Committee Minutes:

Health Care Task Force

Senate Majority Caucus Room

State Capitol, Boise, Idaho

Thursday, January 15, 2004

MINUTES

The meeting was called to order at 2:05 p.m. by Cochairman Senator Dean Cameron. Other Task Force members present were: Cochairman Representative Bill Deal, Senators Joe Stegner, Fred Kennedy and Sheila Sorensen, and Representatives Kathie Garrett, Gary Collins, and Margaret Henbest. Senator John Goedde and Representative Max Black were absent and excused. Staff members present were Caralee Lambert and Charmi Arregui.

Others present included: Representative Joseph Cannon; Bob Seehusen, Idaho Medical Association; Julie Taylor, Blue Cross; 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; Teresa Molitor, Idaho Association of Commerce & Industry (IACI); Shad Priest, Phyllis Stephenson, and Joan Krosch, Department of Insurance; Ray Millar, Ken Deibert, David Butler, and Joyce McRoberts, Idaho Department of Health & Welfare; Molly Steckel, Idaho Psychological Association; Tony Poinelli, Idaho Association of Counties; Julie Kane and Barbara D. Greene, Nez Perce Tribe; Joe Gallagos, AARP; Jim Stark, Boise School District; Carol Brassey, Idaho Department of Labor; Melanie Decker, DirecTV; Lyn Darrington, Norm Varin and Tim S. Olson, Regence BlueShield of Idaho; Elwood Kleaver, Primary Health; Jason Kreizenbeck and Colleen Brenton, Micron; Jim Shackelford, Idaho Education Association; Bill Foxcroft, Idaho Primary Care Association; Toni Lawson, National Association of Social Workers (NASW); Bonnie Haines, Idaho Hospital Association (IHA); Mike Wilson, Idaho State Planning Grant (ISPG); Elizabeth Criner, Veritas Advisors-IPCA; Bill Roden, Hopkins Roden; Bob Weppner and 'Moon' Wheeler.

A motion was made by Representative Margaret Henbest to approve the corrected minutes dated December 3, 2003, seconded by Representative Bill Deal. The motion passed by voice vote.

Mr. Ken Deibert, Administrator of Family and Community Services, Idaho Department of Health & Welfare (IDHW), was invited to respond to questions presented at the December 3, 2003, Task Force meeting. **Mr. Deibert** introduced **David Butler,** Division Assistant Director of Finance, IDHW, and **Ray Millar**, Adult Mental Health Program Manager in the Central Office for Adult Mental Health Services for Family & Community Services, IDHW. There were three

specific questions about which the Task Force requested more information: Rep. Black requested a specific dollar amount figure for the services billed by IDHW and the amount received from such billings for the hospital operations and for other aspects of the Family & Community Services Division. **Mr. Deibert** first addressed the billing and the collection for the two state hospitals for psychiatric services. In FY 2003, State Hospital South billed $19,381,000 and collected in receipts $6,093,000 which includes Medicaid as well as private pay from patrons and other third-party receipts. State Hospital North billed $6,292,000 for services and collected $16,107, so patient population as served as State Hospital North are individuals that are typically not eligible for third-party reimbursement nor are they eligible for Medicaid reimbursement, thus the significant difference between the two hospitals. Additionally, in terms of the outpatient programs for the Family & Community Services Division, for children's mental health services, IDHW billed $292,500 and collected $152,926 which includes insurance billings, third-party payments, private pay and Medicaid payments. Developmental disabilities billed $1,400,000 and collected just over $1,000,000. The adult mental health program billed just under $3 million and collected $1.6 million.

The second question raised by **Senator Stegner** concerned an indication that in fiscal year 2003 there was a downward trend in the expenditures over what was appropriated for fiscal year 2003 in many of the IDHW programs. **Mr. Deibert** stated that in looking at 2003 fiscal year budgets, there were several factors that contributed to the reduction in expenditures by IDHW and by Family & Community Services. There was a hiring freeze for state employees, so personnel costs were not expended. When the hiring freeze was lifted, there was a determination by the Governor that there be a 3 1/2% reduction in state budgets and there was a revised hiring process put into place that required additional approval, both within IDHW through the Director's office as well as the Governor's office, which contributed to some delays in IDHW's ability to process and respond to hiring individuals where there was a vacancy. The second area that had an impact on IDHW's ability to spend personnel dollars was the reduction in overall expenses in IDHW's budgets because of the relationship between general fund dollars and personnel and the impact that had on their ability to collect receipts from other sources, particularly the federal government. The intent language in IDHW's fiscal year 2003 budget limited their ability to shift personnel dollars into any of the other budget categories. IDHW was limited in their ability and in flexibility to utilize any salary savings that had accrued by moving that into other budget categories purchasing services, through contract with other entities or in any way expanding the service continuum by shifting personnel savings into operating existing benefit areas of their budget. The third area that impacted IDHW's budget, was the fact that it was almost the beginning of IDHW's third quarter of fiscal year 2003 before they had a firm budget that they could go back to and see the amount of money they had for fiscal year 2003 to expend. Because of that necessary deliberation, there were unknowns about how much money there was available to expend. One of the major areas of cost that IDHW had direct control over was salaries and how many individuals are hired and working within IDHW. IDHW delayed some hiring and did not fill some positions because of that unknown. When IDHW had staff vacancies in positions providing services to individuals, they were not creating billable activity and IDHW could not generate the federal match. In the adult mental health budget, there was approximately $528,000 that was reverted to the general fund at the request of the Governor to assist in balancing the budget at the end of fiscal year 2003. As a direct result of the revision of that $528,000 being generated from salary savings, IDHW was unable to generate activities that supported billing the federal government for those activities, so when IDHW lost the general funds, they also lost the

ability to generate billable activity to the federal government. Those are the reasons there was money left in IDHW's budget. Had there not been a request from the Governor to redirect that money to the general fund to address the deficit that existed in fiscal year 2003, IDHW had authority granted from the legislature to carry those funds forward and would have been able to expend those funds in fiscal year 2004 for the purposes for which they were intended. IDHW did not have that opportunity, so IDHW began fiscal year 2004 without that carry-over money going into the next year.

Mr. Deibert emphasized that in fiscal year 2004, IDHW is spending at a rate consistent with their appropriation, there is not a hiring freeze, and they have a clearer picture of their budget for fiscal year 2004. Services are being delivered to the consumers for whom IDHW is obligated to provide care and IDHW is spending within the context and authority of the appropriation. When IDHW looks at the overall expenditure related to mental health services, even though the budget within Family & Community Services indicates that there was a reduction in expenditures, that is not a picture that is accurate for IDHW as a whole. IDHW's mental health services specifically target individuals who have no other resources to seek mental health care, so IDHW serves the medically needy, primarily the indigent population within the state structure. Many of the mental health services for the seriously, emotionally disturbed (adults and children) are provided through contractual relationships or provider agreements through the Medicaid program. In fiscal year 2002, Medicaid expenditures for all mental health outpatient services was $37.5 million. In fiscal year 2003, IDHW spent $45.4 million, or a 21% increase in the amount of mental health care provided for the citizens of Idaho just through the Medicaid program. IDHW's projection for fiscal year 2004 indicates that if IDHW spends at the current rate through the first six months of this fiscal year, IDHW will spend $57.5 million from a Medicaid program for all mental health outpatient services in the state, a 26.5% increase in Medicaid expenditures for mental health care in the state. Looking at that Medicaid budget more deeply, for the CHIP program expenditures for mental health services for CHIP-eligible children in fiscal year 2002, just for outpatient mental health care services, IDHW spent almost $1.3 million. In fiscal year 2003, IDHW spent $1.4 or an 11% increase in CHIP expenditures for mental health care.

Mr. Deibert continued by stating that in fiscal year 2002 for outpatient services only, for children's mental health (both Medicaid and state general funds) IDHW spent almost $23 million. In fiscal year 2003, IDHW spent almost $26 million for children's mental health services, an 11% increase. **Senator Stegner** inquired as to why IDHW's budgets were not expended appropriately, and where IDHW was as a whole in supporting services to the individuals for whom they are responsible for providing care. Looking at the whole picture, IDHW's funding and service delivery continue to increase even though within IDHW's particular program budgets, there was a decline in expenditures.

Mr. Deibert suggested that when there is an offset, particularly in the mental health program, as part of IDHW's reduction plan, the regional mental health authority positions were eliminated which were administrative positions within adult and children's mental health. IDHW's responsibility was to be a gatekeeper for the mental health system for the Medicaid funded services. IDHW eliminated those positions because they had the least amount of impact on the primary population served within IDHW. IDHW lost revenue when those services were shifted to the private sector. The private sector billed Medicaid for the services that IDHW was previously providing; the private sector's receipts reflected an increase in part that IDHW is

seeing in overall expenditures for mental health services, both for children and adults. So, the money in essence wasn't lost; it wasn't spent by IDHW; they were services provided by another entity eligible to bill Medicaid and the receipts appear to be lost, but were expended in another area by another entity than IDHW.

Senator Cameron stated that he had some questions and wanted to challenge some of the information presented by **Mr. Deibert**, but time did not allow. **Senator Cameron** invited comments or questions be submitted in writing for discussion at a future Task Force meeting.

Mr. Ray Millar was asked to address what IDHW has done in the past several years with regard to reorganizing, utilization or improvements in the mental health care system, from IDHW's viewpoint. **Mr. Millar** handed out a packet entitled "Idaho's Public Mental Health System". A copy is available in the Legislative Services Office. This handout referred to: (1) Paradigm shifts and implementation of evidenced based or best practices, i.e. Assertive Community Treatment (ACT) Teams, 1990-1992; Psychosocial Rehabilitation (PSR) Option, 1992-1994; Mobile Crisis Teams, mid 1990's; Recovery Model, 1996-97; Crisis Respite Program-Franklin House, 1996; Co-Occurring MHSA Disorders, 1999-2000; Dual Diagnosis MH/DD Crisis Team, 2003; and Statewide Suicide Prevention Plan, 2003.

(2) Consumer and Family Member Empowerment including Idaho Leadership Academy, 1993; Family member coordination services, 1992; Consumer Coordination Services, 1993, State Planning Council on Mental Health was enhanced in 1994; and Idaho Office of Consumer Affairs and Technical Assistance, 1999.

(3) Gatekeeping & managed care including regional mental health authorities, 1994; full regional gatekeeping for all state hospitals, 1998; healthy connections coordination, late 1990's; and gate-keeping for ages 18-21 in local and state hospitals, 1998.

(4) Mental health services that were provided as a result of disaster coordination and use of technology, coordinated disaster counseling services for floods of 1996 and 1997 in northern Idaho established limited telemental health services in 1999 and use of newer generation antipsychotic and antidepressant medications in early 1990's to present.

Mr. Millar stated that IDHW continues to focus on housing, development of shelter plus care programs including regional participation on homeless coalitions and, most recently, in the Governor's Policy Academy on Housing, 2003. **Mr. Millar** noted that one of IDHW's most successful areas has been collaboration and partnerships in communities and he cited numerous examples including statewide mental health service support to Idaho Drug Courts in 2003.

Mr. Millar stated that Idaho trends include a low recidivism rate in state hospitals (2002, 35%) but he noted that the rate is rising (1997, 30%). About 60% of admissions to state hospitals are unknown to the system and IDHW is successful in preventing hospitalizations for those clients receiving IDHW case management services. Staffing patterns are shifting to support crisis and forensic services and program management has been integrated at regional level for mental health and developmental disability services.

A presentation was given by **Mr. Tony Poinelli**, Idaho Association of Counties, regarding

RS 13662, a mental health care proposal, a copy of which is available in the Legislative Services Office. **Mr. Poinelli** pointed out that RS13662 is a baby step in an attempt to get additional authority and responsibility back to the regional level. After 4½ years of study and work by a variety of groups, stakeholders, county officials, legislators, IDHW, hospitals and others, this draft legislation proposes to modify the current regional mental health advisory boards and create a board that has some additional authority. Instead of making it advisory, the goal is to look at unmet needs in a region by actively involved people in that region such as consumers, local government officials, state government officials and others. The intent is to look at those unmet needs, develop some type of a plan on a region-by-region basis, and submit that plan to IDHW for their report to the state mental health advisory board for their comments and final approval. With this draft legislation, there is no fiscal impact. This draft legislation was prepared because studies that have been done show that things need to be done at the local level. The State Mental Health Plan for Children, the 1998 Mental Health Initiative, the Adult Mental Health Program, and the Mental Health Project Report have all expressed that a single stream of funding needs to be created. This draft legislation does not provide for that, but it may lead to that at some point. Local governmental services are necessary, as are increased community-based resources, improved collaboration and cooperation, and improved communication between both public and private sectors, including those current authorities and councils, i.e. children's mental health and the regional substance abuse authorities.

Senator Stegner added that the draft legislation has been a long time in coming. It is an attempt to just open the door for more local decision-making in how the mental health care delivery system looks at the local level. Four or five major studies were looked at within the last 5-10 years, copies of which **Senator Stegner** can share with the Task Force, and they all refer to the need for "local government" and the need for local, committed involvement by individuals at the ground level. This is one of the major detriments of Idaho's mental health care system. Idaho does not have that local involvement and this draft legislation is an attempt to encourage that involvement; it does not mandate it, but it does set in place a fairly well-reasoned expansion of the duties and responsibilities of mental health authorities and broadens their base to allow them to start thinking more creatively. The draft encourages the local mental health board to "develop a service plan component specifically designed to address an identified unmet need in the region. Such a service plan component may be based upon the assertive community treatment team model (ACT), or other available intensive models, or a model unique to the region." This bill has no funding authority, so it does not mean that it is going to be funded by the state of Idaho; that would have to come at some other time in other pieces of legislation.

This draft is a very small step, but a very important one, which opens the door to encourage local participation. It would be incorrect at this time to suggest that IDHW is endorsing this. In fact, IDHW has questions about its usefulness and possibly its implementation. If there is no funding for this draft, it probably will have little impact on the state of Idaho; it does broaden the regional boards to the point that they could hopefully have broader representation and be more effective as advisory groups to the state.

Senator Stegner stated that the beer and wine tax as it currently exists in the state is antiquated in its volume-based taxing method and it should be transferred to a cost-based method. He is planning to introduce a tax bill that would actually create some additional money to go toward this program. Regions could apply for funding for their ACT teams. Health care professionals in

the state have asked for fully funded ACT teams in every region in Idaho to deal with the most chronic and persistent mentally ill patients who continually rotate through the system. Better services could be provided to them, and Idaho could probably save money by being more efficient in how Idaho handles these people.

Mr. Poinelli concluded that RS13662 has been circulated since the December 3, 2003 Task Force meeting and numerous comments have been received, which generated changes since the first draft was handed out. On page one of the first draft RSCAL044, the term "Regional Behavioral Health Board" may have gone too far, so they reworded the "Regional Mental Health Board" and there were very good reasons for changing that. Another change recommends additional consumer involvement and another consumer was added. There very likely could be four; there are three within RS13662 but the Children's Mental Health Committee likely would be another consumer, so more consumers were added.

Senator Cameron summarized that the Task Force is not a standing committee and, as such, could not send a bill to print nor can it table a bill. The Task Force can endorse a bill or state that it merits further consideration and request the germane committee to consider it further, or the Task Force can say they do not think this is the appropriate time.

Representative Henbest expressed her appreciation for RS13662 stating that she sat on a mental health interim committee eight years ago and this RS is the model discussed then. There has been a need for some sort of regional authority with local collaboration, especially with regard to dual diagnosis and how to make mental health services and substance abuse services work better since the problems are so often commingled. With that said, **Rep. Henbest** asked why the RS does not require the development of a service plan? **Senator Stegner** answered that RS13662 is not an attempt to be another local mandate. There needs to be an incentive for funding, and that is not in place presently, so to offer a plan to the regions that is optional, at this very early stage, was easier to implement and much less threatening to counties.

Rep. Garrett expressed her appreciation for addressing two of her stumbling blocks: renaming the Board and more family involvement. **Rep. Garrett** said she has heard about fragmentation of the current system, and it appears that this RS may cause even more fragmentation if each region is doing their own thing, with community involvement. She asked for clarification regarding how the state can have a more comprehensive plan when there are seven regional plans.

Mr. Poinelli answered that the current mental health authority tries to develop the state comprehensive plan, but a core set of services for the entire state needs to be provided. The intent of RS13662 is to look at those other unmet needs in each region. Those needs could easily be coordinated by the submission to the state. IDHW would have final review over it. That is where everything can be brought together, but each region still needs to identify their individual, specific needs at the local level.

Senator Stegner moved that the Task Force endorse the consideration of RS13662 by the standing germane committees in the Senate and House of Representatives this legislative session. Senator Kennedy seconded the motion. Senator Stegner added that there needs to be a public airing of RS13662 to allow people who may disagree with it to offer testimony. He said the motion is specific enough to indicate a willingness of this Task Force to have it further

explored by the germane committees, and it was his intent to introduce this in the Senate and House Health & Welfare Committees.

The motion passed by voice vote.

Ms. Joan Krosch addressed the federal health coverage tax credit. In 2002, President Bush signed into law the Trade Adjustment Act of 2002 which provided a refundable tax credit for eligible individuals to use to purchase health insurance. The Trade Adjustment Act itself was to provide training and income to individuals who lost their jobs or in some cases there was an alternative trade adjustment amendment for people who may have been older and did not have specific training. Within this provision also was a tax credit for people to purchase insurance. There is no mandate that states taking a particular action, but many consumers are aware of the availability of this tax credit. Some northern Idaho consumers were affected by this and were notified through the Idaho Department of Labor.

Ms. Krosch continued by stating that within this tax credit there are three options that are automatic: one is Cobra extension for people who worked in a group and lost coverage; one was coming onto a benefit plan through a spouse's employment; and one was if the person within one month prior to having lost their employment had individual coverage. At this point, Idaho has not elected any other options. Some states have developed their own continuation coverage, like a mini-Cobra, through a high risk pool such as the Idaho High Risk Pool, through the state employee program, or through an agreement between the state and an insurer or health insurance issuer within the state. The tax credit is 65%, which is provided to the consumer. The consumer then adds the additional 35%. At this point, there are eleven states utilizing the high risk pool plans, several states have agreements between an issuer or several health insurance issuers within their state, three states have elected the mini-Cobra and two states have utilized the state employee program. Bart Harwood, an attorney with the Idaho High Risk Pool Board, developed proposed revisions to the Idaho Code that would incorporate these requirements for utilization on the Idaho High Risk Pool. This proposal has been reviewed at the federal level and will soon be ready for review by the Task Force.

Rep. Henbest asked what happened to make the Task Force look at the high risk pool as an option and not, for instance, the state employee benefit packages. **Ms. Krosch** answered that this was just one option. **Sen. Cameron** clarified that the major issue is that you have to disallow any preexisting condition for that product, so if an individual were to use the state employee plan, the preexisting condition period for the state employee program would have to be discontinued which would, in all likelihood, increase the cost of the state employee's health care plan.

The meeting was adjourned at 3:10 p.m.