MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 05, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson(Lodge), Nuxoll, Hagedorn, Tippets, Lee and Lacey.

ABSENT/ EXCUSED: Senator Schmidt

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** convened the meeting at 3:01 p.m. He welcomed everyone there and turned the time over to Director Armstrong for his presentation.

PRESENTATION: **Richard Armstrong**, Director, Department of Health and Welfare (Department), began his presentation by introducing the other members of the work group who were attending with him: Senator Heider; Lisa Hrobsky, Hospital Association; Susie Pouliout, Idaho Medical Association; Corey Surber, St. Alphonsus Health System facilitator; Tom Fronk, Idaho Primary Care; Stephen Weeg, Governor's Health Care Council and board member of the Department of Health and Welfare; and Beth Gray, Nurse Practionner Association. **Director Armstrong** indicated that the full report had been provided to the Committee. **Senator Heider** thanked them for their excellent work and participation in the Governor's work group.

Director Armstrong said that his presentation would cover five steps: 1) is the major initiative and how it will affect all of Idaho; 2) is Idahoan's access to healthcare. What that really means is the ability to pay equals access and how that is structured. 3) is the gap population, which is the group that the work group really focused on. These are individuals whose incomes are at 100 percent or less of the federal poverty guideline. 4) recommendations; and 5) strategies will be discussed last. There are three major healthcare initiatives. They are 1) State Healthcare Innovation Plan (SHIP), which is a strategy to change the delivery of healthcare throughout Idaho, 2) Traditional Medicaid reform, 3) Plugging the gap in healthcare coverage.

Neva Santos, Executive Director, Idaho Academy of Family Physicians (Academy), standing in for Dr. Epperly, stated that the Idaho Academy of Family Physicians has been involved with Idaho's healthcare discussions for many years. The Academy has been very involved in helping draft SHIP. The impact SHIP will have on Idahoans encompasses all of Idaho. SHIP envisions a healthcare system that is focused on keeping people healthy while reducing healthcare costs. The foundation of SHIP is the patient centered medical home (PCMH). This is the model of primary care that focuses on patients receiving the care that they need when they need it. A coordinated care model allows the patient to receive appropriate care without duplication of services and without overlooking an important medical issue. SHIP is designed to replace the fee for service payment system. This system tries to keep the patient healthy and rewards providers for working toward the same goal. Working as a team is much more efficient. Treatments are focused on wellness and preventative care. The SHIP plan will help transform 165 practices over 4 years to the PCMH model. Practices will become part of a PCMH neighborhood and will work with other healthcare providers in their communities. Regional health districts

have the best geographic alignment for the seven regional collaboratives. The entire system will be directed by the Idaho Healthcare Coalition.

Director Armstrong discussed the major similarities and differences between the PCMD and direct primary care (DPC). PCMHs is a patient centered approach to care with expanded services and access to providers. Providers are more focused on keeping patients well. The DPC model is also patient centered, focusing on keeping patients healthy and managing their chronic conditions, but differs in the reimbursement methodology. In both models the healthcare providers work to manage patients through care management options. In a DPC practice the providers have a direct contract with the patients and are able to bypass insurance. The patient is able to access the provider when they need care. The provider doesn't bill an insurance company because the care management fee is paid by the patient. SHIP is designed to transform Idaho's healthcare system by improving patient care, improving patient health outcomes and reducing healthcare costs.

Chairman Heider asked what Ms. Santos meant by wraparound insurance. **Ms. Santos** responded that the patient has a contract with the provider and they can contact their physician at any time. Then they pay for much less expensive wraparound insurance so that if they have to be hospitalized or go to an emergency room, they will be covered. **Senator Lacey** added that when you pay your provider it is like having a first insurance and the "wrap around insurance" would be a second insurance. His concern was who would pay for which services. **Ms. Santos** explained that the contract identifies what each company would pay for so there wouldn't be disagreements about which company pays for what.

Chairman Heider turned the time back to Director Armstrong. He indicated that he would discuss the traditional Medicaid reform which began in 2007. H 260 provided direction to the Department as well as authority to move into care management. It is under that umbrella that Medicaid reform is working. They are using the model of PCMHs to accomplish this. Their goal is to transition all Medicaid participants to the care management model. **Director Armstrong** said he would discuss where people get their insurance today. He specifically referenced the gap population, that included 78,000 individuals which represent 5 percent of the State's population. These people all have a household income of less than 100 percent of the federal poverty guideline. He indicated that services have been delivered to them through catastrophic funds and state indigent funds. The Department has had to deny coverage to many of these people because their income is too low to meet the subsidy standards. Adults without children are not included in Medicaid making them part of the gap population. The Department is a DCP for behavioral and mental health services. Clinicians deliver services directly to these people. They are the last resort for people who cannot receive help anywhere else. About 26 percent of all of the people coming through the program suffer from mental illness and other chronic diseases such as cancer, diabetes, or heart disease. Demographics of the gap population include households that have children; 68 percent have at least one full-time worker. The industries that they typically work in tend to be lower income jobs. They are able to track where these individuals live because of the registration with the State Insurance Exchange. The recommendation for helping to minimize this problem is to use a uniquely designed, hybrid model of healthcare consisting of care management for those under the 100 percent level and private market solutions or the insurance exchange for those above the 100 percent mark. It would have premiums and co-pays depending on their coverage. Attention would be paid to those that are medically fragile and they would be placed in proper coverage. Over 10 years, the savings would amount to over $173 million, freeing up that money for other uses.

The care management group would be made up of those that are under 100 percent of the federal poverty guideline. They would be assigned to a primary care physician, shifting from fee-for-service to a value payment. Incentives would be offered to both participants and providers to work together. They would receive incentive credits toward a health reimbursement account which could be used for future co-pays and expenses. Healthy behavior would be rewarded. The plan would take advantage of all of the co-pays that are allowed by law. Medicaid is restricted by federal rule and the co-pays are small, but it is still a meaningful amount of money to this group. This would give them an incentive to take care of their health.

A discussion was then held on the group made up of those between 100-138 percent. That bracket is an overlap category that resulted from the new law and where Medicaid eligibility already was. It is estimated that there are about 25,000 individuals in this category. Similar plans that are in the exchange now would be used for this group. There would be premiums charged on a sliding scale. Participants would also be given job training and work search requirements. Another recent development is the ability to keep children with the private plan and not require them to split on to Medicaid separately. This results in one household being on two different types of insurance.

The funding side of the formula was then discussed. The federal government allows for an enhanced funding rate for the gap population. It started at 100 percent and goes down to 90 percent. Typically, the cost sharing is 70/30 for the remaining populations. There has been concern expressed that the federal government will not let people out of a program once they enter it. The program being used currently contains a trigger clause to opt out if an unfavorable change in federal funds occurs. A discussion was held concerning the benefits to taxpayers from participating in Healthy Idaho. The savings to Idaho grow as Idaho's population grows, and the expenditures would basically be transferred from counties and states to the federal government. A detailed report was given on what projected ten year savings/costs would be. The 10year total projection for total local savings was $173.4 million. It is estimated that the federal dollars coming in in 2016 would be $600 million. Idaho should continue to reap great savings in health care for this group of individuals.

The Affordable Care Act imposed a lot of taxes around healthcare. It was designed to have the taxes offset the costs. These taxes are being paid for by Idahoans. Idaho's share of the tax increase in estimated at $25-$50 million per year. Healthy Idaho feels it is only fair to make use of those dollars and get them back in Idaho.

The workgroup recommended taking two steps. They proposed considering draft legislation that changes eligibility to include the gap population, providing healthcare coverage through private and care management plans. Conversations with CMS indicate that they are receptive to this idea. It is a slightly different model, but none of what is being proposed is new. They are confident that they will approve such waivers and allow Idaho to amend their state plan.

Director Armstrong said that the Healthy Idaho Plan protects Idaho taxpayers. A three-year pilot program is being proposed. If it does not work or promised federal funding is not delivered, Idaho can opt out at any time. That wouldn't be easy. Those 78,000 people with that coverage would not be happy to lose it, but there is no other way to afford to help fund a health plan for the medically needy. This appears to be the best way to get health coverage for these individuals with the least impact to Idaho taxpayers (see attachment 1).

Director Armstrong asked for questions. **Chairman Heider** thanked him for all of his hard work for the people of Idaho.

Vice Chairman Martin asked if Director Armstrong knew approximately what the amount the co-pays would be. **Director Armstrong** indicated that Medicaid limits the amount of co-pays to small amounts such as $4.00 or $8.00. Providers struggle to bill these small co-pays. His division would be imposing those co-pays and using health reimbursement accounts to get people to realize that there is a cause and effect to use their services.

Senator Nuxoll asked if Medicaid expansion was being paid for with Medicare money, then aren't the plans just switching around from one group to another? **Director Anderson** stated that is part of the basic plan; it is a reallocation. Medicare is not needs driven, it is for everyone. Everyone pays the same price and the same premium. He stated that he didn't know why they decided to do reallocation and have it not affect the program.

Senator Hagedorn asked what the current start date was and the phase in plan to get all 78,000 people covered. **Director Anderson** said it would take a large portion of the year to phase out the old program. The start date would begin on the law start date. He estimated at least a year and that is if everyone moves quickly. **Senator Hagedorn** questioned the reality of saving $64.7 million over the 10 year plan. **Director Armstrong** responded that this was a chance that could be achieved if they get started early. A lot of that depends on how quickly enrollment could be accomplished. **Senator Hagedorn** asked if the transition plan for an opt-out was discussed, how that would happen, and who would be responsible for putting it together. **Director Armstrong** indicated that he would be responsible. The enhanced funding is in the law so it would require Congress to go into the law and pull that percentage back. That would be a very obvious act that would cause a lot of problems. The GOP discussion is leaning toward a block grant and it works very well. If that actually happened, there would be rules for operation. If the dollars were fewer but options were given on how and where to spend the money, a way would be found through it. **Senator Hagedorn** expressed his concern with adding more people to an already over extended budget. **Director Armstrong** responded that Idaho depends on the federal government for approximately 70 percent of the money. He said he felt that the distribution of who pays more could help to pay for those who are not able to pay for themselves. This process would helped by developing a structure for delivering the needed care and a better method of payment. He stated that if the federal government would give the states more latitude they would be able to protect the vulnerable for less money.

Senator Lacey asked if it would be possible to do legislation prior to having the federal government approve variances, or would approval be given for the variances before legislation is passed. **Director Armstrong** said that usually the legislation comes first, and then federal government approval is obtained. The federal government is hesitant to approve legislation before knowing if the State has approved it.

Senator Nuxoll said that she recognized that with Medicaid payments the doctors aren't getting paid as quickly as they should, there is a shortage of doctors, and Idaho's doctors are aging. She asked how that is going to work into this transition program. **Director Armstrong** said he agreed that Idaho is under served in the primary care physician category. As Idaho moves into the medical home model, they will be able to make greater use of the mid-level professionals. One of the current problems is that the physician has to take care of all of the things that mid-level professionals could do. This new pilot program should encourage development of the workforce in that area. **Senator Nuxoll** stated that she was concerned about what doctors would charge while working in this type of environment. **Director Armstrong** said that a pilot program was just completed, results showed that you can put chronic disease patients in a medical home where they get the attention they need, and by taking care of those needs, it reduced inpatient and emergency

room use. If those savings were invested into the system, it would increase the number of providers available and increase the capacity of primary care.

Senator Nuxoll asked if they were looking at health reform as a way to get out of Medicaid. **Director Armstrong** responded that the reason people need these services is because their income is too low. Household income has declined coming out of the recession. Once a household's income gets to the level where they can sustain themselves, they won't need these types of programs. They do job training and outreach programs to help these people get better paying jobs. As a result, they saw a decline in single people using their services because they were getting jobs, and they no longer needed these services. The family household still struggles.

Chairman Heider asked if the Committee was going to see draft legislation and who was going to draft it. **Director Armstrong** responded that there are people working on it, but he can't give details.

Chairman Heider thanked Director Anderson for his work and for his presentation.

ADJOURNED: **Chairman Heider** adjourned the meeting at 4:09 p.m.

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Senator Heider
Chair

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Erin Denker
Secretary

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Sharon Pennington
Asst. Secretary