MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 26, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
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** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:06 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll.
DOCKET NO. 22-0101-1501	**Rules of the Idaho State Board of Medicine related to the licensure to practice medicine and surgery and osteopathic medicine and surgery in Idaho**. **Anne Lawler**, Executive Director of the Idaho State Board of Medicine, presented this docket. **Ms. Lawler** stated that the pending rule docket amends the existing rule regarding the licensure of international medical school graduates. Under the current rule, international medical school graduates (residents) are not allowed to apply for licensure in Idaho prior to completion of three years of their residency program, while U.S. medical school graduates may apply for licensure in Idaho after completion of one year of their residency program. The current rule discourages international medical school graduates from seeking residency training and returning to Idaho to practice medicine. Therefore, the pending rule would allow international medical school graduates who are attending an Idaho-based residency program to apply for licensure after completion of two years of their residency program. The reasons for the change are to increase the pool of resident physicians who can support understaffed rural areas; to allow residents to obtain controlled substance licenses and authorize medical equipment or home health; and to provide residents with additional training and experience that come with medical practice in the community. **Vice Chairman Nuxoll** asked the Committee members if they had any questions. **Senator Hagedorn** asked how "successful completion" is defined in the proposed rules. In response, **Ms. Lawler** reviewed the requirements of successful completion set forth in sections 051.e.i-v of the docket.

Vice Chairman Nuxoll asked for clarification on why some Idahoans have difficulty obtaining licensure after earning a medical degree. **Ms. Lawler** stated that there are no medical schools in Idaho. Therefore, Idahoans who want to become physicians must leave Idaho to attend medical school. After medical school, graduates must attend a residency program, which is typically a three-year program based upon the participant's chosen specialty. Most physicians ultimately practice medicine in the location of their residency program. **Ms. Lawler** indicated that some Idahoans attend domestic medical schools and some Idahoans attend international medical schools. Because Idaho is currently more restrictive than many other states on the licensure requirements for international medical school graduates, international graduates choose to go to other states instead of returning to practice medicine in Idaho.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 22-0101-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 22-0115-1501 **Rules of the Idaho State Board of Medicine related to telehealth services**. **Anne Lawler** presented this docket.

Ms. Lawler stated that the pending rule docket was prompted by the passage of the Idaho Telehealth Access Act and clarifies the obligations of licensed health care providers in providing telehealth services to patients located in Idaho. **Ms. Lawler** stated that the pending rule is based on the model telehealth rules promulgated by the Federation of State Medical Boards and fined-tuned/finalized by the Idaho Telehealth Council. The Telehealth Council is comprised of many stakeholders, including Representative Rusche, regulatory board members and directors and representatives from the insurance industry, Medicaid, the Idaho Hospital Association, the Idaho Medical Association, and various Idaho hospital systems. **Ms. Lawler** reported that a public hearing was held on September 15, 2015. The Board of Medicine received and reviewed two written comments to the proposed rule changes. Strongly believing that patients should have freedom to choose providers where possible, the Board of Medicine did not make changes to the proposed rule draft.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Schmidt asked how the provider selection would work in a telehealth format. **Ms. Lawler** said many of the telehealth service providers are companies located in a central location and provide services to various states. The telehealth service companies have a large roster of health care providers. This rule would allow a telehealth patient to choose, when appropriate, a health care provider from the roster. **Ms. Lawler** gave examples of how patients may opt to speak to a variety of medical doctors, such as a pediatrician versus a family practice physician or a female doctor versus a male doctor.

MOTION: There being no more questions, **Senator Schmidt** moved to approve **Docket No. 22-0115-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

PRESENTATION: **Primary Care Access Program in Idaho**. **Richard Armstrong**, Director of the Idaho State Department of Health and Welfare (Department), made this presentation before the Committee.

Director Armstrong thanked the Committee and gave a brief overview of the topics he would discuss in his presentation (see attachment 1 for the complete presentation). First, **Director Armstrong** discussed how the Primary Care Access Program (PCAP) will build on foundations and strengths of Department and community resources and the demographics of people in the gap. Second, **Director Armstrong** reviewed the nine-step PCAP experience from the perspective of the patient or member, including (i) application, (ii) verification, (iii) eligibility determinations, (iv) medical home assignments, (v) patient engagement, (vi) patient assessment, (vii) patient care plan development, (viii) medical home patient services and obligations and (ix) ongoing case management. Third, **Director Armstrong** presented the values and outcomes expected from the PCAP. Finally, **Director Armstrong** reviewed the next steps for the PCAP.

Chairman Heider asked if the Catastrophic Health Care Cost Program (CAT) fund would remain in place. **Director Armstrong** confirmed that the CAT fund would continue to be used for specialty and hospital care. **Chairman Heider** asked if hospital emergency rooms (ERs) will refer some people to an outside doctor or a patient-centered medical home. **Director Armstrong** answered that, by law, a hospital can't turn people away. However, he believed there would be coordination for patients' outside follow-up care. **Director Armstrong** added that by assigning participants to patient-centered medical homes, he believes there will be a reduction in ER visits.

Senator Hagedorn commented that he was concerned about whether rural health care clinics have the same capabilities as urban clinics and asked if services such as mammograms, colonoscopies and certain cancer screenings would be included in preventive care. **Director Armstrong** said because there are variations in service capacity across the State, the goal is to work with clinics to be able to help them increase their ability to serve. **Senator Hagedorn** asked what the motivation would be for participants to seek preventative care and appropriate follow-up care from the PCAP. **Director Armstrong** responded that the providers in the patient-centered medical homes would assist the participants and provide reminders for care.

Noting his belief that the number of participants could be higher, **Senator Harris** asked how the Department determined that 78,000 individuals would be eligible to receive PCAP services. **Director Armstrong** responded that the number of participants were estimated and tested on several occasions by professional consultants. **Director Armstrong** stated his confidence that 78,000 reflected the maximum number of expected participants in the PCAP.

Vice Chairman Nuxoll asked Director Armstrong to clarify the payment structure for PCAP health care providers. **Director Armstrong** responded that the total cost for 78,000 PCAP participants would be approximately $30 million. The capitated rate paid to health care providers would be $32 per patient, per month. **Director Armstrong** noted that if the PCAP received less than $30 million in funding, PCAP enrollment would be limited instead of reducing payments to providers.

Regarding the costs patients would incur when seeking health care services from a PCAP clinic, **Senator Martin** asked Director Armstrong who would determine the cost, would there be a cap on the cost and who would receive the payment. **Director Armstrong** replied each clinic has a sliding fee scale and that revenue goes to the clinic. **Senator Martin** asked what would encourage an individual to go to a clinic if an ER visit is free. **Director Armstrong** noted that ER services are not free, and he answered that it would be important to educate participants on the value of PCAP services.

Senator Schmidt asked if it is possible to track and report both outcomes and clinical data with the current systems in place. **Director Armstrong** said that, today, the Department looks to Medicaid to pull all the paid claim data. **Director Armstrong** stated that the Department would now need to pull all clinical data from the electronic health records maintained by clinics. He added that the Department would make use of reports already being provided by clinics to the federal government to track PCAP outcomes and clinical data. **Senator Schmidt** asked whether some of the 78,000 estimated participants are currently receiving services from clinics that will serve as PCAP clinics. **Director Armstrong** responded that the Department does believe there is a crossover, but the degree of crossover has not yet been determined. He added the Department was hoping to do a data match, but due to restrictions with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and personally identifiable information, a data match was not done and that information is not yet available.

Senator Lee commented that her district has good, hard-working people, but noted that it has one of the highest gap populations in the State. She asked if the Department would focus initial resources in areas of the State that have the highest gap population in order to reduce costs to the State, hospitals and local providers. **Director Armstrong** answered no and that the Department is not looking at a targeted approach. However, he stated that if the Department has a limited in budget, then the Department may have to take a targeted approach.

Senator Lodge asked if the State has enough medical providers that will go into rural areas and if there are sufficient education programs to ensure there are enough people graduating in the needed disciplines. **Director Armstrong** answered the Department is concerned about staffing levels. Under the Department's proposed approach, clinics will have the opportunity to increase staffing levels to meet necessity. Commenting that Idaho has two law schools but not a medical school, **Senator Lodge** noted that she is still interested in seeing what could be done to expand Idaho's training for medical professionals.

Senator Jordan asked what kind of analysis has been done to determine the clinics' ability to increase their capacity and to sustain the capacity with a proposal that includes a sunset and a year-to-year review of what should be a sustainable funding source. **Director Armstrong** responded one of the reasons the Department wanted to have a dedicated funds source, based on talks with clinics, was to establish a sustainable program. **Senator Jordan** asked what would happen if a person came into a clinic to manage a chronic disease and something else was found, such as cancer. Specifically, she asked whether that person would go back to the same delivery system that exists right now, which is no insurance and the CAT fund. **Director Armstrong** answered the clinics refer patients to a place where they can be cared for, but some of those individuals will then end up indigent and seeking CAT fund assistance.

Vice Chairman Nuxoll asked if, rather than a five-year sunset clause, would it be better to have a three-year sunset clause. **Director Armstrong** stated that five years is the shortest duration that can produce a good scientific outcome.

Noting that the target PCAP funding amount is $30 million, **Senator Hagedorn** asked the minimum amount needed to implement the program or if that sum exists. **Director Armstrong** said the Department does not have that minimum number and hopes the Legislature could reach the Department's target.

Chairman Heider inquired about the Department's next steps. **Director Armstrong** said the Department has drafted a bill and he thinks they will have that ready to introduce soon.

ADJOURNED: **Chairman Heider** thanked Director Armstrong and his Department. There being no further business, **Chairman Heider** adjourned the meeting at 4:42 p.m.

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Senator Heider
Chair

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Karen R. Westbrook
Secretary

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Kara Machado
Assistant