MINUTES
(*Approved by the Task Force*)

Health Care Task Force
October 22, 2012
Capitol Building, Boise Idaho
East Wing, Room 42

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

Others present at the meeting included Kurt Stembridge, GlaxoSmithKline; Dennis Tanikuni, Idaho Farm Bureau; Tim S. Olson, Idaho Academy of Nutrition and Dietetics and Nez Perce Tribe; Richard Armstrong, Paul Leary, Denise Chuckovich, Cynthia York, Elke Shaw-Tulloch, Christine Hahn, MD, Ross Edmunds and Mitch Scoggins, Department of Health and Welfare; Bill Deal, Department of Insurance; Susie Pouliot and Molly Steckel, Idaho Medical Association (IMA); Julie Taylor, Blue Cross of Idaho; Bill Roden, Hopkins Roden; Marnie Packard, PacificSource Health Plans; Corey Surber, Saint Alphonsus; Kathie Garrett, National Alliance on Mental Illness (NAMI); Shad Priest, Regence BlueShield; Lee Flinn, AARP; Stacey Satterlee, American Cancer Society Cancer Action Network; Mike Hammond, Cenpatico Behavioral Health/Centene; Brent Olmstead, MP Idaho; Sara Stover, Division of Financial Management; Toni Lawson, Idaho Hospital Association (IHA); Elizabeth Criner, Veritas Advisors; Joie McGarvin, America's Health Insurance Plans; Shirleane Abbott, Peer Run Center for Hope; Steve Graci and Stephanie Mballo, Idaho Federation of Families; Jason Kreizenbeck, Lobby Idaho; Tony Poinelli and Angenie McCleary, Idaho Association of Counties (IAC); Alex J. Reed, Family Medicine Residency of Idaho; Jenn Connor and Karianne Fallow, Red Sky PR; Jim Baugh, Disability Rights Idaho; Sarah Woodley, Business Psychology Associates; Jerianne Gerloff, Pfizer; Phyllis Reff; Diana Abramowski; Woody Richards, Attorney/Lobbyist; Charlie Novak, MD, Idaho Psychiatric Association; Jim Rehder, Region 2 Mental Health Board; McKinsey Lyon, Gallatin; Vivion Maisenbacher, Mylan, Inc.; Larry Benton, Benton, Ellis; Roger Christensen, Bonneville County Commissioner/Chairman, CAT Fund Board; and Alicia Ritter, Ritter PR. Jack Rovner, Health Law Consultancy, participated via conference telephone call.

Co-chair Collins called the meeting to order at 9:05 a.m. and said he'd talked to **Rep. Wood** on Saturday and reported that his wife is healing from her injuries, asking for continued thoughts and prayers. **Senator Cameron** added that he had visited with **Rep. Wood** on Sunday and that Amy is doing remarkably well. He said **Rep. Wood** wanted to thank everyone who had reached out to express concern for Amy.

Mr. Bill Deal, Director, Department of Insurance (DOI), was the first presenter, and he announced, with sadness, that Joan Krosch passed away on Saturday, and **Director Deal** asked for a moment of silence in remembrance of Joan. He said that Joan was true, gentle lady and probably Idaho's most knowledgeable person regarding health insurance and health insurance law.

Director Deal centered his presentation on the Idaho Health Exchange Working Group, saying that this group had met four times and the final meeting will be on October 26, 2012. After this meeting a report to Governor Otter will be reviewed, including a recommendation as to what type of exchange, if any, going forward. He shared information on presenters and what had taken place at the four meetings. The decision by the Supreme Court left as many questions unanswered as were answered. PPACA requirements, critical dates and options for consideration were discussed. Presentations included how a health exchange could be set up and the blueprint the Governor is going to have to provide to HHS. DOI has been asked to prepare two blueprints, one for a state-based exchange and one for a partnership exchange. Governor Otter had given the group questions for consideration by three subcommittees and the working group is reviewing those responses to be presented at the October 26th meeting. **Director Deal** said that at the next meeting the working group had presenters from other states that have projects that will probably be certified by the November date, one from Colorado (Health Benefit Exchange) and one from Nevada (Silverstate Health Exchange). Both of these exchanges met the benchmarks, hoping for tentative certification by November. More detailed information including meeting minutes and handouts from these working group meetings can be found on DOI's website: **www.doi.idaho.gov**

Director Deal said that at the October 9, 2012 meeting, DOI heard an overview as to how Idaho would be positioned moving forward with an exchange. The working group had requested information from a partnership state, Arkansas, and that was provided. Presentations from Louisiana and Texas talked about why those states chose not to move forward with state-based exchanges. An opportunity was presented on a not-for-profit option type of organization for a state-based exchange. DOI has been receiving many questions on what the cost will be, and KPMG is working with about 15 states and provided very good information on all three options. At the October 26th meeting, some vendors and contractors will address the working group on projects being worked on in other states, availability and the Leavitt Group will address the opportunity to deal with a state-based exchange. **Director Deal** thought that once this was done and after Governor Otter releases the information, it will be valuable information moving forward.

Mr. Richard Armstrong, Director, Department of Health and Welfare (DHW), updated the task force on a meeting held on September 27th where the Leavitt Partners had prepared a final report for DHW commissioned in April, well before the Supreme Court ruled on Medicaid and the Affordable Care Act (ACA). It was dealing with the definition of the population, and one of the later phases of that report included conversations about possible benefit packages. One area covered was mandatory enrollment - changes that will occur because of the ACA, without regard to any decisions the state of Idaho makes. This comes about because of the change in the modified adjusted gross income formula which is different for determining household income than was present under the existing arrangement. With that mandatory change and the reality that people will be more aware of their eligibility, the woodworking effect, children predominantly already eligible will come into the program. DHW's estimate is that if Idaho does nothing, these two pieces will add 37,000 people to Medicaid roles. Because of that, DHW's job is to modernize Medicaid eligibility and make it ready for this act and 92% of DHW's work will have to be done, regardless of any decision the state makes. DHW looked at 3 scenarios: (1) There is no Medicaid expansion and the current indigent program simply receives minimal maintenance. DHW had forecasts going forward that county costs will increase from roughly $29.6 million today to $39.6 million in 2020. DHW also looked at what the CAT fund would be paying and that rises from $39 million for 2012 to $52.5 million in 2020. DHW tried to use normal healthcare trend forecasts to determine what those costs would be with minimal effort on the part of the state of Idaho to comply with the federal law. (2) The second option was that there be no Medicaid expansion; however, DHW would look at a complete redesign of the indigent program. That program has been patched together over decades and is an incident-based program, unlike Medicaid which is a membership-based program. DHW knows they could create more uniformity and standardization working with counties on the claims' processing side and could go more electronic and change some utilization management. The

problem is that the decision will be up to counties, under current statute. As a point of interest, about 60% of claims submitted to counties are not approved, so the dilemma in an incident-based system is knowing which ones to spend time and money managing and which ones to not have responsibility for between DHW and counties. This is a complicated formula, but DHW can upgrade system capacity for better efficiency. DHW's best estimate of the administration system upgrade would cost between $1.5 million and $3.5 million to implement a commercial grade claim processing system. With all of those changes, DHW estimates that claim costs could be reduced by about 2% or perhaps more if Idaho chooses that option. (3) Expansion of Medicaid is the third option and would add approximately 100,000 Idahoans to Medicaid and, on top of that, you would have the woodworking effect and the change in eligibility. DHW forecasted that the current 2012 Medicaid participants numbering 229,000 would move to 453,000 in 2020. From the Leavitt study, there are two polar extremes, one part being a younger, relative healthy adult and the other population is an older adult with chronic disease, as well as the disabled, children, pregnant women, and women with children who qualify categorically under current rules. There will be pent-up demand since DHW sees that on the indigent side where people go without care, and there is a lack of time-appropriate care within this population.

DHW has worked on guiding principles which would guide decisions, many of which will be in the final report. One is benefit design. While the Leavitt study recommended that the basic program be used, the working group thinks that the guiding principles need to include a benefit structure that increases personal accountability, encouraging prevention and drive more toward value. Other states have been studied to compare successful incentives to change behaviors of those involved in Medicaid. Medicaid reform in 2006 and 2007 embraced a Florida model, having a defined benefit for a defined population, and Idaho could do the same. If Idaho does expand, that expansion population will have a unique set of benefits for those individuals, and not put them into regular Medicaid. The other major area is the service delivery side of the business, and while the ACA doesn't address this directly, the working group is committed to moving away from fee for service benefits to managed care. There will be an Idaho version, and those details will evolve within the Medicaid division. They do believe that the ultimate responsibility for delivering care is up to local providers and local networks and they need tools to do a better job of managing the health of that population. Incentives can motivate providers to engage in managing wellness of the population, as opposed to dealing with sickness. DHW knew that costs had to be accounted for, and DHW has contracted with Milliman to do the financial analysis of all costs that affect the state of Idaho and counties. The Milliman study will be done by the end of October and another meeting is scheduled for November 9th at which time the working group will put together the final agreements and decisions for the report to the Governor. The working group is very open and willing to look at all options and the goal is to deliver something better than what is offered today and be the best value for Idaho citizens.

Senator Cameron asked about numbers regarding current enrollment versus potential enrollment, and **Director Armstrong** replied that 2012 Medicaid participants number 229,000 and estimated to be 453,000 in 2020. **Senator Cameron** said he was trying to get a sense as to where that number is in a range, whether that is a conservative or aggressive estimate, and **Director Armstrong** said it is a conservative number, acknowledging that the pick-up rate in Idaho has always been lower than optimum, having fewer people enrolled than were eligible based on income information. This forecast is a bit of a mystery since income standards have never been tested with a real population since they don't know what all the rules are yet to accomplish accurate reporting. **Senator Cameron** asked if DHW was trying to forecast within a range of 10% and **Director Armstrong** said that they forecasted 97,000 to 111,000, so roughly a 10% spread between the two numbers. He added that the financing side of that is interesting because there are 3 years at 100% federal funding and then it scales to 90% in year five on the expanded population, but the woodworking is all 70/30. **Senator Cameron** said that most states have a worse federal match than 70/30 and asked to what extent is DHW or the working group taking into account that at some point the federal government will have to figure out how to balance Medicaid.

That may mean shifting some costs to the state and probably won't maintain at the 100%, 90%, or 70/30 level, so he assumed that the numbers and dollars being estimated do not reflect any potential change in that regard. **Director Armstrong** answered that all the initial numbers take into account the funding arrangements that exist today. However, it will be designed so that it will be easy for anyone to do another set of calculations and he believes it is wise to look at those expanded populations as if they were 70/30 since there is a risk to everyone. He thinks the federal government needs to do what the state of Idaho has always done, to balance the budget, and when that happens, there will be much trauma. Coming back to the 70/30 or 50/50 match, it is interesting the number of states that have studied the issue of walking away from Medicaid altogether, such as Texas and Arizona, realizing this is a lot of money to assume, since a resemblance of benefits must be provided. To get out is a very significant problem, especially if indigency is a responsibility of the counties and then the state, so this is very complicated and cannot be taken lightly, and other scenarios need to be looked at. The total cost of this expanded population in Idaho is about $500 million, which is a figure to compare against as far as what the general fund would have to pick up.

Senator Schmidt asked about changing the CAT plan and whether the state of Idaho could say that indigent health care will not be paid for. He hears this question from his constituents, and they argue this should be considered. **Director Armstrong** reiterated that not expanding Medicaid and getting completely out of the business had not been considered specifically; clearly if the state of Idaho took that position unilaterally, then it would move that obligation to the counties, and if the counties got out as well, the bad debt would fall on the hospitals and providers. **Director Armstrong**'s first guess was that everyone who pays for hospital care through insurance would then end up paying for that cost shift, and there would be no other choice.

Representative Rusche asked about the woodworking effect, saying that as a practitioner, people having a significant illness get sent to the Medicaid office, so when looking at actual costs for woodworked patients, those costs will be lower because, if sick, they would have been on Medicaid already. The whole indigent system seemed to have sprung from the old county clinics and hospitals back in the 1940s and 1950s, asking if there has been consideration of rebuilding that type of system. **Director Armstrong** answered that had not been part of the working group's study, creating a parallel delivery system for those medically needy. **Representative Rusche** said that people change eligibility sometimes monthly changing jobs and income and he asked if the benefit package being considered is going to be similar enough to commercial packages that it doesn't throw offices into confusion about whether someone has coverage or not for certain procedures and will there be consistency between Medicaid and commercial packages. **Director Armstrong** replied that had been discussed because moving people back and forth on the eligibility side is very expensive, plus it breaks continuity on the delivery side. The working group thought that if there is a state-based insurance exchange, then a very similar parallel package could be built. Under a federal exchange it would be more at the whim of whomever we're working with at that time. It needs to be blended so as to limit disruption.

Senator Vick asked about the 37,000 added to Medicaid, primarily children, wondering if that was under Medicaid expansion. **Director Armstrong** clarified that it is under the mandatory Medicaid change and has to do with the formula given for calculating eligibility, taking into account different aspects of how to calculate household income. He added that it doesn't always expand it; in some cases it actually would move people currently on Medicaid off, but grandfathering the existing population would prevent people dropping off, thus the estimation of 37,000.

Senator Vick wondered if anyone had calculated what Medicaid expansion would do to doctors or hospitals, moving from insurance to Medicaid which pays less, asking if this issue was being worked on. **Director Armstrong** answered that is part of the service delivery discussion in the working group and is

relevant. By the time the expansion population comes in, either mandatory or by Medicaid expansion, the delivery system would be moved away from the current fee-for-service system and moving more into a population management system. Many believe that a different delivery system will be much more efficient than today, and the under-supply of physicians modeled today may not be as severe with a new delivery system. The working group is encouraged that as this evolves, the supply side can be augmented effectively for adequate providers, but that is uncertain.

Co-chair Collins asked who would define the defined benefit package and **Director Armstrong** replied that it will be a blend, adding that there would be a state plan amendment which would come through the normal process, through the Legislature, then to CMS to approve; it would not be guaranteed that CMS would approve the design. Since CMS has seen the features of other states used in demonstration waivers, it won't be unfamiliar to CMS, so the working group is hoping that their experience with these kinds of benefits will be acceptable. No state plan amendment has been submitted to CMS, and **Director Armstrong** thinks it is better doing it this way, than doing it in a demonstration waiver. **Co-chair Collins** wondered if the packages hoping to be approved were quite an expansion over what currently exists. **Director Armstrong** said "no." The benefit designs are not richer and the intent is not to expand benefits any further than necessary for the population. If someone has a severe enough disability, they would move to other programs.

Mr. Roger Christensen, Bonneville County Commissioner and Chairman, CAT Fund Board, presented next and his PowerPoint presentation can be found on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_christensen.pdf

Mr. Christensen acknowledged **Senator Schmidt** and **Representative Rusche** who serve on the CAT Fund Board. He defined "medically indigent" and how that person will be impacted by Medicaid expansion. The CAT system, under current statute, is not related to poverty, is incident based, gives the ability to pay over five years, and is not an entitlement program. Three options identified by the Governor's working group are:

1. Option 1: Minor changes – in FY2013 the CAT Fund appropriation from the state general fund is $36, 532,800 and the projection for FY2014 is $42,351,384. Counties are now spending more than the state, in large part due to cost savings/avoidance programs, as well as significant cost increases for mental health.
2. Option 2: Indigent program redesign – basically saying that Medicaid won't be expanded but the current system needs to be completely reworked.
3. Option 3: Medicaid expansion – What happens to the current county indigent/CAT program?

Mr. Christensen said that Option 1 leaves things as they are now, no Medicaid expansion. Drivers that would increase cost would be sunset of PCIP which is January 1, 2014, and the savings over the last year to the state general fund were between $6-9 million. Hospitals, reimbursed at a higher rate, have been working with counties and getting individuals on PCIP instead of coming to counties and the CAT Fund. On June 30, 2013, the Legislature had a 5% adjustment to the reimbursement rate to providers that sunset. Medical inflation is still a factor and in the 5-9% range for the future.

Mr. Christensen said that the Option 2 redesign assumes that Medicaid expansion doesn't happen and that if the Legislature thinks that the CAT system has issues, they may choose to start over if some sort of indigent program is kept. The state might want to redefine indigency, decide what eligible services are necessary, and acknowledge a need for uniformity and standardization of system design.

Under Option 3, **Mr. Christensen** said that under Medicaid expansion it is estimated that 90% of those who now qualify for the county program and CAT funding will qualify for Medicaid. The remaining 10% includes undocumented people who would not be covered under Medicaid, those who qualify for the exchange subsidies but chose not to purchase insurance, and other potential non-covered medical services. If Medicaid was expanded and the Legislature chose to keep current indigent standards in place, there would be a situation approaching 100% coverage universal-type care. If Medicaid is expanded, the options are to leave intact Idaho Code Chapter 35, Title 31, or to replace or repeal Title 31. Legislators have the difficult decision of deciding if Idaho should provide a program for those not covered by expansion. In any event, there would be a transition period, no matter what option the state chooses.

If there is outright repeal, there would need to be funding for approximately 12-18 months as transition takes place to eliminate the program or transitioning to a different program. Statute requires that liens be attached when an indigent application is approved and many are in place and collections would need to continue. **Mr. Christensen** said that all the options present difficult choices.

Senator Schmidt asked about county costs for indigent coverage, his question being how that cost is determined and are we able to actually get a clear indication of how much counties spend on this expense. **Mr. Christensen** replied that a good job is being done gathering these costs and are far more accurate. **Senator Schmidt** clarified that he was referring to the practice seen on the CAT Fund Board of counties deferring claims to the state, postponing applications, believing that year-to-year costs would be very difficult to estimate. **Mr. Christensen** said that claims are affected by changes of staff that require delays and also cash flow shortfalls.

Representative Rusche asked about county expenses exceeding the state CAT fund expense and **Mr. Christensen** explained that in the annual report, this will be the first year that balance will go the other direction. **Representative Rusche** stated that the CAT Fund appropriation for FY 2013 was $36, 532,800 and **Mr. Christensen** said it was about 50/50 county and CAT fund. **Representative Rusche** further stated that this was the first time that CAT exceeded county expenditures and pointed out that healthcare was increasing at about a 7% annual rate so that from the roughly $70 million in 2012 we could expect about $5 million more. **Mr. Christensen** then said that he thought the FY 2012 expenditures were closer to $60 million but that administrative costs of the 44 counties to handle claims were not included in the total.

Senator Goedde asked how much is being spent on undocumented people and **Mr. Christensen** replied that he did not know and that under current law DHW is not allowed to ask. **Senator Goedde** asked if any other states have chosen not to provide coverage for undocumented persons. **Mr. Christensen** replied that he did not know of any, but a study was done by National Association of Counties (NACo) and the system in Idaho is unique since our indigent program is different than most others who pick up everybody not covered, including undocumented people.

Senator Lodge asked about administrative costs for the county and about how many people work on the indigency program. **Mr. Christensen** said that in Bonneville County there is a staff of four, considerably smaller than larger counties, and overall administrative costs statewide are about $5 million. County costs are difficult to identify since county clerks provide many different functions.

A panel of four was invited to participate in a discussion on the status of mental health services in Idaho, and the first to speak was **Mr. Ross Edmunds**, Administrator, Behavioral Health, DHW, and his PowerPoint presentation is online at:
http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_edmunds.pdfdmunds.pdf

Mr. Edmunds said that Behavioral Health is responsible for three primary areas: (1) psychiatric hospitalization including State Hospitals South and North and paying for community hospitalization for individuals committed to the state through an involuntary civil commitment or as part of a criminal process when unfit to stand trial; (2) community mental health programs for adults and children; (3) substance use disorders programs. Budget reductions caused short-term dips in utilization of services and the number of individuals served, but now the number of individuals being served has risen, but a smaller array of services are available. Priority areas include psychiatric emergencies, civil/restoration commitments, court ordered/court involved cases and voluntary commitments.

Mr. Edmunds said that for a decade there have been discussions and efforts to transform Idaho's behavioral health system, all well intentioned, but he thinks it is now time to implement really good recommendations to move this system along into an action phase. Hallmarks of a transformed system would include: (1) local input/local influence; (2) integrated treatment; (3) clearly defined roles and responsibilities; (4) eliminating gaps in services; (5) maximum efficiency with maximum effectiveness; and (6) consumer driven/recovery oriented system. Three waves of transformation in Idaho's behavioral health system include: (1) Medicaid's implementation of managed care; (2) potential Medicaid expansion under the Affordable Care Act; and (3) Idaho's plan for transformation. He said that 96% of individuals served in his division would qualify under Medicaid expansion. Even if Medicaid doesn't expand, if Idaho has an insurance exchange, if there is a benefit package as part of PPACA, actual clinical treatment services he believes will largely be payer driven and determined by insurance and Medicaid. There are gaps, however, in that system for the population served and frequently high-end, really expensive services could be avoided by providing informal services to these individuals in local communities through development and arranging support services. He emphasized the importance of consistency and standards of practice for clinical treatment services. Local communities and regions need to be given the opportunity to become responsible and they have been asking for the ability to have more influence. He sees his division as being a safety net provider in the future to deliver psychiatric emergency services to people who don't have benefits or are between benefits. There must be a statewide behavioral health authority, an entity that looks across the system to make sure that high standards are being achieved with maximum efficiency and effectiveness.

Mr. Jim Rehder, Chairman, Region 2 Mental Health Board, presented next and began by saying that his region had felt a significant loss of service and a survey was conducted which will provide good information to the Legislature. His PowerPoint presentation is online at: http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_rehder.pdf

Mr. Rehder's region has been a very active participant in getting grants amounting to $1.1 million, and a transitional housing unit was recently built. Respite care training for parents of children with mental illness was a very successful program for families. Telemental health was established in Region 2 and it has turned into a wonderful opportunity, providing services not available otherwise, particularly child psychiatry. Discussions are taking place about combining boards and legislation has been drafted for a system to take care of mental illness and substance use disorders in his county. Former **Rep. Liz Chavez** started the Children's Mental Health Coalition pilot project and she works with children in the Lewiston school system using curriculum from the National Institute of Health. This project is receiving great testimonials on preventing bullying and creating more sensitivity toward people with mental illness.

Mr. Rehder said that when Medicaid cuts caused services to decline, the need for mental health services started to rise, causing grave concerns and costly consequences. He expressed gratitude for the suicide prevention legislation passed for a hotline and said that 290 suicides were completed in Idaho in 2010, the 4th highest suicide rate in the nation. Decreases in funding for behavioral health services affected the

entire state, especially the prison population of 7,000 where 25-30% inmates are mentally ill. The shortage of behavioral health service providers is critical, especially recruiting and retaining psychiatrists, and the state may want to look at expanding telemental health to help mitigate these problems and increase access to care. There is a need for behavioral health services in schools so that mental illness can be treated early.

Mr. Rehder called attention to a letter handed out to the task force members written by Jennifer Griffis, a member of the Region 2 Mental Health Board, married to a physician in Grangeville, Idaho. **Mr. Rehder** emphasized that this letter by no means is a reflection on the people who tried to work with this family. Mrs. Griffis was brave enough to come forward with their issues dealing with a five-year old adopted daughter who has severe mental health issues, one of their seven children. A treatment facility for their daughter could not be found in Idaho and she was eventually placed in a residential treatment facility in Montana. If this family moved to another state for the child's care, Idaho would lose a rural family practice physician who wants to stay in the region. This is an example of the failure of the system and gaps in service, though not on individuals who worked with this family. (A copy of this letter from Mrs. Griffis is available in LSO.)

Angenie McCleary, a Blaine County Commissioner, Chairman of IAC Health and Human Services Committee and a member of Behavioral Health Interagency Cooperative spoke next and said she had a master's degree in social work and worked on children's mental health legislation in the state of Washington. The impact of the current mental health system on counties and local communities was her focus at this meeting, and with changes in the last several years and budget cuts, costs have risen significantly. She has seen dramatic changes in Blaine County in terms of funding and critical impacts to the system, and she worries about the funding as well as the health, welfare and safety of individuals in our communities. From her perspective, closures of some health and welfare offices were the result of reducing costs and for some rural communities, patients must travel farther to receive mental health services. DHW has had to prioritize and focus on involuntary commitments, so people who are reliably receiving services are the people who are in absolute crisis or those in the criminal justice system. People getting the most reliable care are in the criminal justice system or in critical crisis. Local services are not readily available to serve local communities very well to treat individuals early to prevent them from entering in to very costly crisis treatment. Probation departments are noticing significant increases in their workload. Prosecuting attorneys sometimes wrestle with charging an individual with a felony because they know that person would be more likely to receive mental health services. Good data statewide is not available for all the counties and expenditures for mental health. Counties are spending money on designated exams, transportation, and hospitalizations up to time of commitment, but she shared some numbers for Blaine County only. Potential solutions moving forward include looking at the difference in hospitalization rates which are very different between hospitals and counties. In Blaine County, Canyon View is paid approximately $3,000 per day and Intermountain (with a contract) is paid $803 per day. If there could be a uniform contract for all counties in the state to pay the same rate, that would be quite helpful and would reduce much cost burden for counties and the state. In remote counties, it is very difficult to find a Medicaid provider. Finding a resource, such as a psychiatrist, can also be a challenge. With possible Medicaid expansion, the state must make sure that those individuals can actually receive services, and some funding must be restored on an ongoing basis. Combining regional mental health boards and substance use boards and giving those boards authority at a community level could work on support services necessary to avoid simply a crisis-based system.

Dr. Charles Novak, a psychiatrist in Boise in private practice for 27 years and presently President of the St. Al's Medical Staff was the next panel member to address the task force. He was asked to talk about the private perspective on the mental health delivery system in Idaho, and he said what he would share was based on his discussions with hospitals he works with. He commended the Allumbaugh House, a

crisis diversion center in Boise. He gave testimony from his hospital-based perspective because probably the number one access for people getting mental health services, particularly severely and persistently mentally ill individuals, is through hospitals. His second disclaimer was that he really didn't have any ownership interests and had been mainly in private practice. He said he did have an ownership interest in Sage Healthcare, a group psychiatric practice, and also practices privately in the community. The data he shared with this task force was gathered over the last week about the state of mental health access and delivery at this point in time.

Dr. Novak said that today in Idaho, in Regions 3, 4 and 5, on any given day 60 people will show up in ERs looking for mental health and about 30 will get admitted. That number does not count people showing up in ICUs for suicide attempts or injuries related to substance abuse, etc. Of those 30 that get admitted, about 55% will be on holds, more on police holds than physician holds, which is a substantial burden. On the positive side, a strength of the system is that people are taken care of who are in real trouble. This system, however, is very emergency-oriented which means that the state pays for ERs and hospitals and not much money is expended for other levels of care. He suggested that while the task force is looking at managed Medicaid, it should consider this as a chance to really shape what happens with the delivery of mental health. He said that the main area he sees as a gap in Idaho is really in information data. The wrong data is being collected and this is a chance to look at what kind of data the state really wants from the Medicaid system. Are you saving people's lives and are there fewer suicides; are suicides being prevented; are people being kept out of nursing homes, state hospitals and institutional levels of care; are fewer people going to prisons and jail; are you improving quality of life for people; are symptoms better and are people recovering and having fulfilled lives? If the state is not looking at these things, the state doesn't know what it's buying or getting with an insurance product or a Medicaid product. Unless the state sets its sites and outcomes, the state will get what they pay for. He encouraged highly, whether in the Medicaid managed care system or any system of care, that there be more physician leadership. This state has not had much physician leadership in mental health; there are more nurse practitioners and alternative care providers who are very helpful, but there is cost to that, since there is a different level of training experience and level of outcome. Admits and readmits to hospitals provide data with regard to costs of medicines, and these things are important. **Dr. Novak** ended by saying that he thought it very important to look at systems that are really public/private partnerships, there being pluses and minuses to each. Probably the best model in this state has been the Allumbaugh House model in Boise.

Representative Block asked **Mr. Rehder** about the need for the partnership between the Department of Education and local school districts for mental health services for children, saying that she hoped that would include substance abuse since those co-occur. She wondered if the transformation working group had discussed that issue and if that might be addressed. **Mr. Rehder** replied that former Representative Chavez put together that pilot project and that information is being gathered and distributed which will hopefully draw attention to children with substance use disorders. **Mr. Rehder** agreed that awareness was extremely important for that age group and he expects good results from this pilot project, and he agreed to pass on her concern to the transformation working group. **Representative Block** commented that it is much easier to address children rather than waiting until they possibly enter the justice system. **Mr. Rehder** mentioned that the Department of Education is represented on the behavioral health interagency cooperative and discussions have resulted in creating plans (aka white papers) about what that transformation looks like in all systems. It is a challenge and, being a separate system, the thought of creating integration between the mental health system and the education system is being collaborated.

Representative Rusche expressed his appreciation for input from this panel to address concerns seen in his community including children with chronic schizophrenia being arrested, 25 years after being in court trying to settle community mental health services through the Jeff D settlement and 10 years of

studying mental health transformation, the state really hasn't taken any action. There have been decreases in community services, cuts to benefits in Medicaid and increased costs shifted to local governments and families in Idaho. He thinks this is really going to be a serious consequence for Idaho since we lack community delivery systems; there isn't organization and financing or the data available because a system has not been put together. The consequence will increasingly be a burden on citizens and taxpayers in Idaho and he asked **Mr. Edmunds** about the managed behavioral health Medicaid RFP or contract and wondered where we are with that right now. **Mr. Edmunds** answered that the managed care RFP is on the street and right now they are halfway through the open competitive process in which potential bidders have about 90 days to prepare their proposals. By early December that will close and the review committees will begin evaluating those proposals. **Representative Rusche** asked if that would include network development or just the plan for network development and **Mr. Edmunds** replied that the RFP in itself includes a responsibility of the provider. There are questions about how providers will build a network of treatment provision. **Representative Rusche** clarified that they didn't have to have a network in place, just have a plan, and the RFP or contract will be awarded and then built out. **Mr. Edmunds** confirmed that once the contractor is identified, there is a period of implementation to get that network together and creating contracts to move forward.

Representative Bilbao asked **Dr. Novak** about readmits in Gem County, mainly for people going off medications, and if there is a better solution for a person coming back 4-5 times yearly due to lack of medication management. Could this be handled better in some way? **Dr. Novak** answered that this occurs frequently and most people can be treated locally and the average length of stay is 4-5 days. Once they are stabilized and can be sent back into the community, the key element is having an outpatient system, having access to that patient and family so that medications are administered regularly and have crisis intervention available 24/7. As funds have been cut and community health centers have had less money and reduced services, that key element has gone away. Getting into some clinics can take 6-8 weeks and the first step in stability is medication management which can cost several hundred dollars over a few months versus spending thousands if admitted to a hospital. There are a number of reasonable ideas whether thru telemedicine or telepsychiatry in order to prioritize, saving money and heartache.

Senator Cameron said that one dilemma faced by legislators is that the system is overwhelming to everyone and the gap between where Idaho should be and where we are makes it difficult deciding what to do, when to do it and what is the highest priority. He asked all the panel members to submit written comments or thoughts that may arise after this meeting for the task force to review. **Dr. Novak** had suggested more physician leadership in mental health, asking what he meant by that, what should be expected by physicians and how does the Legislature better engage physicians in mental health treatment? **Dr. Novak** said that Idaho can learn from other states that have more psychiatric and physician involvement in general and he said it starts from what you want for a state that's undersupplied by physicians. Do you want physicians to see patients face-to-face or supervise mid-level providers and nurses, and at what level do you want them involved in telemedine or telepsychiatry. Being involved with payers, like Medicaid, influence that, even through community mental health centers. Some states have laws that define the level at which physicians need to be involved in leadership in the team model of care, which is what legislators in Idaho will be looking at in the next few years. How do we get teams of people who take care of patients with chronic diseases and illnesses and keep them more stable and out of ERs and hospitals, and that team approach must include physicians. He said, in his humble opinion, that Idaho under-appreciates and under-utilizes physicians believing them to be high priced; you may save money, but there are consequences. Idaho is a hospital-heavy state and they do great jobs, but once out of a hospital, access to other care is difficult, particularly in mental health. How do you ask the state to incentivize and get people involved in other things physicians can do such as supervise systems of team care, which is what you want in the long run.

Senator Cameron asked Ms. McCleary about the dollar amounts per day and a uniform contract rate for hospitals around the state. He asked if other states attempted and achieved a state-based contract? **Ms. McCleary** said that IAC had been talking about this issue and certain counties have individual contracts with a hospital to provide a better rate, and the idea of legislation has been discussed. **Mr. Tony Poinelli**, Idaho Association of Counties (IAC), said that IAC has talked about working with hospitals around the state to develop a uniform contract; in most cases, a number of hospitals have been very cooperative. One problem is that there are several facilities that refuse to discuss this issue and the frustration is how to deal with that. Several hospitals have contracts with counties around the state and are very reasonable contracts. **Mr. Edmunds** added that typically the lesser expensive of those options are free standing and not connected to a general hospital. The more expensive ones are typically connected to a general hospital. He said that Rep. Fred Wood has requested in JFAC that DHW pursue this and try to get to a consistent level. The models they perform under in psychiatric hospitals are so different; some have their own physicians and some contract physicians externally and that influences cost. There are dramatic differences in cost and the Legislature last year moved forward a piece of county legislation that requires that counties pay the Medicaid rate but that doesn't mean it's the same rate from hospital to hospital, just the same rate that Medicaid pays. **Mr. Edmunds** said if DHW and the counties work together to talk about these contracts, perhaps there would be more success in having the same rate at each hospital, whether state-funded patients or county-funded patients.

Senator Cameron asked if any other state has done something similar or is Idaho inventing the wheel in this regard. **Mr. Edmunds** answered that he was not aware of any state that was successful in coming up with a standard state rate for services, but there could be one. He believes Idaho is unique in that regard; he thinks that as Medicaid moves with managed care, those things will change since managed care agencies contract for behavioral health and currently inpatient care is not included. As managed care is pursued around Medicaid funds, they will push for consistency of those things.

Senator Schmidt said he was a family physician, believing that family physicians do a lot of psychiatric mental health primary care work. He asked about the patient-centered medical home here in Idaho and if that would be an integration for delivery of psychiatric and mental health services in the community. Also, is the roll-out of managed care in behavioral health going to be integrated enough in terms of health care that it will promote this and did **Mr. Edmunds** see this as a positive promotion? **Mr. Edmunds** replied that managed care doesn't exist in Idaho right now on the physical health side of Medicaid, so there isn't anything to fold the behavioral health side into. He said that in the request for proposal there is much effort necessary in terms of managed care companies proposing how they would coordinate and collaborate as opposed to integration level, with the general health side of the care offered to consumers and patients, as opposed to a combined approach. Family and personal physicians probably deal with delivery of mental health services more than other physicians in terms of number of people served in Idaho, but at a lower intensity level. A model in which there is flow between those levels would be optimal but, if that medical home opportunity were created for individuals, it could provide really close collaboration and partnership with expert psychiatrists to coordinate care. A patient could consult with a psychiatrist when needed and when stable could see the family practitioner more, believing that could become a very effective model in Idaho.

Dr. Novak said he agreed with that and that, by far, family physicians are treating more people with mental illnesses than psychiatrists, nurse practitioners and all other groups combined. That being said, a system that is set up so that people do collaborate and people who are out of the scope of a family physician's expertise get moved on in a timely fashion is a system that you want and people are overlooking that. As you look at managed care, Medicaid and costs of insurance in general, those systems where traditional physical care and mental health get along well will cost you less money and less shifting of money between the two. A team level of care for people with mental illness that includes

physical and mental health is going to be the best and most efficient system as long as parameters are set up and agreed upon.

Senator Lodge said that she'd like to talk to **Mr. Edmunds** about work he thought needed to be done on Title 30, Chapter 31, that he thought needed adjustments and also the work that needs to be done to bring the mental health and substance abuse appointments together since this is costing the state lots of money. She asked **Dr. Novak** if he worked with telemental health and if this is used by nurse practitioners and family physicians. She said she was very interested in telemedicine and where they were located, since rural areas are often underserved and she believes the answer could be telemedicine in crisis situations especially to eliminate further costs being incurred today. **Dr. Novak** answered that he does not use telepsychiatry or telemedicine. The VA and St. Alphonsus use these services in this area and several private doctors use this with the prison population, which is a great example of servicing a population in need. Medicaid pays for this now but didn't use to pay, and some states charge a fee for the technical side since a system needs to be set up. Psychiatry is set up to do telemedicine and young physicians are going to do great things with this, but some old-timers may not use this as much. Face-to-face technology can be used for an evaluation and recommendations, but he said there are tricky, yet to be decided aspects, such as response to emails. Consultations for psychiatric expertise through telepsychiatry can be invaluable and many fields of medicine are now serving rural areas. This will be a wonderful way to deliver medical care now and in the future. **Senator Lodge** said she thinks this needs to be looked at more carefully.

Co-chair Collins allowed two audience members to give public testimony at this point in the meeting, and the first was **Mrs. Phyllis Ruff**, a former member of the Region 4 Mental Health Board. She said she was the mother of five children who have mental health disabilities ranging in age from 14-26, two being adopted from the foster care system in Oregon, both born with drugs in their systems and previously neglected. Three of her children have had psychiatric hospitalizations in Idaho. Agencies need to cooperate seamlessly with each other for mental health to be appropriately addressed. She believes this does not occur, and thinks Idaho needs to make financial adjustments. Local education agencies often deny special education and related services to students who have mental health disabilities. Physical disabilities are observable, but mental health disabilities are hidden and can be denied by school agency administrators who don't want to spend the money to provide special education services for this population. Alternatively, there is an agency Community Support Center, Inc. in Boise which struggles to survive financially but where individuals with chronic mental illness diagnoses are welcomed and taught needed skills necessary to meet life challenges. Federal funding should be directed from school districts in Idaho and distributed to agencies that will address unique needs of individuals with mental illness.

Dr. Alex Reed offered public testimony next and he said he was a clinical psychologist at Family Medicine Residency of Idaho, one of the largest Medicaid providers in the state. He said this clinic employs five social workers and hosts the Idaho Psychiatry Residency Program through which many patients receive combined behavioral and primary care services. There are new directions in behavioral health care that are focusing on integrating primary care and mental health care, and they do this in their clinic. Primary care is the de facto mental health system through the country and 80% of psychotropic medications are prescribed by family physicians. Integrated care provides increased access and affords opportunities to patients to receive pharmacologic, psychological and psychiatric services at the point of care in a timely fashion. Integrated care also helps reduce stigmas and offers patients a true medical home to address both medical and behavioral health concerns.

The task force recessed at 11:28 for lunch and reconvened at 1:18 p.m.

A telephone conference call was held next with **Mr. Jack Rovner**, Attorney and Principal, The Health Law Consultancy in Chicago, and his PowerPoint presentation entitled "Nonprofit State-Based Health Insurance Exchange Option" is online at:
http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_rovner.pdf

Mr. Rovner said this option would be a private market non-profit solution to preserve state control over a health insurance exchange including governance, operation and financing. To implement, the state of Idaho through legislative or executive action needs to form a nonprofit corporation. The state needs to designate that nonprofit entity as Idaho's state-based exchange to the Federal Department of Health and Human Services (DHHS). The state must exercise some oversight over actions of this nonprofit entity. The Attorney General has inherent power over nonprofit corporations to ensure that they carry out their mission and stay true to the charter of its formation as a nonprofit entity. This exchange would be in the business of insurance which gives oversight of its insurance business activities to the state Department of Insurance. DOI may incorporate a nonprofit corporation under the Idaho Nonprofit Corporation Act and can ensure that it meets minimum federal standards necessary for a state-based exchange to prevent operation of a federally facilitated exchange by HHS in Idaho, which is the fallback position under PPACA. The Idaho Health Data Exchange, Inc. will establish a statewide health information technology infrastructure which will ultimately connect to a similar organization in other states to create a nationwide health information technology infrastructure. This mirrors the same kind of approach that PPACA has given states as an option for establishing a nonprofit corporation to act as its state-based health insurance exchange. The building of the exchange to get it operating would be funded 100% by federal grants. Starting in 2015, an exchange must be self-sustaining and may not use any federal funds for operations.

Senator Goedde said that he assumed that the only difference between a state-based exchange and what **Mr. Rovner** was proposing was how it would be governed. If Idaho's Legislature established criteria for this nonprofit corporation and then found this to be a mistake, could a legislative correction be made to the bylaws of that corporation? **Mr. Rovner** said a correction could be made and if done by legislative enactment, you'd want to put in the articles of incorporation the process by which the articles can be amended and designate they could be amended only by legislative action or executive order so that the board of the nonprofit itself would not have the authority itself to change its own charter. **Senator Goedde** said he assumed the state would also be able to write into the bylaws of the corporation established by legislative action that the board would be subject to Senate confirmation and **Mr. Rovner** affirmed that. He said that in the articles you would define what stakeholders would have what seats. Then you could have the Governor designate who fills those seats subject to the consent of the Legislature.

Senator Vick said that it looked to him like if there is one corporation having the control to make sure it's done the way the state wants, he didn't see any advantage over just having a government agency do it; if there is no competition and we appoint the board members, this doesn't seem like a private market solution. It seems like just a different way to have the government do it. **Mr. Rovner** answered that the one element that involves the state is that the state has to be the entity that creates a nonprofit corporation and has some oversight over its activities. Beyond that, it's relatively up to the state to decide how it wants the nonprofit entity to operate. The nonprofit corporation is not a government agency of any sort, doesn't have to receive any tax money, has no taxing authority, and would operate as a private market entity in offering health insurance products and services to small employers and individuals. **Senator Vick** said what he doesn't understand is why there is any advantage, since the state could set up a government agency to operate off of fees as well and it seemed to him if no competition, then it really is a quasi-government operation anyway and seems like the state would be giving up control without gaining much. **Mr. Rovner** said that the state can create a government agency as an

exchange, as Utah did, or a quasi-government agency, a public authority which is actually what Massachusetts did and what most states have done that are establishing exchanges. The images of the nonprofit corporate entity approach to a state-based exchange is you are essentially establishing a private market entity that is going to have to figure out how to deliver value to its constituency, the small employers and individuals in order to justify revenue needed to sustain itself. If it fails to deliver that value, it will go out of business. The difference between that and a quasi-governmental entity is that they tend not to be operating within the context of having to generate revenue by selling a product or service that has enough value that people are willing to pay for it. The other aspect to keep in mind is that there is nothing that would prevent a private exchange from operating in Idaho in competition with this nonprofit entity as a state-based exchange.

Senator Schmidt asked about an example of the Idaho Health Data Exchange as a not-for-profit that's been in existence, and he asked **Mr. Rovner** whether that business entity is providing a service that is in demand and how it's doing. **Mr. Rovner** deferred to those within the state who have better information than he did. From his research, this Health Data Exchange is operating and selling a product, which is the ability for providers in Idaho to connect electronic health records for sharing and providing coordinated care, but he didn't know how broadly it has penetrated and expanded electronic connections. The process around the country is connecting providers to these health information exchanges and has been much slower in its uptake than hoped by policymakers. It will become more economic and beneficial to providers who have invested. **Co-chair Collins** suggested that information be presented at a future meeting.

Mr. Paul Leary, Medicaid Plan Administrator, Department of Health and Welfare (DHW) updated the task force on the 2012 CHIP-B and Access Card programs and his PowerPoint is online at: http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_leary.pdf

Mr. Leary shared that there had been a 1.5% growth between 2011 and 2012, a bit lower than the overall Medicaid growth of a little over 2%. The downturn has been due to access to health insurance and could be related to the economy, but he wasn't sure. Access to health insurance includes 123 participating employers. In the CHIP-B Program, DHW requires premiums for children that are above 133% of the federal poverty limit and there were 13,377 children required to pay a premium as of June 2012. Approximately 70% of these children keep wellness exams and immunizations up-to-date and the Preventive Health Assistance (PHA) program will offset $10 monthly into an account to help offset premiums owed. This has been a positive incentive program. Number of children closed for not paying premiums in SFY12 was less than 1%. Expenses were over $3 million and $1.3 million was funded out of the premium tax fund. In FY2013 there will be a deficit of $2.9 million in that program. Idaho Code 41-4060 could be amended to allow available funds to be used to used to cover program expenditures as needed. Currently those funds are prescribed as using 80% for children and at least 20% for adults. Alternatively, the CHIP B portion could be covered with state general funds as part of ongoing budget. **Mr. Leary** said there is maintenance of effort through 2019 for CHIP and CHIP is authorized through 2015. Starting in 2016 there is additional federal funding taking us up to 100% of CHIP as well. He said there are many unknowns.

Senator Vick asked for an explanation with regard to CHIP B and access cards. **Mr. Leary** replied that in 2005/2006 Senator Cameron was the sponsor of a bill to provide an opportunity for individuals who would rather have premium assistance and get insurance on the private market. Would they opt for that as opposed to getting Medicaid-type CHIP (Children's Health Insurance Program) coverage? In order to put that program together, the federal government said that premium assistance program could be done but in order to do that, the state must also expand the children's health insurance program.

Representative Rusche asked **Mr. Leary** about CHIP B and the shortfall and whether that was going to be a state responsibility after 2014 since these will be premium under the tax credit through the benefit exchange. For the access card, they will need more guidance from CMS and those will be transitioned to the subsidy program. For the CHIP B program, they have maintenance of effort to maintain that program through 2019. There are questions, so they are looking at face value of the law right now. How many of those individual families who could get subsidies will opt for those subsidies going forward? He said they didn't know the value of that. **Representative Rusche** said that if a family gets a subsidy and has a family policy, then obviously they don't need the Medicaid policy as well, so that would be supplanted by the subsidized tax credit through the exchange **Representative Rusche** also asked about the requirement to continue them on CHIP so they have the Medicaid benefit package or would the commercial packages available through the exchange be what they'd have available. **Mr. Leary** answered that the CHIP B is the state-sponsored benefit package and that there are many questions yet to be asked with CMS. There is maintenance of effort through 2019 for CHIP, CHIP is authorized to 2015, and starting in 2016 there is additional federal funding that will take us up to 100% of CHIP as well.

Dr. Christine Hahn, Division of Public Health, DHW, and State Epidemiologist gave an update on TRICARE financing and the immunization program and her PowerPoint presentation is online at: http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_hahn.pdf

Dr. Hahn provided background information by saying that there have been struggles with TRICARE specifically relating to the immunization program. Idaho is a "universal" vaccine state which is one where children under 19 years of age are eligible for state-supplied vaccines. Providers have indicated they strongly prefer this and don't run a financial risk of purchasing at a loss and also this system gives better access to kids. Medical providers cannot charge for those vaccines since they didn't purchase them, but they do charge a small administrative fee. This system was set up through legislation in 2010 setting up an assessment board and process. Currently there is one pot of funds and vaccines are purchased from this. The Vaccines for Children (VFC) program largely serves Medicaid kids but also uninsured, underinsured, American Indian and Alaska Natives all receive vaccine from this federal funding source. Also into the pot come assessment funds that health insurers throughout the state pay into this based on number of kids in the state per this assessment law. The S-CHIP program pays for S-CHIP kids separately and they put funding in separately. TRICARE is the federal insurance program that provides health benefits for military personnel, military retirees and their dependents and Idaho has approximately 11,000 to 12,000 kids in Idaho who are TRICARE insured. So far, TRICARE has not paid into the assessment fund; of all insurance companies being worked with, the assessment board has been working diligently to get pay-in from all insurers, other than TRICARE. A lot of work has gone into getting this resolved. Seven other states have an assessment system and DHW has worked with these states, trying to collect from TRICARE. Director Deal (DOI) has written letters to Idaho's congressional delegation to alert them about this problem, and Senator Smyser has been working with Senator Risch on this problem. Kids on a military base are being served, but kids off-base might need to go on-base for services. DHW has reached out in every way up until this current crisis. Up until now, DHW was able to use grant funds from CDC (Centers for Disease Control and Prevention) in a discretionary way to purchase vaccine to cover TRICARE kids while all this was being sorted out. A letter from CDC in July said this could no longer be done and those grant funds are no longer to be used for insured children of any sort, including TRICARE, as of October 1, 2012. Providers were notified of this and told that a solution was being sought. The federal program for vaccinating children is the majority payer into this system in the amount of $21,544,397; assessment dollars amount to $17,249,953; S-CHIP contributes $837,000; federally funded TRICARE (one quarter) = $147,500; state-funded TRICARE (3 quarters) = $442,500, the shortfall for the rest of the year.

Dr. Hahn said that a short-term solution was urgently worked on, so guidance was sent to providers, and many options were examined. Military bases can still vaccinate TRICARE kids; private providers still could purchase separate vaccine stocks for their TRICARE kids, but many providers have so few kids that they probably could not do that. Pharmacies are now vaccinating more and pharmacies are willing to vaccinate kids age 12 and above, but younger kids are the problem, especially those under age 4. District health departments were also explored but TriWest said they were out of network and that TRICARE kids would have to go to a military base or primary care physician for vaccinations or to pharmacies. DHW has been working on this problem, and on September 28, 2012, Governor Otter instructed DHW to use funds from within existing appropriations to cover the cost of vaccines while a long-term solution is explored. The Governor requested input from legislators who may be concerned. On October 4, 2012, the Governor announced the short-term funding solution and medical providers were informed that TRICARE beneficiaries were once again eligible for state-supplied vaccine. There was only a 3-day gap when TRICARE kids were turned away from receiving vaccines. TRICARE is still being pressured to pay into the assessment fund, and other long-term solutions are being examined. TriWest has lost the contract for TRICARE and as of April 1, 2013, United Health will be taking on TRICARE. Governor Otter also sent a letter to the Assistant Secretary of Defense for Health Affairs asking that the Department of Defense provide details on why they cannot participate. Director Armstrong (DHW) has contacted Senator Crapo and possible solutions are being worked on, and **Dr. Hahn** expressed appreciation for everyone's help on finding a long-term solution.

Representative Rusche expressed his appreciation for everyone's work on this issue and he said that PPACA requires first dollar coverage for approved vaccines in any health plan, particularly ones renewed after 2011, and with the switch to United, why is United not having first dollar coverage. Is it just that they want to pay more than less. **Dr. Hahn** replied that this is a good question, and she said she thought that TRICARE was not impacted or did not fall under PPACA, but added that she was not sure. **Representative Rusche** said that vaccine manufacturers and distributors often get better payment from private purchase than from the VFC program, asking if that is involved in this in any way. **Dr. Hahn** responded that she did not believe so, adding that manufacturers see the benefit to a process like ours since rates are improved and therefore selling more vaccine, even though the profit per shot might be less. DHW sees TRICARE as a behemoth and it takes a long time for real change, as opposed to others players.

Mr. Matt Ellsworth, Senior Budget and Policy Analyst, LSO, was the next presenter, and his PowerPoint presentation is online at:
http://legislature.idaho.gov/sessioninfo/2012/interim/healthcare1022_ellsworth.pdf

Mr. Ellsworth addressed the task force on mandatory Medicaid changes under PPACA and said that **Director Armstrong** had already covered many issues. Looking broadly, one can think of these changes in two general categories: (1) the mandatory changes which will occur regardless of states' decisions relating to optional expansion, and (2) optional changes, depending on whether the state chooses to expand its coverage to include all individuals who earn up to 138% of federal poverty limitations. The main point he said, was that mandatory changes are fairly significant and will have associated costs.

Mr. Ellsworth said that the Supreme Court decided that Medicaid expansion is optional and states may elect not to expand per the terms of the ACA without jeopardizing federal funding for existing Medicaid programs. Here in Idaho, that comes down to the FMAP (Federal Medical Assistance Percentage) rate and Idaho's is favorable at 70 cents to every dollar of eligible costs incurred for eligible individuals. Presumably the way the law was originally drafted, it would have said that if Idaho does not expand to include this 138% of FPO, then HHS could withhold 70 cents to the dollar. Even in light of the Supreme

Court's ruling on Medicaid expansion, most of the law remains intact and those changes are significant and costly. **Mr. Ellsworth** said that mandatory changes include development costs which include pre-implementation activities that DHW has had in process since last fiscal year trying to lay groundwork for operating the program under these changes. Secondly are operational costs to actually run the program under the new requirements including ongoing operations of the program including administrative requirements and trustee and benefit payment increases.

Mr. Ellsworth said that Medicaid readiness was broken out into three phases: (1) modernization (65%); (2) expansion (26%); and (3) connection (9%). Total funding (90/10 match) for FY 2012: $7.5m ($750k state); FY 2013: $16.3m ($1.63m state); FY 2014: $10.3m (line item request, $1.03m state). Total one-time cost relating to mandatory changes in the Medicaid program (appropriated and requested) totals $34.1 ($3.41m state).

Relating to expansion of caseload counts, there is the woodworking effect and modified adjusted gross income (MAGI). The woodworking effect rationale is that even today there are people eligible to receive Medicaid but not currently enrolled or receiving services through the program. The individual mandate was upheld and as a result each individual is faced with the decision to either gain coverage or be subject to a fine or penalty, so many eligible for Medicaid will enter into the program and costs related to that. The modified adjusted gross income (MAGI) will increase overall enrollment within the program and is new methodology for calculating income which is the basis for eligibility determination. This will standardize things across all states. MAGI is an IRS definition, and will increase enrollment. There is another requirement in the ACA that under this new eligibility methodology, if someone was eligible under the old methodology and no longer eligible under the new methodology, they are essentially grandfathered in. Most people will not be dropped from coverage. DHW estimates a 10% increase in enrollment over current numbers (230,000 to 240,000) and to break it down, as a result of the woodworking effect it is estimated that roughly 12,000 individuals will come onto the program and an additional 12,000 to 24,000 as a result of the change in eligibility methodology for calculating Medicaid recipients.

Mr. Ellsworth discussed funding that would affect three divisions within DHW: (1) indirect support which oversees the IT arm; (2) the Division of Welfare which calculates and determines eligibility for Medicaid and other benefit programs; and (3) the Division of Medicaid which processes the payments and pays claims for eligible individuals. The total cost on the operational side includes 38 new FTP totaling $3,423,400 (50/50) for FY 2014. On the trustee and benefit payment side for FY 2014 in the Division of Medicaid they estimate $8.3 million from state and $22.9 million from the federal government totaling $31,229,000 to pay claims on behalf of those individuals impacted primarily from the woodworking effect. These T&B totals reflect only six months of costs because the relative portion of the ACA goes into effect on January 1, 2014. Standard Medicaid FMAP applies (70/30).

Looking at cost estimates by year, one-time versus ongoing, **Mr. Ellsworth** shared that the FY 2012 supplemental totaled $7,500,000 and for FY 2013 it is estimated to be $16,300,000, all one-time Medicaid readiness. FY 2014 has a one-time and ongoing estimate totaling $44,952,400. An extremely cursory estimate for FY 2015 is projected to be $65,771,600 ongoing.

Mr. Ellsworth said that the ACA in light of the Court's ruling leaves two major decisions for states on: (1) an insurance exchange; and (2) optional Medicaid expansion. There are benefits and risks associated with timing and IBES (Idaho Benefits Eligibility System) staff would recommend to the Legislature and decision makers in considering what to do, whatever direction the state decides to go, that it makes sense to make that decision during this 2013 legislative session because: (1) of that enhanced FMAP rate since 2014-2016 will be 100% federally funded and these folks would have been uninsured for a time.

Once they gain coverage it will be used and costs may be more down the road, so it makes sense to go there sooner rather than later; and (2) because of department/state resources. IBES steps required to reprogram that system will be similar whether programming goes up to all individuals earning up to 138% or to just make the changes associated with that modified adjusted gross income. If the state doesn't go with the optional expansion now and wants to expand to include that, then the department would be required to go back and go through many reprogramming steps all over again. If the change can be made now, the cost will be the same. DHW focus within the department is on contingency planning in order to meet aggressive timelines. As a result, if the state goes in one direction, it may allow DHW to focus energies in that one direction and taking others off the table, depending on whether expansion takes place or not. Finally, the interpretation by CMS is that states may at this point expand up to the 138% of federal poverty limitations starting 2014-2015 and if the considerations for each state change over the next few years, that decision may be reversed without any claw-back repercussions on the funding side. On the ground, as far as individual beneficiary impacts, that is a different story.

Mr. Ellsworth said there is more information forthcoming from the Leavitt report and the Milliman analysis, but he shared figures on several studies estimating eligibility/enrollment. He included figures in his presentation to indicate that the numbers coming out are in the same ballpark as other national research conducted to date.

With regard to the decision-making process, the Governor convened two different working groups, one looking at the insurance exchange and the other is considering Medicaid expansion. Another big decision point is that the fourth branch of government is going to weigh in and this may be on some voter's minds as they vote on November 6th. After that, the Governor will bring his recommendation forward and, presumably, the funding associated with expanding the Medicaid program either will or will not be included in that recommendation. Moving into the legislative session, all these questions will be there for decision makers and based on those decisions, DHW will move forward with their eligibility rules and changes to statute, etc. further down the road.

Representative Rusche asked **Mr. Ellsworth** when he assumed the claims cost, trustee/benefit costs for the MAGI changes in the woodworking effect, did he assume the same dollar amount because it seemed to him that they are different populations. **Mr. Ellsworth** answered that the figures displayed were from DHW's first request submitted to the Governor's office and to LSO Budget & Policy Analysis on September 1, 2012. On the trustee and benefit side of things it included an $8.3 million general fund request and that was only for the woodworking expansion, the 12,300 people that are being looked at there. If the question relates to the MAGI populations, then DHW's interpretation as confirmed by the Deputy Attorney General who works with DHW is that the MAGI group would be considered newly eligible under the verbiage of the ACA. As a result, it would be 100% federal funding for 2014-2016 for those individuals and they are not built in to the estimates submitted by DHW in the first revision, but he anticipated they would be included in the next revision coming from DHW. So, yes, they are different groups, he said, and are being handled accordingly.

The task force agreed to meet again on November 27th and the meeting was adjourned at 2:55 p.m.