MINUTES
(Approved by the Task Force)

Health Care Task Force
November 4, 2013
Capitol Building, Boise Idaho
West Wing, Committee Room 55

In attendance were Co-chairs Representative Gary Collins and Senator Dean Cameron; Senators John Goedde, Patti Anne Lodge, Steve Vick, Marv Hagedorn, John Tippets, and Dan Schmidt; Representatives Fred Wood, Lynn Luker, Brandon Hixon, Luke Malek, and Elaine Smith. Representative John Rusche was absent and excused. Legislative Services Office (LSO) staff members present were Mike Nugent (in a.m.), Eric Milstead (in p.m.), Jared Tatro and Charmi Arregui.

Others present at the meeting included Tim S. Olson and Steve Rector, Idaho Academy of Nutrition and Dietetics and Nez Perce Tribe; Shawn Punnagan and Sue Linja, Idaho Academy of Nutrition and Dietetics; Dick Armstrong, Paul Leary, Steve Bellomy, Dave Taylor, Lori Stiles, Patty Lete, Dr. Christine Hahn, Dr. Roger Perry, Mitch Scoggins, and Elke Shaw-Tulloch, Department of Health & Welfare; Tom Donovan and Kathy McGill, Department of Insurance (DOI); Jolene Crumley and Andrew Campbell, LSO Audit Division; Robyn Lockett, LSO Budget Division; Susie Pouliot, Idaho Medical Association (IMA); Dave Jeppesen and Julie Taylor, Blue Cross of Idaho; Bill Roden, Select Health & Delta Dental; Kathie Garrett, National Alliance on Mental Illness (NAMI); Shad Priest, Regence BlueShield; Stacey Satterlee, American Cancer Society Cancer Action Network; Sara Stover, Division of Financial Management; Jim Baugh, Disability Rights Idaho; Woody Richards, Attorney/Lobbyist; McKinsey Lyon, Lyn Darrington, and Jesse Lewin, Gallatin Public Affairs; Larry Benton and Kris Ellis, Benton & Ellis; Amy Dowd, Your Health Idaho; Lee Flinn, AARP; Elli Brown, Veritas Advisors LLP; Colby Cameron, Sullivan & Rebeger; Brody Aston, Lobby Idaho LLC; Kindel Mason, Jerome School District; Corey Surber, Saint Alphonsus; Toni Lawson, Idaho Hospital Association; Nathan Andrew, Emergency Medicine of Idaho (EMI); Vivion Maisenbacher, Mylan, Inc.; Steve Millard, Idaho Hospital Association; Pat Sullivan, Sullivan & Reberger; Roger Christensen, Bonneville County Commissioner, and Chairman, CAT Fund Board; and Teresa Luna, Department of Administration.

Co-chair Collins called the meeting to order at 9:03 a.m. He called for approval of the October 7, 2013 Minutes and **Senator Schmidt moved that they be approved, seconded by Senator Cameron, and the motion carried by a unanimous voice vote.**

Mr. Steve Bellomy, Bureau Chief, Audits and Investigations, Department of Health and Welfare (DHW), thanked the task force for his invitation to share information on the School-based Services Special Study and his PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_bellomy.pdf

Mr. Bellomy introduced Mr. Dave Taylor, Deputy Director, DHW; Lori Stiles, Supervisor of the Medicaid Program Integrity Unit, DHW; and Patty Lete, also with the Medicaid Program Integrity Unit, DHW. **Mr. Bellomy's** presentation included the purpose, results and future of the study, a full review of communication about the study, and other school audits. He explained that the U.S. Department of

Health and Human Services (HHS) / Medicaid discussed concerns and planned to conduct a federal audit. Claims were rising at an alarming rate, complaints were increasing, and school district audits identified questionable billings. The regional auditor of HHS notified DHW that school based services were on the audit plan for the next year, and other states were experiencing significant findings resulting from federal audits. Fortunately for Idaho, with DHW's own concern and early efforts, the Region 10 auditor agreed to postpone the federal review to allow DHW to conduct their own study. Given the scope of the problem, DHW knew the possible financial risk to the state could have been in the millions of dollars. HHS continues to target school based services. In FY 2009 DHW has seen an average 36% increase in school based services each year for the prior five years. Total claims went from $7.1 million in 2004 to $31.9 million in 2009, and $35.2 million in 2010. A study plan was implemented. Between 2006 and 2009, five school districts were audited and 13% of student files receiving services were examined which found that 90% of the student files had billing problems. Of the 962,000 reviewed claims, 24,000 or 13% were overpayments. With the federal concern, other states' losses, rapid increases in school based services claims, and the problems identified in these audits, DHW believed that a special study was the best course of action. The Division of Medicaid agreed on a scope of study and this was endorsed by HHS. To date, 26 audits have been completed, in addition to the five done prior to the study. In the 31 school districts audited, 3,812 students were receiving services paid by Medicaid; 471 or 12% of student records were audited. Of those, 358 or 76% had overbillings. There were almost 41,000 services billed for $3.6 million, and 23% of services billed or 17% of amount billed was identified as an overpayment. Individual school district errors ranged from zero errors to 96%.

Mr. Bellomy said that DHW was startled by the impact of the study on billings. The cost savings, he predicted, since 2010 amounted to about $34.4 million. DHW's recovery audit contractor will continue this study to include about one-half of all school districts and the recovery audit contractor receives 10% of all overpayments collected. The remaining 90% will be distributed proportionately back to HHS and the school districts. In this way, future school audits will be paid for by a federal program and local school districts. The audits will continue, using a limited sample size in a limited timeframe. Concerns had been addressed by task force members, he said, so he shared that special studies by the recovery audit contractor will **not** include a civil monetary penalty. However, DHW may assess a penalty on any audit, if the findings meet the criteria established in section 56-209h(6) Idaho Code. Penalties must be applied consistently for all providers, including school districts, and a penalty may be imposed on subsequent audits if DHW finds corrective actions have not been implemented. He pointed out numerous communication efforts made since 2010, with the intention to provide feedback to school districts when there is a problem that needs to be fixed. DHW will continue to take advantage of any communication opportunity. He said that there are other types of school audits. He emphasized that DHW's Medicaid Integrity Unit became aware of the billing problem that represented a significant financial risk for the state; they continue to engage with a variety of people in both Medicaid and education while conducting the study, and they are providing feedback as audits progress. He acknowledged that this work may not be popular, but he believes this is a necessary step to protect the state of Idaho from a more far-reaching and expensive federal audit. He hopes this study will result in increased compliance with Idaho state Medicaid standards.

Senator Tippetts asked for a summary of school based services, such as speech therapy and interpretive services, if appropriate. **Mr. Bellomy** replied that the school based services include speech therapy and

interpretive services, a range of mental health services, those being the most common, as well as nursing services and personal care services.

Representative Luker asked about the payment of the recovery audit contractor and **Mr. Bellomy** replied that the Affordable Care Act (ACA) required the state of Idaho to contract with someone to come in independently to do contracts. In order to cover half of the school districts, DHW did not have those resources, since it took DHW 4 years to conduct 20 audits in 31 schools. The recovery audit contractor receives reimbursement in the amount of 10% of everything recovered. Based on the federal funding rate, for example 70%/30%, then the balance is refunded back to the federal partners (70%), and the 30% would go back to the school district. **Representative Luker** asked if 10% was sufficient to cover the contractor cost and if this is allowed within the federal system to take that 10% off the top. **Mr. Bellomy** said it was not only allowed, but required by ACA, the maximum rate being 12% and in state statute, and the state bid came in at 10%. The first preliminary findings report is barely out. **Representative Luker** asked if there was a projection on how long it will take to audit half of all school districts. **Mr. Bellomy** hopes to have this done within two years. **Representative Luker** asked if there is any sense from school districts about the struggle of covering costs that may be mandated. **Mr. Bellomy** answered that he could only speak to how the Medicaid program is used within the educational environment, admitting there were significant problems. The biggest risk, he said, is not what DHW is doing, but whether the federal government comes in to do reviews. **Mr. Bellomy** believes that what would be found could be significant, and many states are going through this. The impact currently on school resources is a precaution to deter what DHW is trying to avoid. DHW is keenly aware of school district constraints; by taking the school study and excluding penalties, DHW gets no effective reimbursement since that goes back to the school district, so DHW is doing this with no means to recover DHW's costs. DHW is trying to have a minimal financial impact in order to improve the school district situation.

Senator Cameron asked about the penalty portion, understanding the need for the audit, and perhaps the penalty if there is an egregious error, but as he reads statute, there is language that the district knowingly submits a fraudulent claim, makes a false statement, etc. and he asked for clarification about how many school districts had paid penalties, and why did **Mr. Bellomy** say that penalties had not been collected. **Mr. Bellomy** explained that if DHW does an audit based on an abuse complaint, if a broad-scoped audit is being done (like speech services provided in a variety of providers) then DHW does use penalties. The area where DHW avoids using penalties is in this special broad-based study in which a lot of schools are looked at with a sample of student records, primarily to get an assessment for each school district for feedback on how well services are being documented and how accurate Medicaid billings are. On those special studies, DHW is not assessing a penalty, so in all the audits done in all school districts, there are some that have been assessed a penalty, but for this special study, no penalty has been collected. **Senator Cameron** asked if he could reconcile that statement with slide 23 that says there are penalties amounting to $33,311 in 13 districts for special studies, since his words did not match the slide. **Mr. Bellomy** replied that there are different kinds of special studies; the school-based study is going into a school to take a random sample of cases for evaluation. Other special studies look at service categories, services provided among all providers to look for trends, speech therapy being the best example and by far the largest amount, a service growing rapidly. Many providers were billing multiple times for one speech evaluation, so when penalties are assessed for all providers, the school districts are included in that as well. So, that is a different kind of study, he said.

Representative Wood thought he heard **Mr. Bellomy** say that when an audit is done and overbilling is found or services not eligible that the Recovery Audit Contractor (RAC) contractor receives 10% off the top and that 10% goes to the RAC contractor and the rest is divided between the federal government and the state. He presumed that 70% of the remaining 90% that goes to the federal government would go to the Federal Treasury. He asked if 30% goes back to the school districts. **Mr. Bellomy** replied: "Yes, you are correct. The state does not keep any portion of the school based recoveries." **Representative Wood** asked if a school district overbills, do they get to keep the 30% , and **Mr. Bellomy** replied "yes, but they have to reimburse the federal portion, so it's still very painful."

Senator Goedde commented on the four states that **Mr. Bellomy** listed where the federal government had done some work, asking if only these four states had been audited. **Mr. Bellomy** said there certainly are more than four, adding that he had used those four only as examples. **Senator Goedde** asked if contractors get to collect a percentage of the penalties assessed as well, and **Mr. Bellomy** replied "no, the state keeps those." **Senator Goedde** assumed that providers, in addition to school districts, are assessed penalties as well, asking if that was correct, and what percentage of penalties go to school districts versus providers. **Mr. Bellomy** answered that he would have to get those figures. **Senator Goedde** said he would appreciate that, and then asked who makes complaints. **Mr. Bellomy** responded that DHW has a hotline, as does the Attorney General, so complaints are received regularly. Service verifications are also sent out to the client or recipient of a service and erroneous billings are found. **Senator Goedde** asked if complaints come from competitors who are providing services or from regular citizens. **Mr. Bellomy** answered that complaints come "from all of them," and he added that occasionally providers do complain about another provider.

Senator Vick asked if the school districts get to keep that portion, doesn't that give them an incentive to overbill. **Mr. Bellomy** answered that they paid to begin with, so the school districts pay 100% and are then reimbursed, so when DHW collects, it is given back to the school districts since they pay the 30%, (the match). **Mr. Dave Taylor** clarified that one thing different about the school based services relationship to the other benefits paid out of Medicaid Trustee and Benefits (T&B) is that the general fund portion does not come out of the Medicaid T&B appropriation received. The school districts provide to DHW the match required to draw down the federal funds, and it goes into a trust fund assigned to that particular school district. When a bill is received from a school district for reimbursement, DHW makes sure they have enough general funds in order to draw down the federal funds for match. If they don't have enough general funds, a call is made asking the school district to contribute those funds to DHW. For example, if the school district bills DHW for $10,000 in Medicaid billings, then 30% would come out of their trust fund, and 10% would be used to draw down the remaining 70% from the federal account. In answer to Representative Wood's question about how the penalty works, the same $10,000 in Medicaid billings and the RAC who reviewed the account and found that $10,000 was overbilled, and 10% would be collected and 70% of the remaining $9,000 or $6,300 would be sent back to the Federal Treasury. The remaining dollar amount would be put back into the school based trust account to be used in future draw-downs of federal funds against future claims for the program.

Senator Schmidt asked about the actual billing for services, since his understanding of having billed Medicaid in the past was that the school district would contract with the provider for services provided,

saying that it wouldn't be a direct employment of the provider by the school district. Therefore, who is actually submitting the bill to Medicaid, is it the provider or is it the school district. **Mr. Bellomy** replied that in most Medicaid billing arrangements, the liability stays with the district and the biller is the intermediary. They collect the information, submit the claim and handle the reimbursement or funds, but they don't normally take on the liability of the accuracy of the claim, so the school district is the officially liable biller, the actual provider.

The next presenter was **Mr. Kindel Mason**, Special Education Director, Jerome School District, and his PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_mason.pdf

Mr. Mason addressed the task force on his school district's perspective on a Medicaid audit. He thanked the task force for the invitation to speak at this meeting, as well as the State Department of Education (SDE) and DHW for collaboration in working together to provide training to school districts. He said he was a very active, vocal director who has ties across the state, and he was here representing other school districts, as well as his own. **Mr. Mason** said that his district's audit was a surprise, and since this audit occurred, there has been a united effort to provide training to school districts on how to bill school-based Medicaid. He expressed appreciation for that and hoped that would continue in the districts. **Mr. Mason** handed out a paper on the process for billing Medicaid in Idaho schools (available in LSO) which listed many forms, since those forms and the paperwork are immense in an audit. Special education directors work through the Individuals with Disabilities Education Act (IDEA) which requires much paperwork, and the teachers also must document each service in order to bill Medicaid, people not familiar with the "Medicaid world." He showed immense files that are the result of billing for personal care, and the same is true for behavioral intervention. The volume of paperwork is a huge issue for school districts and classroom teachers are trying to work with students with special needs, and then to require detailed paperwork for an audit process becomes shocking, pointing out the lack of training. DHW has been collaborative with SDE this past year to provide training to school districts, compared to zero training prior to that with regard to school-based Medicaid billings, especially with constant changes in Medicaid rules. Personal care for students in schools is sometimes hard to document and the teacher is so burdened with the personal care, plus documenting each act on a Medicaid log sheet to keep track of time spent on each service becomes cumbersome. **Mr. Mason** doesn't think that DHW auditors understand special education law and the special education directors do not understand Medicaid, which caused a clash in the beginning, and he said there continues to be misunderstandings.

Mr. Mason said that his district got an initial registered letter in June 2013, when he was not on contract, and the resulting paperwork amounted to two boxes of information being sent in originally to Medicaid. On September 30, the district got a letter with 288 lines and a 16-page spreadsheet for the district to go through, asking about issues on services, which amounted to $56,000 in potential penalties. Having never been through an audit, this was very shocking for a director to be accused of costing a school district that amount of money, wondering if his job might be in jeopardy. The issues ranged from physician referrals, services not documented correctly, missing documentation, unqualified staff, background checks, school closures and absences. The district was given 30 days to respond and come up with 320 pages that referred to the 288 lines in the audit letter. This was on top of what these directors and teachers are trying to do for the students, which is the very hardest part, since they are about providing services. There is so

much red tape and laws surrounding special education, so the audit required an excessive amount of work on top of trying to meet the needs of special students. There was much frustration on the part of both the district and the DHW auditor since neither understood the other, and there was much pressure on both sides of the audit. The Disabilities Act and Medicaid don't mesh well, according to **Mr. Mason**, and he feels like the district is always trying to put a "round peg in a square hole" and he emphasized that there is no intention to do anything wrong. If school districts are taught how to do things correctly, it will be done, and there is no money being made from Medicaid, since the school district pays 30% of every service, so they only get back the 70%. On December 28, revised findings came to the district and the first part of the audit was a learning process, but in this letter there were words like "if medical records do not currently exist in a student's file, they should not be obtained as a result of this review."

Mr. Mason said that his district took that to mean that paperwork was being manufactured, when in reality some paperwork was in various files and some did not get copied and sent. The requested documents were in files all along, and the accusation was unwarranted, in his opinion. The district was asked to go through all 1,200 lines on a spreadsheet and to go through a contractor's timesheets to match up 1,200 lines, and the total payback went up from $56,000 to $154,000, which was even more shocking to **Mr. Mason**.

There was an issue about services being provided, and students are educated in various locations outside of a school building, but in Medicaid's thinking, school is a building, which created discussions around what is a school. A response was due back January 15, so the district had 1,200 lines to go through and on December 28th, district employees were on Christmas break, so that left 12 days to respond to 1,200 lines of requests done by two people. **Mr. Mason** wondered what would happen if he disagreed with the auditor's findings, since there were many disagreements, and it was more about if the district disagreed with the audit process itself, and that became important toward the end of the audit. A final letter was received by the district in March that amounted to about an $18,000 payback; they disagreed and still do, but they decided to pay it to cut their losses. When Medicaid shares data that a school district pays back money, he doesn't want to call it inaccurate, but it was a cheap resolution to get out of a very uncomfortable situation. They didn't think it would be worth it to hire an attorney, as Blaine County did, and they did refute some physician referrals, but his district did not have the luxury of hiring attorneys.

Mr. Mason expected some feedback on the 1,200 lines of information submitted on the employee who was questioned as being qualified, but none was received. Two audits on providers who contract services have been since conducted in this district who assumes responsibility for these providers. On top of getting fined, the district had to pay. **Mr. Mason** again pointed out that DHW and SDE have really been working hard to collaborate since compliance is so important. The audit started out collaborative, but toward the end, the worse it got for the district, like when the term "fraud" was used and the district was accused of making up documentation. He said that once the auditor hung up on **Mr. Mason**, out of frustration, and he thought that was unprofessional. Most errors are procedural, the student having received the service, notes proved such, the service was billed, but in the process something got missed by not checking a box, and the district ending up paying a penalty. Remember, a busy teacher often fills out this paperwork and the audit process takes away time for teaching students, which is what districts are all about. Paperwork is the number one reason that special education staff cannot be retained, yet audits are on top of everything else, so districts are caught between a rock and a hard place. Districts do not want to

bill Medicaid, but with special education needs, services must be provided for students. Districts would prefer to be given the money they need to provide services to the students, but on such tight budgets and expensive needs like for a speech therapist, billing Medicaid is necessary. His district does not even bill for transportation, since there is so much room for error, so districts are actually spending money on reimbursable services, just to avoid the cumbersome process, since districts are afraid of compliance. **Mr. Mason** shared his wish list for directors which included:

- Education vs. audit (teach us and we will do it; districts would welcome education on a regular basis);
- Negotiated agreement needs to be in place between SDE and DHW;
- Physician referral (practitioner of healing arts, such as speech therapist, needs to be able to sign referrals like in other states);
- Administrative claiming (school districts can ask for money back for administrative costs);
- Collaboration for improvement in services for kids (instead of two entities fighting for pockets of money).

Mr. Mason concluded by saying that he hopes this will be the start of coming up with a better collaborative partnership.

Senator Goedde thanked **Mr. Mason** for his work and the challenges he faces, and he expressed appreciation for the wish list as a guide for potential improvement. He asked why there is not a negotiated agreement between SDE and DHW in this area. **Mr. Bellomy** replied that there is not a negotiated agreement because the Division of Medicaid reviewed the agreement and felt like it wasn't ready yet, and perhaps that division could respond further, since Mr. Mason was not directly involved in the negotiation. **Senator Goedde** asked who was directly involved in that negotiation and the reply was the Division of Medicaid, and the actual individual was unknown.

Senator Schmidt told **Mr. Mason** that he had a similar experience going through a Medicare audit, in terms of how the process works, and he referred to the growing costs for Medicaid in school based services, asking for perspective on why a graph in his PowerPoint looked like it did. **Mr. Mason** said that with medical advancements districts serve many students who may not have been in schools 10-20 years ago. Current medical services now allow these students with special needs to be in school, the result being increased billings with more services being provided, and life spans have expanded. Also, his special education budget last year through the federal government was cut by $40,000, school district budgets have been cut in the past, and schools are trying to bill for services now that they used to "leave on the table." **Senator Schmidt** said that in his experience with a Medicare audit, they looked for overbilling, but they ignored under-billing, and he wondered if that was also the case in Mr. Mason's audit. **Mr. Mason** said that by not pointing it out, he guessed that it was ignored, adding that most school districts do under-bill, out of fear of an audit. If anyone has to ask "is this billable, then it is not."

Representative Luker asked **Mr. Mason** about hiring a half-time person to do paperwork, asking how much that cost the district. Having taken that step, is he getting any feedback as to whether his district is now in compliance. **Mr. Mason** replied that the cost to hire a para-professional was $12,000 annually plus benefits, pointing out that this person could be in a classroom working with students. This employee is not at the level of being a bookkeeper, but is learning. There has been no feedback from Medicaid and

he wished that communication could be consistent. **Representative Luker** said he did not want to minimize the need for the special education program, but he asked if the school district programs provided services as a part of their mission or are these programs mandated federally or by the state, and if so, how much funding is received. **Mr. Mason** said that school districts are mandated by the IDEA to provide special education services in schools and there is a small window to get out of that by refusing funding, which a school district is not going to do. The law and manuals dictate regulations, and Medicaid has added forms. There is also a moral dilemma for many people involved in special education, believing it a moral right to provide services whether funded or not. In his school district, $588,000 was funded through the IDEA and out of the general fund. A match is provided for those students as well, so over $1 million is paid out with an amount that is being reimbursed from Medicaid. **Representative Luker** commented that many special education services are provided, and he asked if those services were specifically mandated under IDEA or does the district provide these services to comply. **Mr. Mason** said this goes back to the "square peg in a round hole" dilemma talked about earlier, adding that IDEA does not specifically list some services in Medicaid, like psychosocial rehab, but through IDEA a district is to provide services for kids in special education. Districts are monitored by the state, as well as Medicaid. Some services, although not specifically spelled out in IDEA law, must be included in an individualized education plan for a special education student and sometimes services do not match Medicaid, so this gets hard to juggle, since the two don't match up well.

Senator Cameron expressed admiration for **Mr. Mason**'s courage and willingness to present to the task force on this sensitive topic. He asked about how much of the necessary paperwork is federally required versus how much is requested by the state. **Mr. Mason** replied that was difficult to answer, but the bulk of the paperwork is IDEA mandated, but Medicaid is piggy-backing on that, since the paperwork must be filled out in order to bill Medicaid, and the student must be eligible and have an individualized education plan. The process and potential penalties is the issue for school districts, since it is so "convoluted." **Senator Cameron** wondered about school districts who disagree with the audit findings, and he asked if there was discussion about an appeals process or a mechanism available for the school district to be heard about disagreements. **Mr. Mason** said that it was not clear what came next, except to be told to go to the Idaho Administrative Procedures Act (IDAPA), and the audit process was about all that the district could address. They asked what recourse they had about a disagreement, and they were told that the auditor made the ultimate decision, so it left the district without answers.

Senator Hagedorn thanked **Mr. Mason** for what he does and for his testimony. It struck him that **Mr. Mason** said that school districts really are not trying to do it wrong, and **Senator Hagedorn** said that everyone was trying to do the same thing; unfortunately, in looking at the list of documents that must be provided in an audit, mistakes are going to occur. He wondered if the individualized education plan for a student is approved by DHW and SDE for necessary services. **Mr. Mason** answered "I believe so" but said he was not involved with Medicaid intricately, but the districts are told that if the IDEA paperwork is filled out and the extra Medicaid forms, then that is necessary. **Senator Hagedorn** said that the fact that Mr. Mason was not sure was very telling to him, believing that the process between DHW and SDE is a bit broken. He thinks that a collaborative process including an annual review would be very important, adding that it would cost money to do so. He asked **Mr. Mason** for his suggestions on what would be the best minimal way to educate school districts to ensure billing accuracy. **Mr. Mason** replied that a team of qualified professionals in the schools write the individualized education plan for a student based on a

student's needs. There is no discussion about the funding to accomplish a goal for that student. The district then goes through a process, and he said that SDE periodically reviews files, asking for a small percentage annually, and they do it in a collaborative way to teach districts and ask for something to be fixed. He thinks that minimally, districts should be asked for a small percentage of files each year by Medicaid, not to punish districts, but to teach and show employees what to do in order to pass audits more successfully. **Senator Hagedorn** asked if **Mr. Mason** had seen practices change over the years with regard to audits. **Mr. Mason** answered that their audit was in 2012, and through hearsay, he doesn't think audit processes have changed much, and now rumor has it that Medicaid has a "hired gun" and they get paid by finding infractions. If a bill is getting paid by finding mistakes, he thinks that is incentive to dig deep, and as a special education director, that was very scary to him, believing that to not be collaborative. He thinks the audit process might even have gotten worse.

Senator Vick asked if the auditor was an employee of the state, federal or a contract auditor and **Mr. Mason** answered that he thought the auditor was a state employee, since he called a state office to communicate with the auditor. **Senator Vick** expressed the concern that if auditors are paid based on what is found, he believes this to be a real "can of worms." If the auditor was a state employee, **Senator Vick** is disappointed in how this audit was handled, at least from **Mr. Mason**'s perspective.

Senator Tippetts asked if Mr. Mason had ever requested training for himself or his staff on Medicaid billing, and **Mr. Mason** replied that many directors had requested training and none was received, but they always got referred back to IDAPA, adding that interpretation of those IDAPA rules is different for different people. He is not aware of any training, although the Meridian School District had training and was gracious enough to invite other districts to that training. This year there has been training with DHW, so that piece has changed, but is it enough? He said "probably not." **Senator Tippetts** asked to whom the request for training was made, and have districts taken advantage of the more recent educational opportunities just mentioned that have become available. **Mr. Mason** said that one issue is that so many different agencies and people are involved in Medicaid, but this has been narrowed down recently, so that districts know who to talk to at Medicaid. The regional coordinator for Medicaid in Twin Falls had been asked and they knew of no training, and when DHW was asked, it seemed nobody knew. Communication is crucial, knowing who to contact to ask for training. Many school districts have now accessed training offered, and there are webinars available online also that are being used by employees. He said it would be nice to hear accurate information from SDE.

Representative Smith said that in her district, a Medicaid billing person was hired in about 2000, and she wondered if districts, the size of Jerome, hire employees to do Medicaid billing. **Mr. Mason** replied that almost every school district that bills Medicaid either has to hire an employee specifically for that purpose or it partly consumes another employee's time. Most districts, such as Twin Falls, have a full-time employee who does only Medicaid billing. **Representative Smith** commented that with new requirements constantly changing, she asked if there is yearly training that SDE could offer to help district employees train for Medicaid billing. **Mr. Mason** answered that for him, this year was the best ever for training, and he thanked several DHW employees who did a great job this year, and he said that the training may go back to being haphazard. Medicaid does now have a school-based Medicaid site to get updates. Collaboration is critical, which becomes so clear during an audit process. He said: "Show the districts how to do something and they will be happy to do it."

Representative Hixon asked if there is a technology component that would reduce personnel costs, something at the state level that could be done, considering the complexity of paperwork and time restraints. **Mr. Mason** said there is a lot of software available, but districts have looked at it, and it didn't really fit the needs of districts. Rather than racing to the top of a mountain of paperwork, districts would prefer to race to the top to meet the needs of students. Each service must be tracked, even down to 15-minute increments, and exact times and descriptions of that service must be logged. Therefore, if technology is used, staff must put data on paper and then transfer that to a computer system, so districts deal with volumes of paperwork. One half-time employee would turn into a full-time employee if information had to be documented twice. He wasn't sure what could be streamlined at the grassroots level since services must be logged in real time for accuracy.

Senator Goedde stated that when IDEA was passed by Congress, states were promised 40% of costs and have averaged about 7%.

Ms. Teresa Luna, Director, Department of Administration, updated the task force on the department's new health promotion program "thriveidaho" and her PowerPoint is on LSO's website at: http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_luna.pdf

Ms. Luna said that "thriveidaho" was launched on October 1, 2013 to motivate employees to get healthy, stay healthy, and combat the ever-increasing costs of healthcare. This is a health promotion program which began with a 2011 Governor's initiative, and approval was received from the legislature. **Ms. Luna** gave the history of this program, the vision, how Idaho measures up, Idaho statistics, health promotion program assessments, critical steps for success, and program plans for the next five years. After four weeks of the program, **Ms. Luna** said she was so excited that over 300 employees have taken initial steps to join the program. She believes that "thriveidaho" is a step in the right direction to mitigate yearly increases in healthcare costs. She concluded her presentation by quoting Governor Otter who said: "It's a lot less expensive to keep people healthy than it is to get them healthy after they've had a problem."

Senator Hagedorn commended **Director Luna** on "thriveidaho" and he asked about the return on investment (ROI) being $3.27 per dollar invested, and he wondered if there were metrics for measuring that ROI out for the next five years of this program. He asked if legislators would be able to view those metrics to see when that point is reached or if that point is exceeded. **Director Luna** said that information will be collected annually and she agreed to share that information with the task force as the state workforce moves through this program.

Representative Hixon agreed that this was a great program, and he asked about the compensation incentives in the amount of $125 to $300, asking when and how this would be paid out. **Director Luna** replied that this was an incentive-based program, so when an employee accumulated necessary points, the employee would receive a check from a provider for participating in the program and completing the required steps.

Senator Tippetts expressed his surprise at the fact that only 300 employees had signed up, and he asked what the projection was regarding the number expected to enroll, and is the program where they want to be currently. **Director Luna** replied that her department is thrilled about that 300 number, since many other plans offered in past years have rarely had more than double-digit participation. There is a very lofty goal of 25% participation before the end of the first year, through communication and getting employees engaged. Monetary incentives are what they hope employees need as motivation to participate. This is a way for employees to mitigate increasing premium costs, and they hope that benefits will be seen when employees become active participants in their own good health. This program educates employees about how to use the plan and asks them to be a conscious consumer of the state plan. **Senator Tippetts** wondered if preventive healthcare programs typically see the least healthy or most healthy enrolling, and he asked if there is a noticeable pattern. **Director Luna** answered that typically employees engage who are the most healthy, and she emphasized that they want to keep those people healthy. Her department will be happy to reward employees for good health practices.

Representative Hixon observed that the monetary portion didn't seem like a very large amount of incentive to possibly turn around a lifestyle, and he asked if they had considered cutting a percentage of what an employee's premium would be. **Director Luna** said many options had been considered, but a percentage of a premium was not considered. Best practices across states have incentives that range in the amounts offered by "thriveidaho" and states are seeing positive results, so this is where Idaho decided to start.

Senator Schmidt commented that the Governor also has a program to promote "medical homes" and he wondered if that was one incentive to consider as a reward participation in a medical home. **Director Luna** said she was not familiar with medical homes and how they relate to the state's plan, but she agreed to get information about that to the task force.

Ms. Amy Dowd, Executive Director, Department of Health and Welfare, gave an update on Your Health Idaho and her PowerPoint presentation is on LSO's website at: http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_dowd.pdf

Ms. Dowd's presentation included why Idaho chose a state exchange; local control; the plan for 2013; our reality; resources on the website; plans and rates; tax credit information and a calculator; resources available on the website or over the phone; Idaho statistics; the marketplace; estimated savings for an individual and for various family scenarios; how to get help; consumer connectors; and additional help. **Ms. Dowd** said that Your Health Idaho had launched a website and outreach, even though the federal technology has not been working, about which they were not notified in advance. No explanations have been given, and Your Health Idaho quickly responded to the federal failure by adapting the website and outreach programs. Very helpful feedback has been given and implemented. She thanked Representative Wood and Senator Cameron for their suggestions about improvements which were incorporated into the website. What cannot be obtained on the federal website, citizens can go to Your Health Idaho to get assistance where they can shop and compare plans anonymously, without signing up for an account. Agents, brokers, in-person assisters and call center staff can use tools on this website to help guide Idaho's consumers. In addition, and in response to the failure of the federal system, Your Health Idaho has linked to the Kaiser Family Foundation calculator so people can get a helpful estimate of premium

assistance. This week Your Health Idaho will launch their own calculator which will provide Idaho-specific results. Idahoans can apply online or over the phone, until the federal technology is working. She believes that Your Health Idaho is the right fit for Idahoans. There are currently 225,000 uninsured individuals in Idaho, and many people will benefit from the advanced premium tax credits which help lower monthly premiums and, in some cases, cover a substantial portion of cost. Individuals ages 19-64 with income from $11,500 to $94,000, depending on household members, may be eligible for advanced premium tax credits or cost-sharing reduction options. She gave one example of a 26-year old individual with an annual income of $13,000, and the estimated monthly premium for a mid-range silver plan in the marketplace would be around $185, and the monthly advanced premium tax credit for this individual would be around $159, so the premium out-of-pocket cost would be about $26 monthly. To contrast this with a penalty for the same individual, in 2014, this person would face a penalty of $95; in 2015 that penalty would raise to $325; in 2016 it would raise to $625 if this person did not have insurance.

Ms. Dowd gave various scenarios for individuals of different ages and family members. Currently there are 170 in-person assisters and over 500 agents and brokers across Idaho to assist individuals. In-person assisters are trained and not able to recommend a plan; that is the role of a trained agent or broker. Privacy is very important to Your Health Idaho, and their IPA program is more stringent than in other states. IPA's undergo a full FBI background check; no one is allowed to perform outreach activities until training and background checks are complete. They are not permitted to carry or keep any personal records, and they have existing privacy and security standards. As opposed to in-person assisters, agents and brokers can and do make recommendations and advise individuals on which plans are available for purchase. Your Health Idaho's website is: www.yourhealthidaho.org
Content on the website is refreshed almost daily and Idahoans can also call this number for assistance: 855-YH-Idaho (855-944-3246).

Senator Tippetts said that across the nation, insurance companies are being reported as discontinuing plans that don't meet the federal criteria, asking if that is happening in Idaho, and why plans are being discontinued. **Co-chair Collins** said that afternoon agenda presenters would address those questions.

Representative Luker asked about current enrollment numbers for Your Health Idaho and **Ms. Dowd** said that since the federal technology platform is being used, there is not real-time access to that information yet, even though it has been promised that will be given out at the end of November. She said she knows that Idahoans are enrolling in plans, but she will share those numbers at a future date.

Representative Malek said there had been a delay in the individual mandate in terms of how much savings there would be for a family with the tax credit, and he asked if this delay would mean an elimination of the tax credit. **Ms. Dowd** did not want to speculate on what might happen, since she had no current information about that.

Co-chair Collins reminded the task force that **Ms. Dowd** is working with the state marketplace, and that the many questions everyone has about the federal exchange cannot be answered at this time.

Senator Vick wondered about the security of the federal exchange, asking if there was any difference for an Idaho resident, since they have to go to the federal exchange. **Ms. Dowd** said that the security

protocols for Idahoans would be the same for the federal website. **Senator Vick** said he had heard that if a person in one county moves to another county, that person could not keep the same insurance, through the federal exchange. **Ms. Dowd** replied that was not necessarily true. **Senator Vick** said he noticed on one slide in her presentation policies available in a county, assuming that it could be true if a person moved, a policy might have to be changed. **Ms. Dowd** said that certain plans are offered in certain places across the state, so that might be a consideration, but it is not always true that moving would cause loss of a plan.

Senator Goedde read in the Statesman about people purchasing health insurance at no cost with high deductible plans, and if a low income person purchases such a plan, he wondered about them not being able to afford high deductibles or co-pays, asking if the state still had exposure to indigent care at the county level. **Ms. Dowd** deferred that question to someone more familiar with the indigent fund. **Co-chair Collins** informed the task force that Commissioner Christensen was on the agenda in the afternoon, and could address that. **Co-chair Cameron** said that there is an additional subsidy available for those who meet certain criteria, so there is additional help if an individual with a certain level of income has exorbitant expenses; there are two subsidies, a premium subsidy and the other is on the benefit side.

Senator Schmidt asked if there are agents or brokers specifically trying to address small municipalities or school districts, with less than fifty employees, since it was his understanding that they would be eligible to participate in the marketplace. **Ms. Dowd** said that is correct, and she affirmed that agents and brokers are able to assist any small group interested in purchasing insurance through the marketplace.

Representative Wood suggested that Your Health Idaho needs to get out information to all Idahoans to make sure that they understand that the cost of a product to an individual is not based on the gross cost of the product, but is based on household income, which is not the way a lot of people would look at this. He thinks this information needs to be advertised on the website, since this understanding may create more interest.

Representative Luker asked about the calculator which asked for annual income, and he said it wasn't clear whether it wanted gross or adjusted gross income to determine eligibility. **Ms. Dowd** answered that the subsidy is based on the modified adjusted gross income.

Representative Hixon referred to the window-shopping portion of the exchange, wanting to know the final price before he chooses a product, and he asked for an update on that issue. **Ms. Dowd** replied that this was very critical to the marketplace next year, a very key requirement, and that functionality will be available on our own technology platform. In order to compensate for the federal website right now, the Board was asked for approval to get bids for a product that will assist Idahoans for anonymous window shopping. Development must first occur, then it must be tested with carrier partners, so the soonest that could be initiated is in the next 4-6 weeks.

Senator Hagedorn wondered about federal tax credits as they are applied to the premiums for people buying insurance. He referenced an example of a family of four getting a $410 tax credit, making $50,000, asking if that tax credit comes from the federal government, and is that applied monthly to the provider of the insurance. How does that work. **Ms. Dowd** said that the term is an advanced premium

tax credit, adding that the shopper realizes that tax credit as soon as they enroll, so immediately that monthly premium is reduced. On the back end, that premium is paid to the carriers, she thought, on a monthly basis, and there is a reconciliation process to ensure accuracy. **Senator Hagedorn** said that a family of four, if they elect not to purchase insurance, would be assessed a fine, and he asked when that fine would be levied, and when would that family become aware of the fine. Would it be when the family filed a tax return, or during the year when they chose not to purchase insurance? **Ms. Dowd** answered that the fine would be realized when a tax return was filed for the prior year. **Senator Hagedorn** used himself as an example, saying that if he did not purchase insurance for the fiscal year of 2014, in 2015 when he did his taxes, would he be fined on April 15 for not purchasing insurance the previous year, and that was affirmed to be true.

Co-chair Collins expressed his appreciation to **Ms. Dowd** for clearing up many questions to which there are few answers right now, with regard to the federal exchange.

The task force recessed for lunch at 11:40 a.m. and reconvened at 1:30 p.m.

Mr. Dick Armstrong, Director, Department of Health and Welfare (DHW), presented next and his PowerPoint is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_armstrong.pdf

His presentation included Medicaid: Cost containment strategies that are working; community crisis centers; employee CEC; and program performance. The number of people currently enrolled in Medicaid is 244,000, which is a continuing elevation in enrollment. The expenditures are still below the high point in 2011**. Director Armstrong** said that from a systems standpoint, when the MMIS system was converted, during 2010 there was considerable disruption from the conversion, but as time has passed, there is now a stable trend. During the last few years, DHW was able to revert $47 million from the general fund budget, and forecasts are now made based on the new MMIS system. With regard to Medicaid growth and budget projections, 2015 Medicaid maintenance is projected at $19 million, a 1% increase, one of the lowest maintenance of effort requests in recent memory. This includes $10.5 million, general funds, a 2% increase, and that would be lower, but receipts for drug rebates are decreasing. Generic prescriptions are increasing (to 81%), but rebates have been counted on heavily (to net against expenses). Rebates are not given on generic drugs, and rebates must now be shared with the federal government. The recession is no longer driving enrollment growth and the long-term savings effects of House Bill 260 are beginning to be seen. **Director Armstrong** showed charts on Medicaid prescription utilization and Medicaid participants utilizing services.

Director Armstrong discussed the woodwork effect, pointing out that this is a significant unknown and very complicated. There is an ACA requirement that individuals have insurance coverage and this will bring in people who are currently eligible for Medicaid but have not applied. There were already 35,000 Idahoans, mostly children, eligible for Medicaid, under old rules who had not enrolled, so new enrollees under the ACA process may number another 15,000. DHW believes this population will take longer to enroll, since low incomes could eliminate the tax penalty for the poor. Medicaid verification is working very well in Idaho.

Director Armstrong said that this year DHW is proposing 3 regional community crisis centers for mental health/substance abuse issues, with plans for 7 crisis centers eventually. These centers will provide a place for law enforcement to bring individuals who need assessments, to reduce hospitalizations, incarcerations and emergency room use. Estimated implementation costs for the first year of operations amount to $5.2 million from the general fund.

Director Armstrong stated that on average, state employee pay lags 18.9% behind the labor market; child welfare social workers experience 14% turnover, and overall voluntary agency turnover is 11.5%. There is a 20% turnover in health facility surveyors exiting to the private market for better salaries, and the state could face penalties if federal performance standards are not met. Recruiters are targeting top performers at DHW. DHW is really struggling with the constant training of new employees, with pay, workload and stress being top reasons employees are leaving.

Director Armstrong pointed out that food stamps are the best barometer of what is going on in the economy, and he showed a chart showing that Idaho has peaked in enrollment and there is now a steady decline in the number of people eligible for food stamp benefits.

Director Armstrong shared statistics on other high performing programs including:

- State Hospital South received top performance recognition from the Joint Commission, one of six Idaho hospitals recognized for consistent use of evidence-based practices.
- Vital records: With implementation of the Electronic Death Registration System, records sent to the Social Security Administration on a timely basis improved from 53.2% in 2009 to 93.9% in 2013.
- New immunization requirements for 7th graders that took effect for the 2012-1013 school year resulted in tetanus, diphtheria and pertussis vaccination rates increasing from 14.2% to 79.5%, while meningococcal vaccination rates improved from 5.6% to 78.6%.

Director Armstrong showed a chart of total program participation numbers by region, showing 321,695 people receiving benefits that are only counted once. A total of 500,000 Idahoans are on some form of program in DHW; most of those qualify for food stamps and Medicaid. Child care assistance is focused on return to work, and food stamps also require that the person be in a work-readiness mode. Idaho has always maintained a high level of readiness to work as part of our culture, and 87% of Idaho's DHW participants are involved in improving their position for work. Idaho stands out as a state that moves program participants toward self-reliance, and the Cato Institute recently confirmed that in a study.

Representative Smith asked about where the first three community crisis centers for mental health will be. **Director Armstrong** answered that DHW hopes to have one each in north, southwest and eastern Idaho, although this model concept is in the planning stage currently. DHW probably will partner with hospitals and eventually expand into other areas of the state. **Representative Smith** asked what the timeline was to start and **Director Armstrong** replied that since this will require money, that means JFAC and approval of the legislature. DHW will move as soon as commitments can be made to Idaho providers through contracts. DHW can move relatively quickly, since crisis centers will be housed in relatively small facilities, less than 16 beds, due to those services being eligible for Medicaid reimbursement.

Senator Hagedorn commented that on a Food Stamp chart from 2008 to 2013 there has been population growth, and he thought it would be very helpful for the members to have a metric of the percentage of population change, looking at the growth or reduction of population. He asked about CEC and the pay study done last session and whether there had been an opportunity to look at or consider flattening DHW, similar to what ITD did, to utilize those savings for CEC to raise salaries to better compete with the private sector. **Director Armstrong** replied that when ITD did their reorganization, DHW did the same exercise, and except for hospitals (because they are 24/7 operations) DHW was just under four layers, so considerably flatter than ITD with regard to organization structure. Since then, DHW has collapsed to a three-hub concept (in seven regions) which reduced management and increased program consistency. DHW will always be looking at how to improve processes. Fewer layers result in better communication. **Senator Hagedorn** asked about the community crisis centers and about people who may have a smaller crisis than one that would require being housed, such as a person with substance abuse issues, asking for a broader scope on such issues. **Director Armstrong** said that DHW had piloted home-based therapy, as opposed to facility-based, and DHW found that through crisis intervention and worker outreach into homes of individuals, people were able to stay in their homes. The longer people with issues are out of their home, typically a job is lost, then they can't pay the rent, and then the state ends up paying for everything in one way or another. DHW is trying to keep people stable and comfortable in their homes to achieve a therapeutic outcome. DHW knows this works, so beds in small crisis centers would be only for those who need to be in a facility, and the majority of those would be court ordered. DHW does not expect that facilities will be used significantly for the civilian population. At-home stabilization will minimize the length of time of a crisis, and usually getting a person back on medications will prevent a bigger crisis.

Senator Goedde commented about a news story in Spokane about a person who had visited emergency facilities fifty times in the last year, and that Spokane found it cheaper to rent this person a home. If DHW believes in the premise "if you build it, they will come," is DHW creating something that Idaho will never be able to afford in offering extended services? **Director Armstrong** replied that there are always individuals in society who are extremely difficult to manage. Much time and energy is spent on this population; unfortunately this occurs later in the cycle than would be preferred. Early intervention makes a great difference. There is little organized effort in communities for subsidized housing. In Lewiston, grants were obtained to build apartments to serve that community, and **Director Armstrong** said that was a wonderful example of providing a home for people who might otherwise put a financial drain on emergency services. There is always the risk of providing dependency, so the art is in the development, but without a plan, the problem will not be solved at all. The frustration, according to **Director Armstrong,** is that we go from crisis to crisis, without getting a grip on the situation. This will be an evolutionary process. Looking at models from other communities, many issues can be avoided, but **Director Armstrong** added that we will have to be on guard so as to not be permanently housing people in smaller facilities, as opposed to larger ones. DHW has been able to reduce the number of people in institutional settings dramatically over the last few years because ways are being found to treat people more personally in communities, as opposed to central institutions.

Senator Schmidt asked about several charts and whether the managed care changes instituted in behavioral health were part of that projection or would changes be seen. **Director Armstrong** answered

that the mental health managed care is part of DHW's forecasting and is more stable than fee for services, so managed care has been reflected in this forecast. **Senator Schmidt** wondered about work readiness and eligibility for programs in Idaho. He thought that most were already employed, and asked if there was an overlap and are working people considered to be eligible? **Director Armstrong** said that if a person comes into benefits and that person is employed, that is fine and they are eligible because eligibility is based on household income. If a person is not employed, not under a disability pension or social security or other things on a list, in order for that adult to receive food stamps, they are assigned to a contractor who begins to prepare that person to seek employment and they must be actively involved in that program in order to stay in the program. Medicaid doesn't have that opportunity to push job readiness in a pure adult expanded population at this moment in time. **Senator Schmidt** understood (from the Milliman report) that 60% of people eligible for Medicaid were working, asking if that was correct. **Director Armstrong** confirmed that to be true, adding that there is full time employment *in the household*, so if there were two adults in a household, at least one of them had full-time employment.

Senator Lodge asked about CEC and if the members could receive an average pay scale for the child welfare social workers. With regard to the term "overall voluntary agency turnover," she asked about the word "voluntary." **Senator Lodge** acknowledged how difficult the jobs were for child welfare social workers and the stress involved. **Director Armstrong** explained that "voluntary turnover" meant turnover without a performance issue involved. He said that DHW created a career ladder within most of the divisions to try to move people up as they became more skilled, educated and certified, and he agreed to provide the members with those pay scales.

Mr. Roger Christensen, Bonneville County Commissioner and Chairman, CAT Fund Board presented next and his PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_christensen.pdf

Mr. Christensen gave an update on the CAT Fund, sharing that he thinks DHW has done a great job with the combined application unit and some of the changes approved by the legislature prior to coming back to the county for resources. He showed a history of applications submitted to the combined application unit, which are sent to DHW for screening for eligibility for programs and, if not eligible, the application is sent to the county for investigation as to eligibility for the indigent fund. If there are costs over $11,000, those are passed on to the CAT Fund. Total applications received have decreased (from 7652 in FY2011 to 6767 in FY2013) due to a cooperative work effort between providers, counties and the state to get individuals on the pre-existing insurance program which is now terminated. He shared indigent trends, numbers of cases, county and state dollars spent, provider payments broken down by county for FY2013, and total new county cases with diagnosis codes. **Mr. Christensen** expressed concern about the mental health area, since the FY2013 amount paid was $6,711,059. One of the biggest challenges as a county is special housing in jails for people with mental health issues. He said that PCIP premiums paid to date amounted to $501,577 (split between county and state) which cost the CAT Fund $257,277, the total savings amounting to $6,114,761 which they were able to return. The majority of those savings occurred at the state level. Many hospitals got aggressive in enrolling people in the PCIP program. Cases approved for FY2014 totaled 375 broken down by county. FY2014 projections included these 375 cases for 14 weeks, an average of 26.8 cases weekly, projected for 52 weeks = 1393 cases, the average case cost

to date was $22,800, totaling an annual estimated $38,610,400. This reflects provider payments only and does not include operating overhead or the last of PCIP.

Senator Hagedorn said he was curious about the projected 1,400 cases, stating that 35,000 Idahoans are now eligible for Medicaid under ACA, and he wondered how that Medicaid eligibility is going to impact cases and how much would have to be paid out of the CAT Fund. **Mr. Christensen** said that in 2013, of the 1,150 cases that came to them, the number of PCIP that came in on ten-day priors, cases that would have come to them and will come to them in the future, amounted to 180, so they are on track to reach 1,400.

Senator Schmidt disclosed that he was a member of the CAT Board. He questioned projections, asking if the number of people who had been beneficiaries of CAT Fund payments would have been eligible for enrollment in the marketplace or exchange, those who are between 100% and 400% of the federal poverty level, not Medicaid eligible, but under the individual mandate, who are supposed to buy insurance. How many of those people are included in that 1,150? **Mr. Christensen** said that a very positive addition to the CAT Fund Board was adding legislators for better communication. A study was done on the exchange and everybody who was eligible to sign up on the insurance exchange, based on income, would reduce the number of individuals paid for by the CAT Fund by somewhere in the 40% to 50% range. **Senator Schmidt** said that the projection doesn't indicate to him that they don't believe people will be doing that. Are we building something that will be filled because we're expecting it to be filled? **Mr. Christensen** replied that following the "success" of the initial rollout of the insurance exchange (only 6 completed the first week), he was not ready to be optimistic that there would be an immediate effect, and the CAT Fund is projecting into the next fiscal year based on information they have right now, with much uncertainty on the implementation and possible delays. In order to present budget numbers, they must take the most realistic view.

Representative Luker asked about the CAT Fund caseload and asked if it was roughly 4,000 of the cases handled within the $11,000 limit that the counties provide and that the other 1,200-1,300 are kicked over to the CAT Fund, asking if that is how it's working. **Mr. Christensen** referred to the cases passed on to the CAT Fund out of initial applications (some are denied and some are paid for) that are under the $11,000, so a number of cases do not make it to the CAT Fund. They are either under the $11,000 or denied at the county level. **Representative Luker** asked about the "woodwork effect." When an application is filed and goes to DHW, don't they screen for Medicaid eligibility, so that would take care of that woodwork effect; isn't that being done already, in that application process? **Mr. Christensen** replied: "Yes, and those numbers are reflected and, as a result, why you've seen that leveling off because they are being screened. Otherwise, you would have continued to see that trend line go up." All actions taken have tended to flatten out the natural increase based on population increases, unemployment, downturn in the economy, and the indigent program is usually a trailer of the rest of the programs because once an incident is reported on an application, sometimes it can be six months to one year for that process to be completed.

Senator Goedde said he'd read in the newspaper that people can apply for exchange plans and have zero out-of-pocket expense with high deductibles and co-pays and he assumed that people who qualified might still be eligible for the county indigent fund and maybe to some degree to the CAT Fund, asking if

counties had addressed this at all. **Mr. Christensen** answered that some discussion had taken place, but right now it's difficult to understand what the resource is and how it would fit into the current law, since it's very complicated. It will be watched to see how this fits in, but under current law, it must be figured out how that applies if both programs are continued.

Senator Vick asked if people who have PCIP insurance could be moved to a regular insurance product, since all insurance policies now have to cover pre-existing conditions. Could people who come to hospitals also be signed up due to changes in the law? **Mr. Christensen** replied this is part of the whole complication. The PCIP program didn't have restrictions and, as he understands it, those subsidies come back to the individual to pay that premium, so that is one complicating factor. Also there is a different restriction due to enrollment periods, which you didn't have on PCIP. It might take statutory restructuring to provide that and it would be complicated. **Director Armstrong** affirmed that this was correct.

Senator Cameron said that one of the toughest decisions the legislature may have to make in the future is should someone eligible under ACA coverage and required to purchase under ACA, if they choose not to avail themselves of that coverage, is it the state's responsibility (the taxpayer's responsibility) to then pay claims from those persons. Has the Board taken a position on this? There are individuals who don't currently qualify for Medicaid but are below the 100%, so they don't qualify for the exchange and the subsidy. Those who qualify for Medicaid benefits, that's the avenue of choice. What about those who qualify for coverage and should be enrolling, but who choose to go the penalty route. **Mr. Christensen** said that discussions have taken place at the CAT Fund level, and the philosophical question is, if someone is required under the law to enroll and chooses to not be compliant with the law, should the state be the lifeboat for that person? That will be an interesting debate with various opinions. They are trying to identify what that resource is going to look like right now. Counties are wondering if they can count that as a resource for denial or whether it needs to be more clearly defined in statute, but it goes back to personal responsibility and whether this CAT Fund would continue to be the lifeboat for those who don't comply with the law. **Senator Cameron** said the fundamental question is from a public policy standpoint, and what the appropriate role is of the CAT Fund and the indigent care program, going forward in today's world. **Mr. Christensen** said that the appropriate role is the way the legislature defines it and they will do their best to administer the program the most efficiently they can. The program will continue to be operated under the rules set by the legislature. He has his personal philosophy and would have to visit with the CAT Board to get their position. **Senator Cameron** suggested that the Board needs to have that discussion to make recommendations to the legislature, and the legislature will also have that discussion. He reiterated to the members that all of the plans under the ACA have a cap of $6,350 per person as a maximum out-of-pocket expenditure including deductibles, co-pays, and prescription drug benefits, etc. Most plans prior to that had significantly higher out-of-pocket maximums, so most individuals will have less out-of-pocket expenditures. For individuals in the lower end of the income scale that qualify for most of their insurance coverage to be paid for, but still might have potential claims, there is also help in that arena as well. **Mr. Christensen** clarified that for a person to be determined indigent, that person must **not** be able to pay for a medical bill over a period of five years. The majority of individuals who would qualify, if they complied with the law and signed up through the exchange, would likely not be eligible for the indigent fund.

Dr. Christine Hahn, State Epidemiologist, Department of Health and Welfare was next on the agenda, and her PowerPoint presentation is on LSO's website at:\
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_hahn.pdf
Dr. Hahn introduced Mr. Scoggins, Immunization Program Manager, Division of Public Health, and then she updated the task force on the Idaho Immunization Program.

Representative Luker asked about the assessment for TRICARE and if it was coming from the provider assessments or from general funds, and **Dr. Hahn** replied that those funds are coming from general funds, and the insurance companies are not covering TRICARE kids.

Senator Hagedorn pointed out that this TRICARE issue has been haunting us for almost 3 years, and he asked **Dr. Hahn** to describe why TRICARE will not cover these vaccinations for children. **Dr. Hahn** responded that they had not been able to dialogue directly with TRICARE, even though they have talked to everyone in a position to hopefully do that, including third-party administrators (TPAs). It is her understanding that TRICARE states are only able by law to pay the provider that provided the service, not to a third party, and only after that service has been provided. Paying into a fund ahead of time is outside their authority. They were made aware by the previous TPA that there have been programs to fund creatively, and this model might be followed. There is an autism coverage that was worked out and that is being pursued with a new TPA to see if they would be willing to propose that model to TRICARE. **Dr. Hahn** said this is very frustrating for them as well.

Dr. Perry Brown, Chairman, Idaho Childhood Immunization Policy Commission, presented next and his PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_brown.pdf
Dr. Brown gave a brief history of the commission, and stated the purpose of the commission is to evaluate policies regarding childhood immunization in Idaho and make recommendations to the Board of DHW on policy and to the Idaho Legislature on legislative action to increase immunization rates. This commission was created concurrently with and as part of the Vaccine Assessment Board legislation and will sunset on July 1, 2014, if action is not taken in the 2014 legislative session.

Dr. Brown pointed out that in 2009 Idaho was 50th in the nation in terms of having children up-to-date with immunizations in the age range of children 19-35 months. The only entities worse than Idaho were Guam and the U.S. Virgin Islands. Currently, over 90% of Idaho children 19-35 months of age are fully immunized on time against polio, measles/mumps/rubella and chickenpox. Over 80% of children 19-35 months of age are fully immunized on time against pneumococcal disease and Hepatitis B.

Idaho has a single universal program, which means that as a provider, vaccines are potentially an incredibly expensive resource and to maintain stocks for different populations becomes incredibly cumbersome, running the risk of ordering too much or too little, creating waste with expirations. He noted that the universal program is user-friendly.

Dr. Brown stated that the benefits of the Idaho Childhood Immunization Policy Commission were as follows:

- Vaccine Assessment Board: policy related to private insurers providing money for purchase of vaccine in advance (not arrears) to maintain single "universal" pool
- Childhood Immunization Policy Commission: policy related to vaccine access, performance improvement, and education
    - Complements Vaccine Assessment Board – in no way duplicates it
    - Rare opportunity for DHW, Idaho Immunization Program, IRIS (vaccination registry), medical providers, and other interested parties to sit down, review data, and brainstorm win-win approaches and policies
    - NOT a forum to force those that decline vaccines to immunize their children; rather, the purpose is to improve access to vaccines, and adherence to immunization schedules for those that do want their children vaccinated
    - Meet quarterly + ad hoc when necessary
    - FREE (NO STATE EXPENSE) almost – only cost is DHW administrative support, all commission members serve voluntarily
    - All current active members of the commission feel that this commission is of high value in terms of recommending policy and reviewing possible improvements
    - Sunsets July 1 – **We ask that you please extend this!**

Senator Hagedorn asked what the downside would be of combining the Vaccine Assessment Board and the Childhood Immunization Policy Commission. **Dr. Brown** answered that the potential downside would be that even though the missions of both bodies are related, they are also quite different, and the representation necessary for discussion is quite different. People needed at the table for both the board and the commission would be DHW, but the major contributors to the Vaccine Assessment Board process are really the insurers and it is essential to have them present, along with DOI and many others who play a role there. With regard to the Childhood Immunization Policy Commission, besides DHW, the major contributors are those on the front lines taking care of immunizations, as well as the epidemiology experts statewide.

Mr. Dave Jeppesen, Senior Vice-President, Sales and Marketing, Blue Cross of Idaho, was the next presenter and his PowerPoint presentation is on LSO's website at:
http://legislature.idaho.gov/sessioninfo/2013/interim/healthcare1104_jeppesen.pdf

Senator Cameron pointed out that there had been a request from a task force member for a discussion on the grandfathered plans, and he said that he didn't want the perception by anyone to be that the task force had picked on Blue Cross. He said that this was a very last-minute add-on to the agenda and some carriers were contacted for someone to speak knowledgeably about what the requirements were and how a plan was grandfathered, as well as addressing the issue of people possibly getting policies taken away, which he believes to be exaggerated. He wanted all the task force members to understand why Mr. Jeppesen was here at this meeting and what the situation was.

Mr. Jeppesen discussed the retention and grandfathering of current plans under the ACA. When the ACA was signed into law on March 23, 2010, there was an option created to "grandfather" plans. Those policies in effect on that date could be "grandfathered" and not be subject to most of the new ACA requirements. It was up to insurance carriers to decide in 2010 if they were going to "grandfather"

existing policies. Several years later, HHS put restrictions through published regulations on "grandfathered" plans, stating that the policies must remain essentially the same, and he shared a list of changes that would cause a policy to lose that grandfathered status. By and large, grandfathered plans have not changed; the biggest driver as to why groups move out of grandfathered status is because a new plan is purchased after that March 23, 2010 date, and a few changed due to underlying coverage changes. "Non-grandfathered" policies include any individual or group policy that was purchased after March 23, 2010. For carriers who chose not to "grandfather" policies in 2010, those policies are "non-grandfathered." The number of individual and small group "grandfathered" policies reduces each year due to the high rate of turnover (between 40% to 67%), particularly in the individual market, primarily due to changes in people's circumstances. Back in 2010, Blue Cross chose to grandfather about 42,000 individual members and about 30,000 small group members. Due to the turnover in those two market segments, Blue Cross has seen the number of grandfathered policyholders dwindle, and the number will continue to decline over time. He believes that in 2014 about 18% of the small group customers will be grandfathered and about 82% will be non-grandfathered. For the individual market, about 15% of the customers will be grandfathered and about 85% non-grandfathered. Most policies in the market are "non-grandfathered" and will need to migrate to ACA compliant policies in 2014 at or before renewal. Individual and small groups are guaranteed access to health insurance options in 2014, and if they have a grandfathered policy, they can keep what they have, or they can choose to shop in the new market. Of course, he said that Blue Cross wants to keep their customers, and he believes that to be true for all carriers as they move through this transition. Educating customers has been key to this process, and Blue Cross sent out letters to make sure that customers have continuous coverage in place. Blue Cross has reached out no less than five times to their customers to make sure they understand what is happening with policies. He believes this is representative of what most companies in the industry are doing to inform customers and offer options. If a customer does not respond, then a Blue Cross customer will be transitioned to the best-matched policy that is ACA-compliant, and the customer will be billed to alert them that a change has been made.

Senator Cameron interjected that one of the decisions the state had to make was on individuals who had a non-grandfathered plan. They had the right to run that plan out or to continue it until the renewal date of that policy. Some with non-grandfathered plans renewed early, in order to stay with that plan a few months longer. People with grandfathered plans might stay on their plans even longer, if there are no significant changes. Often when constituents call him, they fail to recognize the difference. For some people who think they are forced to make a policy change right now, that may not be the case.

Senator Vick said that it was his request for this topic to be added to the agenda, since he had so many questions from constituents, and he thanked the co-chairs for adding this to the agenda at the last minute. He asked about the 82-85% of non-grandfathered policies; is that a comparable number to what is being heard in the news, that 3-5% of people are going to have to get different policies. **Mr. Jeppesen** replied that the numbers being reported in the press are referring to the entire "insured universe" so that includes those who have coverage through employers as well as through Medicare or Medicaid. Looking at the universe under that lens, in Idaho about 18% of the population has individual policies which is a little higher than nationwide. Looking at just the individual market, Idaho is pretty typical. The vast majority of individual policies are non-grandfathered, but if you look at everyone who has insurance in Idaho, we're not that far off the norm. **Senator Vick** commented on the President saying that people who like

their insurance can keep their insurance. He asked when **Mr. Jeppesen** knew that a very limited number of people would be able to keep their plans, especially with regard to the individual market. **Mr. Jeppesen** answered that it became fairly clear when HHS released the regulations on how a policy could stay grandfathered and the way the law was written. Even if everyone was grandfathered, which Blue Cross did, that number would shrink over time considerably. HHS and another government agency released a report shortly after the law was passed indicating this would be the case, so it was apparent fairly early in the process that there would be an individual and small group segment who would need to move to ACA-qualified plans.

Representative Hixon asked what the average cost increase is from a grandfathered plan to the ACA-qualified plan. **Mr. Jeppesen** replied that the ACA-compliant plans have more coverage, so it is difficult to compare policies or costs. There is also the complication that many individuals who will purchase a policy on the exchange, when it is running properly, will receive subsidies, so it was very difficult to answer that question.

Representative Luker asked about the grandfathered policies and whether there would be pressure to dissolve that risk pool because of attrition. For example, if there were originally 5,000 policies, eventually that number goes down to 100. Is that, by virtue of the process, going to collapse or eliminate those policies? **Mr. Jeppesen** responded that at this point the law does not require that be done, but he said they will keep an eye on this, in conjunction with DOI, to see if there is a viability issue from a pool perspective. There is nothing in the law that says that has to happen, but this will be watched. **Representative Luker** said that it seemed to him that this will happen, over time, asking if that is a fair statement. At some point, policies will get so expensive for the small group that it will not be economical. **Mr. Jeppesen** answered that he needed to check with DOI, but at some point the state could make a decision to expand the pool to be the entire pool, to provide a safety net, but he needed to check regulations. He added that if that is not the case, then at some point it will not be financially viable.

Senator Hagedorn asked about the exchange and the connection between the federal government and Blue Cross; he asked what his confidence level was and if it's been tested, the business-to-business connectivity between the federal hub and the data systems at Blue Cross. Has this been tested internally and is Blue Cross ready and prepared to operate under those conditions. Also, what is the long-term viability of the federal government subsidies for Blue Cross plans? **Mr. Jeppesen** stated that Blue Cross has tested both, in test and live, to receive data from the Federally Facilitated Marketplace (FFM) which is the infrastructure that Your Health Idaho is using this year. Successful testing has received connectivity, basically passing enrollment data to Blue Cross of Idaho, both with real members and test data. His confidence is, therefore, quite high. Blue Cross is working with CMS to make sure data comes across cleanly and that it does continue to improve. **Senator Hagedorn** asked about subsidies for various policies sold on the exchange. What is the confidence level that these subsidies will continue into the out years and how will Blue Cross change with that. **Mr. Jeppesen** replied that is up to the legislative and regulatory process that takes place in Washington, D.C., adding that Blue Cross will comply with whatever those requirements are. For the first year, Blue Cross thinks the federal government is good for their money and Blue Cross will play it by ear after that.

Representative Wood said that much has been made in the media about people having insurance policies canceled. Blue Cross members (who don't respond) will be assigned another closely-matched insurance policy that meets ACA requirements, so Blue Cross is not summarily canceling policies, and he asked if that was correct. **Mr. Jeppesen** answered that this was accurate. He added that he didn't think that it was in the best interest of any insurance carrier to cancel policies. Even if clients do nothing, they will have continued coverage, since the goal of Blue Cross is to continue coverage for members.

Senator Goedde said that prior to the ACA, insurance companies introduced new products all the time, and there was some responsibility to keep their own products in place as people stayed on them primarily because of pre-existing conditions which would not qualify them for a new product. He asked how this changes under ACA. **Mr. Jeppesen** said that one of the requirements under ACA is that there is no longer any pre-existing condition, so it's possible for any consumer to buy an insurance policy, regardless of their health condition, and there is no more health underwriting with ACA. On the flip side, Blue Cross intends to keep old products as long as they can, and consumers with those policies have selected them for a reason, so they intend to keep those viable as long as possible. Obviously with the non-grandfathered policies, those must be transitioned to ACA-compliant policies, but the grandfathered policies they hope to keep up and running.

Representative Luker said he has seen news reports nationally that some providers and some hospitals are refusing to accept new policies because reimbursement rates are not very well spelled out. He thought this would be between the insurance company and the provider, as opposed to the government, and he asked if that was being seen in Idaho and could he explain that. **Mr. Jeppesen** said that this is a contractual issue between the insurance carrier and the provider community and is not an issue he has seen in Idaho. He could only speak to Blue Cross products, saying that they have what is called a preferred provider and those contracts are still in place for products both in and off the exchange. Insurance carriers have also moved to create specific contracts with specific provider networks and that has happened in Idaho, but has happened in a mutually agreeable way between the insurance carrier and the underlying provider system. He has not seen this as an issue this year in Idaho and he doesn't anticipate it becoming an issue. Blue Cross would not take a product to market unless they were confident that a provider network was behind it to support the product.

Senator Cameron commented that this year we have seen in the Senate individuals who voted against budgets because the state of Idaho had not gone out for bids for the state employee health insurance plan which is a grandfathered plan, so any change in that plan would force it to become completely compliant with the ACA. He hoped that all members understood this. He declared that he is an insurance agent and he represents every carrier in the state, and he doesn't think that any carrier in Idaho is throwing customers off plans. An alternative has been provided, but they were required by law to notify whether a plan was compliant or non-ACA compliant and then give options. He said that sometimes letters were better written than others and sometimes people read only the first paragraph and got angry over various things and failed to read paragraph two that gave alternatives. Nobody in Idaho, as far as he knows, has been thrown off their insurance plan. To most carriers' credit, he said that most kept existing networks, even though there are people disgruntled with the ACA itself. Promises were made and some things were not fixed. One frustrating part is that some rates have gone up, but he said that other rates have gone down. If a person is age 50 or older, as a general rule, there is a pretty good chance that rates went down.

For a younger person, particularly with children, rates may go up. About 70% of his clients have rates that are going up, but when the subsidy is added in, then the rise in cost in not as horrific, even though it's a change that people don't like. He is fearful what will happen down the road, believing that the ACA will implode upon itself at some point in time.

Co-chair Collins thanked Mr. Jeppesen for coming at late notice and providing the task force with good information.

Co-chair Collins announced that the next meeting will be held on December 9th, which will be the last meeting prior to session. If there is draft legislation that needs to come before the co-chairs, he asked that those drafts be sent to the co-chairs prior to the next meeting to possibly include on the December 9th agenda.

The meeting was adjourned at 4:07 p.m.