**Granite State PNHP**

**Agenda/Minutes, July 22, 2015**

1. Introductions
   1. Mina (on phone)
   2. Kelsey and Theresa, UVM Interns
2. Review June minutes
3. Review Agenda
4. Report on June’s 2 events: Ahmed
5. Commissioner Nick Toumpas, Department of Health and Human Services. Question and Answer session regarding how the budget process works and how this could be incorporated into our proposed Bill.
6. Mina’s report
   1. Organizing the speakers bureau
   2. Blog
   3. Weekly “check-in”
7. Strategy for the fall
8. Review of Action Items
9. Next meeting August 26, 2015

Attending:

Rob Kiefner

Camilla Jones

Don Kollisch

Susan Zlotnick-Hale

Ahmed Kutty

John Swartz

Mark Patnaude

Gary Sobelson

Mina Ghobrial (by phone)

Theresa and Kelsey (UVM Med Students, Vermont PNHP Interns

1. June 27 events – we spoke with a number of people at both events – NH Progressive Summit and the Hillsboro Democratic BBQ.
   1. We are invited to sponsor a Workshop next year at the Summit
   2. We met with reps from campaigns of multiple Presidential candidates
2. Commissioner Toumpas
   1. In office since 2007, initially acting and then appointed/reappointed as the full Commissioner; previously Assistant Commissioner
      1. Initially came in 2002 to head up BioTerrorism for the state
      2. Previously Telecommunications and Information for 20+ years (including Lucent)
   2. HHS is a Dept “in perpetual storm”
      1. Largest State agency ~$2billion
         1. Medicaid, Food stamps
         2. Child Welfare, Justice
         3. Special populations Mental health, elderly, disabled
      2. Medicaid serves ~120,000
         1. $1.5 billion
            1. 30% of people drive 70% of cost: **Elderly, disabled, mentally ill**
            2. Low income women and children – 70% of clients – drive ~25% of cost
         2. Reorganizing to be more wholistic – lumping, rather than splitting services
      3. Interested in Population Health (prevention, wellness)
      4. Only part of Medicare population are the Dual-eligible (i.e. Medicaid/Medicare)
   3. Budget development
      1. Five-phase process
         1. Agency budget begins ~12 mo in advance, based on basic assumptions and submitted in October
         2. Governor charges Departments to build a budget at a certain percent of previous budget (e.g. 100% in year 1 and 103% in year 2)
            1. Departments/Agency craft a budget based on Governor’s guidelines
            2. Governor presents budget to House in February
         3. House develops a conservative budget based on anticipated revenues, and instructs Department to cut (sometimes drastically)
            1. Department (part of “Division 3”) submits to the Finance Committee of the House, which votes up-or-down by March/April
         4. Senate reviews House Budget and Governor’s Budget, and instructs Department to refine further (usually with more-accurate revenue projections). Budget passed by Finance committee and then entire Senate
         5. Final Phase: Committee of Conference (between House and Senate) to reconcile the differences
            1. Both Houses then pass the reconciled budget
            2. Governor than signs or vetoes the budget
      2. Biennial budgeting (e.g. 7/15-6/17)
      3. Budget is currently on a 6month “Continuing” resolution, which is messy and in-elegant.
         1. September 16 the Legislature will come in to address the Governor’s Veto
         2. Between now and Sept 16, there are negotiations
         3. Issues are quite political.
   4. Money flow (question asked by John)
      1. Entitlement programs, e.g. Medicaid
         1. Federal dollars (50% match) are deposited after the state spends/commit expenditures
         2. The state pays Managed Care organizations a PMPM fee; the Managed Care Organization contracts and pays providers
         3. The state can directly pay providers fee-for-service. The Department perceives that there is NO quarterback guiding expenditures; that is why they favor working with a Managed Care Organization
         4. The Department sees Managed Care as a cost-control vehicle.
      2. Grants
         1. Fiscal Committee has to accept and approve the budgeting for the grant
   5. Medicaid expansion – for 41,000 new enrollees - is working to decrease ER and decrease uncompensated costs
      1. Care is being reimbursed at Medicare rates
      2. HHS working hard to analyze
   6. Regarding Single-Payer
      1. Recommendation is to focus on the benefits and impacts for business, patients, providers (based on system dynamics)
         1. E.g. less ER use
         2. E.g. less uncompensated care at the Hospitals
      2. Looking at bills, there are two additional steps:
         1. Fiscal Memo
         2. Operational Steps
   7. GDP (state) for health care is currently ~18-19% (similar to the rest of the country) and will continue to grow.
      1. This squeezes other economic areas
      2. Controlling Health Care costs
   8. Gary: public accountability by global budgeting (e.g. Public Hospitals, Managed Care, VA) can decrease the profit motive. What would happen if Medicaid and Medicare and employer-based systems were merged (e.g. Single-Payer)
      1. This would require LEADERSHIP in the state, especially from the Governor
      2. You cannot TRANSFORM and not change; which means that entrenched interests will be upset.
      3. Waivers can stimulate innovation
   9. Rob: is change best engineered at the state or federal level?
      1. Answer: innovate at the state level, because it’ll be too watered-down at the Federal level.
      2. CREATE a map, showing how messy the current status is.
      3. Show how a new map can be drawn
   10. Susan: delinking insurance from employment is a pro-jobs argument
       1. In Europe there are Value-added Taxes, which might be culturally unacceptable
       2. Toumpas: the whole-person approaches in Europe, where there is less health-care spending, there might be more social spending “an investment”
   11. Theresa: health spending forces the Department to spend less on Social Services.
       1. Toumpas: Engineering solutions
   12. Don: there are overlaps of aspiration between HHS and PNHP
       1. Holism, health of community
       2. Toumpas: it IS a cultural change.
       3. It might be good to have a meeting with John Williams, HHS Dir of Legislative Affairs, to help craft our next bill.
       4. Look for the “STATE INNOVATION MODEL” for new delivery system models.
   13. Gary: Health Care providers within HHS would likely be sympathetic and supportive of Single-Payer models
   14. Toumpas: look to partner with the Business community, as well
3. Mina’s Report
   1. Learning about Single-payer and health policy
      1. He has developed 2 little “quizzes” to elicit folks’ knowledge and interest. Embed them on a web-site or link to them in an article.
         1. Susan: use them at the beginning of a talk
         2. Mark: Christian Science Monitor uses them
      2. Go with it!
   2. He has collected video clips of Political figures advocating for single-payer (including Donald Trump!)
      1. Clips last 1minute to 7minute.
      2. SNHAP could help host.
      3. Gary: perhaps a production-quality summary 2-5minute movie would be good.
      4. Ahmed: include a Ronald Reagan
   3. Blog: he has 2 (and soon a third) posts so far, but hasn’t sent us the link yet
4. Ahmed: July 30th is the 50th Anniversary of Medicare. Maine Nurses will be hosting a meeting. He may staff a table on August 1 in Portland, ME
5. Next meeting on August 19, rather than August 26.