MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, January 30, 2012

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Vice Chairman Broadsword, Senators Darrington, Smyser, Heider, Vick, Nuxoll, Bock, and Schmidt

ABSENT/ EXCUSED: Chairman Lodge

NOTE: The sign-in sheet, testimonies, and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

MINUTES: **Vice Chairman Broadsword** called the meeting to order at 3:05 p.m. and announced she would be chairing the meeting today due to the illness of **Chairman Lodge**. She reminded the Committee a vote had been postponed on **Docket No. 16-0310-1104** and that would be the first item on the agenda.

DOCKET NO. 16-0310-1104 VOTE ONLY

Rules Relating to Medicaid Enhanced Plan Benefits (Pending). **Sheila Pugatch**, Principal Financial Specialist, Division of Medicaid, Department of Health and Welfare (Department), advised that the Department agrees with the testimony of the providers that there is an opportunity to partner with them to create reimbursement rules next year that take into consideration all aspects of reimbursements which include access, efficiency and quality of services delivered. The Department recommends either **Docket 16-0310-1104** be approved as written, or be approved with the deletion of the following sections: 119.02.b, 119.03, 140.08.b, 140.09, 659.01.b, 659.02, 706.04, 706.05, 736.09, and 736.10.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #1).

Vice Chairman Broadsword noted that the parties had met and decided there is more work to do and agreed to remove all of the listed sections. **Ms. Pugatch** stated that is correct. **Senator Darrington** asked what happened with this docket in the House. **Ms. Pugatch** indicated she would be presenting in the House next week and would be advising them of the Department's agreement to reject the listed sections. **Senator Schmidt** commented that it looks like we are deleting all rules that have to do with reimbursement and asked how the department will function regarding reimbursement without those rules in place. **Ms. Pugatch** advised that reimbursement methodology is in the State Plan and the Department will continue to follow the current methodology.

Senator Heider commented that the policy to disenrole a provider who does not respond to a cost survey seems very punitive and he does not view it as a fair and honest policy. He asked if it is the Department's intention to do away with that policy completely in a rewrite. **Ms. Pugatch** indicated that the Department will reconsider that policy in their rewrite, and advised the Department does have that procedure in the pharmacy survey process. She further noted that the rule says the Department can disenroll a provider for failure to respond to a survey, but it has not done so to date. She stated the Department is willing to work with the providers to make sure that the process is fair and equitable for both the Department and the provider. **Senator Heider** noted there were providers in the audience and asked if one could speak regarding the Department's agreement to reject the listed subsections. **Vice Chairman Broadsword** indicated she would allow one person to speak on behalf of the providers.

TESTIMONY: **Katherine Hansen** , Executive Director, Community Partnerships of Idaho, Inc., spoke on behalf of the providers. She stated they have been corresponding with the Department by email and have a conference scheduled tomorrow. She indicated they recommended deleting a sentence from one of those subsections in each of the references mentioned. The Department indicated that was not possible and they would need to remove the entire section. Providers are concerned that the reimbursement methodology is not in statute and once it is removed from rule there will not be any reference to the methodology that was adopted in 2005. Therefore the recommendation of the provider association would be to not strike the listed subsections.

Vice Chairman Broadsword asked **Paul Leary**, Administrator, Division of Medicaid, Department of Health and Welfare (Department), to address **Ms. Hansen's** remarks. **Mr. Leary** indicated the State Plan, which governs the Medicaid program, has all methodology identified within that Plan. In order for the Department to change that they would have to amend that State Plan and in order to get the federal 70 percent funding, it would have to be approved by CMS.

MOTION: **Senator Darrington** moved, seconded by **Senator Bock**, that the Committee approve **Docket No. 16-0310-1104** with the exception of sections 119.02.b, 119.03, 140.08.b, 140.09, 659.01.b, 659.02, 706.04, 706.05, 736.09, and 736.10.

Senator Darrington requested that the minutes reflect the Department's representation that payment will continue to go on for providers through reimbursement methodology identified in the State Plan and that the Department will continue to work with the providers through negotiated rulemaking. **Vice Chairman Broadsword** reminded the Committee that a lot of testimony against the cost survey was previously presented by providers and this motion is in accordance with that testimony.

VOTE: The motion carried by **voice vote**.

RS 20803C1 **Relating to Idaho Nurse Practice Act. Sandra Evans**, Executive Director, Idaho Board of Nursing, advised that in 2008 the national Consensus Model for Advance Practice Registered Nurse Regulation was introduced to establish national standards for the uniform regulation of APRNs in all states. The Idaho Board of Nursing endorsed the model in 2008 and this legislation is proposed to come into compliance with concepts established in the model. The legislation will refine titles, change the membership of the current Board of Nursing APRN Advisory Committee and create a statutory framework for identifying by rule educational requirement for licensure, criteria for educational programs and grandfathering of advanced practice nurses currently licensed in Idaho.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #2).

MOTION: **Senator Smyser** moved, seconded by **Senator Heider**, that the Committee send **RS 20803C1** to print. The motion carried by **voice vote**.

PRESENTATION **Richard M. Armstrong**, Director, Department of Health and Welfare (Department), provided the Committee with an update on how Medicaid is being impacted by the Patient Protection & Affordable Care Act (Act) and the Department's approach to working toward their funding. The Act was signed into law on March 23, 2010, and the Centers for Medicare and Medicaid Services (CMS) has proposed rules which are expected to be final in the Spring of 2012, but will not be effective until January 1, 2014..

He summarized the impact of the rule changes and stated that nearly every aspect of Medicaid eligibility will have to change. This will not only affect the IBES eligibility system, but will require modifications to the MMIS system. The Department has less than 23 months to make these changes.

Director Armstrong advised that the majority of the costs for this project will be spent to modify the current IBES system. He reviewed the history of that system and stated the estimated cost of modification is approximately $23.1 million. The Department will have to invest about $4.5 million in the MMIS system to ensure the interface between the eligibility system and the payment system work correctly. Additional costs related to infrastructure will be approximately $7.2 million. This will allow the Department to provide 24 hour service and implement a disaster recovery plan. The cost for the Department to meet minimum compliance requirements is estimated at $34.8 million. With a 90/10 match rate, that requires $3.5 million in state funds and $31.3 Million in federal funds.

Director Armstrong stated the Department must be prepared to meet Medicaid compliance requirements to protect the federal match and will also use this as an opportunity to improve Idaho's Medicaid System. It must also be cautious that it does not implement certain aspects too early as it waits for critical questions to be answered and decisions to be made around how Idaho will approach these new regulations.

He advised that the project would be structured in three phases. The first phase will focus on modernization. The main part of this phase is that the improvements the Department will make to its technology will benefit all eligibility programs. This phase will help solve some immediate problems and gaps the Department continues to struggle with in the current Medicaid system and this is all done without regard to what happens with the implementation of the Act. The estimated cost of this phase is about $22.7 Million.

The second phase of the project will focus on all eligibility rule changes, income calculations and expansion efforts required to be prepared for the 2014 implementation. Medicaid expansion requires extending eligibility to all adults under the age of 65 at or below 133 percent of the Federal Poverty Level (FPL) and removes the asset limits for all adults and children who are nondisabled and elderly. The Department anticipates at least 100,000 new participants in Medicaid with this eligibility change and purposely placed addressing this in plan as phase two to allow time for a possible resolution of the decision pending with the Supreme Court. The estimated cost of this phase is about $9 Million.

The final phase of Medicaid Readiness will meet requirements to connect to an exchange. This connection ensures data and information can be shared back and forth between our Medicaid system and the exchange that Idaho eventually decides to use. This phase is purposely placed at the end of the 23 month project to ensure decisions related to Idaho's approach to an exchange are resolved and the money not spent building these connections until more information is available. The estimated cost of this phase is $3.1 Million

Director Armstrong advised that In the end Idaho will be prepared to meet new federal requirements, minimizing the risk of having an overwhelmed workforce, unpredicted budget impacts, and unprepared automated systems in 2014.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #3).

In response to Committee questions, **Director Armstrong** indicated that whether or not Idaho implements the Act, the $22.7 Million estimated for phase one is needed to update the current system. He explained that IBES is an acronym for Idaho Benefit Eligibility System, which is the system used today to determine eligibility of all welfare programs. He stated that even if the Supreme Court throws out the mandate for expansion, this upgrades Idaho's capacity at a 90/10 cost share. He explained the different cost share programs of the federal government and indicated that because this Act entitles adults under age 65 without children who are not disabled to Medicaid coverage, it is referred to as the expansion part of the Act. The federal government recognized this impact and agreed that they would pay 100% of the newly eligible expansion on the benefits side; however it is anticipated that there will be others who do not fall into the newly eligible category who will qualify for benefits and thus the state general fund will have some costs associated with the new population beginning in 2014. He advised that the 100% funding will gradually decline until it reaches the current Idaho reimbursement of 70/30.

Director Armstrong further advised that Idaho has always been compliant as a Medicaid administrator for CMS and this Medicaid Readiness project is so important because it is now a CMS rule. It is absolutely critical that the project is completed on time and with accuracy. He stated that the $3.5 Million state share of funding is within the Governor's recommendation in this year's budget.

With regard to questions related to the online customer portal, **Director Armstrong** indicated the customer is the citizen who believes that they may be eligible for Medicaid or for some other subsidy. It will allow customers to view case information, report changes, complete re-evaluations, and eventually submit applications on line. It must also have the capability of responding to someone who has become ineligible because of new employment but may be eligible to purchase insurance through the exchange. This is a national secure hub that is being created; it will move across all boundaries, and will make fraud more difficult. The Department will be able to access other federal agency databases to verify citizenship, income, and residence. If any of those facts have contradictions, then the Department stops that process and moves to a manual fact finding mode. This will prevent someone who lives on the border from applying for services in both states.

Vice Chairman Broadsword commented that this is a daunting task and the Department has done a good job in its approach to the project. She complemented the Director for his leadership and the Department staff for the good work they do.

MINUTE APPROVAL **Senator Nuxoll** moved, seconded by **Senator Bock**, that the minutes of the January 12, 2012 meeting be approved. The motion carried by **voice vote**.

MINUTES APPROVAL **Senator Schmidt** moved, seconded by **Senator Vick**, that the minutes of the January 16, 2012 meeting be approved. The motion carried by **voice vote**.

ADJOURN **Vice Chairman Broadsword** announced that the Committee would not be meeting on January 31st and reminded members the Committee will be touring the Idaho State Dental Facility in Meridian, with transportation provided. The meeting was adjourned at 4:05 p.m.

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Senator Broadsword
Vice Chairman

Lois Bencken
Secretary