MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Friday, March 16, 2012

TIME: 8:00 A.M.

PLACE: Room EW42

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

ABSENT/ EXCUSED: None

GUESTS: Denise Chuckovich and John Watts, Idaho Primary Care Association; Bob Luce, Department of Health & Welfare (DHW); Mike Kane, Idaho Sheriffs Association

Chairman McGeachin called the meeting to order at 8:01 a.m.

S 1279: **Robert Luce**, Division Administrator, Family and Community Services, DHW, presented **S 1279**, which originated in 2011 when it was discovered that ten sections of Idaho Code hold a legal guardian financially responsible for acts of the ward. Probate code states that a guardian is not financially responsible for the ward since they are not the parent. This legislation eliminates the legal guardian reference in the conflicted code.

Mr. Luce said that the existing code may affect the recruitment of non-resident guardians for children and persons with developmental disabilities, over whom they have no physical control. He said that the wording may have actually been inserted into code without evaluating the effect of its placement. He stated that meetings with stakeholders had occurred and disability rights groups were sent the draft legislation, with no comments returned. Responding to a committee question, Mr. Luce explained that "or other legally obligated person" is being added for code consistency.

MOTION: **Rep. Roberts** made a motion to send **S 1279** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. Shepherd** will sponsor the bill on the floor.

S 1370: **Mike Kane**, Idaho Sheriffs Association, presented **S 1370**, legislation that updates Idaho Code sections covering sexually transmitted disease (STD) testing of incarcerated prisoners. Deletions include references to acquired immunodeficiency syndrome (AIDS), which is part of the human immunodeficiency virus (HIV) test, chancroid, which is not found in Idaho, a duplication of the term "body fluid," and testing for drug related charges. Additions include testing for chlamydia, the most common infection, and anyone charged with a crime involving the use of injectable drugs.

MOTION: **Rep. Chew** made a motion to send **S 1370** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. Chew** will sponsor the bill on the floor.

PRESENTATION: **Denise Chuckovitch**, Executive Director, Idaho Primary Care Association, presented an update on community health care centers (CHC). She said the thirteen CHCs provide patient-centered primary health care, lowering total health care costs and improving outcomes. CHCs have been around for forty years, are open to all, and are often the only rural community source of primary and preventative care. There are 37 Idaho communities with CHC sites that served 133,000 patients in 2010. Their key areas of emphasis are access, quality and cost. She discussed the funding challenges, use of the 2008 one-million dollar grant, and the possibility of expanding dental service sites.

Ms. Chuckovitch stated that CHCs serve 12% of all Medicaid participants, at a total cost of 1.1% of Idaho's Medicaid expenditures, since primary care is less expensive than hospitalization. She explained that in 2010 the County Indigent and Idaho Catastrophic Care Fund Programs spent $50,864,388, served 1,298 individuals, for an average cost per person of $39,455, while the CHCs spent $78,474,382 and served 133,355 individuals, for an average cost per person of $588.

They are preparing for future changes in Idaho's health care environment by transforming their practices into patient-centered medical homes (PCMH), a team-based care focusing on keeping patients healthy and costs low, with specialist transfers only when necessary. Electronic health record systems are being adopted, with ten sites already transitioned.

Through a unique Medicaid prospective payment system (PPS) rate, CHCs are reimbursed through a bundled payment for comprehensive services modeled to keep patients out of the emergency room and reduce hospitalization. Each PPS rate ensures that federal grant revenues can be dedicated to care for the uninsured rather than subsidizing care for Medicaid patients.

She commented that the upcoming expanded insurance and Medicaid eligibility will lead to a 2014 estimated current patient eligibility increase of 35,042 for Medicaid and 13,855 for insurance exchange coverage. The average patient visit is two to three times a year.

Responding to questions, **Ms. Chuckovitch** said their concerns include the future of federal grants, fluctuating patient incomes that move them in and out of Medicaid eligibility, and inclusion in the provider networks of out-of-area insurance companies. Their goal is to keep patient care stable regardless of coverage. She said attracting and maintaining providers and practitioners in rural communities remains an issue that they are addressing by a pipeline approach.

In conclusion, **Ms. Chuckovitch**, said they anticipate a more focused approach, with a coordinated relationship between specialists and hospitals, including health data exchange to eliminate duplication of tests and assure prescriptions are appropriate. The Medicaid shift will be from current volume payments to value payments with more focus on outcomes.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 8:30 a.m.

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Representative McGeachin
Chair

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Irene Moore
Secretary