MINUTES

HOUSE HEALTH AND WELFARE
MEDICAID SAVINGS AND EFFICIENCIES SUBCOMMITTEE

DATE: January 20, 2006

TIME: 10:30 AM

PLACE: Room 404

MEMBERS: Chairman Block, Representatives Garrett, Nielsen, Loertscher, Henbest, Rusche

ABSENT/ EXCUSED: None

GUESTS: See attached sigh-in sheet.

Chairman Block called the meeting to order at 10:30 AM. The minutes of the Subcommittee of December 28, 2005 were reviewed. Rep. Nielsen moved to approve the minutes with the correction of changing the word Legislature to committee on line 4 in the second to last paragraph on page 10. The motion carried.

The Chairman invited David Rogers, Medicaid Division, Department of Health and Welfare, to give an overview of the progress on the governor's reform legislation. Mr. Rogers recognized Kate VandenBroek who has been spearheading this effort as well as Cathy Holland-Smith. He explained that they have been working with LSO on legislation and have three drafts to review today, which are "works in progress." (See attached documents, Draft #3, Draft #9, Draft #3, cont.)

Mr. Rogers referred to Draft #9 which refers to the new Section 56-250 Idaho Code. The document begins with Section 56-251, Intent, by describing the framework legislation which divides the populations into three separate categories, Low-Income Children and Working-Age Adults, Persons with Disabilities or Special Health Needs, and Elders. He said that setting this policy direction will include policy goals with emphasis on prevention and wellness.

Rep. Garrett expressed approval for the prevention and wellness goals in the first two categories and requested the same goal be outlined for the Elder population related to ensuring their quality and dignity of life. She commented that this may be contingent on federal approval.

Rep. Nielsen suggested emphasized preventive care in wellness in all three population areas.

There was discussion on whether or not to proceed with a motion. Chairman Block stated that without objection, the committee would ask the department to include the wellness and dignity of life inclusion.

Rep. Henbest questioned if network management and cost sharing, etc., need to be defined, subsection (3), page 2.

A concern was raised about staying clear from trying to write statute. Rep. Henbest commented that these are general suggestions for the department to use in their drafting of the legislation.

Mr. Rogers referred to Powers and Duties of the Director, Section 56-253, explaining that the director's first duty is to get federal approval; second is to make proposals and implement changes to the medical assistance program. The language states that the director may create health needs categories and develop a Medicaid state plan specific to those categories. Each state plan shall include policy goals for the identified population and a budget process needs to be defined.

Cathy Holland-Smith expressed concern relating to the power of the director, subsection (2), that the legislature should feel a part of the process. She suggested adding the following language: "subject to legislative approval."

Discussion was raised about whether the proposed statute should read may or shall in subsections (4) and (5). Rogers referred to subsection (6) regarding selective contracting explaining that this is nothing new just more explicit. Subsection (7) regarding agreements with Medicare and school districts to provide medical care (healthy schools, healthy day cares) is not a big stretch in terms of the director's authority, he said.

Mr. Rogers referred to Section 56-254A, Eligibility for Medical Assistance. He explained that they did not address the asset transfer for children. Mr. Rogers agreed to move on through the sections, highlighting only the changes. He referred to subsection (b), where eligibility for a pregnant woman is increased through the end of the calendar month to the 90th day after the end of the pregnancy falls. Currently, the program is limited to a 60-day period.

Moving forward to Section 56-254B, Medical Assistance Program. Mr. Rogers noted subsection 1, on page 5 (Draft #9) the language that includes outpatient mental health services limited to 26 hours per year and subsection 2, inpatient psychiatric facility services limited to 10 days per year. There was discussion and concern regarding using the term limited. Rep. Rusche commented that language allowing flexibility should be considered. Mr. Rogers commented that the order of eligibility may need to be reversed.

Moving forward within the same section, to page 6, subsection (ii). The new language states that participants in the 133% to 150% of poverty level will be required to pay $10 premiums, limited to not more that $30 per month per family. Families above 150% of poverty limited to not more than $45 per month. Concerns raised were that the base needs to remain simple and it will be easier to implement. Currently there is no cap in administrative rule. Discussion continued regarding amount of the premium, splitting the premium, etc.

Referring to Draft #3, Personal Health Accounts, Mr. Rogers presented the proposed statute change to establish personal health accounts for Medicaid participants enrolled in Low-Income Children and Working-Age Adults. These accounts are proposed for participants who keep risk assessment appointments with their primary care provider. The

department will set a base dollar amount by rule and add to it when the participant complies with recommended preventive care and exhibits healthy behaviors. Unmet copayments and delinquent premium payments will be deducted from the personal health account.

Referring to Copayments (draft #3), Mr Rogers explained that the legislation provides for charging copayments to participants who use the emergency room inappropriately. Mr. Rogers agreed to add definitions of "inappropriate emergency room usage" and "prudent layperson" for determining whether an emergency room visit was appropriate. That is, if a prudent layperson would have sought emergency treatment, no co-payment would be charged. There was concern that a missed appointment might trigger a co payment. A representative asked how having a benefit one couldn't use would change behavior. A representative asked if the hospitals agreed to the concept and whether this would be in the rules. Mr. Rogers responded that nonemergent would be determined by the hospital and said most infants would not be turned away.

Referring to Health Information Technology Task Force, Draft #3, cont'd., Kate VandenBroek explained that this legislation establishes what the Task Force is and what it does. The original plan was to give grants to providers to improve their technology. The focus changed and the department was advised to look at how technology is handled by health insurers like Blue Cross, Regence Blue Shield, etc. These companies are working on their own versions of electronic health records. The proposal needs to be strengthened and details added about would be on the task force and its goals.

A representative asked how much the Health Information Technology Task Force would cost. Ms. VandenBroek said the Task Force would cost $400,000, while grants to providers would cost $10 million for 40 providers. She said the idea was taken to an advisory group hosted by the Idaho Medical Association. Mr. Rogers stated not all the $400,000 would be needed for the Health Information Technology Task Force. A representative suggested that the Task Force be funded by federal money or the Robert Wood Johnson Foundation. Mr. Rogers responded that the $400,000 included $100,000 in State General Fund. He said the goal was to create a stable funding source to move technology forward.

Chairman Block said some hospitals and providers were already implementing electronic health records and asked how the department plans to interface with these providers. Ms. VandenBroek said she had met with staff from St. Alphonsus Hospital to discuss this.

Chairman Block asked Ms. VandenBroek if there was anything else of interest to the Committee. Ms. VandenBroek listed more Medicaid Reform issues, including grants for aging and disability resource centers, health information technology for long term care, buy-in for workers with disabilities, premium assistance, reducing barriers to enrollment, allowing enrollment in the Children's Health Insurance Program (CHIP) for Medicaid-eligible children, a pilot Medicaid program for insurance for spouses and removal of the asset test for Low-Income Children Medicaid. Asset transfer penalties are being stiffened and the "lookback" for asset transfers increases from within 3 years of application to within 5 years of

application.

Chairman Block thanked the department for making this a partnership effort.

ADJOURN: The meeting was adjourned at 12:30 PM.

Representative Sharon Block Chairman	Jennifer O'Kief Secretary