Committee Minutes:

Health Care Task Force

House Majority Caucus Room

State Capitol, Boise, Idaho

Wednesday, December 3, 2003

CORRECTED MINUTES

The meeting was called to order at 9:14 a.m. by Cochairman Representative Bill Deal. Other Task Force members present were: Cochairman Senator Dean Cameron, Senators Joe Stegner and John Goedde and Representatives Max Black, Kathie Garrett and Gary Collins. Senators Sheila Sorensen and Fred Kennedy and Representative Margaret Henbest were absent and excused. Staff members present were Caralee Lambert and Charmi Arregui.

Others present included: Senator Skip Brandt; Senator Dick Compton; Bob Seehusen, Idaho Medical Association; Julie Taylor, Blue Cross; Lyn Darrington, Regence BlueShield of Idaho; Ken McClure, Givens Pursley; Woody Richards, Moffatt Thomas; Steve Tobiason, Idaho Association of Health Plans; Christine Pickford Ph.D. and Cindy Anderson, Employers Health Coalition of Idaho; Kate Vanden Broek, Idaho State Planning Grant; Teresa Molitor, Idaho Academy of Commerce & Industry (IACI); Shad Priest, Phyllis Stephenson, and Mary Hartung, Department of Insurance; Ray Millar and Ken Deibert, Idaho Department of Health & Welfare; Greg Hahn, Idaho Statesman; Candice Crow Ph.D., Molly Steckel and Deborah Katz, Idaho Psychological Association; Tony Poinelli, Idaho Association of Counties; Ulla Saarek; J. R. VanTassel, Nez Perce County Commissioner; Bill Foxcroft, Idaho Primary Care Association; Leslyn Phelps, Executive Director, Glenns Ferry Health Center; and Mike Brassey, St. Lukes Regional Medical Center.

A motion was made by **Representative Max Black** to approve the minutes dated October 8, 2003, seconded by **Representative Gary Collins**. The motion passed by voice vote.

Mr. Laren Walker, AmeriBen Solutions, was invited to report on the Idaho Individual High Risk Reinsurance Pool. **Mr. Walker** handed out the most recent board-approved financial

statement, dated September 30, 2003. A copy is on file in the Legislative Services Office. The balance sheet for the program reflected assets including $6,908,998 in cash due to the current year tax revenue. More than half of that cash ($3.6 million) came in just prior to the preparation of the balance sheet. Total assets for 2003 were $6,911,020 compared to $4,127,694 for 2002. Total liabilities for 2003 were $3,875,247 compared to $1,798,348 for 2002. The fund balance for 2003 was $3,035,773 on September 30, 2003.

Statement and expenditures for the nine months ending September 30, 2003, reflected $4,958,656 in total revenues/income compared to $3,244,152 for 2002. The pool is receiving about $141,025 per month in premiums for a total of $1,295,647 as of September 30, 2003 compared with $831,647 for 2002; the reason for the significant increase is the number of ceded lives, or the level of activity in the program which has grown each year. Investment options are being explored to increase the interest income. Total expenditures of $1,798,583 include claims incurred as of September 30, 2003, compared to $1,351,817 for 2002. Looking at a pure loss ratio (premiums compared to claims paid) premiums were $1,295,647 compared to claims of $1,798,583, which is a point of interest. Other significant expenses for 2003 include $108,585 in administration fees including legal and actuary fees. The fund balance ending September 30, 2003 was $3,035,773.

Mr. Walker reported that as of October 20, 2003, the pool included 1,393 total ceded risks (lives) with 43 additions and 98 terminations (in October) totaling 1,338 lives. The non-smoker Catastrophic B plan had 475 and 360 in the non-smoker standard plan, which were the most highly used plans. The non-smoker numbers were significantly higher than the smokers. Ceded risks by carrier reflected 420 insured by Carrier A, 886 by Carrier B, and 32 for all other carriers in the state, totaling 1,338 lives in the program. Activity in the program since inception has grown steadily from January, 2001, to January, 2003. There has been a slight decline since January, 2003, fluctuating from 1,200 to 1,500 ceded lives.

Representative Black inquired about the trend of the plan maturing and leveling off between 1200-1500; if the tax premium income grows, could a surplus develop and what would happen if that does occur? **Mr. Walker** answered that these are high-risk individuals with a million dollar maximum per individual, so high claims are expected. An organ transplant could cost over $500,000. The pool has not seen a claim over $200,000 as yet, but those dollars could be eaten up rapidly, and higher claims are anticipated. Most claims have been in the $50,000 to $100,000 range and his report itemized claims over $50,000 for 2002 and 2003.

Mr. Walker pointed out that a 32% street rate increase for the program in 2004 was recommended by the actuary representative based on studies and trends, which raised debate among the board members. The board determined that a 15% rate increase was appropriate since the board's intent is to make the plan affordable.

Representative Deal noted that the report on this pool was made because the Health Care Task Force is the oversight committee for the high risk pool.

Dr. Candice Crow Ph.D., Idaho Psychological Association (IPA), next addressed the Task Force. The IPA comprises about 120 psychologists throughout the state, both in the public and private sectors, and this organization tries to evaluate and assess issues pertinent to psychologists and also the status of mental health services. **Dr. Crow** conducted an informal survey to get a clearer perspective. She stated that she has been licensed as a psychologist since 1975, working in both public and private settings and was in charge of the mental health care program in Region IV in Idaho before going into private practice. There is a 100% consensus of the IPA that the most severe problem with regard to mental health is access to appropriate mental health care, especially for those with serious mental illness and limited financial resources. Idaho's mental health care program, in her opinion, has been broken for years. Financial resources limit access to mental health for many people who are indigent, are uninsured, or are on Medicaid or Medicare, and for insured individuals who may have mental health benefits but cannot meet out-of-pocket expenses that are established in insurance plans. There is a tremendous stigma attached to mental illness, which makes it difficult for patients to seek treatment or for loved ones to support those who have mental problems. It is extremely difficult to get a Medicaid patient referred to appropriate mental health care, and referrals to a psychiatrist (to evaluate for medication) may take 5 to 12 weeks. If a psychologist is in private practice, they are not able to get direct reimbursement from Medicaid. That closes doors to many people who might want to access various providers throughout the state. If there is a lengthy delay to access service, it is not unusual for an individual to simply give up any hope of treatment. It is imperative that these mentally ill patients continue to take their medications and get the treatment they need. There is a lack of qualified mental health care professionals in Idaho, especially psychiatrists. It is a tragedy that community law enforcement and physicians are being taken away from their important jobs to cope with mentally ill patients who are not receiving the care they need.

Dr. Crow continued by stating that the fragmentation between mental health care services and substance abuse services in Idaho indicates a lack of coordination; each is organized, funded and operated very differently. This is a huge problem identified by the IPA because a patient with both mental health care and substance abuse issues cannot get help for both in the same place. They are not getting the treatment they need, especially when trying to get a patient hospitalized through a commitment process. **Dr. Crow** stated that she does not know how much of the problem is a reflection of the vague language in the law or the difficulty in coordination of services. There is also confusion between law enforcement and the hospitals in response to mental health problems. Often the problem is based on cost, and schools are even hesitant to address mental health issues due to special education requirements for certain students. Cost factors cause many children and adults to fall through cracks and deteriorate even further, eventually costing the state much more than if they received appropriate treatment in the beginning. Funding is limited, but the mental health care system in Idaho must be fixed because many individuals are being denied appropriate mental health and substance abuse critical care.

Dr. Crow believes that ACT teams need to be expanded so that more support and better funding is in place to provide services to more patients. Intensive case management and intervention needs to be the focus, especially in rural areas where there are no mental health care professionals to deal with an acute crisis. **Dr. Crow** highly recommends more funding for mental health care in Idaho, but first an evaluation needs to be done in terms of where money is currently being spent. In addition to looking at a funding mechanism, problems of the uninsured and Medicaid need to be addressed by increasing the reimbursement rate for psychiatrists so that they will be willing to treat patients. Independent reimbursement status for psychologists and other mental health care professionals would also help in terms of access to care. Expansion of ACT teams is necessary as well as more local, secure in-patient psychiatric bed capability. Too many patients are being transported from rural areas to a more populated area for treatment, then released with little or no follow-up care in their own communities and no coordination of services. Coordination of mental health and substance abuse services need to be addressed in insurance plans so there is not discrimination. We need to expand the plans and programs for early intervention such as the Red Flags program, which involves going into rural communities and talking to parents, teachers and children to educate as to the early warning signs of depression, suicide and the potential for violence.

Mr. Ken Deibert, Administrator of Family and Community Services, Idaho Department of Health & Welfare (IDHW), was the next speaker. **Mr. Deibert** is responsible for adult and children's mental health services as well as substance abuse programs operated by the state of Idaho. IDHW partners with Medicaid and the private sector in providing mental health care to individuals with resources they have available within the limitations, guidelines and funding resources of IDHW. **Mr. Deibert** stated that he has observed over 30 years an increase in awareness about mental health issues in the 1960's followed by a significant decline in interest in commitment to the provision of mental health services through the U.S. and within Idaho. Idaho has consistently been among the top ten states in suicide rates. Idaho doesn't have a comprehensive system of mental health services to adequately meet the needs of its citizens with mental illness. However, Idaho does have some of the best professionals, hospitals and dedicated individuals both in the private and public sectors. IDHW needs to evaluate and look more comprehensively at mental health care needs and how to best address them.

Mr. Ray Millar, Adult Mental Health Program Manager in the Central Office for Adult Mental Health Services for Family & Community Services, IDHW, handed out the "Idaho Department of Health & Welfare Mental Health Services Information Packet," a copy of which is on file in the Legislative Services Office. The Task Force asked IDHW to address specifically:

- How are IDHW mental health services delivered in Idaho?
- What programs and services are provided by IDHW?
- Is mental health care provided throughout the state? How is it distributed?
- How much money is IDHW spending on mental health care?
- Are there differences from region to region?
- What challenges face IDHW in delivering mental health services in Idaho?

- What can be done to improve mental health services in Idaho?

Mr. Millar stated that the organizational structure of IDHW includes seven mental health care regions, two state hospitals and the Idaho State School and Hospital serving persons with developmental disabilities. The state of Idaho serves any individual 18 years of age or older who has a severe and persistent mental illness and who meets the following two criteria:

1. The individual must have a diagnosis under DSM-III R or DSM-IV of schizophrenia, schizoaffective disorder, major affective disorder, delusional disorder or a borderline personality disorder; and

2. This psychiatric disorder must be of sufficient severity to cause a disturbance in role performance or coping skills in at least two of these areas on either a continuous or an intermittent (at least once per year) basis: Vocational/academic, financial, social/interpersonal, family, basic living skills, housing, community or health.

In addition to the above population, IDHW serves any individual 18 years of age or older who is experiencing an acute psychiatric crisis, including suicidal and/or homicidal behavior and who may end up in an inpatient psychiatric facility if mental health intervention is not provided promptly. Only short-term treatment or intervention, not to exceed 120 days, is provided to this population.

Mr. Millar stated that Idaho has one of the most rationed mental health service delivery systems in the nation for publicly funded services. IDHW provides services to the most severe and most ill. There are other individuals who have a severe mental illness who do not receive services due to prioritization. IDHW's Assertive Community Treatment Team (ACT) has admission criteria which states that individuals are refractory, meaning their illness (even when receiving treatment and on medication) does not mean they remain stable over time. Patients also have frequent contact with the legal system, histories of incarcerations and hospitalizations. IDHW calls ACT teams "hospitals without walls" and a psychiatrist is assigned directly to that team up to 16 hours per week of immediate care for individuals assigned to that team, as well as several nurses and master level clinicians. As a team they serve the highest risk group of individuals that would otherwise be in hospitals. The team has about eight hours of weekly contact with their patients.

Representative Deal asked what happens to a person who has an acute crisis if IDHW's treatment does not exceed 120 days. **Mr. Millar** answered that if a patient does not meet the first criteria of having "a severe and persistent mental illness" IDHW provides treatment the first 120 days, the ACT or Crisis Intervention team stabilizes the situation, and then that individual is transitioned to other community providers or other medication follow-up services, such as psychiatrists. The funding is inadequate for this care after the 120 days, even though there are services for the indigent. They may be referred to a private mental health clinic provider or a psychosocial rehabilitation provider, depending on circumstances.

Senator Cameron asked how many of those individuals would then end up on the state's indigent rolls. The catastrophic fund for indigents is paying a significant amount for mental health and substance abuse treatment and **Senator Cameron** asked if that is occurring after they exhaust the benefits available through IDHW. **Mr. Millar** responded that IDHW's services are prioritized and many indigents receive care. IDHW does make referrals to county welfare indigent programs to receive medications or to pursue funding for counseling services sometimes for domestic violence or substance abuse. A large number of people IDHW serves are indigent; 27% of the people are not only the severe, persistent mentally ill clients who have Medicaid funding or insurance, and IDHW's collections are very low in trying to collect from Medicare, private insurance or Medicaid. **Mr. Millar** continued that while the federal government prioritizes serious mental illness, IDHW prioritizes serious and persistent mental illness. Individuals with a serious mental illness such as a gulf war veteran who has post-traumatic stress disorder, or a person who has panic attacks would not be served by the Department unless the individuals were experiencing psychiatric crisis. In Idaho, IDHW goes one step further and prioritizes serious and persistent mental illness such as bipolar disorder, schizophrenia, or major depression that is so severe that it causes them to be unable to work and results in them being hospitalized. There are two levels and serious mental illness includes a larger number of individuals. According to the 2000 U.S. Census out of 924,923 representing 71% of total population, the number of adults in Idaho with mental illness, serious mental illness or severe, persistent mental illness totaled 184,984, or 20% of the adult population. The federal government requires IDHW to provide services at a minimum for those with serious mental illness, which is for 49,946 or 5.4% of Idaho's adult population. IDHW prioritizes their services to those with severe persistent mental illness and serves 24,048 or 2.6% of Idaho's adult population. In fiscal year 2003, IDHW served 14,032 to date or 1.5% of adult population. There is a tremendous amount of unmet need for individuals even with a serious mental illness and about 25,000 who could be accessing IDHW's services as severe persistent mentally ill when compared to any other state. The ongoing IDHW caseload numbers about 6,000. **Mr. Millar** noted that children with serious emotional disturbance aged 0 to 17 equals 5% of 369,030, totaling 18,452. Mr. Millar then passed out a handout entitled: "Idaho Council on Children's Mental Health - Community Report Card, December, 2002" which is on file in the Legislative Services Office.

Mr. Millar stated that IDHW provides the following "core" adult community mental health services in all seven regions: Screening; targeted case management; crisis intervention; psychiatric rehabilitation; assertive community treatment; psychiatric services; and short-term mental health intervention. State Hospital South features 90 adult beds, 30 skilled nursing beds and 16 beds for adolescents. The cost per patient day was $407 in 2002. State Hospital North (SHN) features 50 beds and currently admits patients committed by the judicial system; in 2002 the cost per patient day was $358. There are waiting lists at both hospitals for IDHW's highest intensity services for inpatient psychiatric services and the wait is around 10-24 days. Local hospitals serve those patients in the meantime. There is no wait for individuals to be assessed or screened at outpatient services.

Senator Cameron asked how much money IDHW spends on community mental health centers. **Mr. Millar**'s handout lists services provided in each region and **Senator Cameron** mentioned that his observation is that patients sometimes are only being given free cigarettes; he challenged that list of services being provided. What role do free cigarettes play in helping with mental health problems? **Mr. Millar** responded that he also shares concerns and admitted that in the IDHW regions they are not serving large numbers in day treatment any longer, and have focused on ACT teams. IDHW does have a team or a portion of an ACT team in each region; however, those teams are not fully staffed and do not necessarily meet national standards. IDHW does not have certified, fully funded or fully functional ACT teams, but IDHW is preparing to meet national standards and have improvement plans in place.

Senator Cameron inquired if the community health centers that are privately owned, but are funded by Medicaid reimbursement, fall under assertive community treatment? **Mr. Millar** confirmed that the centers are usually private services that would be reimbursed, typically by Medicaid. IDHW's services are primarily centered near urban centers.

Mr. Millar continued by stating that IDHW's family and children's services offices are located in the following seven regions: Coeur d'Alene; Lewiston; Caldwell; Boise; Twin Falls; Pocatello; and Idaho Falls. IDHW is not seeking a way to build 2-3 more state hospitals. **Mr. Millar** addressed IDHW's community services expenditure report dated September, 2003 broken down for adults and children. Idaho ranked 46th nationally for actual mental health dollars spent per capita in fiscal year 2001. Idaho is the 5th fastest growing state and had the 3rd highest growth rate from 1990-1998.

As to differences of IDHW's regional programs, **Mr. Millar** stated that some have more field offices than others, some provide more rural services, with more urban access to psychiatric care. All regions have contracts with local health care providers that provide services beyond IDHW's "core" services. He noted the following mental health system challenges:

1. Service Gaps: voluntary inpatient services; longer term inpatient; longer term substance abuse treatment; rural mental health services & providers; secure inpatient services for violent offenders; and treatment of co-occurring disorders.

2. Early intervention/prevention services

In order to improve the system, **Mr. Millar** set forth IDHW's recommendations: Implement full insurance parity for mental illness; realign resources and technology; implement evidence based practices; develop statewide standards for service delivery; develop new alternatives to hospitalization; increase service system coordination; increase availability of voluntary mental health services for non-priority populations; implement early intervention/prevention services; develop a secure forensic facility for violent offenders; continue to support statewide suicide prevention plan; support care management strategies for service delivery; implement a

comprehensive data system for mental health services; support provision of mental health care in jail and prison; and implement recommendations of President's New Freedom Commission. The goals and recommendations of the Freedom Commission are outlined in a handout distributed by **Mr. Millar**. A copy of the handout is on file with the Legislative Services Office.

Representative Black asked for clarification regarding IDHW's community services expenditure report showing mental health receipts for fiscal year 2002 as $3,408,700. **Mr. Millar** answered that the number represented primarily Medicaid receipts as well as sliding-fee payments from clients. **Mr. Deibert** explained that in the state mental health hospital system, when an individual is committed to the state of Idaho, their private insurance does not pay for the cost of care in a state psychiatric facility; Medicaid does not pay for inpatient psychiatric care even if the person is Medicaid eligible. State Hospital North receives practically no receipts because they serve only adults. The receipts that IDHW receives for payment of services for State Hospital South are primarily limited to treatment of adolescents. IDHW cannot get Medicaid reimbursement or insurance reimbursement for services provided in the state operated psychiatric hospitals. That limitation exists in code and rule. **Representative Black** cited an instance of a patient who was billed $139,000 for services received from State Hospital South. **Mr. Deibert** clarified that IDHW was obligated to submit a bill for services whether or not that individual can pay. IDHW's ability to collect is diminished with the vast majority of individuals entering the state hospitals. **Representative Black** requested that IDHW provide a dollar amount for the services billed by IDHW and the amount received from such billings. **Mr. Deibert** stated those figures would be forthcoming. **Mr. Deibert** added that the expenditure report represents receipts for outpatient services only and not inpatient.

Representative Garrett requested a region by region synopsis of the caseload differences between IDHW regions and asked if there was a difference between needs and services in different regions. **Mr. Millar** answered that the caseload differences vary according to the services they receive. The largest number of services are provided by ACT teams. IDHW's Region IV (covering Boise, McCall and Mountain Home) has the largest number of ACT teams. Almost 50% of state hospital beds are occupied by residents in Ada County. Court related evaluations have risen from 60-80 per month in Region IV several years ago to 130-150 per month currently. IDHW used to get defense attorneys and judges ordering evaluations related to competency to participate in their defense in numbers from 5-6, and recently the number has risen to 18 per month.

Senator Stegner referenced the Community Services Expenditure Report under adult community mental health services for fiscal year 2003, which shows $16,438,100 total. He stated that it appeared the Legislature cut the funding by nearly $2 million for that service, but in fact the appropriation for that fiscal year was $18,131,700. IDHW shifted funds downward in four different categories, reflecting a funds adjustment reduction of $832,000, a transfer between programs of $120,000, and other adjustments for a total reduction of about $1.8 million or 10%. He queried why, if there is so much need for increased service delivery for mental health services to adults in Idaho, IDHW reduced its own appropriation by 10%. **Mr. Deibert** responded that the last few years have been challenging for IDHW from a funding perspective

and the funds returned to the general fund are those potential carryover funds requested by the Governor to be returned to the general fund to address the deficit at the end of the fiscal year. Those funds were returned to the general fund at the Governor's request. The fund shifts could not be explained specifically by **Mr. Deibert** without looking at detail. IDHW set as a priority, working with the Governor's office, that the focus of any cuts made over the past two years had the least amount of impact in children's services in both mental health and child protection services. Within the Division of Family and Community Services, that left IDHW very few options. Substance abuse, mental health and developmental disabilities were areas that ended up with reductions to meet the budgets for those programs. **Mr. Deibert** volunteered to respond to **Senator Stegner's** inquiry in detail after gathering more data. **Senator Stegner** stated that it does appear to be a pattern not only in adult mental health but with the budget for State Hospital North, which was appropriated $6.2 million with actual expenditures $5.7, a reduction of nearly 10%, and an appropriation to State Hospital South of $16.3 million with expenditures of $16.5, which went up. Developmental disability services had an appropriation of $18 million and expenditures of $16.6 million. Children's services program under family and community services received an appropriation of $55.1 million and expenditures were $51.9, a reduction of $3.2 million. There appears to be a pattern of reduction in almost all categories and **Senator Stegner** broadened his request for an explanation to all of those programs for fiscal year 2003. **Mr. Deibert** responded that there were hold-backs during 2003 and those are reflected in the figures presented. IDHW had a 3.5 percent general holdback within family and community services which amounted to about a 7% reduction of programs. Maintenance of effort requirements must be addressed, and for substance abuse, IDHW was within $3000 of falling below federal maintenance of effort funding formula for substance abuse. If they had fallen below that figure, IDHW would have lost federal dollars. IDHW ran into that same situation with the infant and toddler program and were very close in mental health services for both adults and children.

Senator Goedde commented that IDHW was working on a comprehensive data system since 1991 and asked when that might be finished. He also inquired about the accuracy of the IDHW information being provided to the Task Force. **Mr. Millar** responded that within two years IDHW will have a prototype of the database ready. With regard to the accuracy presented to the Task Force, **Mr. Millar** stated that IDHW is doing better than in the past, but acknowledged there have been duplications in their system. **Senator Goedde** stated that he heard that there are existing assets not being utilized as well as they could be and that coordination would help. IDHW's list of ways to improve the system do not appear to require any legislative directive for a starting point. **Senator Goedde** asked what steps IDHW has taken on their own to implement some of these improvements and to better utilize the assets. **Mr. Millar** answered that IDHW has been working with public providers to change the role of the regional directors to work specifically with hospitals, jails, county commissioners and other individuals in communities to develop these coalitions. Improvements have been made in children's mental health by developing 37 Children's Coordinating Councils in the last two years, bringing together schools, the Department of Education and the IDHW itself, gathering other service providers into local councils to review cases for children and staff these cases. For adults, IDHW has been trying to maintain services and seek information about how they can improve their standards of practice. Everyone recognizes that IDHW often sees the same clients publicly and privately and are receiving services across programs and they are trying to better coordinate these programs.

Mr. Deibert added that some of the challenges faced in Idaho as well as other states are not self-imposed limitations. There are significant restrictions on funding from the federal government and many strings are attached that often prevent adequate collaboration. Substance abuse and mental health are both within the division of family and community services, but it is extremely difficult to make these programs work with each other. Given the funding priorities and the requirements of federal dollars, if a person has a mental illness and is also a substance abuser, they may not qualify for substance abuse treatment with the federal priorities that are set for the funding. In some cases, people with a mental illness are excluded from receiving substance abuse treatment based upon the federal criteria.

Mr. Deibert continued by stating that IDHW is working with the courts to develop a strategic plan between family community services around mental health, substance abuse and child protection issues so that there is a more coordinated effort. IDHW recently signed a memorandum of understanding with the Department of Corrections to assist them in the development of services to individuals who are being released from the prisons who are in need of mental health services and substance abuse services. The President's Freedom initiative, if implemented, would enhance the state's ability to have funding flexibility.

Representative Deal requested that IDHW gather data for the Task Force regarding the money available for mental care. Money from the general fund has been identified, but **Representative Deal** asked for figures and sources of additional funding, including from the catastrophic program from the counties and other grants that are used and available and what strings may be attached. **Mr. Deibert** will gather that information but stated they do not have figures or facts from the counties. **Mr. Tony Poinelli** agreed to work with **Mr. Deibert** to obtain this information for the Task Force.

Representative Garrett requested more information regarding where mental health dollars are already being spent, and suggested that if more dollars were spent on prevention and medications, it would save money in the long run by avoiding crises.

Senator Goedde requested from IDHW facts about what has been done in the past several years with regard to reorganizing, utilization or improvements in their system from IDHW's side. The Task Force can see what needs to be done, but it would be worthwhile to see historically what IDHW has done in the past several years.

Senator Stegner distributed a draft proposal relating to mental health services. A copy of this draft proposal is available in the Legislative Services Office. **Senator Stegner** stated that the proposal would be a very small but important step toward an effort to improve mental health care services in Idaho. The draft basically sets in place a change in philosophy of the state about who makes mental health care decisions and how these decisions are made. This proposal is the product of four years of work by a group of people including an attorney, Senator Stegner,

county commissioners, clerks and other officials and hospital personnel. Health and mental health care professionals and advocacy groups have also been involved. The process began when the problem of defining the area of responsibility for mental health in Idaho arose. Is it a county indigence problem or a state responsibility? It was evident that it was a much bigger problem.

Senator Stegner stated that decisions need to be made at a regional level by concerned people who work "down in the trenches" of mental health, who are committed to improving the system and who recognize the deficiencies of the current system and the individual assets of a region. The counties, in some cases, are too small to handle this. The committee's vision is to someday have a behavioral health regional office in every region in the state, very similar to the public health offices in Idaho, or possibly in combination with the public health offices. They'll be able to set priorities and design a system unique to each region, recognizing that they'll have to share assets and that small communities may not have every service right in town, but they will know they have service within a reasonable distance. That is the vision of the committee, and **Senator Stegner's** personal vision includes a state hospital in central Idaho. When 47% of the people are transported to state hospitals from Ada and Canyon counties, we need one closer, and we haven't increased beds in that service in fifty years, even though the population and the need has grown incredibly. **Senator Stegner** stated that the function of the state hospitals should be expanded to meet the service needs of the counties and local communities with regard to holdings, commitments, voluntary commitments and substance abuse.

Senator Stegner asked the Task Force to give some consideration to the concept of regional authority in making mental health care decisions which starts from the base and builds a system responsive to local needs, rather than a top-down authority from the state of Idaho which mandates downward. In order to do that, an existing structure in the state could be modified, giving them a little authority (if they want to take it, which is optional) and setting up the process to allow that. **Senator Stegner's** committee has been sensitive to IDHW, and their involvement would still be key and would require their approval for any plan improvement. If this plan were in place in one or all regions and they would want to take the initiative, they could develop a plan that will allow that region to get full funding for an ACT team, since they are very effective in reducing people moving through the state health, court and emergency room systems. ACT teams create that concept of "hospitals without walls" and **Senator Stegner** thinks they should be expanded statewide. ACT teams are not currently fully funded.

Senator Stegner's committee has developed a process where regionally, people can establish behavioral health boards; this does not mean that this would be funded, but rather applications could be submitted, the plans presented to IDHW for approval and the Legislature can work on a plan for funding. Funding would involve increasing beer and wine taxes and putting that money to specific uses, one being ACT teams. **Senator Stegner** recognizes the uphill battle of increasing beer and wine taxes, but he hopes there is broad support from cities and counties and there would be a component that would benefit education and liquor control enforcement. There is a coalition that recognizes not only the policy improvements by changing beer and wine from a volume to a price-based tax, but also the benefits of the money generated by that process.

Mr. Tony Poinelli, Idaho Association of Counties, spoke next in support of the draft proposal introduced by **Senator Stegner**. He explained that the current law addressing mental health advisory boards would be changed to "regional behavioral health boards," the primary reason being that there is constant dual-diagnosis of individuals, with mental illness as well as substance abuse problems. The regional behavioral health boards would allow the counties to be involved more closely than they are at present, as well as other parties in the community who have a major influence and impact in determining what needs are. In Section 2 of the draft proposal, the makeup of the boards is outlined. All of the studies over four years suggest that more involvement at the local level is needed. The appointments would be submitted to IDHW, but the final appointments would still be made by the local commissioners and regional people.

Section 3 deals with individuals serving on the current advisory boards and it has been suggested that members of the current mental health advisory boards serving their current terms may continue until end of current term. Appointments made after that effective date would be made in a manner to achieve the representation provided in that section as soon as reasonably practical. Most of the mental health advisory boards are made up of consumers, licensed practitioners, etc. There are not many who have any county representation. There may be a welfare director, but there are no policy makers. The county commissioners are policy makers.

Under Section 4, additional duties were added. In Section 5, the focus is the creation of ACT teams. There are ACT teams within each region, but only two may meet the national standards. There are gaps with members of individuals on those ACT teams. Establishing 8-member ACT teams that meet the national standards would be a good first step in all regions. The proposal may not appear to do much, but it brings the right people together, including policy makers who are not there now and will "hold everyone's feet to the fire."

Representative Garrett emphasized her support for strong community mental health. She stated that there are inconsistencies and fragmentation in regions identified by IDHW. With regard to development of statewide standards, best practices and service system coordination, **Representative Garrett** inquired how the proposal would dovetail with those concerns. **Mr. Poinelli** answered that they wanted to look at basic services for each region with each region's different needs to allow flexibility. There is focus on ACT teams, but in some regions they may have a need for a crisis response team if their ACT team is fully intact, fully funded and working well. Local people need to determine what they feel their county's primary needs are, but every region should have the same basic services. **Mr. Poinelli** emphasized the need to expand the ACT teams in regions where they are not fully staffed, clarifying that these ACT teams must remain under IDHW at the present time. The cost for a fully functioning ACT team of eight members is $650,000, so $4,550,000 would be the approximate cost for the entire state.

Senator Stegner stated that the fiscal impact for the proposal would be zero; the key to this bill would be the very last paragraph "Cooperative Service Plan Component" which would provide that community groups develop the service plan. It would be **Senator Stegner's** hope that the

legislature could put forth a bill that would provide that money. That potential bill would have a fiscal impact in terms of costs associated with the increase in readjustments of tax fees and where that money would be specifically spent through dedicated funds.

Senator Goedde reiterated the proposal did not appear to do much if there was no tie to funding. **Senator Stegner** answered that the proposal could be key in granting the authority to local entities. It is a broad idea to improve a service and the immediate question is how to pay for it; there is a way to fund it, if the legislature approves. It would not be a companion or substitute bill; it would have to start in a specific committee in the House of Representatives because it's a tax bill, it's an issue not really germane to that tax issue and to divide them made the most sense. The draft slightly changes structure, but the wording is key in developing the actual authority for these local groups to make these decisions. If this whole system worked and ACT teams became successful, and if these behavioral health boards became an integral part in determining mental health delivery system in a region, additional programs could be authorized for them to control.

Mr. Poinelli emphasized that right now in many areas of the state, there is a constant battle between the state and the counties. By bringing the groups together, it does give some authority, and meshing the two together will help communication and will bring policymakers into the procedure.

County Commissioner J. R. VanTassel explained that IDHW is funded by the Legislature and does not garner revenue themselves. They therefore have a finite number of dollars to spend. They have a well-defined clientele who cease to be served when that money runs out. On the other hand, counties are operated by county commissioners who have to go directly to the taxpayers to get the money. There are two different pools of money that are not working together. IDHW can plan for mental health services, but counties just react to the bills they get, and pay millions of dollars in reactive payments.

Senator Goedde stated that he likes things done on a local level, but his concern is that if boards are established with a mission but no tools to accomplish that mission, this could lead to frustration.

Representative Deal requested that the proposal be circulated until the Task Force's next meeting and if the sponsors want to bring the draft before the Task Force for consideration prior to going before the Legislature, the Task Force will consider the proposal.

Ms. Leslyn Phelps, Executive Director, Glenns Ferry Health Center, gave a presentation on Community Health Centers (CHCs). **Ms. Phelps** presented on behalf of the Idaho Community Health Centers and the Idaho Primary Care Association, stating the CHCs are unique because of who they serve, where they are located, their local ownership in government and because of the

comprehensiveness of the care they deliver. **Ms. Phelps** explained that CHCs serve medically under-served communities in Idaho and are not-for-profit corporations that:

- Provide comprehensive primary and preventive medical, mental health, and dental care;
- Incorporate health education and support programs in the clinical practice;
- Create formal and informal referral arrangements with community hospitals, other providers, and specialists; and
- Collaborate with other organizations including hospitals, clinics, schools, Head Start, WIC, public health districts and homeless shelters when appropriate and available.

CHC services are available to everyone. A sliding fee schedule is in place for low income, uninsured, under-insured and under-served individuals. Everyone pays at least a nominal fee and insurance is billed for those who have insurance.

Ms. Phelps stated that CHCs use limited resources effectively, including: federal grants; favorable drug pricing (340B); cost-based reimbursement under the "Prospective Payment System" (PPS) for Medicaid patients, low income or uninsured; patient revenues; and other grants and donations. The mission of the CHC is to provide access to primary health care to all residents in communities. They provide services without regard to insurance status or income. CHCs serve high-need rural areas and communities. Seven CHCs provide primary health care services, operating in 26 locations, and saw nearly 65,000 patients with 236,683 visits in 2002 state-wide. In 2002, CHC in Idaho had 203,295 medical encounters, 18,091 dental encounters, and 15,297 mental health/substance abuse encounters. Current full-time equivalent by provider type equals: 33.1% mid-level; 10.6% dental; 22.3% mental health; 35% physician.

Ms. Phelps said that Idaho CHCs are unique because they serve a higher proportion of Idahoans who are poor. Eight-five percent of CHC patients are at or below 200% of poverty. Sixty-one percent are below 100% of poverty and 47% are uninsured. CHCs provide a broad scope of care to many Idahoans; 56% are white, 37% are Latino, 4% are Native American and 3% other.

CHC's philosophy is "everyone is responsible to pay" and services are not free and every individual is charged for service delivered. Charges are based on local prevailing rates; charges are approved by the CHC board of directors; individuals below 100% of poverty pay a nominal fee; and there is a sliding fee available based on family income (poverty level guidelines). Federal grant funds in 2002 accounted for 25.7% of revenues. 33% of revenues were from third-party reimbursement, insurance, private insurance, Medicaid and Medicare and 33% were from patient fees.

Ms. Phelps stated that CHCs are guided by Idaho values. A majority of the board of directors must be users of the CHCs. Board members represent a variety of areas of business expertise vital to the operation of the CHC, and health care industry board representation is allowed and critical to success. CHCs also follow rigorous performance and accountability requirements

regarding the administrative, clinical and financial operations, and are required to meet and report key performance, effectiveness, and quality measures annually. Operational business and health care plans are updated and reviewed annually. Risk management standards, including continuous quality improvement activities, are incorporated on a quarterly/annual basis. According to **Ms. Phelps**, the CHCs are cost effective because they reduce emergency room and hospital admissions.

Ms. Phelps stated that the CHCs would like to partner with the state to increase their capabilities to provide mental health services to their patients. Because their resources are limited, they cannot meet the needs of communities without additional support. CHCs are asking the state to fund a Primary Care Grant Program that would expand primary medical, mental, and dental care capacity at CHCs. With four million dollars, Idaho CHCs would serve 13,072 additional patients (approximately 44,500 visits) and the potential cost-avoidance could equal $90 for a primary care visit versus $650 for an emergency room visit. According to the Idaho Primary Care Association, increasing usage of CHCs and reducing emergency room care could save $23,045,680 annually. Idahoans made 411,533 emergency room visits last year; 10% were for non-urgent conditions that could have been treated in a primary care setting.

According to **Ms. Phelps**, CHCs in Idaho save the state $3.4 million annually in state Medicaid expenditures alone. The federal government saves $1.00 in Medicaid expenditures for every $1.00 it invests in Idaho's CHCs through the federal primary care grant program. The Idaho Medicaid program spends $1,011 per beneficiary for children under age 20, $2,669 per beneficiary for adults ages 20-64, $12,360 per elderly beneficiary; 39% of Idaho CHC patients are children, 53% are adults ages 21-64 and 8% are the elderly. The average total Medicaid spent for each CHC Medicaid patient is $2,798. Several studies have found that CHCs save the Medicaid program more than 30% in annual spending per beneficiary due to reduced specialty care referrals and fewer hospital admissions. According to the federal Bureau of Primary Health Care, Idaho CHCs served 14,135 Medicaid patients last year.

Ms. Phelps, speaking on behalf of the Idaho Primary Care Association, expressed their desire to create a state primary and preventive care grant program to provide state funds to expand primary care capacity to serve low-income and uninsured Idahoans at Idaho CHCs. When the grant program is established, pursuant to an appropriation, a Primary and Preventive Care Grant Program Board will be appointed to oversee administration of the program. Service grants may be used to expand hours of operation, offer new services or hire additional clinical staff at CHCs.

The Primary Care Grant would follow the lead of at least 29 other states and create opportunities for Idaho to leverage federal funds to expand primary care services. Arizona, Colorado, Oregon, Utah and Washington all have state funded grants.

Senator Goedde asked how many uninsured people in Idaho fall below 200% of the Federal Poverty Level? **Mr. Bill Foxcroft** answered that studies indicate that 2/3 to 3/4 of the uninsured

cannot afford to buy insurance. **Senator Goedde** asked for clarification because some people who may be uninsured have luxury items such at snowmobiles, so "cannot afford" can be interpreted in many ways, and he again requested a specific number of people who fall below 200% of the Federal Poverty Level. **Mr. Foxcroft** agreed to get that figure for the Task Force on a state-wide basis.

Senator Cameron inquired about the current financing that CHCs receive. **Ms. Phelps** responded that at the Glenns Ferry CHC, federal dollars represent about 45% of their funding. Glenns Ferry receives a higher percentage because in rural areas there are fewer resources available. Other CHCs receive 30-40%, depending on the year, from third party Medicare, Medicaid and other insurance. In Glenns Ferry, many people have some insurance, some for catastrophic illness which does not cover primary care. Currently, 187 insurance companies are billed by the Glenns Ferry CHC and the rest of their funding comes from self-paid patient fees, either nominal or reduced sliding fees. **Senator Cameron** requested a more formal report to see where the specific dollar funding comes from for CHC. **Ms. Phelps** stated that the Glenns Ferry budget is up to $1.8 million. Other CHCs are running from $3-5 million budgets. CHC faces problems with health insurance rate increases for coverage and changes will have to be adjusted accordingly to meet those rate increases.

Senator Cameron recognized the importance of the CHCs and reiterated that **Ms. Phelp's** request from the Task Force for additional CHC funding caused him to wonder if the Legislature had $4 million to spend on the uninsured population, where would Idaho get the most for their money? If $4 million were put in through the Medicaid system, either through expanding CHIP or other systems, at least a federal match on a 70%-30% basis or perhaps 80%-20% basis, depending, the $4 million could be leveraged into about $12 million. **Ms. Phelps** suggested working through this together since the uninsured population is growing; CHC could expand their services and if they could do it through Medicaid, they could get the matching dollars; **Ms. Phelps** would need time to gather more information about this. **Senator Cameron** admitted his question may be a hypothetical one, since Idaho, in all likelihood, will not have an additional $4 million to spend on additional health care services despite the need. The Task Force recognizes the need for citizens to be insured.

Senator Stegner stated that the savings calculations presented assumed that CHCs would garner all of the 10% of non-urgent care. If the assumption is made that the study was correct yet CHCs received only 5%, then the savings would only be 5%, and not the 10% shown in the handout. **Mr. Foxcroft** answered that the handout shows how much inappropriate use is costing the state that could be diverted to a primary care setting, especially if CHCs are open later or on weekends. **Senator Stegner** continued that Idaho currently has a law that says hospitals have to take all patients, whether or not they are urgent care, and asked if the legislature should consider eliminating that statute and allow hospitals to divert non-urgent care services to a community health center. **Ms. Phelps** responded she would not want to see this changed; however, if the uninsured had a medical home where they could go in for visits, CHC estimates that those uninsured people would be kept out of the hospital emergency rooms more often. In many

instances, non-urgent visits are seen in hospitals due to the hours at night or on weekends when situations occur and primary care centers may not be open for service. CHCs could provide extended hours with more funding.

Representative Garrett had questions regarding utilizing physicians for mental health services at CHCs which concern consumers as well as family members as follows: 1) What type of mental health treatment do CHCs give?; 2) What kind of services and what are the qualifications of CHC's licensed mental health providers?; 3) Do CHCs serve the severe, persistent mentally ill?; 4) Do CHCs have a restrictive formulary?; 5) What kind of training and diagnosis of treatment do CHCs give your primary care physicians?; and 6) How do CHCs use a psychiatrist?

Ms. Phelps responded that due to billing with regard to state law, there are requirements for professionalism and qualifications that must be met in order to treat patients. Primary care physicians are allowed to treat depressed, highly stressed or anxiety-ridden patients. Patients with severe conditions are referred to CHC's licensed clinical social workers, but they are not allowed to prescribe any medications, so they must work collaboratively with a psychiatrist. CHC does not have enough psychiatrists on staff. CHCs do work from a formulary which would include psychotropic drugs, and follow-up would be a part of this.

Representative Garrett questioned if CHCs diagnose, treat, and prescribe medications for mental health treatment, rather than psycho-social rehab or any therapy and regarding formulary, do CHCs provide the full range of psychotropic medications including the new atypical medications? **Ms. Phelps** answered that CHCs do provide counseling and, depending on the education of the staff, they provide a system of support. It could be counseling such as drug and alcohol abuse counseling. CHC is required to provide counseling due to their funding requirements. Only psychiatrists or physicians prescribe medications. More severe diseases require the treatment of a psychiatrist and CHCs do not provide any inpatient care.

On other matters, **Representative Black** asked about the status of the insurance premium tax. Senator Stegner said that a bill is being drafted and will be before the Legislature to consider this session. **Representative Deal** agreed that the premium tax issue should go before the Business Committee, Commerce or Tax Committee.

Representative Collins asked about the status of the pending lawsuit? **Steve Tobiason** answered that it was postponed from July to December of 2004, and the primary reason was to allow more time for the legislative session because the discovery cutoff date was set for April 1st, which created problems because discovery had to take place and that costs money. Both sides agreed to move the trial date back so that they wouldn't have any further discovery until the session is completed. Obviously, if there is a favorable outcome in the session, there would not be any further need for the lawsuit. **Senator Stegner** added that he had received a letter from MetLife and NY Life representing that companies who filed taxes under protest would give up such

claims if the Legislature was able to craft a solution. He stated that he was also expecting a letter from General Fire & Casualty saying that the lawsuit would be dropped if an agreeable legislative solution is adopted.

Senator Stegner continued by stating that draft legislation relating to the premium tax structure was being drafted and would include in part a mechanism that would frontload some of the programs currently funded with premium tax dollars.

The next meeting of the Health Care Task Force was scheduled for January 15, 2004, at 2:00 p.m. in the Senate Majority Caucus Room. The meeting was adjourned at 2:45 p.m.