MINUTES
Approved by the Committee
Healthcare Alternatives for Citizens below 100 percent of Poverty Level
Wednesday, July 20, 2016
9:00 A.M.
Room WW17
Boise, Idaho

Co-chair Senator Hagedorn called the meeting to order at 9:02 a.m.; a silent roll call was taken. Members present: Senators Lodge, Thayn, Guthrie, and Jordan; Co-chair Representative Loertscher and Representatives Boyle, Vander Woude, and Chew; Representative Wood was present via teleconference; Legislative Services Office staff Elizabeth Bowen, Jared Tatro, and Jennifer Kish.

Other attendees: Director Richard "Dick" Armstrong, Kathie Brack - Dept. of Health and Welfare; Tim Olsen - Pacific Source; Fred Birnbaum - Idaho Freedom Foundation; Kelli Brassfield - Idaho Association of Counties; Kendra Knighten, Tammy Perkins - Office of the Governor; Judy Halverson - United Methodist Women; Francoise Cleveland - AARP Idaho; Tamara Masarik - Close the Gap; Mike Wetherell - Statesman Editorial Board; Yvonne Ketchum-Ward - Idaho Primary Care; Toni Lawson - Idaho Hospital Associations; S. Thomas - IAHP; Gayle Woods - Idaho Interfaith Roundtable Against Hunger; Sylvia Charitou - AAUW; Elizabeth Woodruff - IVC; Beth Rader - Select Health; Cory Surber - Saint Alphonsus; Betsy Russell - The Spokesman-Review; Lee Flinn - Idaho Primary Care Association.

Note: presentations and handouts provided by presenters/speakers are posted on the Idaho Legislature website: http://legislature.idaho.gov/sessioninfo/2016/interim/citizenshealth.htm; and copies of those items are on file at the Legislative Services Offices located in the State Capitol.

Co-chair Hagedorn made his opening remarks stating that there was much to discuss before accomplishing the task of the committee's charter which was to bring policy solutions to the legislature. He commented that the Senate members were not as "in the loop" as the House members on issues since proposed legislation never reached them for discussion.

Co-chair Loertscher reported that a couple reasons for the failure of proposed legislation was due to the confusion as to whether the legislature was attempting a full Medicaid expansion and just a general lack of understanding about Medicaid itself by the membership. He explained that Idaho was unique because it already had programs to serve special need groups: the medically indigent program and the Catastrophic (CAT) healthcare fund. He looked forward to discussing the failed proposed legislation and the possible funding mechanisms.

Representative Vander Woude provided a brief summary of the legislation that was proposed last session and the history of each (see Presentation). He summarized that one of the proposed bill's purposes was to permit the Department of Health and Welfare to draft the waivers that would be needed to specialize Idaho's program; and the other proposed bill was to provide $5 million dollars to the health clinics to begin providing basic and primary care as folks were folded into the process, in an effort to get on target in the near future. Ms. Bowen, LSO Senior Legislative Research Analyst, noted that HB 484 was proposed by the governor, HB 644 was the Health Care Grant Program proposed by House members, and HCR 63 was intended to authorize an interim committee to study healthcare for Idahoans in the healthcare "gap".

Co-chair Hagedorn reported on the fact that a health clinic, certified as a federally qualified health clinic, would receive a higher Medicaid reimbursement rate because it was serving individuals known as the Gap population. He questioned why then were there not more clinics trying to

achieve that certification, and maybe the committee needed to schedule someone speak to them about the process.

Senator Thayn commented that there needed to be a discussion about who would be the fiscal agent of the proposed programs--the Department of Health and Welfare or the County Commissioners--and a discussion about the advantages of state versus federal money.

Senator Jordan emphasized the importance of receiving information from the same source so that data were not skewed. Rep. Vander Woude commented that the Department of Health and Welfare had provided the most consistent and most accurate data.

Co-chair Hagedorn asked whether the issue of "what happens first?" had been solved? Rep. Vander Woude explained that the issue was still a problem: the legislature has to give the department permission to negotiate before a waiver may be submitted, but the legislature wanted to provide what should be negotiated.

Co-chair Hagedorn solicited whether there was anyone present that could speak to HB 484 (aka PCAP - Primary Care Access Program)? Jared Tatro, LSO Principal Budget and Policy Analyst, explained that HB 484 would have created an alternative state-run plan which was recommended by the governor and developed by the Department of Health and Welfare. He further added that PCAP was designed to provide increased access to primary and basic healthcare to those in the Gap population, the Gap population defined as those individuals between 0-100% of the federal poverty level, which was estimated to be approximately 78,000 individuals. Mr. Tatro added that the majority of care of this nature would have been done through federally qualified healthcare centers. Funding was budgeted at $19.3 million the first year and $30 million for years two through five of the program to cover the cost of those receiving access to the primary and basic care in that manner.

Co-chair Hagedorn inquired why it was necessary to receive additional funds when such funds were already budgeted? Ms. Yvonne Ketchum-Ward, CEO of the Idaho Primary Care Association, explained that the federally qualified healthcare centers (FQHC) receive a base rate for the work they do; the base rate does not increase whether the clinic serves more or less patients/uninsured patients. She spoke to the fact that no matter what was done during the visit, the clinic receives the base pay which was a national average that was geographically adjusted. This base pay, she continued, does not, however, cover such costs of the clinic such as uninsured patients, people who don't pay their bills, and write-offs or contractual adjustments. She explained that the federal government gives a flat rate every year essentially just to help keep the doors open; health centers bill to Medicaid.

- Co-chair Hagedorn asked whether a federally qualified clinic received the same rate as those that were not federally qualified? Ms. Ketchum-Ward responded that the clinic does not receive the same rate; a normal clinic charges by the service and Medicaid pays a certain fee for each service, whereas a federally qualified clinic charges an average visit fee.
- Senator Guthrie requested of Ms. Ketchum-Ward to confirm the conclusion that clinics would not have received any additional federal money if the PCAP program and its funding had been approved; Ms. Ketchum-Ward agreed with his statement.

Co-chair Loertscher vocalized that there was another drafted bill regarding healthcare that did not make it out of the House State Affairs Committee; this bill would have accessed tobacco settlement money for the use of funding healthcare for individuals. Rep. Wood spoke about the bill referenced, which he had authored. He explained that the idea for his bill was to access the master tobacco settlement money, which this year should be about $13.5 million--by 2025 it should be $25 million as it increases $1-2 million a year and continues "in perpetuity." The purpose of the bill was to divert tobacco settlement money to fund healthcare coverage programs; it was solely a funding bill.

- Senator Guthrie inquired where exactly the money would be diverted from? Rep. Wood explained that 80% of the tobacco settlement money was delegated to the permanent endowment fund, which was not accessible, and 20% of the tobacco settlement money was delegated to the

traditional Millennium Fund; both funds accrue interest. He added that a rolling average was figured (first 12 months of the previous 24 months), and that amount was put into the Millennium Income Fund, which was available any given year at the recommendation by the Millennium Fund Committee to the Joint Finance and Appropriations Committee.

- Co-chair Hagedorn requested that Senator Lodge, who was also the co-chair of the Millennium Fund, further explain the meaning of "in perpetuity" regarding the tobacco settlement money. Senator Lodge clarified that 5% of the money was moved annually for access, and asked whether Mr. Tatro could better explain the funding of "in perpetuity?"
- Mr. Tatro explained that:

  1) $25 million was received from the master settlement agreement: $20 million to the Endowment and $5 million to the Traditional Fund; then, 5% of the first 12 months of the prior 24 months was transferred into the income fund (last year it was about $12 million and next year it should be closer to $14 million);

  2) as for "in perpetuity", the master tobacco settlement had no end date; so as long as folks buy and smoke tobacco products (vaping was not included because it was not tobacco) then funds will be collected, as long as the state follows-up on how the funds were used. There were also no parameters as to how the funds may be used.

  Mr. Tatro added that the state Millennium Fund maintains approximately $25 million a year; the Endowment Fund was now at approximately $250 million and the Traditional Millennium Fund at approximately $29 million.
- Co-chair Hagedorn asked how the Endowment Funds were used? Mr. Tatro explained that the Endowment Fund was constitutionally protected so that the state would only use the interest from such fund; hence the 5% of the first 12 months of the previous 24 months was made available to the spending fund each year.

Co-chair Hagedorn questioned Rep. Vander Woude about the discussions of HB 484. Rep. Vander Woude explained that there was caucusing with the members about the bill but the bill did not formally come to the Health & Welfare committee.

Co-chair Hagedorn shared that the proposed bills from the Senate were: SB 1204 which proposed to expand Medicaid for those below 138% of poverty level; and SB 1205 which proposed to expand Medicaid for those below 100% of poverty level. He reported that both bills were printed and hearings were held on both, but neither bill made it out of committee.

- In regards to the financial statement for those bills, Senator Jordan inquired whether such state costs to fund such proposals could be mitigated by the savings to the counties? Co-chair Loertscher explained that such a process was very complicated because levies were limited and to change those one would need to legislatively change those limits. Senator Jordan emphasized that she was requesting to study how those funds *could be* moved and whether it would be effective. Ms. Bowen suggested that LSO could look at such information and provide some hypothetical situations at the next meeting.
- Senator Guthrie requested that fiscal notes be more detailed to summarize multiple categories such as federal money to be provided, state money to be expended, or savings to counties, because doing so would provide a better overall picture.
- Rep. Vander Woude added that information regarding how the proposed bill would save the county "X" amount of funds would also be a helpful piece of information. He also reminded the committee that the legislature had permitted LSO to provide fiscal notes on a trial basis; maybe these recent requests could be worked into the process and systematically formatted for each bill.

Co-chair Hagedorn explained that the Senate amendment to HB 644 was essentially the "Hail Mary Radiator Cap" which passed the Senate but died in the House.

Senator Thayn requested an opportunity to present how items were billed by providers and what tools could be used to reduce costs. Senator Lodge agreed with Senator Thayn as it seemed that costs were way above what was necessary.

At 10:15, Co-chair Hagedorn then asked the committee to take a short break and allow Director Armstrong to set up for his presentation.

After the break, Co-chair Hagedorn called upon Director Dick Armstrong, Department of Health and Welfare, for his presentation "A History of Alternative Healthcare Plans in Idaho." Director Armstrong explained how a work group was authorized by the governor in 2012 to study possibilities for coverage of the adult population commonly known now as the 'Gap population', and what types of individuals comprise that population; an additional work group was authorized in 2014 that proposed a hybrid model of the original ideas for coverage to low-income individuals. The director testifies that the hybrid model, Healthy Idaho, brought about the need for federal waivers (aka a demonstration waiver) which was a 3 to 5 year, revenue neutral plan requested by a state. He reported that 19 states had not expanded Medicaid. Most states reported larger numbers of enrollees into their programs than expected, whereas Idaho was well on target with their expectations of enrollees.

Director Armstrong identified two (2) sub-populations that may need further study due to their expected return to healthcare programs: indigent/CAT (Catastrophic Health Care) individuals and probationers/parolees. He explained that indigent/CAT individuals often return to/remain in programs because they have chronic diseases which are not cured at the first treatment. Programs do not provide for follow-up care to maintain the efforts of the initial visit, and hence, individuals often return with more severe symptoms. For probationers/parolees, immediate and continued care was given while the individual was incarcerated, but once the individual was released, care was not provided. He cited that the WICHE Justice Reinvestment Analysis on Behavioral Health reported that 80% of such individuals have some type of a behavioral health issue which often leads to physical health issues. Director Armstrong suggested that consideration be given for additional monies to be assigned to individuals for follow-up care, possibly for a 2 to 3 year commitment to ensure that the effort of the initial work not be lost.

- Rep. Vander Woude asked whether Director Armstrong would consider a separate program to reach probationers and parolees? Director Armstrong explained that, yes, he would; he would budget the monies, approach healthcare partners (Department of Correction (DOC), law enforcement--who has oversight of the individuals, etc.), and outline the limits of care that would be provided. He further stated that the department would not propose the program to be part of Medicaid, it would be a state program. Rep. Vander Woude then asked whether the savings from other programs that the director spoke of earlier could be used to fund this new program? Director Armstrong responded that it may be possible but it would be indirect; savings from other programs was difficult to forecast and would fluctuate.
- Co-chair Hagedorn asked the director to confirm an earlier statement about 80% of the those on parole or probation as having a health issue. Director Armstrong explained that per the WICHE report (discussed in his presentation) 80% of inmates were diagnosed with mental health or substance issues and most of those issues lead to additional physical issues. The director further added that 95% of probationers/parolees were in the Gap population. Co-chair Hagedorn inquired whether states had to get a federal waiver to cover this prison population on their programs? Director Armstrong replied that the 31 states that expanded Medicaid did not have to do that because it was part of their expansion.
- Senator Lodge requested that the members of the committee receive a copy of the WICHE report referenced in Director Armstrong's presentation.
- Senator Guthrie requested an explanation of how a waiver request operates in regards to sideboards, legislative permission, and the Center for Medical Services' (CMS) approval? Director

Armstrong explained that the sideboards were a big factor to approval; it is necessary to realistically define what was desired to be accomplished. He added that CMS has been very helpful with feedback. He countered that the CMS does not grant waiver approval without the legislature's authorization of the department to move forward with a waiver's submission. Senator Guthrie queried whether HB 644a would have given the department the authority to create and submit waivers to CMS? Director Armstrong stated that it would have. He also voiced the fact that, after an approval of a waiver, the authority remains with the legislature because ultimately funds have to be budgeted/appropriated for such a program and that such power resides with the legislature.

- Co-chair Hagedorn asked the director to explain the ramifications with CMS if the funding for a program was not allocated after a waiver's approval? Director Armstrong cited that the request simply dies for lack of support; CMS has no power to make the legislature or the department do anything.
- Senator Lodge requested the director to identify the age range of the Gap population. Director Armstrong explained that it was predominately between the ages of 18 and 40, mostly with kids. Senator Lodge thanked the director for breaking out the data regarding where the Gap population was employed. She then asked him to further explain how these individuals were employed by education and military and were still found to be in the Gap population? The director explained that such individuals in education were only part-time, and those in the military may be of a lower rank and hence a lower pay scale and additionally have large families. He also commented that many employers were often offering only 25 hours of work and so many individuals worked multiple jobs. Director Armstrong observed that the majority of these jobs were service/retail related and the need for them would never go away; even by offering a higher wage, the jobs still need to be done by someone for society's operation.
- Senator Jordan asked whether information was available to identify the quantity of individuals that would fall out of the Gap population if the minimum wage was increased? She also asked if day care was offered for the stay-at-home parents would that likewise affect the number of individuals in that category? Director Armstrong felt that the best information he could provide would be tiers of income for folks at those jobs. He also observed that these groups have a high mobility (approximately 75% new faces) and were in/out of eligibility even monthly (estimating that those below 100% poverty = less than $1000/month) and so numbers were hard to track.
- Co-chair Hagedorn commented that he knew of a single parent who epitomized a Gap individual because she was working ($11/hour), had subsidized child care, and still could not qualify for healthcare. Co-chair Hagedorn asked if information from the SNAP (Supplemental Nutritional Assistance Program) could be cross-referenced with this data to have a better understanding of who those individuals were? Director Armstrong said that it could be done.
- Rep. Chew asked the director to identify what percentage of the 43% that return to prison do so indirectly because of the lack of healthcare? Director Armstrong said that he could not identify that number, but there was quite a bit of information in the WICHE report that may answer the request.
- Rep. Vander Woude wondered if the same percentage of individuals cycled in/out of the SNAP program as did the Medicaid Gap program? Director Armstrong responded that such percentages were similar: about 70% cycled out, about 25% cycled in/out multiple times, and about 4% never left.
- Rep. Vander Woude asked if the director would provide his perspective on the failure/success of PCAP? Director Armstrong professed that he felt it was a good plan but he lost support along the way; it didn't solve counties' problems, it didn't solve hospitals' problems, and it didn't solve problems for the Idaho Medical Association. He confessed that it lacked solutions to the costs that everyone was bearing. He felt that it was a good starting point to provide basic and primary

care to a lot of people, including some behavioral health. In addition, he noted that the $30 million price tag was a problem once other items were competing for the same pool of money.

- Senator Guthrie questioned whether the director expected the committee's work to be a catalyst to retool Medicaid and move it toward a managed model to cover the Gap population? Director Armstrong replied that he felt very strongly about moving the program to convert Medicaid payment into a value-based proposition. He explained that this was the trend with many other states because it worked best, as well as the fact that the federal program itself was moving towards the value-based model. The confusion and complexity of the frequency/utilization model was good to a point, but it has been too frustrating; and the unit price model has gone as low as it could without losing providers because it wasn't cost effective.
- Senator Guthrie then asked whether the director saw these efforts as separate programs--Medicaid population and the Gap population--or tied together? Director Armstrong explained that he saw the programs as separate; and the department has the authority to do such via HB 260 [2011, Ch. 164] to transition the system to alternative payments for the existing Medicaid population.
- Co-chair Hagedorn asked whether the director, by authority of HB 260, was currently in negotiations with CMS to change the Medicaid delivery system? Director Armstrong responded "no" and explained that was because no waiver had to be submitted as it was simply a change of the state plan, which the department already had the power to do. He felt that Idaho would probably always have a hybrid system due to its rural nature; whereas CMS was really built for an east coast/more urban model.
- Senator Thayn asked the director to name some of the more prevalent chronic conditions that individuals of the Gap population possessed. Director Armstrong listed diabetes, mental illnesses, congestive heart failure, and cardiovascular and pulmonary diseases. He also commented that many individuals possessed multiple conditions. Senator Thayn then asked what percentage of the 78,000 individuals in the Gap population possessed these chronic illnesses? Director Armstrong responded that he could not identify that number as it was not data he had tried to extrapolate. In truth, he acknowledged that the only health data the department had access to was for those in the CAT program and that group was only about 4,000-6,000 of the 78,000. Director Armstrong asked Ms. Yvonne Ketchum-Ward, who was in the audience, if she could report any data based on her experience with the Community Health Centers. Ms. Ketchum-Ward could not access such information at the time.
- Co-chair Hagedorn requested that Ms. Ketchum-Ward be scheduled to speak at a future committee meeting on how her program worked and statistics on the population she served. He made an additional request to Director Armstrong to have information/reports from previous meetings with Lori Wolf about SNAP be distributed to committee members as additional reference material.
- Senator Thayn asked what efforts the director had installed to engage patients in the need to hold down medical costs? Director Armstrong responded that compliance was a huge part of the effort. He explained that through the department's pilot program it was discovered that when individuals have knowledge of available, planned care that it was used; but most places in Idaho don't have a medical clinic available, and so folks go to emergencies because the problem was so severe or it was the only known place to go. The program also discovered that specialty services were underserved in the state by the lack of providers; and that low-income folks were complacent with basic/general care received because they cannot justify the cost of a specialist.
- Co-chair Hagedorn asked whether data was available on those who were turned down after applying for assistance through the indigent fund and whether such information was useful? Director Armstrong responded that 60% of applications were denied and that such information could possibly be available at the county level. Co-chair Loertscher provided that such information/data was kept by the counties because it was required to be kept.

- Director Armstrong then answered the earlier asked question regarding what percentage of those in the Gap population had chronic diseases: a 2012 Gallup pole reported that 52% of those in poverty were more likely to have a chronic disease.

Co-chair Hagedorn thanked the director for his time and information and then called on the committee for comments and suggestions.

- Senator Guthrie offered that he would like to see the committee get busy making policy and not get bogged down in gathering data.
- Co-chair Loertscher commented that he would like to see information on what other states have done--successfully and not so successfully.
- Co-chair Hagedorn emphasized that the directive of the committee's charter was to provide policy to the legislature for the next session. He also noted that it was important for the committee to provide more than one policy solution because, due to election results, the ACA (Affordable Care Act) requirements could be changed.
- Rep. Boyle stated that she wanted to hear the process of switching a normal health clinic to a federally qualified health clinic; possibly inviting Dr. [Ted] Epperly to speak about the process as he did such for the clinic in her district town of Council. Senator Thayn agreed with Rep. Boyle's request, and he commented that there was also such a clinic in Challis now.
- Senator Lodge commented on the fact the committee could be influencing society's perception of what was the "norm" in regard to health care. She recognized that individuals should accept responsibility for themselves by making better choices about employment opportunities and not using welfare programs as a "norm" to maintain a lifestyle. She lamented how an individual with a chronic disease--which was uncontrollable--may not get assistance or viable employment. She urged the committee to consider policy that would influence not just healthcare but teaching personal health lifestyles.
- Senator Guthrie recognized that today was somewhat of an "organization day" but suggested that the committee consider meeting for longer durations in the future.
- Rep. Chew requested that there be an opportunity for community to testify or share their ideas/experience with the committee.
- Senator Jordan proffered these requests: 1) study the Montana program as it seemed to expose some unexpected numbers/results beyond the predictions; 2) receive further explanation of requirements in negotiation with CMS on waivers; 3) have access to a spreadsheet for the allocation of tobacco funds; and 4) study if minimum wage increases would influence/affect Gap population numbers for healthcare.

Co-chair Hagedorn suggested that the committee aim to meet every three (3) weeks and suggested a full-day meeting for the week of August 8th with an agenda to be forthcoming.

At 12:07, Co-chair Hagedorn adjourned the meeting.