FINAL REPORT

Healthcare Alternatives for Citizens below 100% of Poverty Level

Members of the Working Group

Senator Marv Hagedorn, Co-Chair
Senator Patty Anne Lodge
Senator Steven Thayn
Senator Jim Guthrie
Senator Maryanne Jordan

Representative Tom Loertscher, Co-Chair
Representative Fred Wood
Representative Judy Boyle
Representative John Vander Woude
Representative Sue Chew

Staff

Elizabeth Bowen, Senior Legislative Research Analyst
Jared Tatro, Principal Budget and Policy Analyst
Jackie Gunn, Committee Secretary
Jennifer Kish, Committee Secretary

November 22, 2016

I. Working Group Charge

The Healthcare Alternatives for Citizens below 100% of Poverty Level Working Group was authorized by the Legislative Council at its meeting on June 17, 2016. The purpose of the working group was to investigate and identify alternative policies for providing health care to Idahoans in the "coverage gap," i.e., low-income individuals who neither qualify for Medicaid nor qualify for subsidies to purchase health insurance on the state exchange.

II. Meetings

The working group met six times at the State Capitol in Boise on the following dates:

1. July 20, 2016;
2. August 11, 2016;
3. August 29, 2016;
4. September 28, 2016;
5. October 24, 2016; and
6. November 22, 2016.

III. Scope of Investigation and Findings

At its meetings, the working group considered information and proposals presented by a number of stakeholders. The working group also heard public testimony from 35 individuals and considered over 500 written public comments submitted to the Legislative Services Office between July and November. A complete list of persons who presented or testified to the working group may be found in Appendix I of this report. The written comments are on file in the Legislative Services Office: Division of Research and Legislation.

Based on the information, proposals, and comments considered, the working group finds that it would be in the best interest of the state to provide health care of some kind to the individuals in the coverage gap. The gap population includes the working poor as well as individuals who face significant or potentially significant challenges due to physical, mental, or behavioral health conditions. Investing in this population now to ensure better health and productivity will likely benefit the state, fiscally and otherwise, in the long term.

IV. Recommendations

Having completed its authorized investigation, the Healthcare Alternatives Working Group has identified two potential methods by which to provide health care of some kind to individuals in the coverage gap. Both methods have advantages and disadvantages as discussed below.

One method would be to expand the state's Medicaid plan to cover individuals whose income is at or below 138% of the federal poverty level. This would qualify the state for increased federal funding under the Affordable Care Act; however, the state would, by 2020, be required to provide 10% matching funds to cover the expansion. For Medicaid expansion to be a viable option, certain provisions of the Affordable Care Act would need to remain in effect in 2017 and thereafter. In light of the recent election results, it is unknown at this time if Medicaid expansion will continue to be an option going forward.

Another method would be a state-funded program that provides health care of some kind to at least some individuals in the gap. It is the belief of the working group members that a comprehensive state health program could be prohibitively expensive; therefore, a state program might need to be limited in scope, both in the number of persons covered and in the type of care provided.

Again in light of the election results, the working group will not recommend a specific method at this time. The working group does, however, make the following recommendations:

1. A policy to provide health care of some kind to the gap population should be enacted by the 2017 Legislature;

2. If legislation to expand Medicaid of any type is considered by the Legislature, such legislation should include a conditional sunset clause in the event that federal policy changes;

3. All Medicaid populations, including any expansion populations, should be moved to managed care as soon as possible;

4. A state-funded program should include a direct care component for primary and preventative care; and

5. Funds for a state program or for the state share of Medicaid expansion should come from the Millennium Fund and from the general fund as needed.

APPENDIX I

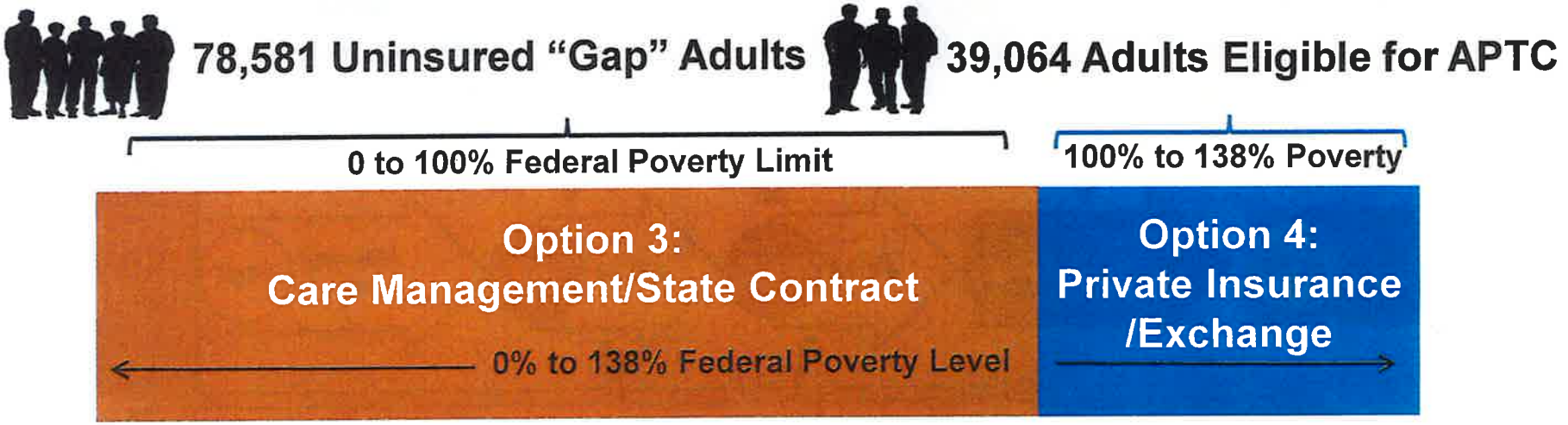
Persons who presented or testified to the working group

Persons who presented or testified to the working group (date of presentation or testimony)

1. Aaron White (9.28.16)
2. Alec Porteous, Maine Department of Health and Human Services (8.11.16)
3. Anna Rostock (9.28.16)
4. Bill Leake, Idaho Public Health Districts (9.28.16)
5. Brittany Ruland (9.28.16)
6. Bruce Belzer, Idaho Medical Association (9.28.16)
7. Chelle Gluch (9.28.16)
8. Clella Steinke (9.28.16)
9. Corey Surber, Close the Gap Coalition (9.28.16)
10. Darin Lee, St. Alphonsus Hospital (8.11.16)
11. Dannielle Ryals (9.28.16)
12. Deborah Bachrach, Manatt (8.29.16)
13. Deborah Fournier, New Hampshire Department of Health and Human Services (10.24.16)
14. Dick Cauchi, National Conference of State Legislatures (10.24.16)
15. Elizabeth Bowen, Legislative Services Office (8.29.16; 9.28.16; 10.24.16)
16. Elting Hasbrouck, Valley County Commissioner (9.28.16)
17. Erika Bliss, Qliance Medical Group of Washington (8.11.16)
18. Francoise Cleveland, AARP Idaho (9.28.16)
19. Frank Monasterio (9.28.16)
20. Fred Birnbaum, Idaho Freedom Foundation (9.28.16)
21. Gregg Pfister, Foundation for Government Accountability (9.28.16)
22. Heidi Traylor, Terry Reilly Health Services (8.11.16)
23. Ingrid Brudenell (9.28.16)
24. James Baugh, Consortium for Idahoans with Disabilities (9.28.16)
25. Jared Tatro, Legislative Services Office (8.29.16)
26. Jeremy Monroe (9.28.16)
27. Jesus Blanco (9.28.16)
28. Jim Brook (8.29.16)
29. John Livingston, Idaho Freedom Foundation (9.28.16)
30. Jon Miller (9.28.16)
31. Katharine McNeery (9.28.16)
32. Lauren Necochea, Idaho Voices for Children (8.11.16)
33. Leanne Rousseau (9.28.16)
34. Lorin Nielsen, Bannock County Sheriff (9.28.16)
35. Luke Cavener, American Cancer Society Cancer Action Network (9.28.16)
36. Marilena Delgado (9.28.16)

37. Marshall Priest, Idaho Heart Association (9.28.16)
38. Mary Barinaga (9.28.16)
39. Matt Forge (9.28.16)
40. Melody Hayden (9.28.16)
41. Mike Foutz (9.28.16)
42. Mindy Hong (9.28.16)
43. Neva Santos (9.28.16)
44. Richard Armstrong, Department of Health and Welfare (7.20.16)
45. Samantha Joseph (9.28.16)
46. Scott Dunn (9.28.16)
47. Scott Shurtleff, Project Access Northwest (8.29.16)
48. Steven Kohtz (9.28.16)
49. Stewart Lawrence (9.28.16)
50. Susan Souvenir (9.28.16)
51. Ted Epperly, Family Medicine Residency of Idaho (8.11.16)
52. Tim Heinze, Close the Gap Coalition (9.28.16)
53. Tina DeBoer (9.28.16)
54. Travis Applebaum (9.28.16)
55. Xenia Williams (9.28.16)
56. Yvonne Ketchum-Ward, Idaho Primary Care Association (8.11.16)

Option 3.5: A Blend of Managed Care/Private Insurance



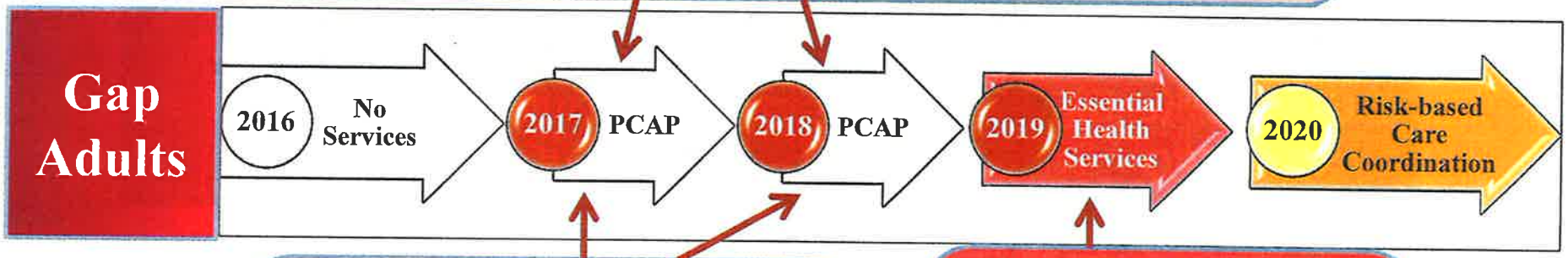
- During the next 10 years, state and local offsets totaling $915.4 million cover the recommendation's costs and result in a state/local tax savings of $173.4 million.
- Provides 103,000 people with access to healthcare coverage
- Supported by CMS

IDAHO DEPARTMENT OF HEALTH & WELFARE

2015-2016: Primary Care Access Program

PCAP sets foundation for successful transition to all essential health services

Primary Care Access Program (PCAP): State funded effort connects adults in Gap to coordinated preventive and primary care, setting the foundation for easy transition to all essential health services.



- Sliding income based fee
- Care coordination for chronic conditions
- Discounted pharmacy, office-based basic behavioral health
- Does not include hospitals, specialists

Access to coordinated, essential health services:

- **Preventive & primary care**
- **Hospitals**
- **Specialists**
- **Full pharmacy**
- **Behavioral health**

Transforming Idaho Healthcare

IDAHO DEPARTMENT OF HEALTH & WELFARE

1 STATE HEALTHCARE INNOVATION PLAN (SHIP)

- Convert Idaho primary care practices to Patient-centered Medical Home Mode
- 7 Regional Collaboratives
- Align payment mechanisms to focus on quality
- Improve care coordination through electronic health records

2 IDAHO MEDICAID

- Moving providers to PCMH
- Paying for quality
- Transforming to episodic payment
- Share savings when quality achieved

3 GAP ADULTS

- PCAP sets foundation
- Improve access to essential health services

4 RISK-BASED CARE COORDINATION

- Healthcare delivered through PCMH model
- Everyone has access to essential health benefits
- Payment systems reimburse for quality
- Providers and taxpayers share savings

Where Are We Now?

IDAHO DEPARTMENT OF HEALTH & WELFARE

Risk Base Care Coordination for Medicaid

- Begin payment change 2017
- Significant transformation 2018

Gap Sub-Populations

- $12M with 10,000 people indigent/CAT
  - 35% cycle -- multiple times
  - Each time increased costs per episode

- $10.5M with 5,600 people in Probation/Parole

(Based on information from WICHE Justice Reinvestment Analysis on Behavioral Health)