MINUTES

# HOUSE HEALTH & WELFARE COMMITTEE

**DATE:** Monday, February 08, 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, Chew

**ABSENT/ EXCUSED:** None

**GUESTS:** Caroline Keegan, Julie Walker, Deena LaJoie, Jaclyn St. John, Crystal Wilson, and Megan Williams, Idaho Academy Nutr/Dietetics; Colby Cameron, Sullivan & Reberger; Toni Lawson, Idaho Hospital Assoc.; Sue Linja, S and S Nutrition; Ryan Vance, Peggy Bodnar, and Christy Smith, Idaho Academy; Alex Adams, Idaho Board of Pharmacy; SeAnne S. Waite, Acad. of Diet.; Elizabeth Criner, ISDA.

**Chairman Wood** called the meeting to order at 9:01 a.m.

**RS 24359C1:** **Rep. Phylis King**, presented **RS 24359C1**, proposed legislation to license medical science practitioners to ensure those working in medical laboratories are qualified to perform laboratory testing and all related activities. Additional rules will be promulgated. Three practitioner categories are defined, along with their qualifications and licensing fees. A medical laboratory board is established with defined power and duties. Administration is provided through the Bureau of Occupational Licensing. Grandfathering is provided for those individuals already practicing in the field.

**MOTION:** **Rep. Rusche** made a motion to introduce **RS 24359C1. Motion carried by voice vote.**

**Lance McCleve**, Principal Evaluator, Office of Performance Evaluation (OPE), presented the Idaho Behavioral Health Plan (IBHP) evaluation results. Concern was raised regarding the vendor, Optum, implementing program contrary to the Department of Health and Welfare's (DHW) intent. The evaluation found the major stakeholder criticisms were about changes necessary for the transformation plan. A separate set of operational change issues are being addressed by the management team and the DHW. Outcome analysis is limited to services utilization and resultant cost changes, without available state level member health outcomes.

**Ryan Langrill**, Senior Evaluator, OPE, further presented their findings. **H 260** directed the DHW to develop a plan to redesign the Medicaid behavioral health (BH) system into an accountable care system. The primary motivation and planning efforts for this move revolved around psychosocial rehabilitation (PSR) increases in costs, accounting, at its peak, for 65% of Medicaid spending.

The DHW managed care plan's PSR focus excluded inpatient care. In lieu of inpatient services, the request for proposal (RFP) included three primary strategies to encourage vendors to add services to the array. First, vendors were asked to include value-added services and commit to providing additional new services. The governor's work group findings were used to list the comprehensive BH system services. Second, an included administrative vendor cap required allocation of 85% for medical services or community reinvestment. Third, the 5% vendor payment hold back, depending on inpatient spending, could be partially or completely returned to the vendor.

Based on claims data since implementation, the PSR costs have declined, although it remains the highest spending service array. While the vendor has some power over service implementation, system changes would have happened regardless of which vendor was selected.

The August 2013 to March 2015 spending decline amounts to $28M, while the per member per month fee remains the same. Since Optum can only keep 15% of their fee for administrative costs, approximately $5.1M is slated for contract reinvestment.

When looking into the concern regarding the vendor shifting treatment responsibility to services not under their umbrella of treatment, OPE reviewed inpatient claims data, which excludes the state and intermountain hospitals. They also reviewed hospital and school based data. No evidence of cost shifting was found.

Although the main managed care goal to reform PSR has been significantly addressed, a successful program has more than a purchasing regulations adhering contract and a compliant contractor. It also requires strong communication, well developed program design, and an understanding of the product the state is buying.

**Lance McCleve** stated the DHW plan has been successful in addressing accountability for outpatient BH care and PSR. The DHW managed care plan has successfully emphasized evidence-based practices as they have been defined. Additional goals, such as expanding the continuum of care, are proceeding, but have not been successful. Funding reinvestment has begun, although federal regulations and limitations make DHW funds use difficult.

The DHW learned a well-developed program design is key for contracting. Differences between the plan and the vendor's product are to be expected. Vendor collaboration is a key component to success, assuring the contract is carried out effectively. Communication is necessary to help people understand and manage issues.

Going forward, addressing outpatient system needs must continue. The plan restructures a network, made up of private businesses to reflect the state's goals. This is not a one-to-one relationship. It involves incentives and changing what is beneficial for all parties. The DHW was successful in addressing the problem and how the network functioned by changing service approval standards and increasing accountability.

To change the network they had to first create a need for other services. The next step is assuring the needs are completely met. Integration of payment for a full continuum of care would include inpatient services under the same plan as outpatient services. The managed care vendor and the network dynamics changes once inpatient services are added, although a stronger and more linear method for low cost less restrictive outpatient services is provided.

The OPE recommends the DHW evaluate the merit of including inpatient services by making a formal statement of need, a plan, and assess the mechanisms and abilities of options to include or exclude inpatient services. They further recommend the plan components are linked to internal resources and outcomes. The DHW has committed to conducting the evaluation and reporting to the legislature. An important aspect is the inclusion of sufficient expertise, either in-house or third independent party.

Answering committee questions, **Mr. Langrill** said he would provide information from other states, although comparison with other managed care systems was difficult. The DHW solicited outside sources input as an outreach experience effort, instead of a fiduciary relationship.

**Mr. McCleve** responded to committee questions by stating there are clinical management components to the DHW plan which are left up to the vendor. The vendor has systems in place to review patient outcomes, not assess how well the program is working.

The hospitalization information indicated admission, re-admission, and bed days, without any Medicaid coverage distinction and no visible cause or relationship.

**Rakesh Mohan**, Director, OPE, was invited to answer a committee question. He said it became evident policy or program design was the basis for the contract delivery problems. This was found in other state contracts when the program or agency working on the contract had neither inhouse nor independent expertise to do the design and monitoring. The DHW has a good monitoring team.

**Mr. McCleve** further responded to the question, stating the DHW contract monitoring team has made collaborative improvement. This is not a major project issue and there is no recommendation for a third party independent monitor.

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

Further answering committee questions, **Mr. McCleve** explained, the providers had no managed care experience. Although some communication was built into the contract, a lot more was needed to convey the DHW intent and the program changes. Provider communication was primarily through the vendor as new policy, instead of direct help from the DHW. The decision to exclude inpatient services was not communicated to policy makers and providers. Given the scope of issues identified by previous BH efforts, the DHW plan wasn't sufficiently developed to accomplish all its goals. Vendor expectation and supply differences are being worked through. The DHW learned it needs more collaboration with the vendor.

**Mr. McCleve**, answering additional committee questions, said the DHW planned for an experienced entity to administer benefits to maximize the effect of pushing for evidence-based practices. Managed care works by providing a per member per month rate to a vendor who provides the care. Higher service costs are the vendor's problem, providing a reward and incentive for reductions. The vendor followed direction, with a natural outcome of initially high service reductions.

**Caroline Keegan**, President, Idaho Academy of Nutritionists and Dietetics, updated the committee on their 2015 activities. Registered Dietitians and Nutritionists (RDN) are nutrition professionals registered with the national Commission on Dietetic Registrations and licensed with the Idaho Board of Medicine. They work in a variety of settings with the commitment to improve the health of Idahoans and contribute to healthcare cost reduction.

The answers to the increasing number of people with obesity related problems lie in lifestyle changes for healthy eating and active living. RDNs are dedicated to solving this problem.

In the past year they have actively supported three specific efforts to educate and partner with other healthcare professionals. RDNs are participating in the State Healthcare Innovation Plan (SHIP). Last fall they presented a one-day diabetes management conference for over 200 healthcare workers. They continue to revise and update the Idaho Diet manual, used by over 400 healthcare facilities to plan meals for their clients.

**Megan Williams**, Registered, Licensed Dietitian, Certified Diabetes Educator, reported SHIP continues development of Patient Centered Medical Homes (PCMH), with help from health district collaboratives, including volunteer local RDNs. They have also provided PCMHs with information about nutrition services, patient outcomes, and provider benefits when dietitians are a member of the healthcare team.

A primary SHIP goal is diabetes control and prevention. Data specific to ninety patients who visited with an RDN indicates the average hemoglobin A1c test levels (A1c) dropped 1.03%. Twenty percent went from an A1c above 7% to below 7%. After RDN intervention, 75% saw an A1c decline. An A1c drop of 1% results in a cost savings of $820. When expanded to 100,000 Idahoans, it can equate to a savings of $85 M.

Medical home patients who saw an RDN for two hours or more had an average A1c drop of 3.1%, saving $2,500 per patient or a $35,588 total savings.

Weight loss data for 145 patients who visited an RDN showed an average weight loss of 5.5 lbs. Health benefits, such as improvements in blood pressure, blood cholesterol, and blood sugars occur with even modest weight loss.

An interdisciplinary team study at St. Luke's Hospital analyzed the cost savings of preventing or delaying development of Type 2 diabetes in 34 individuals. Through participation in 24 sessions of individual assessment, group exercise, and education/support, the following data was collected. Participants lost an average of 14 lbs., Body Mass Index (BMI) dropped by less than 2 points, and triglycerides dropped into the normal range. Central adiposity, measured by waist circumference, decreased by 4.4 inches. A1c dropped into the normal pre-diabetic range. Both diastolic and systolic blood pressure improved dramatically. A few patients even dropped their blood pressure medications. Depression and anxiety assessments improved. Extending the study to twelve months, the group has maintained an average 6.9% loss in body weight.

Further recognition of RDN services would emphasize their role in improving the healthcare of all Idahoans.

**ADJOURN:** There being no further business to come before the committee, the meeting was adjourned at 10:46 a.m.

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| Representative Packer | Irene Moore |
| Chair | Secretary |