MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 14, 2024

TIME: 9:00 A.M.

PLACE: Room EW20

MEMBERS: Chairman Vander Woude, Vice Chairman Erickson, Representatives Blanksma, Kingsley, Mitchell, Dixon(24), Gallagher, Healey, Redman, Wheeler, Chew (Wilson), Rubel, Roberts

ABSENT/ EXCUSED: Representative(s) Chew (Wilson)

GUESTS: The sign-in sheet will be retained in the committee secretary's office; following the end of session the sign-in sheet will be filed with the minutes in the Legislative Library.

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

MOTION: **Rep. Roberts** made a motion to approve the minutes of the February 12, 2024, meeting. **Motion carried by voice vote**

Jenny Robertson, Director, Dual Eligible and Medicaid Program, Blue Cross, presented information to the committee regarding the value and impact of Medicaid managed care. She shared the history of the managed care program for the Idaho dual eligible population enrolled with the Department of Health and Welfare (DHW). There are currently 14k members in the program.

The cornerstone of managed care is the use of care managers for coordinate care, member advocacy, innovative support, and assure quality care access. A dedicated contract monitor and regular reporting requirements ensures program accountability and transparency. A dedicated community engagement team provides community outreach on a personal level.

Drew Hobby, Executive Vice President, Chief Revenue Officer, Blue Cross, discussed why managed care is perfect for Idaho. The state provides requirements of the plans with specific network standards for member access, quality of care, fiscal stability, accountability, and provider protections.

Medicaid managed care provides accountability and transparency through oversight, performance measures, regular reporting, and strict non-compliance penalties. Improved health outcomes are achieved through value added benefits, tailored incentive programs, innovative member support, and personalized care coordination.

With capitated rates, the plans take risk to deliver the quality care within the budgeted amount. Reviews assure fraud waste and abuse are discovered. Provider protections include equitable rates through state established fee schedules. Blue Cross has teams building contracts and data for providers to help them be successful.

Responding to questions **Ms. Robertson** said both the state and federal government requires reporting and oversight. The DHW contract is quite extensive and calls for regular reporting. Outcome based performance measures include quarterly cost savings reports. Some states use performance measures and incentivized plans. There are also non-compliance penalties to assure everything is being done right for the members and providers in compliance with the contract.

Some of the member incentives in other states include job interview needs, writing resumes, and heating or cooling financial support. Some of the programs expand beyond the members into the communities. Care coordinators have close relationships with members and can impact their living conditions dramatically, when they see a need.

Any provider contract termination includes a clear time frame to assure the members are still covered. The Idaho contract has reporting requirements with accountable measures and targets they must meet. In other states there are quantifiable measures, so it depends on the program. **Mr. Drew** explained while Idaho establishes the contract requirements, an external quality review organization would evaluate if the requirements have been met. There are usually financial penalties tied to any lack of performance.

Norm Varin, Government Relations, PacificSource Health Plans, appeared before the committee to present the PacificSource Oregon Medicaid Managed Care Plan, which will work very well in Idaho. PacificSource believes they do not succeed unless the providers succeed. He shared information on the history of PacificSource's health plans.

Erin Fair Taylor, Vice President, PacificSource Medicaid Programs, shared how they are working with providers to risk their comfort level to move away from volume of care to a whole person care model. Joint operating councils include providers to review roles, responsibility, and provide payment support.

The coordinated care model (CCO), which is unique to Oregon, is aligned with the model possible for Idaho's Medicaid managed care program because it works well in both urban and rural areas. CCOs have one global budget that grows at a fixed 3.4% rate. There are quality metrics and standards for safe and effective care. There is local governance and accountability for health outcomes and budget performance. Pay for value requirements include value based payment road maps.

The difference between Value Care Organization (VCO) and CCO models is found in risk. CCOs accept full risk for physical, behavioral services, dental care services, non-emergency medical transport, and social health detriments. VCOs are focused on primary and acute care.

Ms. Fair Taylor, answering a question, said some states split service contracts, which allows existing contracts.

The state contract agency selects the CCOs, who are held to five-year contracts which can be extended by the state. She explained the Health Council, its advantage, composition, and interaction with PacificSource through joint management agreements.

The communities benefit through shared savings consisting of the CCO net income minus 2% of the adjusted CCO revenue. The shared savings go to the Health Councils who invest them in such areas as workforce development, peer support programs, community infrastructure, nutrition and exercise programs, parenting classes and supports, as well as culturally-specific programs.

Oregon has a CCO contract rate of growth cap, which provides state financial predictability. Quality metrics are accountable along with a quality incentive bonus program, based on member clinical outcomes.

She noted the state drives how the Medicaid program works to assure the funding is used for the programs and services necessary to keep Idahoans healthy. This is done through community governance and transparency, along with shared prioritization and decision making.

In reply to committee questions, **Ms. Fair Taylor** said the capped growth of 3.4% can be less. Testing is ongoing to find out if it holds with inflation. The cap was a commitment by Oregon's Governor to demonstrate cost savings and bend the inflationary curve at the time. It is holding at 2% below the medical trend which existed when it was established.

The high emergency department (ED) use at the beginning of the program was a huge issue. A quality incentive measure the CCOs held to was reporting on ED utilization and incentives to reduce that percent over time. Reduction also required payments to PMPM patient centered primary care homes who could demonstrate their own performance and educate members to use them instead of the ED. This moved the focus to the right care at the right place at the right time, and assured providers had the necessary support infrastructure. This approach worked. Reduction of ED use is a part of hospital value based payments. Electronic CCO and hospital shared real time information allows immediate contact between the primary care team and the member to assure support at discharge and reconnect with a primary care home to find out why they went to the ED.

Care coordination staff comes from regional offices, the community, the member engagement group, and the centrally located telephone support office.

The integrity unit ingests outlier data and reaches out to providers to address concerns. Providers may be reported under the federal or state law provisions. They may also be given coaching or support around best case practices.

The medical loss ratio (MLR) varies annually and is now operating at approximately 87%, depending on the community. Administrative costs have a contract cap of approximately 7%. PacificSource voluntarily caps at 2% and shares anything above that cap with the communities. Several years ago they did lose money with this process.

There are sixteen CCO contracts in Oregon. Those who have been successful have strong incentive provider and community relationships, assuring everyone is going in the same direction. For those struggling, Oregon has corrective plans and sanctions. When one became insolvent another CCO absorbed that membership and risk.

Prevention is an attribute of the CCO model, with focused health councils and building primary care provider networks. The local focus is very effective in addressing individual community issues. Early pilots are addressing nutrition using part of the capitation funds for non-medical services or needs. This is expected to be supplemental to existing programs.

One of the incentive measures was tobacco cessation, with a focus on providers talking to patients and offering supports. It had mixed success.

Providers are incentivized through value-based payments and quality bonus payments. Federal law prohibits incentivizing use of the program, but members can receive low amount gift cards and community gatherings offer other items. Based on the contract, Oregon has the discretion to pay above the set floor rate. Rates are negotiated with each provider and may vary in different regions.

ADJOURN: There being no further business to come before the committee, the meeting adjourned at 10:15 a.m.

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Representative Vander Woude
Chair

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Irene Moore
Secretary