Attachment #1

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Budget Presentation for Health and Welfare Committees 2-12-2015

Mr. Chairman, members of the committee, good morning.

Today, I want to present a high level review of the budget recommendation for the Department of Health and Welfare. I think you will find the recommendation adds up to a maintenance budget overall, along with several significant opportunities to improve the health and safety for our citizens.

Slide 2:

In this presentation, I will cover these five topics and then answer any questions.

The first is the State Healthcare Innovation Plan, which we refer to as the SHIP. We received a federal grant last month, which can help us improve the healthcare for all Idahoans.

Second, I will update you on our specific budget requests.

Third, we are beginning to see increased employee turnover as the economy recovers and jobs become available, and pay is the main issue. An employee CEC is vital for us to retain our valued workforce.

Fourth, we share eligibility services with Your Health Idaho. I want to update you on our performance.

Last, even though the state unemployment rate continues to improve, we are still experiencing extremely high workloads. I would like to share information on that.

Slide 3:

Let's start with a brief overview of our budget recommendation. Overall, this is a maintenance budget with several opportunities that I consider to be smart governance.

You'll notice our overall budget has increased 3.3%, equaling almost $83 million. This is a large amount of money in anyone's book. However, if you subtract the non-discretionary adjustments, the CEC, employee benefit costs, and the federal SHIP grant recommendation, the actual increase is much smaller, closer to 1 percent.

The increase in receipts is 32 percent, due mostly to new federal regulations in Medicaid, which require us to collect an estimated two years of hospital settlements in 2016.

Slide 4:

As you can see from this slide, Medicaid continues to be four-fifths of our budget, which has not changed much from last year. One thing that has changed on this chart is in the lower right-hand corner. We propose a new program called Healthcare Policy Initiatives to replace the Medical Indigency program.

The Medical Indigency Program funded our activities to reduce the costs to the counties and the state for indigent healthcare. We propose transitioning to Healthcare Policy Initiatives to expand our vision and scope to a new level, one that can improve healthcare and lower costs for all Idaho citizens.

We have accomplished all we can for controlling indigent healthcare costs within that program's framework. Now we have the opportunity to think bigger with Healthcare Policy Initiatives. We can now do something extraordinary for the healthcare system as a whole through the Idaho SHIP initiative. We will talk about that in a few minutes.

Slide 5:

The percentage distribution of our funding is largely unchanged from last year. Eight-five percent of the appropriated funding goes to the private sector for their services and goods.

Slide 6:

The evolution toward a more sustainable and effective healthcare system began back in 2007. Our agency became very involved with this initiative because Medicaid is one of the larger insurers in the state, covering almost 270,000 Idahoans today.

As you know, many of Medicaid's participants have serious illnesses or disabilities that can result in very high costs. Because of this, one of our department's early emphases was to transition Medicaid participants to health homes and care management solutions. The health homes are extremely important for helping us manage expensive, chronic conditions.

For care management, Medicaid now has programs in transportation, dental, and behavioral health services. Our vision is to transition all Medicaid participants to care management, so people receive the most appropriate and evidence-based services at the right time and for the right cost.

Idaho was awarded the SHIP grant last month—it is a four year grant for almost $40 million. Idaho's SHIP proposal for transforming our healthcare system is based on the patient-centered medical home. This is the model we have been focusing on for years in Medicaid. It helps refocus our healthcare system on the benefits of primary care.

Slide 7:

In this patient-centered medical home model, a primary care provider and his or her team coordinate all of a patient's needs. This includes management of chronic conditions, visits to specialists, hospital admissions, and reminding patients when they need checkups and tests.

Medical homes make extensive use of electronic health records to track medications and tests. They also collect outcome data to evaluate how a patient's health has been affected by specific treatments. This outcome data will be extremely important in the future, as we share best practices with other providers, so they too can achieve better outcomes and lower costs.

The payment model for patient centered medical homes also changes. Today most insurers and Medicaid pay a straight fee-for-service claim for each treatment that is given. With the SHIP model, medical providers receive a per-member-per-month fee for managing the care of their patients.

Other states are conducting similar reforms and showing great success. Adults with primary care physicians have much lower costs of care, especially if they have chronic conditions such as diabetes, heart disease or asthma.

They are less likely to receive unnecessary tests or seek ER treatment for a non-emergency, and have fewer hospital admissions. With expanded use of electronic health records, their prescriptions are more easily monitored by their primary care physician so there are fewer adverse effects or prescription abuse.

Slide 8:

In Idaho, we conducted a pilot of Medicaid adults with chronic illnesses to see how a health home affected their hospital use. During the two-year pilot, we reduced hospital admissions by 26 percent, hospital readmissions by 41 percent and Emergency Room visits by 24 percent. We are still analyzing the data, but overall we saved an average of 20 percent during the pilot.

We paid the health home a monthly fee to manage these participants, with preliminary data showing a 10/1 return on this investment. Now these Medicaid participants in the pilot were some of our most chronically ill and expensive participants who would greatly benefit from coordinated, care management.

With the general Medicaid population, we expect savings and improved outcomes, too. But we will probably not realize such a high rate of return as this pilot population.

Slide 9:

The grant is for $39.6 million spread over four years. We are asking for spending authority for $8.9 million of the grant for SFY 2016, which will be administered by the Healthcare Policy Initiatives program.

With that funding, we will begin the transition of 165 primary care practices to the medical home model, targeting one-third, or 55 of them, in 2016.

We also will use grant funding to connect these practices' electronic health records to the Idaho Health Data Exchange, which is very important to manage the patients and collect outcome data. The Idaho model for the grant relies heavily on developing regional collaboratives to support local, coordinated care.

Our plan is to work with the seven Idaho public health districts to achieve this, which will mutually benefit all of us as we work to improve the overall health in each of our communities.

Slide 10:

Next, I would like to present our budget requests. I'll start with our supplemental requests for SFY 2015. First, we are requesting $615,000 for the plaintiff's attorney fees for the Jeff D. lawsuit. This is a lawsuit concerning children's mental health services that have been going on since 1980.

There were two primary issues:

1. Mixing of adult and juveniles at the State Hospital, which has been remedied.
2. Providing community-based mental health services, which has been the primary focus since 1990.

The case was actually dismissed by the courts in 2007, but reinstated on appeal in 2011.

We have been in confidential mediation since October 2013 to develop an agreement that we hope will lead to a mutual request for dismissal. A draft agreement is currently under review by all parties, which is very good news for all of us.

Slide 11:

Our next supplemental request is for a hepatitis C drug treatment that can cure the disease. Prior to this treatment, people infected with hepatitis C either died or underwent a liver transplant. The drug is only effective with specific genotypes of hepatitis C, so we require prior-authorization for treatment.

This is an expensive treatment; however, state Medicaid programs are required to pay for FDA approved drugs when medically necessary. There may be an opportunity to reduce this cost, for there are new, similar drugs coming onto the market. We are exploring possibilities to do this.

Slide 12:

We were awarded a substance abuse treatment grant last October that is targeted for three specific populations.

1. Veterans who are involved in the criminal justice system and on parole
2. Families involved with child welfare, in which part of their problem is substance abuse
3. People who are homeless.

All told, this grant is projected to help 3,400 Idahoans with substance use disorders over the next three years.

Slide 13

Next, I would like present our SFY 2016 requests

I want to thank you for appropriating funds last session for the development of a Behavioral Health Community Crisis Center. I am happy to report that the Crisis Center opened successfully in Idaho Falls last December. This year, the Governor is recommending funding for a second crisis center.

The purpose of the crisis center is to provide a safe, voluntary, effective, and efficient alternative to emergency rooms and jails for people suffering a behavioral health crisis. Hospitals, counties, cities, and the state should all realize savings from the crisis center. It can save on law enforcement resources, county indigent funds, emergency department services to uninsured patients, as well as reduce court-ordered civil commitments.

The contract we developed with Bonneville County for operation of their crisis center requires them to develop a plan to cover 50 percent of the operating funds within two years. It is critical we work with communities opening crisis centers so they contribute local funding to the greatest extent possible.

Future crisis centers will have the same contract requirement. It may be a challenge for communities to generate enough funding to cover 50 percent of costs. But we believe communities need to have "skin in the game" to sustain the crisis centers and to ensure they have the greatest possible impact for the people and communities they serve.

Slide 14

Last legislative session, we agreed to expand our Food Stamp benefit distribution from one day to 10 days. We had been providing the benefit on the first of each month, but will now go to the first 10 days of each month. The annual cost is estimated at $211,400 per year.

Initially during the first year, we have one time costs for computer programming, mailings of public notices to participants, and new card embossing machines. We are covering these one-time costs with a bonus we earned for high performance in the food stamp program.

Slide 15:

Our next request is for our licensing and certification program that licenses nursing homes, assisted living facilities, hospitals, certified family homes and others. We are having a difficult time retaining trained workers, due primarily to stress and workload.

We are working hard at improving productivity and efficiency, but we are barely avoiding financial penalties for meeting federal performance standards. As of December 31st, we had 275 overdue surveys and 135 open complaints that require investigation. We also anticipate conducting over 3,100 surveys during 2015.

As baby boomers age and need these types of facilities, the workload will continue to increase.

Slide 16:

Community hospitalization treats patients who are committed to the state and waiting for an open space to become available at a state hospital. We negotiate with the hospitals individually, but overall, it will be about a 10 percent increase.

The hospitals are not renewing contracts at the current rates, but have agreed to short-term contract extensions with this request being made.

Slide 17:

We have been very successful in finding adoptive homes for children who cannot safely live with their families. Many of these children have suffered from the trauma of abuse and neglect, so finding adoptive families for them is a major victory in their lives.

We provide a monthly stipend for adoptive families, because many of these children have special needs due to the abuse or neglect they suffered. We also have experienced a decrease in the federal funding, which shifts some of the costs to the state.

Adoptions have a life-long, positive impact on children. The alternative is perpetual foster care until a child ages out at 18 years, which also can have a lifelong impact on a child. But that is not as positive, and can be more expensive in the long run.

Slide 18

Currently, we are experiencing a high rate of turnover among our scientists at our state lab. An analysis shows us that our workers' average earnings are 23 percent less than surrounding states and the private sector.

Our inability to retain public health scientists diminishes Idaho's ability to respond to health threats like Influenza, Rabies, Anthrax, and Ebola. We will target the majority of funding for mid-level scientists, and also use some for hard to recruit positions.

Slide 19

Idaho uses an assessment program with insurance companies to buy children's immunizations. Idaho insurers are assessed an amount per child they cover and they pay into the fund to purchase the vaccines, at a greatly reduced cost. There are 8 other states with similar assessment programs.

TRICARE is a federal insurance program for military personnel and their families, but they stated they are unauthorized to pay into state vaccine assessments like other insurers. We are now partnering with the state of Washington, which is in the same boat, in trying to work out an equitable solution. But until then, none of us wants to put the children of our military men and women at risk.

Slide 20

The Governor is recommending a 3-percent salary increase this year. We have been working hard to reduce turnover, but as you can see from this chart, we saw a slight increase in 2014.

Our turnover rate had been declining since 2011, primarily because there were fewer job opportunities available during the recession.

But that is changing.

In exit interviews with workers taking jobs in the private sector, over half identified pay as the main or contributing factor in their decision to leave. They also reported their average pay increase in the private sector was substantial, averaging 38 percent.

I know we cannot compete with the private sector on pay alone; but we need to be in the ball park. Over 30 percent of our turnover in 2014 was with workers who had less than two years of service. 57 percent included workers with less than six years.

We don't want to become the training ground for the private sector. It is expensive to train someone in a position, just to see them leave as their skills reach a productive level. Our workload remains high, and we cannot afford to lose talented workers.

We urge your support for the Governor's 3-percent recommendation.

Slide 21:

Next, I want to talk with you about the eligibility services provided to Your Health Idaho, the state's insurance exchange. Undoubtedly you have followed the national news stories about the high cost and low success rates of state insurance exchanges throughout the country.

Congressional research shows that most states that implemented state exchanges have costs climbing well over the hundred million dollar mark.

In November, Idaho implemented our own Insurance Marketplace, doing so at less than half the cost of most states. With just over 2 months under our belt in operations, Idaho has one of the most effectively operating exchanges in the country.

You may wonder why?

Because other states have struggled and even failed due to the complex functionality of their eligibility systems. On this chart, you can see that five states that committed to state exchanges are not operational, primarily because of eligibility system problems. Oregon, after spending more than $200 million, pulled the plug in April because of failed technology and is no longer pursuing a state exchange.

In Idaho, we figured it out.

Our agency's eligibility services are recognized nationwide for being efficient and accurate. Rather than attempt to re-invent this system for the State Exchange, Idaho leveraged its high-functioning eligibility system to include determinations for tax credits. We call this model "Eligibility Shared Services".

As of October 2014 Your Health Idaho was approved for $70 million in federal funds to build its exchange.

The development costs for DHW to provide eligibility shared services for the exchange is expected to total $14 million over a two year period.

Slide 22:

That brings us to our request for receipt authority from Your Health Idaho to cover those development costs, along with ongoing operations. This has been a very pragmatic and successful operation to date. Shared services not only allowed Idaho to implement an exchange quickly, but also ensured that we built Idaho's investment on proven technology, minimizing risk and maximizing functionality.

Throughout this process, we have been extremely careful to meet the legislative intent that no state funds will be used to implement Idaho's Exchange. That was the legislature's direction, and it has been strictly adhered to.

Slide 23:

Your Health Idaho went live on November 15th. Open enrollment was supposed to begin operations on October 1, but was delayed by six weeks. This caused problems and system bottlenecks as brokers and consumers raced to meet the enrollment deadlines.

However, even with the rollout of a newly adapted system and the shortened enrollment period, DHW determined tax credits for almost 95,000 people to date. By sharing eligibility services, Idaho was able to do what no other state accomplished in 2014—we successfully converted from the federal marketplace to our own state exchange.

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Slide 24:

One advantage we are realizing with sharing the same eligibility system is new data we are gleaning. Along with determining tax credits for Your Health Idaho, our system also determines eligibility for public assistance programs that include Medicaid, Food Stamps, cash and child care assistance.

By analyzing system data that takes a global view of participants in each program, we have identified approximately 53,000 people below the poverty limit who are not receiving Medicaid or a tax credit. They are part of the Gap population I spoke to you about last Thursday. I provided you with a map that showed our estimates for each county.

This is the first time we have actually been able to put a human face on who the Gap population are. These are Idaho citizens who have no access or options for healthcare.

Slide 25:

Both our national and state economies are recovering, which is great news. However, the number of Idahoans receiving public assistance remains high, even as unemployment falls.

We believe it goes back to the wages—people are working, but they are not earning a livable wage and they still qualify for public assistance. This chart shows the number of Idaho citizens receiving public assistance through Medicaid, Food Stamps, child care or cash assistance programs.

In 2006, only 14 percent of our state's population received some form of this public assistance. We were at full employment. But then the recession hit. Unemployment reached double digits across our nation.

Like other states, Idaho experienced huge increases in people needing public assistance for their families. No one was exempt; it affected all of us in some way. Our agency is still feeling its effects. In 2014, the percentage of Idahoans receiving public assistance increased to 20 percent.

Slide 26:

This shows a little bit different view. Medicaid is the blue line. It shows a pretty steady increase over the last eight years. Idaho has pretty restrictive eligibility requirements, so much of the increase is in children from low-income households.

Food Stamps, on the other hand, are often considered a barometer of the economy. It is the red line. When we went into the recession, unemployment more than doubled, with Food Stamp enrollment mirroring a similar increase, delayed by several months. People tried to get by, but couldn't without some assistance.

Now as the economy recovers and unemployment drops to near pre-recession numbers, Food Stamp enrollment is declining. But it is not declining at the numbers we might anticipate looking at the historical trend.

Why? Because people are back to work, but they aren't earning a livable wage. They still qualify for Food Stamps. They don't get as much in benefits, but they are still struggling to get by.

Slide 27

The Idaho Department of Labor estimates the number of jobs that pays subsistence wages, so no public assistance is necessary. For a family of four, a subsistence wage in Idaho is estimated at $20.30/hour. If you look at this chart, only 30 percent of Idaho jobs pay subsistence wages for a family of four.

That means 70 percent do not. That percent of Idaho jobs that can support families has been slowly declining due to the recession. This is the reality our programs and workers are dealing with on a daily basis. People are working, but they are not earning enough to meet the basic needs of their families.

Slide 28

With this slide we can see that the need for public assistance varies throughout the state. The lowest use areas are regions 2 and 4. The highest are regions 3 and 5. We have adapted our systems and procedures to handle the increased workload. But we all know the long-term answer is livable wages for Idaho workers.

Gov. Otter's Accelerate Idaho strategic plan sets the course for creating new opportunities for our citizens and communities. I also sense a powerful commitment in this body not only for future economic growth and development, but also in our education system to fuel a vibrant, self-reliant workforce.

We are confident we are on the right path, but it may take some time before the utilization of public assistance services returns to pre-recession levels.

Until then, we will continue to do everything we can to help our citizens achieve self-reliance.

That concludes my presentation. I would be happy to answer any questions.