) can manage only 10 technicians at the most; technicians can manage only 10 children; ratio model constrains how many children can be served
- If need/want to serve more children, need to hire more BCBAs; centers need sufficient funding or access to funds to build staff and get to the point that they have a sufficient number of paying patients to support start up; Medicaid does not support start up (rates)
- Michelle Hoffman: Are there work force developments? HCA go to colleges, fairs, etc.?
- Gail Kreiger: We have talked about that and pushed plans to contribute, asking them to dedicate a BCBA to Medicaid and build startups; it takes time
- Michelle Hoffman: DOH submitted grant for autism; intentionally added rural pathways to reduce backlog; there are such long waiting lists; hopefully we can work on workforce development
- Gail Kreiger: One provider is preparing to do a day program in Clark county
- Bob Perna: Have worked with Pediatric Society to be more active?
- Gail Kreiger: Not directly; we have reached out to practitioners; they are more interested in the Pediatrician level
- Michelle Hoffman: Washington Chapter of the American Academy of Pediatrics (WCAAP) collaborative that has been working with champions in partnership with rural health; usually have 10-20 providers; people can go to Great Vine to view (rural pathways, billing, etc.); not sure what the Washington chapter has been doing to promote that
- Bob Perna: Is there an estimate out there of kids with autism disorder, not receiving services?
- Gail Kreiger: The key is in getting providers to complete infant assessments since 2013; they need to have a Center of Excellence referral and evaluation; there are probably thousands; SC has a backlog of something around two years; have had excellent response for kids that are older
- Gerry Yorioka: Is there an advantage to working with Microsoft to use their EHR system (UW uses it?); something carried around by the individual
- Michelle Hoffman: Build a Child Data Repository; when you need it (immunizations, records, et) providers would have the ability to pull information; trying to get Child Health Intake Form (CHIF); being redesigned and modernized, going to a cloud based system; will have interoperability capabilities

9:50-10:20 30 min	9. Tribal Update	Jessie Dean	Informational

- Presenting an overview of how HCA works with the tribes
- Jessie Dean: Is an attorney; practiced law 10 years before coming to HCA
- Apple Health for American Indians and Alaska Natives (AIAN); coverage/enrollment data based on self-identification; federal programs specify who can benefit from them; we do not ask, because there is no single database; strictly based on self-identification
- Federal rules and laws require the Medic program to AIAN to opt out of managed care because tribes manage care of tribes; don't appreciate having an intermediary
- In a sense, Medicaid expansion took management of health services away from tribes
- Indian health service costs are typically below $3K per person, typically half of what is spent on prisoners
- Funds are appropriated dollars, not an entitlement; congress has used Medicaid as a back stop to fund the Indian Health Service (IHS)
- Want to be clear on terminology; IHS is the entity that receives federal dollars for health funds (also sanitation); tribes are now the dominant form of provision; larger tribes have a tendency to go to feds

- Urban populations represent only 1% of IHS appropriations; between 60-70% Indians live in urban populations (see data highlights)
- There is a geographic mis-match between where tribal members are, and where the tribes are located; this creates some gaps in healthcare coverage
- Calendar year 2017 spent $352M on Indians (see data highlights)
- IHS and tribal facilities receive a cost-based facility encounter rate; tribes for 2019 rcvd encounter rate of $455; Exceptions to encounter rate exist; tribes responsible for state match; still pay for out-patient
- Bob Perna: What drives differential between rates?
- Jessie Dean: Clinics are typically smaller than FQHCs; more difficult to operate in rural areas
- There are Dental Health Aide Therapist (DHAT) State Plan Amendment (SPA) issues; SPA hearing with CMS occurred 12/18/10; expecting CMS hearing officer decision at any time
- MaryAnne Lindeblad: Federal government would not approve ability to draw down match at FQHCs; if I wanted to see a DHAT, I couldn't; CMS declined our SPA; a lot of back and forth continues; we hope that legislation will change the language that CMS objected to
- Historically, treaties provided for healthcare; based on how the treaties were negotiated and done under duress, when tribes refused to sign the tribal negotiators were executed
- Treaties (now) are always interpreted in favor of the tribe; from this perspective, tribes shouldn't have to sign up for Medicaid; it has improved over the years, but need to see tribes continue to enroll, and keep enrolled
- Medicaid Transformation: Set aside almost $625K per tribe, no matter the size, to receive incentive payments; exciting to see what they are doing with these funds; using to integrate physical and behavioral health; second most common program(s) implement FQHC set-up; essentially provides alternative payment methods, expanding and opening their own clinics
- CMS identified problem in 2017; if tribal clinic is not affiliated as hospital, it is defined as a clinic; CFR will not allow them to received money outside their four walls (schools, clinics, etc.); FQHC enables them to provide services outside their four walls, contract services and bill FQHC rate (tribes automatically considered FQHCs)
- Various projects going on related to tribal and Indian health
- DBHR is responsible for SAMSA grant for all 29 tribes; working on contracts with tribes; will be working with tribal attorneys towards that end
- CMS said state can receive 100% federal match for tribal providers; changed to 100% can also receive non-tribal HIS through coordinated care agreements; there is a bill in legislature to help take excess and put back into a fund, help to set up an incentive feature
- Tribal and Evaluation & Treatment (E&T) Facility Workgroup: how do you come up with a plan where tribes can open an E&T Facility; working on report for making recommendations
- Five times the level of need in Indian/Alaska Native population, compared to rest of population
- Working with Managed Care Organizations (MCOs) having the entities sending billing; helps to alleviate administrative burden of billing
- Self-attestation Medicaid enrollees; not a reliable indicator of eligibility; there is a PDX database that would help identify, enroll, provide services/care; not changing our method, trying to identify others eligible to pull into the orbit
- Crisis Intervention: Involuntary treatment act/assessments; need to be able to have conversations with the tribal member in a culturally appropriate way; culturally appropriate assessment; cultural queues; we don't want conversations to be re-traumatizing
- Investigating how to research cultural and historical trauma; it can be built into a treatment plans, but not a diagnosis; hopeful that we can work this into policy
- Tribes have been asking us to reexamine reporting (for funding); so as not to cause administrative overburden

Data Highlights

- Apple Health coverage for American Indians and Alaska Natives

    - Coverage/enrollment data based on self-identification
    - 72,236 AI/ANs out of 1,833,839 = 3.94%
    - FFS:
        - AI/ANs: 49,720 out of 74,806 (64% of AI/ANs)
        - Non-AI/ANs: 110,286 out of 1,744,611 (6% of non-AI/ANs)
        - AI/ANs are 31% of FFS clients
- Apple Health payments for services to American Indians and Alaska Natives
    - Calendar year 2017: $352,000,000
    - Covered lives: 72,000
- Apple Health payments for tribal health care services
    - Medicaid now largest funding source for some tribal health programs; IHS per capita appropriations have never exceeded $3,000
    - Calendar year 2017: $133,000,000
    - Programs: 27 tribal health programs, 14 tribal transportation programs (NEMT), 14 administrative services (MAC)
    - IHS and tribal facilities receive a cost-based facility encounter rate
        - $455 for 2019
        - Exception: Tribes responsible for state match for outpatient SUD services
    - Rules for encounter rate are set forth in Medicaid State Plan
- Medicaid hearing on Dental Health Aide Therapist SPA
    - Hearing on December 18, 2018
    - Decision by hearing officer at any time
- Medicaid Transformation
    - February 26, 2018: CMS approved Indian Health Care Provider Protocol
    - Each of 29 tribes and 2 urban Indian health programs may receive up to nearly $625,000 in pay-for-reporting incentive payments
    - Projects:
        - Physical-behavioral health integration: 12
        - Tribal FQHC: 7
        - Start/expand tribal clinic: 2
    - Varying levels of tribal/IHCP engagement with ACHs

Projects

- Tribal contracts for non-Medicaid behavioral health services: Transition DSHS to HCA
- HCA Tribal Consultation Policy being updated

- 100% FMAP Expansion through Care Coordination Agreements between IHS/tribes and other providers
- SPA 19-0009: Tribal FQHC APM
    - No cost reporting
    - Tribes able to provide services outside their 4 walls
    - Tribes able to receive facility encounter rate for all clients
- Tribal E&T Facility Workgroup – Report being finalized
- MCO payment of IHS encounter rate – July 2019
- 100% FMAP for Medicaid managed care premiums
- Data match to identify IHS eligible clients
- Training for DCRs in how to conduct culturally appropriate assessments
- Research in how to incorporate historical trauma into health care policy

Reporting requirements crosswalk for tribes

10:20-10:35 15 min	10. Break	All	Informational
10:35-10:50 15 min	11. Trueblood Update	Michael Brown MaryAnne Lindeblad	

- Best understood that the case started in 2015, when Behavioral Health Services was with Department of Social and Health Services (DSHS); there was a class action lawsuit; class members were waiting in jail for court ordered competency tests; the task in law, lies with DSHS; now that Division of Behavioral Health and Recovery (DBHR) is part of HCA; we are working on the community side of that
- *Trueblood v DSHS* (Trueblood) challenged unconstitutional delays in competency evaluation and restoration services; subject (plaintiff in case) sat in hospital without assessment, condition worsened
- As a result of this case, the state has been ordered to provide court-ordered competency evaluations within 14 days and competency restoration services within 7 days
- Trueblood helps individuals who are detained in city and county jails awaiting a competency evaluation or restoration services, and individuals who have previously received competency evaluation and restoration services, who are released and at-risk for re-arrest or re-institutionalization
- Settlement agreement approved in August 2018; ;DSHS was being fined 4M month; agreement requires state to make changes in certain areas, which will be phased in; creates system to monitor state to make sure the system is working; mechanism to make changes to ensure working
- MaryAnne Lindeblad: The reason we want to brief you on this, as we take on more responsibility for implementation, many of these services are a big part of how services will be delivered through Medicaid; we have this lawsuit that has been layered
- Michael Brown: HCA is not named a plaintiff; mostly the lawsuit agreement was already negotiated before HCA was pulled into it; mental and behavioral health is a governor priority this year; expect bills to pass that will impact how we will deliver these services
- Without adequate capacity, patients sit in hospital or jail; keep most serious cases in Western or Eastern State Hospitals; standing up programs that manage all cases, not just the class action case(s)
- MaryAnne Lindeblad: It starts to build out a system where individuals have done non-egregious crimes, are evaluated and transitioned to community
- Michael Brown: Lawsuit is really a result of the state's failure to plan; will support class of individuals and needs not typically addressed (housing supports, competency restorations, etc.); services will be (transformed) to include Medicaid services, and outside Medicaid IMC - well as physical and behavioral health whole person
- There will be a connection to prisons and competency restoration in the adult system; what is the best opportunity for not guilty on a basis of insanity
- There is a hierarchal, committed, executive committee and multiple workgroups
- We will provide periodical updates on where we go, as it will have an effect on organizational resources

More information: https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2019Trueblood/19-0274BHATrueBloodFAQ.pdf

10:50-11:00 10 min	12. Legislative Update	MaryAnne Lindeblad	Informational

- Has been quite a session; the last month of session will be a lot of back and forth; hope to have a budget by the end of April; House and Senate are on different planes; HCA is taking on School Employee Benefits (SEB)
- A lot of bills die; may get resurrected if can be attached to a budget
- Tobacco: Changing legal age for sales of tobacco from 18 to 21
- BH facilities: Activity to create more community capacity

- UW BH Services: Creating on-campus services up to 125 beds
- All Payer Claims Database: bill would move this to HCA; right now it sits with OFM
- Indian Health Improvement: bill improves AIAN services
- Watching governor request SSSB5432; redefines where BH sits; takes out of DSHS and puts it in HCA and more of how it fits in BHI; as integration goes on, licensure has gone to DOH; this bill sorts that all out
- Trueblood Bill; Ensures competency, restoration, etc. (previously discussed)
- Improve Managed Care Organization: Defines ways we use withholds certain % of premium that they are incentives quality of care; most of what in it, we are already doing
- Watching about 50 bills; probably one of the business sessions I have seen
- Budget forecast came out a few days ago; a bit better, but still issues on the education side; issue with decertification of Western State Hospital creates $52M hole in the budget (result of de-certification)
- A lot of our focus over the next two years will be on the integration of behavioral and physical health
- Bob Perna: Is there a way to recoup with Western State Hospital?
- MaryAnne Lindeblad: There is nothing retroactive; recertification will look at the elements, physical plant, elements of the electrical system (parts) haven't been made since the 1950's; when remodel of certain areas occur, uncover new issues
- Barb Hannemann: O'Ban bill(s) increasing providers (some can be resurrected through budget proviso)
- MaryAnne Lindeblad: DHAT issue, there is some legislation that may fix the language problem for us
- The request for proposal (RFP) for dental managed care has had issues and budget questions; identified three apparently successful bidders; looking at implementation in July 2019; letters going out today informing folks dental changes are coming; some counties will not have two plans; major delivery system changes; as part of their bids, applicants had to provide proof of an adequate network

11:00-11:10 10 min	13. Organizational Update – Appointments	MaryAnne Lindeblad	Informational

- DBHR folks that came over to HCA and were reporting through to Sue Birch; Effective 5/1/19, DBHR will report to MaryAnne Lindeblad
- Chris Imhoff: Retired in August; there was as lengthy detailed search; Keri Waterland, a Senate staffer, has a PHD in psychology and strong community background; will get try and get her here after she begins
- Mary Wood: Retired; Taylor Linke has taken her place; she shadowed Mary for about a month before Mary left to help with a more seamless transition
- Isabel Jones: Accepted as position with Premera in January; we hired Teresa Claycamp to the Integrated Managed Care and will come 4/1/19
- Dr. Dan Lessler: Chief Medical Officer retired; replaced by Dr. Judy Zerzan from Colorado
- Recruitment for the Director of Medicaid Program Operations and Integrity is actively ongoing; hopeful to have an announcement in April

11:10-11:30 20 min	14. Potential Future Agenda items	All	Decision

- Leg Update - **call**
- Healthier WA Initiatives across three initiatives - **call**
- Hearing Aid Utilization - **call**
- Pediatric & Other Value Based Purchasing – WCAAP alternative payment mechanism – **in –person**

11:30-12:00 30 min	15. Around the Room	All	Informational

- Andrew Busz: Busy in legislative session, waiting to see what comes up
- Bob Perna: Retired, trying to staying involved

• Barb Hannemann: ALTSA Waiver; New Freedom waiver – person directed waiver; budget and spend on treatment center things (King & Pierce); consumer gets the money, works with financial management services; straight renewal only – may expand in future • Janice Tufte: Now involved in help for the homeless; services are not necessarily person centered • Michelle Hoffman: Cynthia Morrison is going to retire by end of May; Lacy Fehrenbach's successor hired now Title V Director; Michelle is the family programs coordinator; Joan Zerzan health nutrition leaving; applied for another autism grant, looking for renewal, not in Trump budget; Maternal health poster session (?); working with HCA and CMS ; internal health child's needs assessment every five years and national priorities; will re-examine agency priorities • Sophie Doumit: WSDA – Leg has kept us all very busy • Adjourn at 11:34			
12:00	16. Closing	Janice Tufte	

Potential Future Agenda Items – for Telephone		
1.	Healthier WA Initiatives across three initiatives	☒
2.	Hearing Aid Utilization: haven't had benefit for many years; are people using the benefit [Tonja Nichols]	☒
3.	Leg update [Shaw O'Neill – LEG]	☒
4.	Prisoner (jail/prison) Medicaid suspension update [Amy Dobbins – OMEP]	☒
5.		

Potential Future Agenda Items – for In-Person	
1.	[7/27/18] Core Measurements Adult/Child Medicaid - there is a work group through the Governor's office that oversees the measures and suggested that Laura Pennington attend a future in-person meeting to discuss
2.	[3/22/19] Peds VBP & Other Value Based Purchasing – WCAAP alternative payment mechanism
3.	
4.	
5.	

Action Items:

- Breakdown on churn [Karin Kramer]
- Geri Yorioka: Data over time; aging out Medicaid; aging out of parental coverage
  MaryAnne Lindeblad: Ask Bob Marsalli; look at association and see if willing to do presentation
  Karin Kramer – HBE may have some data [Karin Kramer]
- Department of Health – Immunizations Update; data online [Michelle Hoffman]
- Update – Prisoner (jail/prison) Medicaid suspension [Amy Dobbins – OMEP]
- Update – CDR Update
- Update APCDB

Other Guests/Participants:

Busz, Andrew
Perna, Bob
Hoffman, Michelle
Doumit, Sophie