REVISED MINUTES *
(*Approved by the Task Force*)

Health Care Task Force
September 10, 2012
Capitol Building, Boise Idaho
East Wing, Room 42

In attendance were Co-chairs Senator Dean Cameron and Representative Gary Collins; Senators John Goedde, Patti Anne Lodge, Joyce Broadsword, Steve Vick and Dan Schmidt; Representatives Sharon Block, Carlos Bilbao, Fred Wood and John Rusche. Absent and excused were Senator Tim Corder and Representatives Janice McGeachin and Elaine Smith. Legislative Services Office (LSO) staff members present were Ryan Bush and Matt Ellsworth.

Others present at the meeting included Kurt Stembridge, GlaxoSmithKline; Dennis Tanikuni, Idaho Farm Bureau; Ana Fuentevilla, MD and Blaine Bergeson, United Healthcare; Steve Rector and Tim S. Olson, Idaho Academy of Nutrition and Diabetes and Nez Perce Tribe; Richard Armstrong, Denise Chuckovich, Mitch Scoggins, Elke Shaw-Tulloch, Christine Hahn, MD, David Simnitt and Cynthia York, Department of Health and Welfare; Bill Deal, Department of Insurance; Richard Roberge, Board of Health and Welfare; Colby Cameron, Sullivan Reberger Eiguren; Susie Pouliot and Ken McClure, Idaho Medical Association (IMA); Jack Myers, Steve Tobiason and Woody Richards, Blue Cross of Idaho; Bill Roden, Hopkins Roden; Marnie Packard, PacificSource; Corey Surber and Tiffany Whitmore, Saint Alphonsus; Kathie Garrett, National Alliance on Mental Illness (NAMI); Kris Ellis, Idaho Health Care Association (IHCA); Shad Priest and Lyn Darrington, Regence BlueShield; Lee Flinn, American Association of Retired Persons (AARP); Casey Meza, Kootenai Medical; Stacey Satterlee and Reiley O'Brien, American Cancer Society Cancer Action Network; Janet Trujillo; Mike Hammond, Cenpatico Behavioral Health / Centene; Brent Olmstead and Bruce Gorman, Magellan Health Services; Astrid Shadle, Boise State Nursing; Sara Stover, Division of Financial Management; Toni Lawson, Larry Tisdale and Steve Millard, Idaho Hospital Association (IHA); Jesus Blanco, Idaho Primary Care Association (IPCA); Russ Elbel, SelectHealth; Heidi Low, Ritter PR; Elizabeth Criner and John Watts, Veritas Advisors; Christi Lundeen and Matt Cowley, Aetna Medicaid; MacKenzie Rodgers, Alzheimer's Association; Jesse Taylor, Westerberg & Associates; Julie Robinson, Family Medicine Residency of Idaho; and Sarah Toevs, Boise State University.

The meeting was called to order at 9 a.m. by **Co-chair Senator Cameron.** He welcomed everyone and called for a motion on the July 30, 2012 minutes. **Co-chair Representative Collins moved that the July 30, 2012 minutes be approved, seconded by Senator Lodge, and the motion passed unanimously by voice vote.**

***** Page 2, paragraph 5, line 8: (Senator Broadsword) **" …** Medicaid expansion might **not** be the best option." This was changed to read: " … Medicaid expansion might be the best option."

Director Richard Armstrong, Department of Health and Welfare (DHW), was the first presenter. **Director Armstrong** updated the task force on the Governor's working group on Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA) and stated that the working group will meet again on September 27. In the meantime, they are doing additional study on the Medicaid expansion population. One problem that DHW is having is that the federal government has not given final guidance on the modified adjusted gross income (MAGI) calculation. This causes problems in narrowing expansion numbers. DHW will end up using a range of numbers until the rules are known, and the range will be significant. DHW does know that the expansion population is made up of the working poor. Sixty percent of these people are employed, and DHW has a good understanding of this income level which will allow DHW to develop the profile. This information was shared in the Leavitt Partners' final report on the expansion population issued on September 14. **Director Armstrong** stated that this report was very neutral and factual and outlines risk factors. DHW does know that this population has chronic disease greater than normal population. **Director Armstrong** stated that the report gives very good data on the ongoing costs of the expansion population.

Representative Rusche asked if it was correct that if Idaho does not choose Medicaid expansion, then it would still have the statutory responsibility to provide indigent care for those below 133% of the poverty guidelines. **Director Armstrong** replied that this was correct and that existing statutes would remain in place regarding indigent care. He further stated that indigent care is not based on household income but is incident based. Someone at 200-300% of federal poverty guideline could be indigent because of high costs.

Representative Wood asked if the federal government has given any indication on deadlines or timelines with regard to Medicaid expansion. **Director Armstrong** replied that the only deadlines would be the deadlines for financial support. DHW has to be ready soon because the process must be in place regardless of the exchange.

Senator Goedde asked if the lack of clarity from the federal government is affecting the enrollment study. **Director Armstrong** replied that it is not, but the numbers are not as exact as they would like. An estimated expansion population of 100,000 to 125,000 could be 200,000 depending on how the federal government defines eligibility. This is a big difference when calculating cost. **Director Armstrong** stated that the Leavitt study on the expansion population would be available on September 14.

Senator Broadsword asked if Idaho decides to opt in or opt out of Medicaid expansion, does it need to apply for a waiver, if it is a long process to opt in later and would it be past the one-year deadline for 100% payback from the federal government. **Director Armstrong** replied that DHW is not planning on using a waiver but that it would be the normal time frames in getting those approved. A waiver would be complex and will depend on the November election. The fastest plan is a state plan amendment and that is what DHW is planning to do. The clock is ticking for financial opportunities, but they need to do what's right for Idaho. **Senator Broadsword** stated that since Idaho is paying for care one way or another through the catastrophic health care plan, the prison system or hospital care, Medicaid expansion might be the best option. **Director Armstrong** stated that they will have a few options. They now know through this Leavitt study where the expenses are. Costs will not go away but they now know how to best manage them.

Senator Schmidt asked if expansion would increase the population for those with disabilities and in nursing homes and if this is being provided for. **Director Armstrong** replied that the current population is for children, pregnant women and those with disabilities. There will be some woodworking from

children coming in with newly eligible parents. Asset tests stay in place for determining the existing population. The expansion population has a different set of rules, and they don't always go well together. It is very complicated, and DHW is trying to account for all pieces of eligibility.

Senator Cameron asked if DHW was looking at the long-term costs of Medicaid expansion, 10 or 20 years out, as well as the shorter term. **Director Armstrong** replied that they are trying to forecast into the future, but it is difficult to forecast healthcare inflation rates that far out. The CAT fund shows how difficult this can be, and DHW will be conservative on its forecasts. The federal government will pay 100 percent of the cost for the expanded population for the first three years, phasing that down to 90 percent in six years and thereafter. It is possible that the federal matching rate might fall to 70 percent depending on who is in office. **Senator Cameron** stated his concern that Idaho would look at the short-term savings, and then in 10 or 20 years the Legislature will be trying to figure out how to pay for this. **Director Armstrong** stated that the anticipated savings needed to actually happen as well.

The next presenter was **Director Bill Deal**, Department of Insurance (DOI). **Director Deal** updated the task force on the Governor's working group on a health insurance exchange under the PPACA and stated that Deputy Director Tom Donovan had attended meetings on insurance exchanges conducted by the Center for Consumer Information and Insurance Oversight (CCIIO) which is part of the Department of Health and Human Services (HHS). **Director Deal** stated that there was not much new information in these meetings since DOI is still waiting for rules from the federal government. CCIIO recommended that states implement state-based exchanges and that states should regulate different items such as the addition of coverage for pre-existing conditions and the waiver of annual and lifetime benefits. The message from CCIIO was that if a state does not have this authority, then legislation would be necessary. **Director Deal** stated that essential benefit benchmarks are due on September 30 and must be supplied to CCIIO. However, a rule on this will not be forthcoming until November. DOI has enough info to provide the benchmarks for essential benefits. However, these essential benefits are not etched in stone and can be changed.

Director Deal then discussed the first meeting of the working group on an insurance exchange that was held on August 2. The group is trying to do what is best for Idaho's citizens. The meeting was an overview of the PPACA, requirements for an exchange, critical dates, the charge to the working group and questions to be answered for the Governor. In the working group's meeting on August 29, the group heard from Michael Cannon from the Cato Institute, Sean Riley from ALEC and Jack Rovner from Health Law Consultancy. The group got reports on some of the questions to be addressed, and DOI contracted with a group of experts to provide cost analysis. This report will be available at the working group's meeting in October. **Director Deal** discussed the agenda for the meeting on September 11. Idaho has been working with representatives from Colorado and Nevada on a fast way to move if they decide on a state exchange. Representatives from Colorado, Nevada and from CCIIO were scheduled to speak. **Director Deal** stated that the big project for the states is to provide a blueprint for approval for a state-

based or partnership exchange. Answers to questions posed by CCIIO must be provided to CCIIO by November 16, but this is unlikely to happen since the Governor and Legislature must act first.

Senator Goedde asked if there was any room in the PPACA for something other than a state or federal exchange such as a private solution. **Director Deal** answered that an accredited exchange must conform to the PPACA and that a hybrid exchange would likely not meet these requirements. **Director Deal** mentioned that in the last meeting of the task force there was discussion of Utah's exchange. It was his understanding that Utah's hybrid exchange may not work. **Senator Goedde** then asked if it was accurate that Idaho had some of the least expensive health insurance rates in the country. **Director Deal** replied that this was accurate and that Kaiser and the IRS were sources for this information. **Senator Goedde** asked how many insurance companies are licensed to sell insurance in Idaho. **Director Deal** answered that there are 782 but only about 192 pay a premium tax to the state.

Senator Vick asked how much flexibility there would be in a state versus a federal exchange. **Director Deal** stated that the state would have some latitude in a state-based exchange such as how Idaho producers do business with an exchange; the role of navigators and how they are compensated; and DOI's regulatory authority over insurance companies and their rates, policy provisions, etc. Idaho would also have flexibility in consumer services and outreach. **Senator Vick** asked if Idaho chooses a federal exchange, would it lose the ability to regulate insurance companies in Idaho. **Director Deal** answered that DOI would pretty much lose that authority in a federal exchange. **Senator Vick** then asked when essential benefits are decided, if there will be flexibility to go less strict or only more strict. **Director Deal** replied that states can decide the essential benefits with 10 categories that must be covered. Idaho will likely take a group plan with the highest participation in Idaho and use these coverages to recommend what would be essential benefits. **Senator Vick** asked about instances of requiring coverage for birth control. **Director Deal** answered that HHS has given institutions like universities and hospitals with religious belief the ability to ask for a waiver. **Senator Vick** asked if it was correct that these waivers would be granted by the federal government and not by Idaho. **Director Deal** stated that this was correct.

Senator Cameron stated that if Idaho sets up an exchange, it should set up an exchange how it wants and make the federal government argue why it should have certain components. This would allow for a public discourse on what Idaho disagrees with and why it doesn't qualify. **Senator Cameron** stated that there has been some indication of federal flexibility if Idaho goes this route with a state exchange. This is a third option of a state exchange that is best for Idaho and makes the federal government argue why it does not qualify. **Director Deal** stated that Idaho needs to get to a state exchange first and build in essential benefits. **Senator Cameron** stated as an example that under a federal exchange people have to give certain proprietary information about themselves which does not seem pertinent. If Idaho chooses a state exchange, Idaho should let the federal government argue why this information is required.

Senator Schmidt asked about essential benefits being based on the most common policy sold and if this could change over time from one package to another. **Director Deal** answered that he believed so. There is some authority in the rules for states to change position and remodel coverages to fit the needs of citizens.

Representative Rusche expressed concern with the timeline for an insurance exchange and stated that the working groups are being diligent but that there is not much time for a blueprint. **Representative**

Rusche asked Director Deal to discuss the timeline for an exchange, from the working group's recommendation to the Governor's decision to the creation of a blueprint. **Director Deal** stated that he should know more after the September 11 working group meeting. Some states are meeting benchmarks and are going to discuss how they met the timelines in this meeting. If Idaho could participate with some infrastructure already in place and potentially borrow from other states' technology, this would help Idaho meet the deadlines. The critical dates for an insurance exchange are as follows:

- November 16, 2012 - the declaration of the type of exchange must be made to HHS;
- January 1, 2013 - if Idaho chooses a state-based exchange, its plan must be certified by HHS;
- October 1, 2013 - initial individual open enrollment in an exchange would begin; and
- January 1, 2014 – if Idaho chooses a state-based exchange, it must be fully operational.
- The next applications for federal grants are due on November 15, 2012, and February, 15, 2013.

Director Deal stated that it was his belief that if Idaho has a plan that could meet the benchmarks and be ready by 2014, then that might work and buy Idaho some time. **Director Deal** stated that he is concerned with the time frame in assembling a board to craft legislation for a state-based exchange and in establishing governance of an exchange.

The next presenters were **Casey Meza** of Kootenai Health and **Tiffany Whitmore** of Saint Alphonsus Health System. **Ms. Meza** and **Ms. Whitmore** provided the task force with an overview of a TeleMedicine program in Idaho. Their PowerPoint presentation can be found on LSO's website at: http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_whitmore_meza.pdf

Ms. Meza gave the task force an overview of TeleMedicine and why it is important in a rural state like Idaho to use communication technology to provide specialty services for patients in remote areas. **Ms. Whitmore** discussed the origins of the TeleMedicine program and gave an overview of services offered, discussed the growth of the program and the cost savings from serving patients at home. **Ms. Meza** then discussed specific programs such as TelePsychiatry and TeleHospitalist services and gave examples of how these services saved costs. The TeleHospitalist services allow family practice providers to get second opinions on those that are elderly or have multiple issues, retain patients in their communities and avoid duplication of tests. **Ms. Whitmore** then discussed the Emergency Specialist Program where sub-specialist physicians provide consultations in emergency situations using TeleMedicine so that patients can get care in community hospitals. **Ms. Whitmore** also discussed the TeleBurn service in partnership with the University of Utah and TeleStroke services. **Ms. Meza** then addressed the future vision of the TeleMedicine program.

Representative Rusche asked about the telecommunications infrastructure and the grant to Region 2 mental health for TelePsychiatry. **Ms. Meza** replied that they have had struggles with infrastructure but are adding capacity. Technology such as videoconferencing is advancing and becoming seamless. As for Region 2 services, they are working with the same equipment. **Ms. Meza** stated that she is trying to initialize this work and connect more resources through the technology that Region 2 was able to acquire.

They are looking to bring adult and child services into the Moscow and Lewiston areas. **Ms. Meza** stated that TeleMedicine brings people together who understand the needs of a community and keeps specialists excited about bringing care to those who need it most while allowing primary care physicians to care for their patients. The Region 2 money has been used well, and they are talking with Moscow about bringing in neurology services.

Senator Broadsword discussed the shortage of providers in Northern Idaho, particularly in the psychiatric area, and asked if local doctors sit in on TeleMedicine appointments and personally interact. **Ms. Meza** replied there need to be physician champions in rural settings. Staff in a rural setting also needs to be involved because they know the people and families, and patients have different preferences. Their model is to have appointments in clinics where the primary care doctor is located so that there is always access to primary care providers if they need to step in. **Senator Broadsword** then asked if a patient's medical records are linked between practices so that the local doctor has information such as new medicine prescribed. **Ms. Meza** replied that they use a consultative mode and that the primary care physician is in control of care and the specialist is a consultant. **Ms. Seibert** stated that immediately after an appointment, documents and notes are faxed to the primary care physician, and they have access to a dictation system to know what was discussed.

Representative Collins asked how the TeleMedicine program is funded and how reimbursements are handled. **Ms. Seibert** answered that the program relied on grant funding initially. One reason that they are pursuing multiple applications in TeleMedicine is so that multiple organizations can share costs. They have had reimbursement challenges since not all payors pay. For TelePsychiatry, there is reimbursement and partner hospitals pay for a block of psychiatry time. For TeleStroke they do not charge network hospitals. For other services, there are flat fees and offsets for paying for a portion of technology through keeping patients in a local community. **Representative Collins** asked if the grants were government grants and asked if the reimbursements not being paid were by insurance companies. **Ms. Meza** replied that because Idaho is rural, Medicare pays for TeleMedicine so long as it is medically necessary. Most commercial payors are now paying for services. Medicaid only pays for adult and child psychiatric services. **Ms. Meza** stated that Idaho cannot afford to not have TeleMedicine because it gives patients easier access to specialists. Regular providers are also able to see a multitude of patients, and since it is a cost-based reimbursed critical access hospital, technology is an allowable expense. **Ms. Meza** stated that TeleMedicine is saving dollars by keeping patients in the community.

Representative Rusche stated that TeleMedicine is important but it does not help with physician capacity. Shortage of practitioners is still a problem, especially the shortage of psychiatric physicians.

The next presenters were **Dr. Christine Hahn**, State Epidemiologist of DHW, and **Jack Myers**, Chair, Immunization Assessment Board. **Dr. Hahn** and **Mr. Myers** gave updates on the Idaho Immunization Program and Immunization Assessments. Their presentations can be found on LSO's website at:
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_hahn.pdf
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_myers_immunizations.pdf

Dr. Hahn gave an overview of the functions of the Immunization Program and discussed the recent history of the program in rules and statutes. **Dr. Hahn** also discussed developments in 2012 including a new immunization registry and proposed legislation on the registry. **Dr. Hahn** then discussed the challenges of the rise in cases of pertussis or whooping cough and gave updates on the immunization rates of various diseases and immunization rates for teens. **Dr. Hahn** then discussed how the program purchases vaccines and gave an update on assessment funds.

Mr. Myers discussed the intent of the legislation that created the program, House Bill 432 (2010). **Mr. Myers** then discussed rising assessment rates and how the Board is recommending an increased rate of $79 for fiscal year 2013. He explained that this was because stimulus funds are going away. Also HPV is an expensive vaccine and was introduced for girls. It is now being introduced for boys. The Board will estimate usage for new vaccines and build that into the rate. Also for 2013, physicians will be required to administer influenza vaccines. **Mr. Myers** then discussed how insurance carriers are assessed. Not all carriers have children or an immunization benefit, but all carriers who are assessed are current with payments. **Mr. Myers** then discussed how savings expectations for the program have decreased and that estimation of savings is difficult due to changes in vaccine coverage and the instability of estimation during the initial years of the program. **Mr. Myers** discussed the sunset provision for the program on July 1, 2013. The Board recommends a two-year extension to further evaluate cost savings.

Senator Cameron asked if the Board is carrying over funds from year to year and in what amounts. **Mr. Myers** responded that the funds were being carried over. This is one challenge in determining the rate. He believes that they carried over around $500,000 from last to current fiscal year. This carryover has to be built into the assessment rate. **Senator Cameron** asked about the Board's recommendation in increasing the assessment rate to $79 and if this was based on an increase in the number of children, an increase in the costs of existing vaccines and on expensive new vaccines and asked how secure the Board is in this number. **Mr. Myers** stated that these were the reasons for the increase. They are assuming about a 3% inflation rate. There are a greater number of children, and the HPV vaccine is a major reason for the increase. Also, the carryover from 2011 to 2012 was more than they will have this year.

Representative Rusche stated that the PPACA has vaccine coverage as an essential benefit and asked if this will affect the program. **Representative Rusche** also asked if new vaccines are added, if the mechanism for acquisition through the CDC would still provide a cost/benefit for the policyholders of Idaho. **Dr. Hahn** replied that there is a great deal of uncertainty with the PPACA. This is another reason to extend the sunset provision. Underinsured children not covered for vaccinations will go away as insurance is required.

Senator Cameron asked why the Board is recommending a two-year extension in the sunset provision and not longer. **Mr. Myers** replied that one of the larger carriers said that there are no cost savings at all. The Board needs more time to evaluate this information and convince carriers of savings. **Mr. Myers** believes that savings may improve.

The next presenter was **Matt Ellsworth**, Senior Budget and Policy Analyst, LSO. Mr. Ellsworth gave the task force a brief history of managed care in Idaho. His presentation can be found on LSO's website at: http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_ellsworth.pdf

Mr. Ellsworth described Medicaid managed care, primary care case management (PCCM) and Healthy Connections, Idaho's PCCM program established in 1993. **Mr. Ellsworth** then discussed legislation that expanded managed care in Idaho and how DHW is required to prepare a plan for managed care in Idaho. DHW received $650,000 for fiscal year 2013 to prepare this plan which is scheduled for completion in June 2013.

The next presenter was **Julia Paradise**, Associate Director, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. **Ms. Paradise** gave a nationwide overview of managed care and discussed the North Carolina model of Medicaid managed care (MMC). Her presentation can be found on LSO's website at:
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_paradise.pdf

Ms. Paradise began by discussing the HHS definitions of managed care and risk-based managed care, the major models of managed care in Medicaid including primary care case management (PCCM) and the statutory authority for managed care. **Ms. Paradise** then discussed states' motivation in adopting managed care, concerns about risk-based managed care and evidence on the impact of Medicaid managed care. **Ms. Paradise** next gave the task force information on how managed care is operated across the states. This included which states operate comprehensive MMC programs, penetration rates, number of enrollees and enrollees in different types of plans. **Ms. Paradise** addressed how states are using quality data to improve MMC performance; initiatives to improve care; the extension of MMC to beneficiaries with complex needs; states that are moving forward with proposals to participate in dual-eligible demos which includes Idaho; and the key issues in managed care such as payment, provider networks and care delivery and beneficiary protection.

Ms. Paradise's presentation then focused on the Community Care of North Carolina (CCNC) enhanced medical home model of MMC which included the fundamentals of CCNC. These fundamentals include the premise that the costs of medical homes will be more than offset by reduced inpatient hospital and ER use as access to primary care, prescription and chronic care management increases. CCNC is comprised of 14 regional, non-profit, physician-directed networks, and nearly all primary care providers participate with per-member-per-month fees paid to the network and providers. CCNC has mechanisms and informatics for managing care and quality improvement. **Ms. Paradise** then discussed CCNC's improved utilization patterns, the evidence on savings under CCNC which are nearly $1 billion over 4 years and concluded by discussing initiatives underway to enhance CCNC.

Representative Rusche stated that the PCCM model varies from state to state and stated that in Idaho there is not much of a requirement for primary care physicians to do much management. **Representative Rusche** asked where North Carolina was before it started this model and if it was in a similar situation to Idaho, and asked if North Carolina is focused on high-cost individuals where the greatest impact would be felt. **Ms. Paradise** replied that CCNC began to be compiled in 1998, but she was not sure what it looked like before 1998. Programs do vary from state to state as far as expectations on primary care providers. Thirty-nine states have some medical home programs in various stages. **Ms. Paradise** stated that she would provide more information to Representative Rusche on per-member-per-month fees.

The task force recessed for lunch at 11:50 a.m. and reconvened at 1:15 p.m.

The next presenters were **Susie Pouliot**, Idaho Medical Association (IMA), **Larry Tisdale**, Idaho Hospital Association (IHA), and **Kris Ellis**, Idaho Health Care Association (IHCA). They participated in a panel discussion on what providers would like to see in a Medicaid managed care system in Idaho. Ms. Ellis' PowerPoint presentation can be found on LSO's website at: http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_paradise.pdf

Ms. Pouliot stated that IMA physicians support integrated, coordinated, patient-centered care but dislike the term managed care. They prefer community care networks or coordinated care. **Ms. Pouliot** stated that coordinated care can provide better health outcomes, especially for those with chronic diseases. This can be achieved by building on the patient-centered medical home (PCMH) model. Benefits of PCMH include better coordination and follow-up, integration of care and consistent quality measures. **Ms. Pouliot** stated that a drawback of the old model of managed care was top-down directives from managed care organizations (MCOs) that were focused on cost management rather than care management. **Ms. Pouliot** stated that practice-based care managers and care coordinators as well as a robust health data system are important in a PCMH model. **Ms. Pouliot** then discussed the Community Care of North Carolina (CCNC) enhanced medical home model and stated that this model has meaningful applicability in Idaho. This model would provide community-based and coordinated care with an emphasis on wellness and preventative care. Patients would have access to appropriate care and information, providers would have clear accountability for total care of patients, and members of the system would be continuously innovating.

Mr. Tisdale first addressed the benefits and drawbacks of managed care programs and stated that there are no drawbacks to managed care programs if done properly by managing patient health and not access to care. **Mr. Tisdale** stated that even when done properly, financial benefits of managed care can be lost due to increased overhead and that insurance companies can have disparate treatment of disease management programs making it difficult on physician offices. **Mr. Tisdale** then discussed what provisions are important in managed care and stated that health improvement and disease management programs, a strong data environment to predict risks and outcomes, and accountability that improves efficiency and rewards improved health outcomes are important.

Mr. Tisdale next discussed the models of managed care that work best and those that should be avoided. He stated that the IHA favored a patient-centered model and was not in favor of insurance-based MCO models because other states have had mixed results with this model. **Mr. Tisdale** stated that the North Carolina model was a mature and proven model but was not the entire answer for Idaho. This model has standardized disease management protocols, created a data infrastructure, linked medical homes into community-based networks and saved North Carolina over $1 billion over a traditional Medicaid program. **Mr. Tisdale** stated that he does not want to duplicate the North Carolina model but adapt it for Idaho. This would include leveraging reimbursement and incentive programs and using the Idaho Health Data Exchange. **Mr. Tisdale** stated that Idaho should avoid implementing the next outdated model and can skip a full generation of modeling because of current technology. **Mr. Tisdale** expressed that the Center for Medicare and Medicaid Innovation (CMMI) has allowed states to be testing grounds for

innovation and that there is a grant to expand on an integrated health care delivery system for multiple payers. IHA would like to see all payers have consistent disease management protocols, and they will be reaching out to providers and insurance companies. **Mr. Tisdale** stated that one insurance company had joined in that effort.

Ms. Ellis discussed how today's nursing homes and assisted living facilities relate to managed care and how access to care is critical in a managed care system. **Ms. Ellis** then discussed how the rural nature of Idaho presents unique challenges and how savings for managed care are measured especially when high overhead costs are considered. **Ms. Ellis** stated that savings could be realized through the medical home model with integrated care management, disease management and education of preventative services and healthy behaviors. **Ms. Ellis** then discussed incentives to reduce both Medicaid and Medicare costs in long-term care which would include reducing the time for required hospitalization. **Ms. Ellis** expressed that providers are concerned about payment delays and confusion associated with potentially new billing systems. **Ms. Ellis** stated that the IHCA is in support of a physician-led model of care similar to North Carolina's. **Ms. Ellis** stated that providers in managed care should not be subjected to duplicative surveys by multiple MCOs and DHW, and she concluded by stating that the IHCA supports innovative, efficient models of care that are receptive to specialty programs, allow patients to reside in assisted living and reduce required hospitalization.

Representative Rusche asked about reconciling medical management success and the fee for service model. **Mr. Tisdale** answered that they are there to treat patients that are sick, not hope that they get sick. Hospitals are capital intensive as far as providers go and they do not make money on Medicaid patients. They need to figure out how to keep an aging demographic out of hospital beds, and they do not want more hospital beds once this population works through the system. Everyone understands that the current delivery system is unsustainable. Half of physicians work for hospitals, and nearly 80% of nursing students are looking for jobs after graduation, so they are invested in the entire process.

Representative Rusche expressed concern about consolidation in the provider community and what this means for negotiation and independent practice and asked if a managed care model protects against consolidation or if more regulation like a utility will be required. **Mr. Tisdale** replied that Idaho is in a unique place because this is a small, urban place. With 2 hospitals, someone will have 50% of the business and be subject to scrutiny. Hospitals are pursuing managed care for a better delivery system and they will live up to the scrutiny. **Mr. Tisdale** stated that he does not see healthcare as a utility. Hospitals will compete for business through their centers of excellence and their outcomes.

Representative Wood asked about what information that the IHA has on a true accountable care organization where all providers banded together to form a network to care for a defined population and if there are any examples of states or regions that have done this. **Representative Wood** stated that Idaho should not repeat mistakes of the last 15 years of other states. **Mr. Tisdale** replied that those systems are premature but are developing. They are looking for a solution for Idaho. North Carolina has many strong attributes but is not the entire answer. Hospitals in North Carolina are part of networks and the coordination of care includes hospitals and primary care physicians. One issue with the North Carolina model is that the environment has changed a lot since it was implemented.

Senator Goedde commented on how Medicaid barely covers the costs of hospitals and asked if these

were fixed costs or variable costs and how these were calculated. **Mr. Tisdale** stated that they look at cost in a holistic fashion. They are paid at 100% of allowable costs, but under CMS rules there are costs not allowable such as costs that are needed to run a hospital but not related to patient care. They talk in terms of both variable and fixed. **Senator Goedde** asked if a hospital buys a new piece of medical equipment and it is used on Medicaid patients half of the time, if all of the cost of the equipment is passed on to those patients not on Medicaid. **Mr. Tisdale** replied they would not buy a machine to break even or get their cost back. If physicians need it and there is a need in the community, these are the factors more so than getting cost back.

Senator Schmidt asked if North Carolina has seen a significant decrease in variation in patient care across geographic areas with community care networks. **Ms. Pouliot** responded that she does not have the North Carolina data, but theoretically all providers should follow the same guidelines in treating chronic diseases and that variances should be lower. **Senator Schmidt** then asked about the demographic differences between North Carolina and Idaho such as the number of frontier counties and primary care physicians available to the population. **Mr. Tisdale** responded that North Carolina is a rural state, but they are 2/3 the size of Idaho and have 10 million citizens. They have one small network of one county but no frontier counties. Frontier counties in Idaho may have to become a network that includes the four northern counties and other smaller counties. There are no easy solutions for creating a network in frontier counties.

Senator Broadsword commented on the possibility of a minimum increase of 10% for administrative costs if a managed care organization comes into Idaho and asked if there is further research on cost savings from preventative care in a managed care program. **Ms. Ellis** replied that they have no statistically valid data, but they have compared data from certain facilities and from certain geographical areas. Cost savings in rural areas where there are no options are difficult to determine.

Senator Cameron stated that it seems that providers are okay with managed care so long as they are doing the managing and asked why hospitals, physicians and long-term care facilities have not been managing care on their own without government or the private sector stepping forward. **Ms. Pouliot** responded that for primary care physicians there is a lack of resources in establishing services for coordinated care which are often non-reimbursed services. In the model that they support, a network would be formed by physicians working with hospitals and would have practice-based care coordinators with some enhanced form of reimbursement from Medicaid that helps to pay for care coordination resources. For physicians this is the biggest thing, along with an integrated data system, that is holding them back. **Mr. Tisdale** responded that when you build a reimbursement model, it directs how you do business. Data and informatics are also important. Until recently there has not been integration between hospitals. The rollout of health information systems and electronic medical records and other efforts to coordinate care have helped. Hospitals have joined health data exchanges for hundreds of thousands per year before managed care moved forward. The initiative towards managed care has not just started.

Senator Cameron stated that he does not believe that government can manage a system better than the private sector and that if the issue is provider reimbursement, then this is a separate issue from managing

the care. **Senator Cameron** stated that an integrated data system and staffing to manage the care would likely be better run by the private sector rather than DHW and asked the panel to explain why they felt differently. **Mr. Tisdale** stated that in the North Carolina model, the data system is not a state-run system. It began as a state-run system but moved to the private sector. North Carolina has created compliance with physicians by giving them buy-in into the disease management and protocols and thus control over their patients. **Ms. Ellis** commented on physician accountability and stated that they are accountable just like hospitals are accountable. But once patients leave, physicians and hospitals no longer have responsibility. Nursing homes and assisted living facilities then have people come to them without any coordination with no one telling the patient which is the best place for them. It has been hit or miss and is somewhat financially based.

The final presenters were **Jack Myers**, Blue Cross of Idaho (BCI), **Blaine Bergeson and Dr. Ana Fuentevilla**, United Healthcare, **Russ Elbel**, SelectHealth, and **Matt Cowley**, Aetna. They participated in a panel discussion on what carriers would like to see in a Medicaid managed care system in Idaho. Their PowerPoint presentations can be found on LSO's website at:
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_myers_managedcare.pdf
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_unitedhealthcare.pdf
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_elbel.pdf
http://www.legislature.idaho.gov/sessioninfo/2012/interim/healthcare0910_cowley.pdf

Mr. Myers began by discussing the evolution of managed care at BCI and what works well in managed care. This includes using coordinated care, aligning incentives between providers and members, and sharing information between health plans and providers. **Mr. Myers** then addressed the savings from averted admissions and the population health of BCI members. BCI has around 30,000 members in disease management programs and has added new wellness programs. **Mr. Myers** discussed BCI's project on behavioral health readmissions and its results and BCI's pharmacy generic initiative. **Mr. Myers** discussed BCI's transition to Medicaid which includes its dual eligible SNP contract, the Idaho Smiles Dental Medicaid contract, and BCI's evaluation of a bid response to the Idaho Behavioral Health RFP. **Mr. Myers** concluded by discussing the report given by the Lewin Group to state policymakers in 2011 regarding managed care and its savings and the quality initiatives that BCI has undertaken.

Mr. Bergeson began by discussing United Healthcare, its experience in Medicaid managed care and its national footprint. **Mr. Bergeson** then addressed the challenges and choices of Medicaid such as whether or not to expand, insurance exchanges and dual eligibles. Different states are taking different approaches. **Mr. Bergeson** then discussed the different models of managed care and the factors to be considered, and he stated that MCO-based, integrated Medicaid managed care delivers the highest value in terms of quality and cost efficiency. **Mr. Bergeson** recommended an MCO-based capitated Medicaid managed care program with no carve-outs. There should be no more than two plans to provide member choice, create competition and reduce complexity. Two to three percent of plan capitation should be withheld if performance objectives are achieved, and MCOs should bid on a statewide basis. **Mr. Bergeson** recommended an MCO-based approach because it gives predictability in expenses, shifts risk to MCOs, and provides sustainability.

Dr. Fuentevilla stated that she agrees with much of what providers said previously and discussed the United Healthcare model. They think of themselves as a fully integrated health plan to deliver on care for

a vulnerable population, and their model is member and patient centric. Primary care and hospitals are integrated, and United Healthcare acts as a navigator. When they are assigned Medicaid eligibles, they must figure out what the patient needs and if they are assigned to a medical home. They must also determine if they need behavioral health providers and if the medical home is aware. United has good data on who is getting care. They have a better overall view of who is getting care than providers would. **Dr. Fuentevilla** stated that they are a health plan fully committed to development of medical homes. United uses the term accountable care communities because this implies more than just the practice and the member but also the hospital and the health plan. **Dr. Fuentevilla** stated that United serves over 300,000 Medicaid eligibles in Arizona and around 100,000 of these are in accountable care communities. United has developed a registry or data cloud that all medical homes can access, and they are ready to work with providers. They let providers know when there is a chronic illness through the data exchange, and this helps providers provide the best care. United has assembled provider advisory councils that include physicians, nurses and mid-level providers that guide United in meeting the needs of the community.

Mr. Bergeson then discussed how an MCO-based approach also holds a single entity accountable for quality, increases access and gives technological support. **Mr. Bergeson** concluded by showing the savings that the state of Louisiana had achieved with United's plan.

Mr. Elbel gave the task force an overview of SelectHealth and discussed the benefits of managed care. These benefits include integrated service, disease management, comprehensive data systems, and outreach and education. **Mr. Elbel** then discussed provisions that are important in Medicaid managed care which include integration of benefits and reduction of fragmented services, quality reporting, fixed enrollment periods, lock-in programs for inappropriate use and preferred drug lists. **Mr. Elbel** addressed components that he believes are critical in a managed care model. These include integrated care that aligns incentives between plans and providers and creates shared accountability; disease management; patient advocates to assist enrollees' access to providers; strong information systems; facilitated enrollment programs; and outreach programs.

Mr. Cowley gave the task force an overview of Aetna Medicaid, discussed its focus on dual eligibles and described its national presence. **Mr. Cowley** then discussed the savings achieved by serving needy populations and described how 5% of Aetna's member population that is the sickest drives over 64% of the costs. This is even more pronounced in the dual eligible population. Predictive modeling is important to control costs for this population. **Mr. Cowley** discussed how Aetna integrates behavioral health into patient care and how they deliver lower costs and better outcomes for dual eligibles by simplifying beneficiaries' care and service. Aetna also provides enhanced benefits not usually covered by Medicare such as dental and wellness and employs integrated processes to coordinate care for dual eligibles. **Mr. Cowley** then addressed how Aetna's model uses preventive care and comprehensive care and discussed Aetna's approach to risk assessment and how it identifies the types of member risk. **Mr. Cowley** concluded by discussing Aetna's experience and success in managing the dual eligible population.

The Task Force agreed to reconvene on October 22, 2012 at the Capitol Building in Boise.

Co-chair Senator Cameron adjourned the meeting at 3:45 p.m.