MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, January 27, 2016

TIME: 9:00 A.M.

PLACE: Room EW20

MEMBERS: Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Romrell, Vander Woude, Beyeler, Redman, Troy, Rusche (Van Tassel), Chew

ABSENT/ EXCUSED: None

GUESTS: Michael McGrane, Idaho Nurses Assoc/Nurse Leaders; Denise Chuckovich, Lori Wolff, Russ Barron, and Matt Wimmer, DHW; Tami Fife, Terry Reilly HS; Corey Surber, Saint Alphonsus.

Chairman Wood called the meeting to order at 9:00 a.m.

MOTION: **Rep. Hixon** made a motion to approve the minutes of January 19, 2016. **Motion carried by voice vote.**

Chairman Wood turned the gavel over to **Vice Chairman Packer**.

Dick Armstrong, Director, Department of Health and Welfare, presented information on the Primary Care Access Program (PCAP), which is designed to address the medical needs of the 78,000 uninsured Gap population by providing preventive care through existing systems and foundations.

Eligibility determination will use the existing welfare program system. The community health clinics, who already have the obligation and duty to serve the low-income population, will be the primary care medical homes. Most clinics have the required advanced certifications. PCAP fits under the State Health Innovation Plan (SHIP) umbrella in the move toward medical homes.

The Gap consists of an estimated 78,000 adults, some with Medicaid eligible children in their homes. Approximately 50,000 participants have been identified through the Idaho Benefit Eligibility System (IBIS). Of that amount, 55% are female, 84% are 18 to 50 years of age, 65% live in households with at least one child, 25% are households of one, and 58% live in households with three or more children. Household income often includes Social Security, child support, or pensions.

These adults have a higher chronic disease incidence. The Gap population is under served by the medical system and accesses care through hospital EDs, health clinics or centers, charity care, indigent healthcare programs, and catastrophic healthcare programs. They frequently wait until conditions escalate, resulting in the most expensive and least effective care. For those in poverty, chronic conditions are twice as high. Poor health outcomes are impacted by substandard housing, food insecurity, transportation issues, lower levels of education, and risky behaviors.

This is not a static population. Participants are expected to move on and off PCAP as circumstances change and health issues are stabilized.

PCAP is a nine-step process that moves from application through patient engagement and ends with ongoing care management. The first four steps are DHW activities for application, verification, eligibility determination, and medical home assignment. Once done, the health clinic activities begin. These consist of patient engagement, assessment, care plan, services, and care management.

Application can be made through idalink, Your Health Idaho, by phone to DHW, in person to DHW state offices, mail, e-mail, fax, and through clinics. The universal application will be run through the existing eligibility system, with an average five-day processing time. Applications can be completed by the individual or someone acting on their behalf.

PCAP will verify eligibility through real-time interface with a variety of data bases. Qualification is based on age, access to health coverage, income, legal residency, and circumstances. Enrollment starts the same month as the application and is recertified every twelve months.

The medical home assignment uses the existing health connections geographic-coded system. Assignment is important to get funding to the clinic. The participant can change the assigned location. The notified provider can use the 24x7 database to verify the participant's eligibility status.

Once assigned, the provider has an outreach obligation to contact the individual, explain the patient centered medical home (PCMH) model, health assessment process, and care plan. The participant is responsible to pay their cost share and actively participate in the assessment and care plans. All of the clinics have an income-based sliding scale to collect the payments. PCAP will not collect the fees.

Initial assessments of the patient's health status are completed over the telephone or in person. This tells both the clinic and patient what ongoing level of care is needed. A healthy individual may require basic preventive care, guidance for self care, and education to access appropriate care. Individuals with more issues would develop care plans, access needed medications, and agree to actively participate in self care. Those with more chronic conditions would develop care plans, have regular PCMH monitoring, and agree to actively participate in their care plans.

Medical home services would include primary and preventive care, acute care, basic medications, labs, x-rays, coordinated chronic care, and connection to community services. Community health centers (CHC) with on-site pharmacies or contracts with local pharmacies have access to comprehensive low-cost out-patient formulary. The medical home is obliged to counsel patients on the best pharmacy product at the best price possible.

CHC care for only behavioral health (BH) issues managable in a primary care setting. All PCAP providers will be expected to have on-site BH services and connect more serious cases to community resources.

Ongoing case management is dependent on the participant's health status and care plan. Providers are required to track patient care and outcomes. This will determine participant engagement with both the program and care plan. It will also provide aggregate data on chronic conditions. The information will be reported to the Legislature for program evaluation.

Vice Chairman Packer turned the gavel over to **Chairman Wood**.

The Catastrophic Fund (CAT) pays for care routinely provided at the wrong end of the health spectrum, often with no outcome change. Conversely, PCAP actively engages at the clinic level and provides education for the appropriate use of the health system, reducing ED use. The assessment provides a health discussion and leads to the active care plan engagement by both parties.

PCAP enrollment is subject to available funding. A waiting list will be utilized if funding does not support the demand. Participants can be dis-enrolled if they do not share in the costs and are not invested in their care plan. Eligibility criteria can be adjusted to improve the program performance or administrative efficiency. A five-year sunset automatic clause is provided, if performance outcomes are not achieved or the state wants to change the program.

The program launches January 1, 2017, with programming to begin after the SNAP multi-day issuance launches on July 1, 2016. Modifying business processes, hiring, and training new staff start on July 1, 2016. PCAP eligibility will be coordinated with the current insurance exchange open enrollment, although it continues throughout the year. The launch date allows CHCs and other providers the time to expand for projected enrollees.

Answering committee questions, **Director Armstrong** said the twelve month recertification gives enough time to assure the participant can settle into the process, and is a lower administrative cost. The core clinics provide a broad scope of practice, which will limit referrals to specialists. This is the initial boundary of expected service, which will be expanded as the standard scope of practice is defined. The capitated fee is $32 per month. PCAP is not insurance. It deals with primary care services, not hospital services, where most inflation is seen.

Individuals entering the program will benefit from having a medical home and, if trained, they will be better managers of their health care. This population has not been studied before, so there is a lot to learn. Setting the budget for the 75,000 to 78,000 participants prepares for the maximum, although this is not expected to be the number of enrollees January 1st. The enrollment continues all year long. Open health exchange enrollment provides a lot of advertising, healthcare activity, and the highest applicant by-product flow.

Clinic payments will be made each month the individual is enrolled, with a twelve-month eligibility. Payments stop when the person is no longer enrolled. Recertifications will be in the fall, at the same time other programs recertify. This means some individuals, depending on when they enrolled, will have less than twelve months before they have to recertify. Individuals eligible for an insurance policy are better served by the policy's improved coverage and tax credit.

The PCAP $30 M funding request is for the maximum budget amount. There are a lot of funding sources still being considered within the budgeting process.

The GAP is a highly sensitive population group with many households driven by $2 to $3 an hour. An increase in the minimum wage would move many of them completely out of the GAP.

Private insurance and Medicaid studies show Idaho to be a no-appointment based healthcare system. Local healthcare professionals will not have any immediate appointments available for medical issues arising in the afternoon, except in the ED, which is always open. The SHIP pilot program results indicate providing daily open appointment slots for walk-ins and extended evening hours will dramatically impact this trend. Hospital coverage is a possible future avenue for the program.

Health clinics are found in population centers, leaving some counties without this health care avenue. PCAP would look at existing clinics to deliver only basic BH services, with serious BH issues addressed through the Medicaid system.

The clinics have been asked to do an outreach to existing patients they know would fall within the GAP population. They have identified 50,000 individuals as members of this crossover. The residency requirement is consistent with other programs. Increasing healthcare costs can be attributed, in part, to our high national technology interest. The safest place to address improved health is in primary care. By design, this program is keeps the decisions at the clinic level for administrative efficiency. The challenge is to extract participation data from a clinical record.

Healthcare for persons in the Gap is just beyond their means. Mobile clinics for rural areas would be a great tool. Some clinics provide basic dental care, although not all providers have the same capacity. Flexibility is needed in the early years as the program evolves. Community connections will be used to help with issues such as housing. Care will be needed to assure links are to quality services.

Lori Wolff, Administrator, Division of Welfare, was asked to answer committee questions. She said individuals must report income and household changes. Any change reported in one program will result in a reaction on all programs in which they are involved. The eligibility system connects all programs at the case or individual level.

Responding to further committee questions, **Director Armstrong** explained the $30 M was calculated by multiplying the $32 per member, per month figure by 78,000 participants, which is the maximum amount. Persons on a PCAP wait list are without PCAP benefits. This is not a first of multiple steps program, it can stand on its own and run for decades, although it isn't the ultimate healthcare answer. The CAT and indigent fund programs still exist. Outpatient surgery, imaging and services beyond the medical home may be future options, depending on the economy and budget. Changing incentives and education will lessen the ED use, although there will still be occasions when it is necessary.

Rep Chew commented **in opposition** to the PCAP proposal, stating the state healthcare is first and foremost. Half measures avail us nothing. This is not the answer.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10:59 a.m.

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Representative Wood
Chair

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Irene Moore
Secretary