MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 10, 2013

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Guthrie, Martin, Lakey, and Schmidt

ABSENT/ EXCUSED: Senators Hagedorn and Bock

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

CONVENED: **Chairman Heider** called the meeting to order at 3:02 P.M. He welcomed guests and introduced Committee Secretary, Linda Hamlet; Senate Intern, Dahlia Berreth; and Page, Emma Fredericksen. **Chairman Heider** asked the Committee Secretary to take roll call. He advised the committee that **Senators Hagedorn** and **Bock** were excused. **Chairman Heider** stated that the committee will begin the Department of Health and Welfare overview.

PRESENTATION: **Richard Armstrong**, Director of the Department of Health and Welfare, presented an overview. He stated that he would like to review the organization and present a chart of the current structure of the organization. He indicated that there are three major sections with its own deputy, and that ten divisions meet with those three deputies. He furthered that there are currently 2,886 employees in the department, who are divided under these three major sections. **Mr. Armstrong** stated that the handout he provided to the committee listed a sample of the services provided to the citizens of Idaho by the Department of Health and Welfare, which included Medicaid, Family and Community Services, Welfare (Self Reliance), Public Health, Behavioral Health, and Licensing and Certification. He furthered that the department is an umbrella agency for all the human services within the state of Idaho and also centralize all eligibility under one operation.

Mr. Armstrong stated that each of the divisions of the department will speak briefly about what they do. He indicated that for this year, the overall appropriation recommendation is $2.52 billion, of which 65 percent comes from the federal government. The federal government administers those dollars according to their rules, as well as state rules. **Mr. Armstrong** furthered that most everything has matching dollars, and that the department puts up general, dedicated funds and then include the authorized federal dollars for the programs. He indicated that the matching range is anywhere from 50-90 percent, and that each program has a different appropriation structure. He stated that the 2014 Funding Recommendations for State Fiscal Year (SFY) 2014 are: $2.52 billion appropriation; $1.64 billion federal funds; $617.3 million general funds; that many of the department's programs have federally matching fund leveraged by general fund expenditures; and, for example, on average, for a $100 health bill submitted by an Idaho Medicaid provider, the state pays $30 general funds and leverages $70 federal funds. **Mr. Armstrong** stated that most of the department's appropriation pays for benefits for Idaho citizens; and that the department purchases services from nearly 12,000 companies and more than 31,000 Medicaid providers.

Mr. Armstrong stated that 86 percent of all the dollars go to the Trustee and Benefits, which means that those are dollars going to services delivered to citizens in the state of Idaho. He indicated that the department is a highly privatized organization, and that the personnel only represents 7 percent overall. He furthered that of the personnel budget, one-fifth of that is oriented toward three state institutions, which provide care 24/7: State Hospital North in Orofino, State Hospital South in Blackfoot, and the Southwest Idaho Treatment Center in Nampa. He stated that these are full-time facilities with full-time residents.

Mr. Armstrong indicated that there are currently 255 fewer employees in comparison to the number of employees in the year 2010, due to the recession and a rapid growth in the number of citizens that met the guidelines and programs that the department administers, which impacted the budget and the way business is conducted.

Mr. Armstrong directed our attention to operations, and indicated that Medicaid is the 81.4 percent of the budget. He furthered that of those dollars, 3.4 percent are for operating personnel. He stated that some of the programs are funded by the federal government and by personal dollars, and that the two biggest examples are the Food Stamp Program (also known as the Supplemental Nutrition Assistance Program, SNAP) and Child Support. He indicated that in Child Support, $290 million. cumulative dollars are collected annually from non-custodial parents and provided to custodial parents. **Mr. Armstrong** explained that the reason the department is involved in Child Support payments is to ensure that the court-ordered payments reach the children and to keep the benefits within the family. He then concluded his speech and asked for questions. **Senator Nuxoll** asked for further comment regarding Medically Indigent Services listed in the presentation handout as being 0.01 percent. **Mr. Armstrong** explained that the 0.01 percent figure does not represent the dollars that goes toward health care costs, which are in separate appropriations directly to the cap funds from the Joint Finance-Appropriations Committee (JFAC) in the amount of about $38 million. He furthered that other monies come from the county budget, which is an assessment that goes to property taxes, generating about $40,000. **Mr. Armstrong** indicated those two sources are apart from the Department of Health and Welfare.

PRESENTATION: **Russ Barron**, Administrator for the Division of Welfare, began by stating that the Division of Welfare programs are typically referred to as the Division of Welfare Self Reliance Programs, to help individuals and families who are in need or who are in low income to become more self-reliant. He indicated that support is given to those seeking employment.

Mr. Barron introduced two deputy administrators, Greg Kunz and Laurie Wolff; Bureau Chief Julie Lister; Bureau Chief Kandee Yearsley; Bureau Chief Julie Hammon; and Bureau Chief Alberto Gonzalez.

Mr. Barron stated that the Division of Welfare takes about 5.7 percent of the department's budget for 2014. He furthered that most of the budget goes to the Trustee and Benefits of the actual services available, and then the division of thirteen individuals who operate nineteen offices statewide. **Mr. Barron** stated that the operating budget includes 86 contracts with community action agencies, and indicated that the Division of Welfare programs include those listed in the chart in the handout. He furthered that in 2012, the Division of Welfare serviced one in three people in Idaho with a combination of these programs.

Mr. Barron referred to the chart in the handout, and indicated the Food Stamps service; Child Support; Medicaid Eligibility Determination; Aged, Blind and Disabled program; Idaho Child Care Program; and Temporary Assistance, all of which are state delivered programs. He stated that Community Services; Emergency Food Assistance; Home Energy Assistance; and the Weatherization Program are contract services. He further indicated that applicants for these services must meet requirements, such as being a citizen or legal immigrant, an Idaho resident, limited household income; must be employed or enrolled in a public training program, must report changes (such as wages) and complete reevaluations, and must cooperate with child support. **Mr. Barron** continued that a Self Reliance Specialist (SRS) will verify, check and confirm the facts, and that only those eligible will receive services. He indicated that his department strives to streamline the process to make it more efficient, and that the Division of Welfare handles nine million transactions per month.

Mr. Barron stated that the current challenges the Division of Welfare faces are mandatory Medicaid changes; workforce demands with a high case load; and food stamps single-day issuance (food stamps are issued the first day of every month). He continued that common constituent calls and complaints are in regard to ineligibility of services, child support, busy lobbies and phones. He concluded by stating that the Division of Welfare strives to make same-day decisions, to be timely and accurate, and to open a portal to aid with overcrowding.

Chairman Heider asked about the SNAP program. He indicated that last year, there were about 250,000 people in it, and now there is about 331,000, and was inquiring if it was on the increase. **Mr. Barron** answered that it has gone down slightly over the past year, and that the figure **Chairman Heider** mentioned was a snapshot in time. **Chairman Heider** asked about the single-day or multi-day issuance to take place in 18 months from now, if it would require legislation, and what is the process. **Mr. Barron** answered that it does not require legislation, but that it something that requires additional funding to be done, and is a goal. **Senator Guthrie** asked, if under a garnishment situation in a divorce with a child, if the court and the state get their money first before the mother, who could wait for months or years before any money is seen. **Mr. Barron** said that the custodial parent is paid first, and that the federal government charges a $25 fee to be paid by the parent who is court ordered to pay support. **Senator Lodge** asked how much it would cost to make the changeover to the multi-day issuance. **Mr. Barron** answered that the estimated cost for the first year to start would be about $400,000, with that amount being reduced to about $220,000 ongoing every year after that. **Senator Lodge** asked who complained about the issuance of the food stamps and if it was the people receiving the food stamps. **Mr. Barron** answered that some grocers complained that when the stamps are issued at the first of the month, the grocery store patrons were upset because of the crowding and long lines. **Senator Lakey** asked what major mandatory Medicaid changes there are. **Mr. Barron** said that, basically, the way his department does Medicaid eligibility today is being thrown out

the window and there's a whole different way to do it. **Senator Nuxoll** asked how of his budget goes into personnel who are working on federal programs. **Mr. Barron** said it is a little less than 25 percent. **Senator Nuxoll** asked if all the programs are intertwined federally. **Mr. Barron** answered yes.

PRESENTATION: Ross Edmunds, Administrator of the Division of Behavioral Health, introduced himself and said his division has an annual appropriations of just over $80 million; it has 663 Full Time Permanent (FTP) and serves about 25,000 individuals a year. His division includes adult mental health, children's mental health, substance abuse disorders, State Hospital South and State Hospital North. He said Americans with mental illness die on average 25 years earlier than those without. And, nine out of ten adult addicts starting using before the age of 18. **Mr. Edmunds** said his division is important in that there is a tremendous need for the services provided. He said, in his opinion, behavioral health is critical to overall health because it affects a person's physical health. Some of the challenges in his division, **Mr. Edmunds** said, are improving the quality of care for Idahoans with addiction and mental illness; that Idaho has, traditionally been amongst the states with the highest rate of suicide; and, lastly, needing to work seamlessly on the system of care that transitions people from corrections back into their community. **Mr. Edmunds** said some constituent calls the senators may get might be people asking for assistance to get family members treatment and consumers complaining of mistreatment or being forced into care against their will. Oftentimes the complaints being described are a manifestation of that person's illness.

Chairman Heider asked if we are working specifically for programs dealing with those under the age of 18. **Mr. Edmunds** said they focus a lot of attention on children's services and that it's critical to catch mental illness early because sometimes it can have a snowball effect.

PRESENTATION: Rob Luce, Administrator of the Division of Family and Community Services (FACS), said he has been with FACS for five years and has been the administrator for the past three legislative sessions. In this division, kids and families are first. The division has statutory obligations for child protection, foster care, adoption, the 211 care line, certain individuals with developmental disabilities, the Indian Child Welfare Act and the Interstate Compact on the Placement of Children. **Mr. Luce** said the appropriation and FTP for his division is $95.2 million; the division is 3.8 percent of the department's budget; 32.7 percent is general funds; and there are 803 authorized Full Time Equivalent (FTE). There are three programs within the division. Those are the child welfare program, the service integration program - which is the navigation and the 211 care line - and the Individuals with Developmental Disabilities (DD) Program - which is Infant Toddler Community DD Program and the Southwest Idaho Treatment Center. **Mr. Luce** touched on a couple of statistics from last year, saying that there were 19,104 total referrals in the child welfare program. To give a context to that number, he said that a child has been abused every 71 minutes, 24 hours a day, seven days a week. **Mr. Luce** said that's an astounding fact, an astounding statistic for Idaho. Another number that stood out was that there were 162,587 calls into the 211 care line. **Mr. Luce** said that's the fifth highest in the nation and yet look at our population. It shows how many people are accessing the care line, he said. The last number **Mr. Luce** gave was on the individuals with DD program. He said there were 33 residents at the southwest Idaho treatment center. At one point, there were over 1,000 people, which shows a huge movement in down-sizing. **Mr. Luce** said that was great, great progress there, moving people with developmental disabilities from an institutional setting out into the community.

Mr. Luce said the Foundation for Government Accountability ranked Idaho number one in child protection, out of the 50 states and District of Columbia, in terms of services provided. At the same time, Idaho spent the least amount of money. **Mr. Luce** said the governor recognized the department, stating the ranking proves that Idaho's approach to doing more with less does not mean sacrificing the quality of service Idaho's children deserve. **Mr. Luce** touched on an urban myth in child protection - and you will see it in the newspapers and hear it on the radio and television - which is that the department takes kids into care. That is simply not true. He listed the process as: law enforcement declare children in imminent danger, then the courts place children in the custody of the Department of Health and Welfare after they find that a child has been abused, abandoned or neglected. **Mr. Luce** said there are two common complaints. one, that the department took children into care that they shouldn't have and, two, that the department didn't take a certain child into care that they should have. **Mr. Luce** said the department deals with highly emotional calls and that the work is very draining and emotional for the social workers. The social workers work with dysfunctional families and kids that have been taken away from their families -kids who love their parents and want to be home and not in foster care. It is an emotional roller coaster. Yet, **Mr. Luce** said, they come to work every day with the hope and expectation that they're going to save the life of one child or that they're going to reunite a child with a family after making progress with safety and whatever else has been a problem. That's what drives them. **Mr. Luce** said he is lucky and blessed to work with such a remarkable group of people.

Senator Nuxoll asked how many of the 19,104 referrals end up being abuse? **Mr. Luce** said the best way to parse that out was to say that in 2012 they had 1,289 children in foster care. He said he could have the department's analyst get back with a better number on that.

PRESENTATION: **Elke Shaw-Tulloch**, Public Health Administrator, said she has been with the department and the division for the last 17 years, being new to her position for the last four months. **Ms. Shaw-Tulloch** said public health is about addressing population health and about preventing communicable diseases and other threats through targeted efforts. It's about supporting and encouraging health lifestyles, healthy behaviors, healthy communities and healthy environments. **Ms. Shaw-Tulloch** said just some of the public health services range from education, the testing of communicable diseases, immunizations, food safety, certifying emergency medical personnel, vital record administration, compilation of health statistics, laboratory testing, bio-terrorism preparedness and environmental public health. **Ms. Shaw-Tulloch** said the overall budget recommendation for this coming year is $105.3 million, which is approximately four percent of the department's budget. It's broken up into three appropriations for physical health services, emergency medical services and laboratory services. **Ms. Shaw-Tulloch** said her division has eight bureaus and is supported by 213.5 FTP. She then introduced her leadership team and said they were amazingly talented individuals who provide oversight and guidance to all the work the division is doing and who are instrumental in helping her set the direction of their division. **Ms. Shaw-Tulloch** said the bulk of what is done in public health is really at the local level. Their trustee and benefits category makes/accounts for approximately 380 contracts - which range from the local public health districts that provide support to all the seven local public health districts, hospitals, emergency medical services agencies, universities, community based organizations and others. The division's operating budget supports an additional 88 contracts that for other private partners that help do the work that is done. 17 million of that operating budget really is for the purchase of vaccines. The division's personnel is 13 percent of its overall budget, with work being centrally

located out of the division of public health and the primary responsibility to set directions for programs and managing the programs.

Ms. Shaw-Tulloch said the main issues that public health faces today are ongoing issues that they've been addressing: disease detection and response, addressing not only communicable disease and chronic diseases but also making sure to identify any anomalies in the system around pandemic and around bio-terrorism; continually evaluating its changing role with health care reform, making sure to serve as that community clinical linkage between what's happening in the communities and what's happening in the health care setting and making sure to help people well and out of the hospital settings; and focusing a lot on keeping up with data demands and needs with shift to electronic data sharing. **Ms. Shaw-Tulloch** said the top two constituent complaints are really around emergency medical services and immunizations. **Ms. Shaw-Tulloch** said that in the 2012 legislature, the Bureau of Emergency Medical Services (EMS) and Preparedness was asked to explore the concerns around the recruitment and retention of volunteer EMS providers in rural Idaho. And to that end, the bureau held 16 town hall meetings throughout the state and really listened to what folks were saying. We tried to make sure that everybody had a voice at the table, that we were actively working with them and seeking input from them. The three main concerns that were brought to the forefront were that the public is largely unaware of the services that these providers perform, that they feel they spend a significant amount of uncompensated time in their communities and that the certification exam process is not well understood. **Ms. Shaw-Tulloch** said that, as a result, the report has been finished and was already sent out this last week and they are looking into finding solutions to some of the issues that were raised and are continuing to work on the long-term plan for this.

Ms. Shaw-Tulloch said there are two key issues for the immunization program that tend to arise, both really around immunization requirements. One is the thought that the requirements for the immunizations for school and child care entry are too stringent. To that end, the division has exemption forms readily available on the department's web site to individuals who would like them for religious, medical or philosophical reasons. Another issue raised in the past has been around the exemption forms being hard to find or difficult to complete. So the sentiments heard were taken to the Idaho Immunization Policy Commission to help look at that tool and make sure that it was understandable and easy to use.

Senator Lodge thanked everyone at the **Ms. Shaw-Tulloch's** bureau, specifically thanking Wayne Denny, Chief of the Bureau of Emergency Medical Services and Preparedness, for the work done on the very contentious situation with the rural EMS and said she really appreciated the carry-through. **Senator Lodge** said she hasn't read the report yet, but that she will.

PRESENTATION: **Tamara Prisock**, Licensing and Certification Administrator, said she oversees the administrative rule-making process for the department, that she's been with the department for over 27 years and that she's been in her current position since late October. She introduced Debby Ransom, Chief of the Bureau of Facility Standards, who has been in that position for over 11 years. **Ms. Prisock** said the Licensing and Certification Division surveys, inspects, licenses and certifies the health care facilities in Idaho that require certification or licensure by either state or federal regulatory requirements; works with the federal Centers for Medicare and Medicaid Services (CMS) to certify a variety of Idaho health facilities to receive Medicare and Medicaid payments; and will license and certify health care providers based on state requirements. **Ms. Prisock** said her division is new and was established July 2012. Prior to that time the division was part of the division of Medicaid. **Ms. Prisock** said there were a couple of important reasons for removing the licensing and certification function from the division of Medicaid: first, was to separate the

regulatory enforcement functions from Medicaid benefit management; second, to position the department to explore possibilities for moving other licensing and certification functions to the new division if those moves would improve service and efficiency. **Ms. Prisock** said a couple of examples of other types of licensing done in the department is to license day care facilities and foster homes. The division's core purpose is to ensure that Idaho health facilities and agencies comply with applicable federal and state statutes and rules. Those rules and statutes exist to promote individual's rights, well-being, their safety, their dignity and the highest possible level of functional independence. **Ms. Prisock** said the division licenses and certifies thirteen different types of facilities and agencies and are responsible for over 3,100 health care and residential facilities with over 21,000 treatment beds across the state. Some of the types of facilities the division work with include skilled nursing facilities, residential assisted living facilities, hospitals, hospice agencies and certified family homes. The team works closely with partners in the respective industries; with advocates and guardians; with other governmental agencies and with other stakeholders to ensure safe and effective care in a variety of settings.

Ms. Prisock said the primary issues facing the division at this time include the modernization of business processes. We are working toward streamlining our processes and better using technology to increase productivity and the quality of our work. The division is also addressing retention of registered nurses. **Ms. Prisock** said another issue continually faced is maintaining the balance between the enforcement of licensing requirements with education and support for providers. Maintaining that balance is difficult at times, but it's critical to ensuring that Idaho maintains high quality care in all areas of the state. **Ms. Prisock** said some complaints the senators could get against the division could be from family members or the general public about the care given to residents in a specific facility. She said the division would appreciate knowing about those complaints and concerns just as soon as possible so we can investigate them. **Ms. Prisock** said there also might be complaints from facilities or providers about actions the division is taking such as revoking their license or certification. Although the division works hard to help providers be successful, sometimes we do have to revoke a license or certification because the facility or agency just fails to bring the facility back into compliance. **Ms. Prisock** said there also might be complaints from providers and facilities about the length of time it takes to complete an application for license or certification. **Ms. Prisock** said there are times when the division is faced with competing priorities, such as increases as the number of complaints needing investigation at the same time that we're experiencing a number of applications for new licenses or certificates. So applications might take longer to complete than the provider would like or that the division would like the application process to take. When faced with competing priorities, the division does the best it can to direct its resources to the work that it needs to do to ensure the safety and well-being of residents and that sometimes creates temporary backlogs in other work that the division needs to do.

Chairman Heider said thank you and wanted to remind the committee that everyone is welcome at the Department of Health and Welfare at any time and that he appreciates that. He thanked those from the department for being who they and for representing what they represent and for serving the committee and the citizens of Idaho. He welcomed the department staff to stay for the next presentation if they wanted to.

PRESENTATION: **Christie Herrera** said she is the President of Policy at Foundation of Government Accountability (FGA), which is a think tank based in Naples, Florida and that the organization was the one that did the child welfare ranking Mr. Luce mentioned in his presentation. **Ms. Herrera** said her organization runs Project Medicaid Cure, which helps states reform their Medicaid programs with a pro-patient, pro-taxpayer focus based on the successful reforms already under way in places like Florida, Texas, Louisiana, Kansas and Utah. **Ms. Herrera** said FGA hopes to start a child welfare project in the next couple of years and to talk to other governors and state legislators about all of the great things that are being done in Idaho with the child welfare program. She thanked the senators and those at the Department of Health and Welfare for all they do. **Ms. Herrera** said that Medicaid reform will be a hot topic here in this session and that she knows the senators are also grappling with Medicaid expansion. She said she wants to share some of the great things that FGA is doing in Florida and some of the lessons learned in hopes to inform policy choices here in Idaho. **Ms. Herrera** said there are many similarities with the size of Idaho Medicaid and the size of Florida's Medicaid reform pilot program and - when comparing Idaho and Florida Medicaid reform, because there are so many similarities - she thinks the two states could learn a lot from each other.

Ms. Herrera said Florida was in a position seven years ago that many states are in today: if Florida did not curb its Medicaid spending it would consume about 60 percent of the state's budget. The state had 20 waivers going at the same time, multiple delivery systems, two-thirds of the population was in current fee-for-service, where what some called the pay-and-chase Medicaid system. Florida decided to enact a pilot program - a pilot in Florida is 300,000 people on Medicaid and Florida has about 3 million people on Medicaid – with both urban and rural counties to make sure the kind of reforms that tested were good for urban and rural folks. **Ms. Herrera** said that over the past couple of years, the pilot not only ran but was also expanded statewide. It should be going statewide this year. **Ms. Herrera** said some of the large take-aways of Florida Medicaid Reform is that it's so important that, when talking about issues of expansion, if we're going to say no that we also had to say yes. We say yes to reforms that change Medicaid from an open-ended federal program – an unpredictable program - for state legislators and change that to a defined contribution system that moves patients from sickness to health to a better life. And that is what we are doing with this Medicaid Reform Project. Mentioned other take-aways: A Medicaid marketplace - people on Florida's Medicaid Reform have up to 11 plans to choose from; customized benefits - we heard a lot during the federal health reform debate about how private entities were looking to drop the sick and, in Florida, we have actually enacted this customized benefits provision so that managed care entities are encouraged to take the sick and make them well; and choice counseling, which is something that is key to our program.

Ms. Herrera said the Florida Medicaid Reform was started by Florida Governor Jeb Bush, who often says that the people on Medicaid really need to be empowered to make their own healthcare decisions. **Ms. Herrera** said there are choice counselors that help Medicaid patients pick the plan that's best for them and that is really the way that to improve patient care is to allow people to vote with their feet and go elsewhere. 70 percent of Florida Medicaid Reform patients are actively choosing their own plan, which I think is a pretty big take-away. **Ms. Herrera** said a fourth take-away is enhanced benefits rewards for healthy living. And, finally, there is an opt-out provision - so if someone on Medicaid qualifies for employer sponsored insurance, they can take that subsidy and buy coverage in the private market for themselves or for their entire family. **Ms. Herrera** said the reform pilot is bi-partisan. It was started by Governor Bush, approved by President Bush in 2006 and, recently, extended another three years by the Obama Administration extended our pilot for another three years. She said the reform is proven. None of us want to stick our necks out there with reforms that might be untested. Now, we're entering

our seventh year of operation; there are other states like Kansas, Louisiana, Texas and Utah pursuing these kinds of reforms as well; we are seeing better access to care and better health; as well as pretty big cost savings.

Ms. Herrera said some of the key components of Florida's Medicaid reform are, first, the Medicaid reform marketplace – with those meaningful plan choices, patients can chose from as few as two and as many as 11 Medicaid reform plans. The plans have to cover federal minimums but they also offer optional services as well as some services not even offered by Medicaid like adult vision or dental or over-the-counter pharmacy. Secondly, the customized benefits - plans are customizing themselves based on special health needs. For example, there is a plan run by the AIDs Healthcare Foundation called Positive Healthcare and it only provides services to Medicaid reform patients who are HIV positive. The choice counseling patients have 30 days to pick a plan with the help of 31 full time choice counselors. They're multi-lingual, they perform field visits for people who are institutionalized and provide the Opt-Our provision. A patient can get employer sponsored coverage if they have that subsidy and they can go purchase coverage for themselves or their entire families.

Ms. Herrera said she wanted to talk about some of the outcomes being seen in Florida and hopes that other states would want to look at what FGA is doing and, hopefully, get these results. There is an apples-to-apples comparison of specialty care access for patients not only in Florida's Medicaid Reform counties, but also for patients on old Medicaid and for people with private Health Maintenance Organizations (HMO). Patients in Florida's Medicaid reform counties have equal or better access to specialists than everyone else. And, about half of the patients in Florida's Medicaid Reform for them it's actually easier for them to get an appointment with a specialist than it is for people in a private HMO. **Ms. Herrera** said Florida's reforms are also improving patient health, such as asthma management, diabetes care, mental health treatment, and that people in Florida's Medicaid Reform are actually out-performing other Medicaid patients in the state of Florida and nationwide.

Ms. Herrera said the potential for state savings is definitely a policy choice when state legislators move from an open-ended Medicaid program to a defined contribution system and legislators can set level savings anywhere they would like. Louisiana set a 5 percent savings target for their first five years and Kansas did it at 3.5 percent. **M. Herrera** said if Idaho matched Florida's per-person cost for the Temporary Assistance for Needy Families (TANF) and Supplementary Security Income (SSI)/Medicaid populations, we would have a combined state and federal Medicaid savings of about $407 million. Your match is about 7921 on Medicaid so that would be a state savings of $85 million. **Ms. Herrera** said she thinks that a big part of what her organization is doing is not only helping state law makers try to improve their fiscal health by reforming Medicaid but, more importantly, fixing Medicaid to help the people that are on the program.

Ms. Herrera shared two stories of some patients that they are working with in Florida as part of Project Medicaid Cure. Laureny Sanchez is a widowed, single mom of four. Her son, Alan, has a brain tumor on his pituitary gland, and has chronic heart and growth problems. Under the old Medicaid program, Laureny couldn't get the care she needed to make her son, Alan, healthy again. The maze of doctors under the old fee-for-service structure was too confusing – and good luck getting in to see a specialist that would actually see a Medicaid patient. Laureny and Alan are now part of Florida's Medicaid reform. Laureny now works with her case manager, Cathy, to coordinate Alan's many doctor appointments and ensure that he's getting the care he needs. Thanks to Florida's reform, Laureny is a happier mom, Alan will become a healthier kid, and Laureny's case manager, Cathy, will spend less time and money on administrative tasks and more time doing what she

loves best—making her patients happier and healthier. **Ms. Herrera** said Florida's Medicaid reform is making patients healthier and happier and the goal is to move Medicaid patients from sickness, to health, and onto a better life. **Ms. Herrera** said they want to help people like Laureny, Alan, and an amazing person, Moise Brutus, who everyone at FGA are so fortunate to work with in promoting the power of Medicaid reform. **Ms. Herrera** said, two years ago, Moise was coming home from a study group and got into a bad car wreck and became a triple amputee. Before the crash, Moise was working as an assistant manager at a car dealership. After the crash, he could no longer work or afford private health coverage. Moise got a letter in the mail, saying that he was going to be enrolled in a privately-run Medicaid plan, but he just didn't want to deal with any more disappointment. The old Medicaid program denied Moise what's called "stump revision" surgery, which led him to depression and thoughts of suicide. His doctors under old Medicaid gave him psychotropic drugs to keep him heavily medicated. Finally, Moise's mom and his private Medicaid plan helped Moise get the care he needed.

Ms. Herrera said it's one thing for her to tell the committee, but it's another thing to hear it directly from Moise. **Ms. Herrera** then played a short video about Moise (link to video listed in attachments). **Ms. Herrera** said Moise's story is really amazing and when he is asked what his long-term plans are, it's to get off of Medicaid so people who really need it can get it. **Ms. Herrera** said Moise is getting a bionic hand, is getting his chemistry degree, is training for the 2016 paraolympics and is a good example of the changes that happen when you move from a one-size-fits-all government run Medicaid program into an option with many private plans where they really view these Medicaid patients as a person rather than a number or a claim to be filed or paid.

Senator Lakey asked how the reform correlates with the mandatory changes going through. **Ms. Herrera** said the reform is completely independent of some of the other health care decisions that states have to make as part of the Affordable Care Act. **Senator Lakey** asked if the program incorporates some of the mandatory changes, does it apply them or is it a separate, alternative approach. **Ms. Herrera** said it's an absolutely independent part of the healthcare delivery system. This is something that you could implement regardless of what a state decides. **Senator Lakey** asked if there are cost savings that go along with increased usage and enhanced client services. **Ms. Herrera** said that was absolutely correct.

Senator Guthrie asked about the presentation slide that showed $400 million in savings and how Ms. Herrera talked about the ability of a patient or a client to pick their plan. He said it seems as people were given the latitude to pick the plan, human nature would say you pick the most expensive plan. He said he's not saying that negatively, but how do you direct them to a plan that best saves the state money. How does that work? He asked Ms. Herrera to talk about that a little more and then you talked about the 400 million was that potential savings in Idaho is that what you were getting at and is that total money or just federal money? A little bit more on that. **Ms. Herrera** said a patient picks a plan through the 31 full-time choice counselors. Based on patient's claims history, who their primary care provider is, and what medications they are taking, they are directed into what plan might be best for them. States can bid and put a savings target in the bidding process. **Ms. Herrera** said patients are able to pick any plan because those plans are valued at whatever the per member, per month payment for the patient is. So, what's been seen in Louisiana is and in Florida that patients are not only able to pick a plan that provides basic Medicaid services, but the high-risk high-health cost folks we have specialty plans. **Ms. Herrera** said FGA is working now to have a private Medicaid plan that deals with mental health. They also have one for kids with special health needs and one for people with HIV and AIDs in one of our counties. So for those very high risk Medicaid plans with that higher dollar target,

they would go into a specialty plan. All of the other patients would pick the rest of the plans that are available to them.

Senator Schmidt asked for clarification on the plan numbers. **Senator Schmidt** then said it appears the number of plans to choose from has been reduced over time and so that is somewhat of a selection process, it sounds like, amongst the plans as to whether they're finding it profitable. He also asked for clarification on the number of years Florida has been participating in the reform and to clarify the characteristics of the counties involved. **Ms. Herrera** said there are five counties which comprise about 290,000 Medicaid enrollees - about ten percent of Florida's Medicaid enrollment as a whole. The reason behind picking two urban counties and three rural counties was just to test to see if this was actually working in both scenarios. As part of the competitive procurement process, once this goes statewide, it will be a targeted number of four to six plans. **Ms. Herrera** said, right now, Florida has a rolling admissions, so as soon as a plan has network adequacy and financial solvency the plan is automatically deemed to be a Florida Medicaid reform plan and it can start serving patients. **Ms. Herrera** said the problem that Florida ran into with the existing plans was saying if insurance company X decided to play in Florida's Medicaid reform, they said well we thought we were expecting this amount of business. Now in years two and three, you are accepting all these competitors and it's hard for us to maintain a financial solvency in the state. They call it competitive procurement so that the bids go out every five years so the plans know these are our competitors and we know that we can expect this minimum level of market share. So it was a concession to the plan and it makes things a little bit more predictable for them. **Senator Schmidt** said Ms. Herrera mentioned a per member, per month number and asked her to share that with the committee. **Ms. Herrera** said the per member, per month for the TANF population - moms and kids over age 1 - is over $140 per member, per month. The per member, per month for the SSI - aged and disabled folks - is about $800-900 dollars per month, depending on the patient.

Senator Lodge asked for copies of Ms. Herrera's slides. **Ms. Herrera** said she would be happy to give them to her and mentioned FGA's website, medicaidcure.org. **Ms. Herrera** said the website not only has the legislation that was passed in these states that are pursuing reform, but also the copies of the waivers and the state plan amendments that states have filed with the federal government – so readers can know what has been tried before and what has been approved.

Senator Nuxoll asked how Ms. Herrera set her base and if patients all go through case managers. **Ms. Herrera** said Florida Medicaid benefits, as well as the provider rates, are based on current fee-for-service levels so those create a floor rather than a ceiling. They pretty much all go through some sort of case management since the plans know they have that risk-adjusted per member, per month cost that they have to work with. **Ms. Herrera** said a huge hospital system in Florida has a Medicaid Reform plan with a care coordinator in the Emergency Room. By putting the coordinator there, folks who come in for frivolous things can be sent home or asked to make an appointment with their primary care provider. **Ms. Herrera** said they are seeing that this care management really works well when it's imbedded either with the provider or with the plan because they have the financial incentives to properly coordinate care.

Chairman Heider thanked Ms. Herrera for coming from Florida and said the committee was appreciative of her time and the information she brought with her. **Chairman Heider** reminded the committee of the DEQ books on their desks, said the books are the rules from DEQ that they would be discussing on Monday and approving. He asked them to look them over.

ADJOURNED: **Chairman Heider** adjourned the meeting at 4:38 p.m.

Senator Heider
Chairman

Linda Hamlet
Secretary