MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Friday, February 24, 2012

TIME: 8:00 A.M.

PLACE: Room EW42

MEMBERS: Chairman McGeachin, Vice Chairman Bilbao, Representative(s) Loertscher, Shepherd, Thayn, Wood(27), Guthrie, Roberts, Rusche, Chew

ABSENT/ EXCUSED: Rep. Wood(27)

GUESTS: Ken McClure, Idaho Medical Association; Christy Neuhoff, St. Luke's Health System; Toni Lawson, Idaho Hospital Association; Steve Thomas, Idaho Association of Health Plans; Leslie Clement, Department of Health and Welfare; Kris Ellis and Tony Smith, Benton Ellis; Kathie Garrett, Idaho Academy of Family Physicians; Jeremy Pisca, Saint Alphonsus Health System; Molly Steckel, Idaho Medical Association.

Chairman McGeachin called the meeting to order at 7:59 a.m.

H 541: **Ken McClure**, Attorney, Idaho Medical Association, presented **H 541**, which clarifies that hospitals can establish their own criteria for medical staff membership, but cannot deny membership to a doctor who practices elsewhere, has ownership in another facility, or is a competitor of other staff doctors. He stated that exclusive contracts between the hospital and doctor can exist.

Responding to questions, **Mr. McClure** said a large multi-specialty clinic would be included in this legislation. He explained that hospitals are free to specify contract terms and, since maintaining a specialist is important, second privileges can be denied, if there is not enough business to fulfill the existing contract. A federally allowed self referral is also allowed under the statute.

Christy Neuhoff, General Counsel, Saint Luke's Health System, testified in **support** of **H 541**, stating that St. Luke's does not use any prohibited criteria such as indicated in this bill, but has heard concerns from physicians about other hospitals using such criteria to deny privileges.

Toni Lawson, Vice President, Idaho Hospital Association, stated she **supports H 541**.

Steve Thomas, Idaho Association of Health Plans, stated he is **neutral** on **H 541** since it does not apply to health insurance companies.

MOTION: **Rep. Guthrie** made a motion to send **H 541** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. Guthrie** will sponsor the bill on the floor.

Chairman McGeachin turned the gavel over to **Vice Chairman Bilbao**.

SCR 114: **Rep. McGeachin** presented **SCR 114**, which is a rejection of seven subsections and three paragraphs in a Department of Health and Welfare (DHW) pending rule for Medicaid Enhanced Plan Benefits. Both the provider community and the DHW asked for these rejections.

MOTION: **Rep. Loertscher** made a motion to send **SCR 114** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. McGeachin** will sponsor the bill on the floor.

PRESENTATION: **Leslie Clement**, Deputy Director, DHW, presented an update on Idaho Medicaid Managed Care. She explained that Medicaid is a major state budget driver, critical health care services payor, and provider of coverage for the uninsured. Ms. Clement then discussed the challenges of Medicaid management and the increasing number of enrollees. She stated that the current approach has exhausted short-term budget strategies and Medicaid is now paying for volume rather than value.

Ms. Clement reported that the Medicaid programs in twenty-six states contract with managed care organizations, thirty-one states operate primary care case management programs, and nearly all states have limited-benefit plans, with many plans expanding managed care to improve service delivery and payment systems.

She stated the results of the prepaid ambulatory care plan, special needs plan, primary care case management, and selective contracting. The utilization management, preferred drug list, and Idaho home choice program are all working well, achieving their purpose, and on track for savings targets.

Ms. Clement presented an actuarial overview for fiscal years 2009 to 2011 that summarized the number of enrollees, with total expenditures for physical health, mental health, long-term care, and pharmacy. Managed care opportunities exist in six areas: dual eligibles, mental health carve out, health home (mental health and chronic care conditions), disabled medicaid, pregnant women and newborns, along with the temporary assistance for needy families (TANF) and children's health insurance (CHIP) programs. Ms. Clement said that the analysis revealed a high prevalence of common chronic conditions among nonpregnant, adult populations and detailed the analysis by co-morbid conditions.

As a result of meetings with Medicaid experts from Oregon and Utah, **Ms. Clement** shared what is working, what isn't working, and what they find challenging. Common focuses are anchoring the change on the medical home, integrated benefit management, outcome rewards, and quality.

Ms. Clement presented public forum results for behavioral health managed care, health plan collaboration (duals), long-term care managed care, and Medicaid managed care.

Hospitals and health systems suggestions included patient-centered regional integrated, coordinated care, accountable managed care, and electronic health records. They stated that commercial insurance companies could become another layer between Medicaid and providers, and indicated that they are not ready for risk-based arrangements.

Physicians and medical practices shared their concern for the current physician/patient ratio. They described their regulatory and reimbursement pressures, and encouraged the use of an integrated model, including electronic outcome and claims data.

Community Health Centers expressed their desire to be recognized as essential providers. They discussed the variety of pressures they encounter, and medical homes as the foundation of care. They indicated that focus needs to be on increased access, improved quality, and reduced costs.

She detailed the combined panel's five key elements, which were patient-centered medical home improvements, patient incentives, real time data sharing, feedback reports, and payment incentives for high risk populations.

Ms. Clement said that an application has been made to the National Association of State Health Policy to adopt or adapt the North Carolina Community Care model. She said they plan to learn how one state has managed Medicaid services through community provider networks anchored by the patient-centered medical home to achieve improved health outcomes at reduced costs. Then they will draft a state work plan to pilot a similar approach with Idaho health system providers.

She reviewed the current medical home pilots and initiatives, which are the governor's multi-payer medical home collaborate, health homes, Children's health care improvement collaborative, and the dual eligibility plan.

Ms. Clement said there are two one-time budget requests for support staff for both the managed care design services and the continued medical home developments. She concluded that the Medical Care Advisory Committee keeps track of developments, providing oversight with subcommittee focus on different managed care approaches.

Responding to questions, **Ms. Clement** stated that precise actuarial information is available and she is expecting additional regional information on Idaho's capitation fee. During the forums repeated requests were made, because of the population's vulnerability, to make sure any implementation is working well.

Ms. Clement remarked that the Dual Eligible Discussion (Duals) office has offered all states the chance to review new financing models. Of interest is the three-way contract between Medicaid, Medicare, and health plans, because it reduces the complexity of three plans to one plan that includes all benefits under a single capitation.

In answer to additional questions, she explained that the Idaho Health Data Exchange (IHDE) is a practice-to-practice service for patient records, so information is not directly available. There are two incentive programs for funding to eligible providers to help pay for electronic health records. She said that funding from the American Recovery and Reinvestment Act (ARRA) is available for physicians with 30% or more Medicaid patients (20% or more for pediatricians).

She described how the medical home team model engages team members in their areas of expertise, and their need of an informational system

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10:03 a.m.

Representative McGeachin
Chair

Irene Moore
Secretary