

**MINUTES**  
**Approved by the Committee**  
**Healthcare Alternatives for Citizens below 100 percent of Poverty Level**  
**Thursday, August 11, 2016**  
**9:00 AM MDT**  
**State Capitol, Room EW42**  
**Boise, Idaho**

Co-chair Representative Loertscher called the meeting to order at 9:00 a.m.; a silent roll call was taken. Members present: Representatives Wood, Boyle, Vander Woude, and Chew; Co-chair Senator Hagedorn and Senators Lodge, Thayn, Guthrie, and Jordan; Legislative Services Offices staff: Elizabeth Bowen, Jared Tatro, and Jackie Gunn.

Other attendees: Kelli Brassfield - Idaho Assoc. of Counties; Yvonne Ketchum-Ward, Lee Flinn - Idaho Primary Care Assoc.; Geoffrey Ward; Heidi Traylor - Terry Reilly Health Services; Toni Lawson, Brian Whitlock - Idaho Hospital Assoc.; Kathie Garrett - Idaho Federation of Families; Tim Olson, Norm Varin - Pacific Source Health Plans; Elwood Kleaver - Conex; Erin Russell - United Health Group; Ron and Sharon Oberleiten; Jennifer Poole - American Cancer Society Cancer Action Network; James Turner - Living Independence Network Corporation; Tari Fife; Corey Surber - Saint Alphonsus; Dr. John Livingston - Idaho Freedom Foundation; Neva Santos - Idaho Academy of Family Physicians; Graham Paterson - Idaho Oral Health Assoc.; Jim Baugh - Disability Rights Idaho; Lauren Necochea - Idaho Voice for Children; Bill Roden - Select Health, Delta Dental; Sharon Hawkins - Idaho Assoc. of Commerce & Industry; Françoise Cleveland - AARP Idaho; Kris Hooker - American Assoc. of United Women; Kristen Binda; Colby Cameron - Sullivan & Reberger; Teresa Molitor - Molitor & Associates, LLC; Dr. Ted Epperly - Family Medicine Residency of Idaho; Tabby Jolley; Tim Heinze - Valley Family Health Care; Judy Cross - Interfaith Alliance of Idaho; Larry Maneely - Ada County; Scott Kreiling - Regence BlueShield; D. Necochea; Mike Reynoldson - Blue Cross of Idaho; Carrie Foster - Lobby Idaho; Dr. Darin Lee - VP of Medical Affairs, St. Alphonsus Hospital; Peter Lichtenstein - Idaho Interfaith Roundtable on Hunger; Susie Pouliot - Idaho Medical Assoc.; Alex Livingston, Tyson White - KTVB.

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 Loertscher brings the first item of the agenda: approval of the minutes from the July 20 meeting. Senator Thayn makes a motion to accept the minutes of July 20th with corrections; Senator Jordan seconds the motion. All vote in favor of the motion by voice vote.

Co-chair Loertscher invites Yvonne Ketchum-Ward, CEO of the Idaho Primary Care Association, to the podium for her [presentation](#) on Idaho's Community Health Centers. Ms. Ketchum-Ward described the uniqueness of a Federally Qualified Health Center (FQHC). Highlighted/additional information from her slides:

- Requirements of a FQHC program (outlined five but there existed 14 more).
- How payment was received - not based on number of uninsured patients (Medicare pays one base rate for all centers of Idaho, Medicaid pays base rate per health center).
- 50% of patients below 100% federal poverty level (FPL); 20% between 101% and 200%; and 25% "unknown" because often self-pay or insured.
- Health centers were community-based non-profit organizations - private practice would have to become such to become a FQHC.
- Service was focused on preventive and basic care, not emergency, advanced, or specialized care.
- Federal government considers location and population when granting qualification.

Upon completion of her presentation, Ms. Ketchum-Ward answered these questions from the committee members:

- Rep. Chew asked whether the providers of a health center were able to provide referrals for specialized care, such as mental health, when diagnosed during a normal visit? Ms. Ketchum-Ward responded that it was a challenge to find low-cost or pro bono services of such when a patient's needs were identified, because most often a patient does not have the money to follow through on such tertiary care.
- Rep. Chew then asked whether such advanced care needs would not be addressed by health center providers? Ms. Ketchum-Ward replied that the provider would most certainly attempt to address the issue.

Heidi Traylor then approached the podium to continue the [presentation](#) [page 14] from her perspective as CEO of the Terry Reilly health services, which provides medical, dental, and mental health services. Ms. Traylor explained the difference between a community health center (CHC), which she defined as the business, and a patient centered medical home (PCMH), which she defined as the service model. She emphasized the fact that 70% of her board was comprised of patients who were direct members of the community and who provide feedback.

- Senator Jordan asked Ms. Traylor, in relation to slide #19, what was the fourth possible type of federal funding that a center could receive? Ms. Traylor responded that the fourth type was public housing, where a center would be operated in a public housing building, which Terry Reilly does not do.

Ms. Traylor continued with her diagram of Terry Reilly's uninsured patients (56%) as compared to the national average (34.9%). She explained the services that were included during visits: depression screening (even in dental visits), diabetic/hypertension tendencies, weight assessment, and tobacco use intervention.

- Senator Thayne asked Ms. Traylor how she would use one million dollars for patients with chronic health conditions? Ms. Traylor replied that she would focus on telehealth for rural areas, such as Marsing, Melba, Middleton, and Homedale (stating that a telehealth clinic costs approximately \$30,000 to establish). She would also hire more care managers for tasks outside the exam rooms, such as health education, paperwork, etc. And finally, she suggested that she could use it to build more clinics in underserved communities, but that would use a huge portion of the one million dollars since it takes approximately \$750,000 to build a clinic.
- Senator Jordan requested Ms. Traylor provide more detail on how Medicare/Medicaid made payments based on outcomes of care. Ms. Traylor responded that it was different for both and also continually evolving; currently Terry Reilly receives payment based on the "fee-for-service" model. She added that, depending on the provider, Terry Reilly may also receive a per member per month (PMPM) fee, which was an additional revenue that helped with the expenses of a PCMH. She explained that another type of payment may be based on the severity of illnesses within one's clinic. Senator Jordan then inquired whether Ms. Traylor could identify a couple methods that stand out as better than others? Ms. Traylor identified the fee-for-service model and the PMPM model; explaining that the first method covers the baseline cost of medical care and the PMPM then helps cover the extra follow-up services that were needed in addition to the initial visit.
- Senator Guthrie inquired whether Ms. Traylor saw herself as a gatekeeper to patients for care and, hence, policy? Ms. Traylor replied that CHCs were at the root of the same issue that the committee was trying to solve: how to help people get the care needed. She stated that she would like very much to be part of the policy creating process.
- Rep. Vander Woude asked Ms. Traylor to identify a method or policy to provide follow-up care to the individuals that were underinsured/uninsured? Ms. Traylor explained that her PCMH has "registries" that track patients based on disease states; this provides benchmarks where

the patients should be within their care or what type of follow-up should be prescribed. She lamented that the barrier to meeting the benchmarks was due to not having the manpower to make the follow-up calls to the patients, to file the necessary paperwork, or to make home visits, etc. She proposed that the efforts of a service such as Terry Reilly could reduce the amount of non-emergent 911 service calls made, if individuals had better access to preventive care or were more knowledgeable about the services in their area.

- Rep. Vander Woude asked whether Ms. Traylor felt that Terry Reilly services were proceeding toward providing additional staffing? Ms. Traylor responded that she absolutely was trying to move the services in that direction - one grant at a time, one donation at a time, one fundraiser at a time - but it was difficult to ensure a steady service for such reasons. Rep. Vander Woude then inquired whether Ms. Traylor had an estimate as to the cost to provide these consistent services? Ms. Traylor replied that she had not.

Co-chair Hagedorn commented that he had recently visited a Terry Reilly clinic and was very impressed with the model. He encouraged the other committee members to also make a visit.

At 10:06 a.m., the committee moved to the next speaker on the agenda: Alex Porteous, Deputy Commissioner of Finance for the Maine Department of Health and Human Services. Mr. Porteous joined the committee by telephone for his presentation [Review and Discussion of MaineCare Expansion](#). Mr. Porteous explained that MaineCare was the state of Maine's Medicaid expansion program and this presentation would outline how Maine got where it was and how it was faring as compared to other states.

- Rep. Wood asked Mr. Porteous to comment on the MaineCare payment methodology: was it at-risk contracting, a fee-for-service process, or a combination of both? Mr. Porteous explained that it was primarily a fee-for-service, but also employed at-risk contracts to complement some services.
- Co-chair Loertscher inquired whether other states were moving to a value-based model or keeping the fee-for-service method? Mr. Porteous theorized that most were moving toward value-based models.
- Co-chair Hagedorn asked whether Maine had a catastrophic care fund? Mr. Porteous stated that it did not have such a contingency fund; hence, any cost overruns came to the state and it was responsible for paying the overages. He noted that Maine traditionally overran its Medicare fund each spring by \$50-100 million.
- Co-chair Hagedorn asked Mr. Porteous to identify the population of Maine and how many Mainers were on the Medicaid program? Mr. Porteous answered that, of the 1.3 million individuals in Maine, approximately 275,000 were on Medicaid (in comparison, in 2002 with the same population there were 190,000 on Medicaid.) He noted that Maine had removed childless, able-bodied adults and parents who were over 100% of FPL from its Medicaid program in 2011.
- Senator Guthrie questioned whether, in other states' attempts to cover those in the "gap," why did the numbers get so much larger? Mr. Porteous explained that most often the state budget shortfalls were attributed to increased Medicaid costs and poor predictions on the number of individuals needing coverage. He added that additional administrative costs were incurred because of the larger numbers of participants. Mr. Porteous noted that most states were receiving 100% match, so it was difficult to truly pinpoint where overruns were. He added that other states were starting the sliding match, so numbers were difficult to adjust for every year.
- Senator Guthrie then inquired whether research or data had identified any offset areas/items that would no longer be needed due to the new type of coverage? Mr. Porteous reported that there had been much discussion on that topic after using data from Manatt; but overall, the Maine Legislature did not see any realistic savings, which was attributed to the fact that Manatt did not truly understand the makeup of Maine.

- Senator Jordan asked, in reference to slide #8, what was the source of the research that reported states had underestimated the population needing coverage and when were the estimates provided? Mr. Porteous explained that Maine typically used the Foundation for Governmental Accountability for predicting enrollments and overruns. He theorized that, when states missed the estimates, it was because much of the parent population was very fluid in the category of 100-138% FPL; at one point individuals were eligible for subsidies and then, with an expansion of Medicaid, they were eligible for free coverage, so the numbers move. He stated that he could not speak to the reasons or sources of the other states.
- Senator Jordan inquired whether Mr. Porteous noted any commonalities in those states that were most accurate in their predictions? Mr. Porteous responded that he could not identify any commonalities; in truth, of the 17 states that expanded and publicly released projections, they all reported overruns.
- Senator Jordan then queried whether the reported losses in general funds were entirely due to increases in medical coverage and care? Mr. Porteous reported that it was not only the increased spending on healthcare coverage - such as in Vermont - but it was also the reduction in commodities and an unstable economy within the state - such as in North Dakota, Alaska, and New Mexico. He also noted that Connecticut was unique in that it continually has had a shortfall in tax revenue.
- Rep. Wood asked Mr. Porteous to identify the number of individuals not insured in Maine, how those individuals accessed healthcare, and who paid for such healthcare? Mr. Porteous responded that he did not know the exact number at the moment.
- Rep. Chew requested Mr. Porteous to describe Maine's indigent and Medicaid before its expansion? Mr. Porteous reported that Maine currently had 275,000 individuals on Medicaid and before expansion the number was 354,000.

Co-chair Loertscher thanked Mr. Porteous for his time and information.

At 10:48 a.m., the committee welcomed Dr. Erica Bliss by telephone to provide her comments, along with her submitted [presentation](#) of the Qliance program. She explained that Qliance was a direct primary care organization based in Seattle, Washington, and that she was a family physician, as well as, the CEO of the company. Highlighted/additional information from her presentation:

- Described the concept of direct primary care (DPC) to be lower-cost; combination of prevention, maintenance, and management of healthcare issues; values relationships with the patient.
- Commented that the fee-for-service models were inefficient to direct primary care, as that model succeeds on the volume of patients seen and the number of services performed, rather than the value of the visit.
- Qliance model was a DPC that was funded by a periodic fee (essentially a membership), which allows unrestricted access to primary care.
- Reported that the incentive as a provider was to work with the patient to get and keep them healthy, and hence, not need a visit; this eventually allows providers to visit with more needy patients, while still maintaining the healthy ones.
- Observed that the concept of health insurance was distorted, essentially it was just a payment method; whereas, in other types of insurance (auto, home, etc.), one chooses the level and areas that one wants to protect against.
- Qliance model offers a comprehensive set of services for a flat fee (approximately \$100/month + access fee).
- Providers were not incentivized to see more patients; actually there existed a patient quota of 800-1,000; whereas, the fee-for-service often needed a 3,000 patient quota.

- Qliance made services available seven days a week and had after-hour clinicians.
  - Reported that Qliance operated its own clinics and had added telehealth services this year.
  - Qliance used its own proprietary IT platform, which was compatible with other healthcare carriers, purchasers, etc.
  - Qliance had outperformed other Washington state PCPs, as supported by testimonies and surveys of its customers.
- In regards to slide #2, Co-chair Hagedorn asked whether the administrative function was missing? Dr. Bliss responded that the program had minimal administrative functions after the initial set-up, because the billing occurred automatically.
  - Co-chair Hagedorn inquired whether the Qliance DPC model was in rural areas? Dr. Bliss reported that though it did not have clinic facilities in rural areas, Qliance had patients within the rural areas. She noted that it was still cumbersome to cover expenses in locating clinics to rural areas, and that transportation was a continual barrier to patients seeking service.
  - Co-chair Hagedorn wondered, in regard to the limits on patients per provider and the monthly fee collected, whether Qliance had a minimum number of doctors per clinic to keep a clinic profitable? Dr. Bliss responded that such a quota was flexible per clinic. She explained that a clinic often started out by renting space from an established clinic; then, once a profit margin was attained, a new facility would be acquired or expanded into by Qliance providers.
  - Co-chair Hagedorn inquired how patients paid for specialists or other providers outside of the monthly fee? Dr. Bliss explained that Qliance starts by working with the patient's insurance to negotiate the service under the patient's coverage or negotiate a discount rate for cash payment. She added that Qliance also helps them find assistance with other types of community services.
  - Rep. Vander Woude asked where Qliance got the information regarding who was eligible for Medicaid and who paid the flat fee? Dr. Bliss explained that Qliance negotiated a price with the plan providers, so there existed different fees for different types of patients. She reported that Qliance also had a small savings plan, as allowed under Washington rules. She added that any Medicaid enrollee must choose the plan he/she wants, an enrollee can not be assigned to a primary provider arbitrarily.
  - Rep. Vander Woude then inquired who would pay for individuals on Medicaid who were unable to pay the monthly fee? Dr. Bliss explained that the plan had been negotiated to pay the full amount and the patient has no payment under the Medicaid plan in Washington.
  - Senator Thayn asked whether Dr. Bliss could identify the reduction in healthcare costs for those with chronic health conditions? Dr. Bliss commented that it was difficult to study and label such a percentage, because when issues were caught in primary care the cost was not seen in advanced or emergent care; she predicted that the savings for that group would be larger than the identified 20% of the normal population, because there would be less referrals to specialists and the more advanced care expense.
  - Senator Lodge inquired as to the difficulties that Qliance had in recruiting healthcare professionals to its program, and what was the turnover rate of such professionals? Dr. Bliss reported that Qliance had no difficulties in attaining healthcare staff; in truth, its recruiting was very passive. She felt that staff were easily attracted to the model, as it allowed them to be the kind of professional originally intended, where the provider was able to spend quality time with patients and build a relationship; it was also seen as a benefit having a known/limited work load so there was not as much "burnout." She predicted that the model could easily be adapted to more rural areas when supported; but, she noted that a key concept to a rural clinic's success was having professionals with a background in rural service, much like the WWAMI program provides

to its students. [WWAMI-Washington, Wyoming, Alaska, Montana, Idaho alliance regional medical training program.]

- Rep. Chew, in reference to slide #5, questioned why there was a significant cost reduction in the category of *Specialist Visits* while the actual number of visits was decreased by only 10%? Dr. Bliss explained that in that data all types of specialists (physical therapy, oncologists, surgeons, etc.) were lumped together. She suggested that it could be studied better in order to identify the different types of services. She theorized that the cost of the service was less because of the type of specialists that were being engaged; if more physical therapy (a low-cost treatment) was prescribed, then there would, in theory, be less surgeries (a high-cost treatment) needed.
- Rep. Chew asked whether Dr. Bliss could share any of her experiences that would help Idaho enhance its efforts at closing the "gap?" Dr. Bliss identified the following items on which Idaho should focus: consider primary care and advanced care as two different levels/programs; compare the relationship of public health, primary care, and advanced care; and, study the funding of primary care for everyone, and leaving advanced care to private insurance choices. Rep. Chew then inquired how Dr. Bliss would recommend incorporating public health into the model? Dr. Bliss noted that public health was not her speciality, but she could theorize that primary care and public health were very much intertwined at the base of a community, much more than advanced care was related to either.

Co-chair Loertscher thanked Dr. Bliss for her time and her presentation.

At 11:55 a.m., the committee called upon Dr. Ted Epperly, a practicing physician and the Chairman of the Idaho Healthcare Coalition (IDC), for his presentation [Idaho's Evolving Healthcare System: The Importance of Both Coverage and Delivery](#). Dr. Epperly's emphasized the fact that patients need some type of insurance and need access to care. He expounded that the basic steps toward a healthy community were: having timely access to care, trusting the care and advice, committing to necessary changes in behavior for better health, and decreasing the need for advanced healthcare beyond basic maintenance. Highlighted/additional information from the presentation:

- SHIP (State Healthcare Innovation Program) - \$40 million federal grant supervised by the Idaho Department of Health and Welfare; program run/accountable by Idaho Healthcare Coalition.
- Public health should become more than water sanitization and immunization; more about Hygeia (prevention of disease) than Asclepius (treatment of disease).
- MACRA (Medicare Access and CHIP Reauthorization Act) - new Medicare pay system (adopted April 2015, final rule expected this fall); no longer fee-for-service focus; first data collection targeted 2017, first payments targeted 2019.
- Co-chair Loertscher inquired whether HIPAA (Health Insurance Portability and Accountability Act of 1996) was a problem in attempts to share data across providers? Dr. Epperly responded that HIPAA was a hindrance, but it was necessary to comply. He believed that technology existed to overcome those hindrances. He also felt that the younger generations were not as sensitive to these established levels of privacy.
- Senator Guthrie commented that he would like Dr. Epperly to be "at the table" and be aggressively involved in policy development. Senator Guthrie then asked what funding model would take place when the SHIP grant expired? Dr. Epperly stated that he would like to see the shared savings of programs (approximately 50%) be returned to the practices as incentive to continue in their efforts and goals; and then the remainder of the savings (approximately 50%) be distributed to regional collaboratives to continue in their efforts and goals. He felt that the role at IHC in year 2 of the grant was to have more discussion about the sustainability of a model.
- Co-chair Hagedorn commented that the process of incentivizing patients and providers to "buy in" was the desired model with which to move forward, and he felt that the SHIP model best fit Idaho. He then asked Dr. Epperly how MACRA would impact the SHIP model? Dr. Epperly

responded that MACRA would be beneficial to the SHIP model; it would serve as a catalyst in the evolution of the payment system. He reported that CMS, Medicaid, and Medicare (the largest system of payers) want one-third of the payment model to be value-based as of this year and one-half of systems by 2018. He theorized that primary care was best served by the value-based model; however, sub-specialist/advanced care may need to stay a fee-for-service model.

- Co-chair Hagedorn asked who was the target patient with the SHIP program and how could the "gap" population be incorporated into that established target? Dr. Epperly answered that SHIP was for all Idahoans; those in the "gap" population were the ones who did not have a place to get the usual care that was available to them.
- In reference to slide #3, Senator Guthrie inquired whether Kentucky, Arkansas, and Texas were at the same level when they began? Dr. Epperly responded that he did not know the starting baseline level.
- Senator Lodge wondered how to encourage individuals to care for themselves? Dr. Epperly commented that most people want to better care for themselves; however, they may not know how to or where to get assistance to learn. Dr. Epperly proposed the possibility of encouragement by rewarding those who do improve their behaviors for better health through insurance incentives, such as offering a lower copay or a refund at the end of year for less claims on the policy. He also wondered how the providers might reward their patients for better behavior.
- Senator Lodge commented that such a problem existed in the food stamp program where individuals were not rewarded for making better food choices with those funds. Dr. Epperly noted that such a situation was referred to as the "social determinates of health." He observed that issues that determined an individual's health were influenced by the health system by only 10%, the remaining 90% was influenced directly/indirectly by their other needs: diet, exercise, transportation, safety, housing, etc. Dr. Epperly suggested that the best way he could combat behavior was with the relationship he builds as a physician with his patients; he created connections to other community services so that his patient could access additional avenues for better health. He reported that he was working to have the Idaho food bank located in a clinic where a nutritionist could work with the patient while at the original appointment. He acknowledged, however, that the billing system does not encourage physicians/clinics to provide this type of benefit.
- Senator Jordan asked whether Dr. Epperly witnessed reductions to the prescriptive drug addictions as the delivery systems changed? Dr. Epperly commented that he had. He reported that his clinic keeps a registry of chronic pain patients; patients were engaged in a contract of care and agreed to meet the requirements of the contract: no doctor shopping, no refills before the agreed date, take urine drug tests, etc. He theorized that in this manner the providers then could build that relationship and assist patients to find solutions without patients feeling the need to bounce to other providers.

Co-chair Loertscher thanked Dr. Epperly for his service and his enlightening presentation, and then recessed the meeting for lunch.

At 2:05 p.m., the committee was called to order. Co-chair Loertscher called Ms. Lauren Necochea, Director of Idaho Voices for Children, to the podium for her presentation [Understanding the Coverage Gap in Idaho](#). Ms. Necochea explained that Idaho Voices for Children was part of a larger coalition known as *Close the Gap*; she commented that she was only representing her organization in today's presentation. She had distributed a handout to the members, which she referred to as a [Chart Book](#), from which many of her slides were pulled. Highlighted/additional information from the presentation:

- Chart Book, page 19, used January 2016 updates from Milliman and projected over the next five years.
- Montana recently passed legislation for better coverage of veterans.

Ms. Necochea then introduced Dr. Darin Lee, an emergency room physician for 12 years. Dr. Lee shared some of his experiences while serving in the ER and interacting with uninsured patients. He commented that he has worked with Mercy Room at Boise's Saint Alphonsus Trauma Center, Community Hospital in Nampa, and the West Valley Medical Center ER. He reported that 1 in 5 patients that he tended to in the ER was uninsured. Dr. Lee expressed concern that these patients would not follow-up for additional care. He had witnessed legal documents where patients had to file for bankruptcy after medical care. He commented how sad it was that folks want help but they know it may ruin them financially and, hence, may not come in for the help they needed. Dr. Lee also discussed how he sees patients who did not have emergent needs but rather chronic, painful conditions (such as a hernia, a torn rotator cuff, or gall stones) that were considered elective, and so were not covered.

- Co-chair Hagedorn inquired whether it was Saint Alphonsus' policy to refer uninsured patients to community health centers? Dr. Lee responded that he was not sure it was policy, but he personally refers patients to services like Terry Riley clinics, free clinics, or community centers. He noted that even those services were overwhelmed and had a backlog in scheduling patients.
- Co-chair Hagedorn then asked whether there was a way in which the emergency rooms could educate staff about the services of health centers and commit to working cohesively to reduce patients' costs? Dr. Lee replied that he did work very closely with the Terry Rielly clinics, but noted that the service was not free and so was still a burden to the patient.

Seeing no more questions for the presenters, Co-chair Loertscher called upon LSO staff members Elizabeth Bowen and Jarod Tatro to present the information requested of them during the July 20 meeting.

Ms. Bowen, Senior Legislative Research Analyst for LSO, explained that the members have an additional stack of handouts that included a copy of the [Milliman report](#) on Medicaid expansion for Idaho; an update to Dr. Armstrong's presentation from the last committee meeting ([slide #7](#)); a copy of the proposed PCAP (Primary Care Access Program) Fund draft legislation; and finally, a brief summary of the public comments that had been received: to adopt Medicaid waiver model, to request an expansion of Medicaid, and to wait until after the November elections. She also reported that information regarding the increase to the minimum wage and its affect on the number of individuals in the "gap" was found to be contradictory; she observed that the source of such studies tend to lean towards the source's platform.

Mr. Tatro, Principal Budget and Policy Analyst for LSO, reported on the request for information regarding the [Idaho CAT \(Catastrophic Health Care Cost Program\) fund](#) and suggested that Ms. Kathryn Mooney, Director of the CAT fund, be invited to present to the board, if there were additional questions. His second report was a [flow chart](#) of the Tobacco Master Settlement Program, referred to as the Millennium Fund. And finally, he reviewed a brief comparison of the four [healthcare plans proposed](#) in the 2016 legislative session. Mr. Tatro then commented on the following items from the MaineCare presentation: CA federal Medicaid match was 50 cents on the dollar (for every dollar spent, CA recovered 50%); and Maine's federal match was closer to 62 cents of every dollar, while Idaho's was 71 cents of every dollar. He further explained that a state's FMAP (Federal Medical Assistance Percentages) was tied to the state income, so it was all relative when trying to use it as comparative factor. Idaho's Medicaid percentage of the general fund for FY 2017 was 15.9%. He emphasized that it was difficult to compare one state's healthcare program to another. Reasons for this included: because the state populations were different; the dedicated funds of a general fund were different; and the identities of the populations being covered or the benefits provided were not always the same.

- Rep. Vander Woude asked whether it was correct to summarize that if a state's income increases then the assigned FMAP decreases? Mr. Tatro responded that a state's FMAP was tied to the state's personal income and the per capita income, which was an average of the last three years; but there was a floor to that FMAP amount, which was 50%.



- Co-chair Hagedorn asked for further clarification on Mr. Tatro's earlier statement that Idaho's Medicaid percentage was 16% of the general fund. Mr. Tatro restated that Idaho's Medicaid expenditures were 15.9% of all general fund expenditures or 29% from all fund sources; in comparison, Maine's Medicaid program was about 24% of their general fund expenditures. Co-chair Hagedorn requested Mr. Tatro provide a comparison of the numbers between Maine and Idaho, considering that the FMAP rates were the same.

Co-chair Loertscher reminded LSO staff to provide at the next meeting a report on the asset recovery plan conducted by the Department of Health and Welfare.

At the request of Rep. Chew, Co-chair Loertscher asked Ms. Necochea to return to the podium for some questions.

- Rep. Chew asked Ms. Necochea to clarify an earlier statement about a comparison of Idaho's plan and the MaineCare program. Ms. Necochea noted that Maine's overall program was going to be more expensive than Idaho's and that the FMAPs were very different? She added that Maine did not have the same offsets that Idaho had, such as the CAT fund. She also explained that Maine was in a predicament, because it had expanded before it was necessary and was now having some difficulties in hindsight in coverage of different populations.
- Referring to page 26 of the Chart Book, Co-chair Hagedorn asked whether Ms. Necochea could speak to the listed types of waivers and delivery options. Ms. Necochea replied that she would need to do more research on each waiver to better describe them, but overall the 1115 waiver was written by the state to personalize its healthcare plan. Co-chair Hagedorn then commented that this graphic was, at the very least, helpful in showing that a state could personalize its healthcare plan. He then asked whether it would be Director Armstrong of the Department of Health and Welfare who would do this drafting of a waiver to CMS (Centers for Medicare & Medicaid Services within the United States Department of Health and Human Services). Ms. Necochea deferred to Lisa Hettinger from the Department of Health and Welfare. Ms. Hettinger explained that a state's Medicaid Director or the Department of Health and Welfare has the authority to approach CMS with any type of waiver. She further explained that while there existed a multitude of waivers that could be employed to address the gap population - traditionally the 1115 waiver was used. As to actual approval from CMS, Ms. Hettinger noted that, if a state wanted to approach CMS with an idea, CMS would counsel the state on how the waiver reads, but would not commit to an approval until the actual waiver was submitted and through the entire process. She added that CMS was reticent to approve a waiver if a state had existing rules or statutes that would not support what the state was asking to be approved. Co-chair Hagedorn summarized that when CMS approved a waiver, the waiver would not be implemented until the state had a policy on the actions of the waiver, and also had funding for the waiver. Ms. Hettinger agreed with his statement; if a state does not have these items in place, then the waiver was considered null and void. She also noted, that when a state wanted to change a waiver, there were consequences, yet it was not implicit that a waiver was forever; a new waiver could be filed to correct an earlier one's shortfalls.
- Co-chair Hagedorn then inquired whether CMS would help states cover those with "gap" populations only when the state had a plan for implementation? Ms. Hettinger responded that was a loose summary of the issue; essentially a state had to have its plan formalized at the onset. She commented that, traditionally, CMS was much more likely to approve a waiver that mimicked another state's process; while it was more difficult, or took a longer amount of time, if the request was unique.

Co-chair Loertscher commented that some states were not successful in their changes to Medicaid, and that it would be helpful to have a list of such items. He stated that the FGA (Foundation for Government Accountability) would be providing a comparison of those items for the committee to study; that being said, he felt that the members needed to come up with policy that was unique to Idaho. The next meeting was set for August 29th. Co-chair Loertscher encouraged committee

members to review HB 260 [2011, Ch. 164], to review recent presentations, and to review Medicaid in general.

Co-chair Hagedorn commented that the committee had received quite a bit of information and directed the members to meet with Ms. Bowen to begin formulating policy with that information.

Rep. Wood also implored the committee members to begin drafting policy and deciding whether to spend funds or not, and to decide whose funds would be spent; and, not to worry so much about how the process would be implemented, as that was the function of other departments, not the Legislature's.

Senator Guthrie encouraged the members to begin eliminating non-options and to making decisions on where the members wanted to focus.

Ms. Bowen offered to provide examples of waivers from other states.

- Rep. Wood then asked Ms. Hettinger whether waivers were used only for programs that adopted a full expansion of Medicaid? Ms. Hettinger explained that, if a state wanted the enhanced FMAP rate, that was a true statement; if a state was not seeking the enhanced FMAP, there were many ways a waiver could be used.

Co-chair Hagedorn commented that he was in communication with an individual from New York who had helped many other states with waivers and that she would be providing a report of items that did and did not work per the company's work.

At 3:26 p.m., Co-chair Loertscher adjourned the meeting.