MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 05, 2015

TIME: 9:00 A.M.

PLACE: Room EW20

MEMBERS: Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Romrell, Vander Woude, Beyeler, Redman, Troy, Rusche, Chew

ABSENT/ EXCUSED: Representative(s) Perry

GUESTS: Corey Surhar, Saint Alphonsus; Lisa Hrobsky, IHA; Jim Baugh, DRI; Christine Pisani, DD Council; Toni Brinegar, ICDD; Ellie Brown, Veritas Advisors; Russ Baron and Dave Taylor, DHW; Toni Lawson, IHA.

Chairman Wood called the meeting to order at 9:00 a.m.

Dick Armstrong, Director, Department of Health & Welfare (DHW), presented the findings summary of the Idaho Workgroup on Medicaid Redesign. The state's healthcare initiatives are: the State Healthcare Innovation Plan (SHIP); traditional Medicaid reform; and, plugging the uninsured Gap in healthcare coverage.

Dr. Ted Epperley, Family Physician, President, Chief Executive Officer, Family Residency of Idaho, Chairman, The Idaho Healthcare Coalition Board (IHC), said SHIP transforms the existing healthcare delivery system to a patient-centered medical home (PCMH) model, where a team focuses on the patient's overall health, not their disease. It replaces the current fee-for-service payment method with a value-based multi-payer model. Participant and provider incentives encourage chronic condition management, wellness exams, and preventive care. Although PCMH and direct primary care offer the same models of care, their reimbursement methodology differs.

After Medicaid's review of the model, Idaho has been awarded a $40M transformation grant. The reward was based on the plan's soundness, cost savings, delivery, and PCMH model design. The Medicaid redesign for 274,000 participants is also a part of SHIP, providing an integrated preventive and wellness healthcare system with a team of providers. The Gap population would be brought into the system through the Medicaid redesign/expansion, while SHIP improves their outcomes.

The redesign creates seven regional community health agencies with Boards of Directors. They will work with the IHC to transform practices, design quality outcome metrics, and compare incentive-based outcomes. The IHC will oversee the entire transformation project.

Director Armstrong reported the state began moving to care management principles in 2007, with further direction as part of **H 260**. Four major Medicaid delivery systems have been moved to care management.

In evaluating everyone's insurance ability, the work group focused on the 78,000 (5%) Gap population that falls within the 25% to 100% federal poverty level (FPL). Their crisis care is handled through hospital EDs, and the payment is often through county indigent services, the state catastrophic (CAT) fund, and other charity care. With care management continuity, their chronic diseases often progress to become very expensive indigent costs.

More than half of these adults have children and at least one full-time worker in their households. Their professions include food service workers, construction laborers, farming, forestry, home health aides, childcare workers, retail sales, transportation, janitorial, and office or administrative support. Canyon County (7.30%) has the highest Gap population, Power County (6.93%) came in second, and Payette County (6.41%) was third. Indigent provider payments in 2014 totaled $51,528,726. The three highest counties for those payments were Ada ($16,842,323), Kootenai ($5,448,018), and Twin Falls ($4,730,457).

Director Armstrong presented the Healthy Idaho Plan, a unique hybrid model for care management and private market solutions. The plan assures premiums are charged and the maximum allowable co-pays are collected from participants. Medically fragile assessments are required, with a core principal to eliminate the state and county indigent programs. This would save Idaho taxpayers more than $173M over ten years, freeing money for use toward education or other state priorities. It would bring the $25M to $50M Affordable Care Act (ACA) taxes back to Idaho citizens per year .

Gap adults would be assigned to a primary care physician or direct primary care provider, enhancing the existing Medicaid Healthy Link program. The payment model would shift from fee-for-service to value, subject to approval from the Center for Medicare and Medicaid Services (CMS). Participants and providers would be offered incentives to enhance their working relationship. Cost-sharing would be maximized and co-pays would be required for non-emergent ED utilization. Participants would be automatically referred to work search and job training, as is already done in other programs.

Approximately 25,000 adults fall within the 100% to 138% FPL. The Health Insurance Exchange (HIX) would be used to deliver the same products used by the general public. Children on Medicaid would be able to join their parents' plans.

The federal government pays 70% claims costs for traditional Idaho Medicaid. The federal match rate for Healthy Idaho claims costs would begin at 100% (2015-2016) and annually decrease to 90% (2021 and beyond).

With the increasing state and county indigent costs, Healthy Idaho saves both county property taxes and state General Funds. County and state medical indigency programs would be eliminated. The resulting savings could be used as a tax break, education funding, or applied to other state/county priorities. The ten-year projected state and local savings is $173.4M.

Director Armstrong explained the next steps require legislation to change insurance eligibility to include the Gap population and provide the hybrid delivery model. The Healthy Idaho Plan uses federal funds targeted for traditional Medicaid expansion in a uniquely Idaho way. It incorporates unprecedented federal government concessions to support Idaho's values of personal responsibility and accountability. If the proposed three-year pilot program is not working or the promised federal funding is not delivered, Idaho can opt out at any time.

Answering questions, **Director Armstrong** said continued use of a private contractor for job training and work search is proposed. Without a plan to access funding that became available in 2014, the state has had to pass on millions of dollars paid at 100% for claim costs.

The Healthy Idaho Plan focuses on the 78,000 Gap population. The DHW will continue to move ahead with all Medicaid enrollees and the SHIP Program, compressing efforts during the transformation, taking advantage of early high federal percentages, and putting the minimum cost amount on the health care providers. With the help of Meridian, a Medicare contract payor, Medicare's work group participation has begun.

Dr. Epperley answered questions, stating physician cooperation starts with education and incentives for more preventive care. Current procedure technology (CPT) reform begins within Medicare, decreasing procedural payments while improving integration and coordination payments.

Dave Taylor, Deputy Director, Support Services, DHW, was invited to answer a question. He said the ten-year swing costs for counties total $367.8M. The state swing costs total $194.4M, with a savings in 2016 of $33.9M that migrates to $45.9M in 2025, through the 90% federal and 10% state funding. The state costs include $110.6M offsets from the CAT fund, behavioral health program, and other DHW programs. Total federal funds for the same ten years is $7.4B, which migrates from $653M in 2016 to $874M in 2025.

Director Armstrong said the issue with children being put on the Medicaid system instead of the same coverage as their parents is recent and, as yet, has no resolution. Free or sliding-scale clinics will become a major Medicaid primary care deliverer and continue to serve those not enrolling in Healthy Idaho.

The Healthy Idaho Plan includes health reimbursement account earned incentive credits that offset co-pays. Medicaid co-pays range from $3 to $15 and payment would be enforced.

The DHW and Idaho Hospital Association are analyzing ten-year projected uncompensated hospital care costs. The transformation impact on clinics, although not included in the study, will become evident as claims are reviewed.

If we continue with the status quo, the DHW, as a safety net agency, will make sure some fashion of care is delivered to everyone. The proposed approach is the least expensive direction for our local tax dollars, giving the broadest coverage and solving the Gap issue.

Answering further questions, **Director Armstrong** said, when forecasting, a fairly narrow focus was maintained, with consideration of the low estimate errors made by other states. If the estimates are off by 10%, the General Fund impact would be manageable, due to the federal government payment amount.

Dr. Epperley, responding to questions, said physicians, reluctant to take Medicaid patients under the current payment system, view the new payment model as sustainable. The delivery and payment system must change at the same time. With lack of coverage, 75 to 179 Idahoans die annually. A direct primary care model with a smaller patient panel, although not scalable to our state, needs to be a portion of the redesign. More primary care physicians and providers must be trained and added to amplify the community integrated team care.

Director Armstrong explained the PCMH pilot program had 3,700 chronically ill volunteers. A fixed monthly fee was advanced to the volunteer medical homes. Reviewing six months' worth of claims from the two-year pilot period has revealed the annualized advance amount of $755k resulted in an annualized savings of $8M. Inpatient care decreased by 26% and hospital readmissions decreased by 41%. He acknowledged the severe chronic illnesses of the pilot volunteers offered the highest savings potential. It was rewarding to see how thirty Idaho clinics delivered the integrated care to the participants.

Health savings accounts have not produced the assistance expected to the average Idaho wage earner. Incentives effectively bring patients and providers together to assure the right care is delivered at the right time.

The Gap population moves from job-to-job to improve their lives. By offering them the tools to secure better paying jobs, their self reliance is increased and encouraged. Individuals unwilling to improve make up less than 10% of the population

Community walk-in clinics handle patients needing appointments the same day. This is an important community method needing expansion to decrease ED visits.

Lisa Hettinger, Administrator, Medicaid Program, DHW, was invited to answer questions. The state has a shortage of primary care physicians for all payers. Medicaid has seen no decline in Medicaid physician assignments or care access through the Healthy Connections Program. Medicaid participant ED utilization does not appear greater than the general population.

Answering further questions, **Director Armstrong** said the justice reinvestment process is being analyzed. The current probation and parole treatment costs are estimated at $5.7M, with eligibility after completed incarceration. Those with medical and behavioral health issues are expected to merge into the PCMH for fully integrated recovery and would be a part of the Gap population.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10:43 a.m.

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Representative Wood
Chair

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Irene Moore
Secretary