MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 14, 2024
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chair VanOrden, Senators Lee, Harris, Bjerke, Zuiderveld, Wintrow, and Taylor
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:	**Chair VanOrden** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m. **Chair VanOrden** introduced physicians from the Second Year Family Residency Program at Full Circle Health in Nampa.
PRESENTATION:	**Page Farewell: Draycen Lamm**. **Chair VanOrden** thanked **Draycen Lamm** for all he had done for the Committee this session. **Mr. Lamm** relayed he had enjoyed his time here and learned a lot. He planned to attend the College of Southern Idaho in the fall. **Senator Zuiderveld** was his sponsor and thanked him for coming.
PRESENTATION:	**Medicaid Modernization: Blue Cross of Idaho (BCI)**. **Jenny Robertson**, Director of Medicaid and Dual Eligible Programs and **Drew Hobby**, Executive Vice President and Chief Revenue Officer provided information about BCI plans related to managed Medicaid care. As a local company, BCI had a history of providing programs for Medicaid and Medicare in Idaho. The company had the ability for innovation in managed care plans with targeted plans, specialty coordinated programs, improved health outcomes, member access and quality of care, program accountability and transparency, stability and continuity of continuous care, dedicated community engagement, fiscal stability, and provider protections. BCI had existing network adequacy standards, preventative care standards, and fiscal predictability. Appropriate data monitoring of expense and utilization trends, member engagement, and provider engagement and protections were included in planning and programs (Attachment 1).
DISCUSSION:	In response to Committee questions, **Jenny Robertson** stated that the provider-to-patient ratios were generally one provider for 35 patients depending on the level of care needed and whether the contacts were via telephone or in-person. The contracts provided through BCI were monitored by the Idaho Department of Health and Welfare via the Bureau of Managed Care. Complaint resolution and service satisfaction were important for both clients and providers. Contracts included accountability and better service levels which were achieved through use of a local Idaho company. Survey feedback focused on support for providers and outcomes for patients. BCI was required to pay based on the Medicare fee structure.

PRESENTATION: **Medicaid Modernization: PacificSource**. **Norm Varin**, Director, Idaho Government Relations and **Erin Fair Taylor**, Vice President of Medicaid Programs stated that their sustainable provider relationship plan used a value rather than volume model. As a coordinated care organization with community governance and accountability, PacificSource ensured that prudent reserves were in place and the margins were used or invested for system maintenance and upgrades. By using most of any savings generated, the company created an incentive to manage costs and keep members healthy. They used a health council model which included representation from a broad range of care organizations. Cost savings or net revenue were able to be earmarked for community-based prevention programs, provider capacity building, education and training, and workforce development. Community governance ensured that Medicaid payers were accountable to the local communities by requiring transparency, shared prioritization, and for no single part of the system to drive the agenda (Attachment 2).

DISCUSSION: In response to Committee questions, **Erin Fair Taylor** clarified that self-sufficiency was always a goal, but often a long-term plan was needed that included training and various other needs. The ultimate goal was to help with housing, nutrition, and employment in addition to medical assistance. No-shows were a continuing challenge. Repetitive no-shows were connected to managers for follow-up, i.e. to address a need for transportation, anxiety issues, or other challenges for keeping appointments. The 10 percent who were fee-for-service with exemptions such as dual eligibility could opt out of managed care. Examples would be Alaskan/Native Americans or those with complex conditions. The fee-for-service group often experienced network access challenges or were unable to find providers.

ADJOURNED: There being no further business at this time, **Chair VanOrden** adjourned the meeting at 4:09 p.m.

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Senator VanOrden
Chair

Lena Amoah
Secretary