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GOVERNOR

## Idaho Primary Care Access Program FAQs

### Program Description

#### 1. What are the benefits of creating the Primary Care Access Program (PCAP)?

- PCAP provides a model of health care based on the patient centered medical home. The focus is on connecting program participants with an ongoing healthcare provider who takes responsibility for providing primary and preventive care to improve or stabilize the health of each participant.
- PCAP creates a public/private partnership with established local community health centers (CHCs) and Rural Health Clinics (RHCs) that now are only able to provide limited care to our lowest-income citizens.
- This is an all-Idaho plan for coordinated and managed primary healthcare for uninsured, low income Idahoans, with no federal money and no federal rules. The State would be completely in charge of eligibility requirements and rulemaking. This is not an insurance program.
- Providing access to primary care and care coordination will keep people healthier and stable, reducing healthcare costs due to expensive hospitalizations and emergency department visits.
- Investing in disease prevention and care management can strengthen the health of the state’s workforce.

### Program Participants

#### 2. What are the eligibility requirements for an Idaho citizen to participate?

- They must be an adult 19-64 years old with household income of less than 100% of the federal poverty limit and not eligible for other health insurance. For a single adult, the income limit is less than \$1,000/month; for a couple it is \$1,327/month.
- Participants must agree to a sliding fee scale of payment for services based on income.

#### 3. Will people be required to participate?

- Participation in this program is entirely voluntary. People who complete an eligibility application and meet the eligibility requirements will be connected to a participating clinic based on location.
- Program participants will receive an initial health assessment from their clinic to determine their health

status and to identify any chronic conditions which need to be managed.

- Participants with chronic conditions will work with their provider to design an effective treatment plan and commit to following the recommended treatment.
- To stay in the program they must be engaged in the process, demonstrating a commitment to their own health. For example, if a patient has a chronic illness such as diabetes they commit to a treatment plan including consistently coming in for blood tests, taking prescribed medications and following dietary recommendations.

**4. Can the adults registered for the program take their children receiving Medicaid benefits to the CHCs for healthcare?**

Yes. The clinics already accept Medicaid patients. The whole family would be able to receive medical care from the same source.

**5. Do patients contribute financially to their own medical care?**

The program requires payment for services on a sliding-scale fee, which encourages greater personal responsibility for the patient's own health.

**6. Is there a time limit for participating in the program?**

No. There is no time limit.

## **Provider Participation**

**7. What kind of providers will participate in PCAP?**

- Any licensed physician, physician assistant, or nurse practitioner who agrees to charge a sliding fee based on participant income, and to provide aggregated patient health outcome data to the state, is eligible to participate in PCAP.
- The state anticipates the most probable providers will be Idaho's network of community health centers, which have 72 clinic locations in 47 Idaho communities. Rural health clinics, with 38 operational sites that offer a sliding fee scale, are also potential providers for PCAP.

**8. What is a Community Health Center (CHC) and how is it funded?**

- CHCs are community-based, nonprofit organizations operated under the direction of a local citizen board. These clinics deliver preventive and primary care, dental and behavioral health services to anyone, including those without insurance, residents of rural and underserved areas, Medicare, Medicaid and private insurance patients.
- CHCs are required by law to provide services regardless of ability to pay. Because of this, CHCs rely on federal grants and fundraising to support some of the care for the uninsured.
- Current CHC funding comes from patient fees and insurance payments, federal grants, in-kind donations, foundations, and the United Way.

**9. Are community health centers located throughout the state?**

- There are 16 community health centers with 72 sites in 47 Idaho communities across the state.
- Examples of CHCs in Idaho are the Terry Reilly clinics in southwest Idaho, Health West or Community Family clinics in eastern Idaho, and Heritage Health in the Panhandle. A map of sites is included at the bottom of this document.

**10. Can the State afford to participate with the CHCs in a managed care program?**

- The program is not meant to provide comprehensive health care that is beyond tax payers' means, but to encourage preventive care to improve the overall health of those who have had very little consistent care from a health professional.
- People in the program with extensive health needs would still have to be directed to reduced-rate or charitable-care services through specialists, hospitals, and the county and State indigent funds. The participating primary care provider would continue serving that patient with follow-up care management following a catastrophic health event.
- Our federal tax dollars already provide partial support for the establishment and maintenance of CHCs. The State would be providing additional financial support in return for care coordination, management of chronic conditions and continued primary care services.

**11. How does the state benefit financially from providing additional funding to the CHCs?**

The State's contribution, on a per member per month basis, would provide financial support to the clinics to provide a patient centered medical home to each program participant. This care would include an initial health assessment, personal treatment plan, ongoing primary and preventive care, and care management. This care model is focused on keeping each participant healthy and keeping those participants with chronic conditions stable, out of hospitals and their emergency departments.

This is a state investment on the front-end of healthcare, focusing resources on preventive and primary care. This approach will reduce the degree of financial strain on the state at the other end of the care continuum which can incur extensive, catastrophic health care costs.

**12. What is a Rural Health Clinic (RHC) and how is it funded?**

- RHCs are located in rural, non-urbanized areas with a federal shortage area designation.
- RHCs provide primary care services and basic laboratory tests on-site. They also have arrangements with hospitals to furnish medically necessary services not available at the RHC.
- The RHC must have a nurse practitioner or physician assistant on-site seeing patients at least 50 percent of the time the clinic is open.
- RHCs may be independent or provider-based. As of December 2015, Idaho has 44 certified RHCs, which includes 18 independent and 26 provider-based RHCs.
- 38 of the 44 RHC sites presently offer a sliding fee scale for payment for services, which will be required for provider participation in PCAP.
- RHCs are reimbursed an all-inclusive rate for Medicare primary care services, although this per-visit limit

does not apply to RHCs which are part of a hospital with less than 50 beds. They also receive cost-based reimbursement from Medicaid.

**13. What are the responsibilities of participating providers and how can we be sure providers are actually providing appropriate care to those who are assigned to their clinics?**

- Each eligible provider will sign a contractual agreement to provide care management services and to submit required utilization and outcome data to DHW.
- Data analysis can identify provider performance issues.

**14. Are there enough primary care physicians to care for this population?**

- PCAP is provided through a medical home model that consists of a team of providers and is not focused on just a primary care doctor. If a person came in with a sore throat, they would probably be cared for by a nurse practitioner or physician assistant.
- Many of the people in the Gap are already receiving some episodic care from community health centers. These are not all new folks coming into the care system. Many are receiving some form of care, just not regular care.
- Not all of the estimated 78,000 will enroll in the program at once. We expect that it will take time for people to learn about the program, go through the enrollment process and be connected to a care provider.

## Funding

**15. How do we know the State's contribution won't increase or fluctuate?**

The State's per member per month contribution would be set contractually and remain at that rate for the term of the contract. The amount appropriated for the program would determine the number of individuals that could participate.

**16. What is the cost of the program and how will it be funded?**

- If the entire estimated eligible population of 78,000 were to register, at \$32 per member per month, the cost would be \$30 million per fiscal year. That's the equivalent of \$384 per person annually.
- The funding source is currently being discussed with the legislature.

**17. Do we have to raise taxes to fund the program?**

No.

**18. How did you choose the \$32 per member per month amount?**

Many of the CHCs participated in the statewide Medical Home pilot project to determine the efficacy of a care management program for patients with chronic conditions. This pilot gave the clinics the ability to determine the amount of time that was necessary to render effective care management and this rate is the result of those averages.

**19. By providing funds to the CHCs, are we competing with other health care providers?**

- All qualified primary care providers can participate in this program if they agree to provide the primary care management services and aggregated patient health outcome data to the state, and charge participants an income-based, sliding fee.
- Uninsured individuals traditionally have a very difficult time accessing care and are often unable to pay for services. Private providers do not typically compete for these patients and are unlikely to be interested in participating in this program.

**20. How long would this program last?**

With program evaluation data provided to the Department of Health and Welfare, legislators can decide if the program is providing the desired outcomes. Beyond a yearly review, the legislation has a five year sunset clause, allowing for a time-certain review for continuation or dissolution of the enabling legislation.

## **Program Administration**

**21. What are the Department of Health and Welfare’s responsibilities associated with this program and will there be administrative costs?**

- DHW will be responsible for administering eligibility determinations for this program through the Welfare Division’s IBES System, as they currently do for all applicants for Medicaid and the Your Health Idaho insurance exchange. This will require development of an additional system module to determine eligibility for this program, but allows for the leveraging of existing state infrastructure to minimize costs.
- DHW will connect program participants to a participating provider based on participant’s home and clinic locations. Program participants may ask to be reassigned if a different clinic location is preferable.
- DHW will issue monthly payments to participating clinics based on number of participants served by each clinic.
- DHW will collect data from participating clinics to measure program utilization and effectiveness.
- There will be initial program start-up costs, including IBES system development. There will also be ongoing administrative costs to provide support to program participants and providers.

**22. How would program success be evaluated?**

- All participating providers would be required to provide specific aggregated program utilization and health outcomes data to DHW. This data will be analyzed to measure program utilization by participants, initial health status of participants and health outcomes/improvements over time.
- Data required from participating providers would be aggregated and would not include individual patient data, protecting sensitive health information.
- Outcomes will be reported annually to the legislature, or as often as requested.