Minutes
Health Care Task Force
Thursday, December 13, 2007
8:30 a.m., Room 204
Capitol Annex

The meeting was called to order at 8:35 a.m. by Cochairman Senator Dean Cameron. Other members present were Cochairman Representative Gary Collins, Senator Joe Stegner, Senator Patti Anne Lodge, Senator John Goedde, Senator Tim Corder, Senator Elliot Werk, Representative Carlos Bilbao, Representative Fred Wood, Representative Jim Marriott, Representative John Rusche. Representative Sharon Block and Representative Margaret Henbest were absent and excused. Legislative Services Office staff present were Eric Milstead, Amy Castro and Toni Hobbs.

Others present at the meeting were Kathie Garrett, Partners in Crisis; Denise Chuckoviak, Idaho Primary Care Association; James Schroeder; Corey Surber and Amanda Kelly, St. Alphonsus; Toni Lawson, Idaho Hospital Association; Julie Taylor and Woody Richards, Blue Cross of Idaho; Amy Holly-Priest, Mackenzie Miller and Lynn Darrington, Business Psychology Associates; Sandra Forester, Idaho Statesman; Tim Olson and Georgann Benjamin, Regence/Blue Shield; Benjamin Davenport, Evans Keane; Cliff Green, Idaho School Board Association; Steve Millard and Molly Steckel, Idaho Medical Association; Chuck Halligan, Ross Edmunds and Bethany Gadzinski, Department of Health and Welfare; Karen McGee and Tammy Perkins, Governor's Office; Leslie Clement and Paul Leary, Department of Health and Welfare/Medicaid; Rakesh Mohan and Jared Tatro, Office of Performance Evaluations (OPE); and Elizabeth Foster, Southwest Idaho Medical Society.

After opening remarks from Cochairman Senator Cameron, **Mr. Rakesh Mohan**, introduced Ms. Lynn Quincy from Mathmatica Policy Research, Inc. and Ms. Donna Spencer and Ms. Lynn Blewett from the State Health Access Data Assistance Center (SHADAC) from the University of Minnesota. These groups were hired to do a study for the Joint Legislative Oversight Committee (JLOC). **Mr. Mohan** said that in addition to these two groups, Mr. Bob Thomas from Olympia, Washington and Mr. Ted McDowell from Boise State University did a lot of consulting including quality control and special projects related to the study. This study was done with a special appropriation of $250,000.

Ms. Donna Spencer and Ms. Lynn Blewett, SHADAC, began the discussion with a Powerpoint presentation: Idaho's Health Care Costs and Options to Improve Health Care Access. This presentation is available at the Legislative Services Office.

Ms. Spencer explained that they broke the project down into the following five subjects:

- Task 1: Public health care expenditures in Idaho
- Task 2: Private health care expenditures in Idaho

- Task 3: Insurance coverage in Idaho
- Task 4: Programs to address the uninsured in Idaho and other states
- Task 5: Trends in and drivers of health care spending in Idaho

Since this complete presentation is available in a report from the JLOC committee, the speakers only discussed tasks 1, 2 and 5. (The report is available on the Legislative Office of Performance Evaluations website.)

Ms. Spencer began by discussing Idaho's health care expenditures by funding source (2004). She explained that our total expenditures were $5.6 billion and $58% of that came from private sources.

Task 1

The first task involved cataloguing public health expenditures in Idaho. **Ms. Spencer** explained that in 2005 total public expenditures in Idaho were $2.6 billion. CHIP makes up 41% of that. Public health care spending by level of government of the $2.6 billion breaks down as 72% federal, 20% state and 7.1% local.

State health care expenditures in 2006 break down as follows:

Area of Spending	**% of State Spending**
Medicaid/CHIP	56.3%
State Employee Health Benefits	22.1%
Public Health Services	13.0%
Catastrophic Program	3.5%
Adult Corrections Health Care	2.7%
Tax Expenditures	1.8%
High Risk Pool	0.4%
Juvenile Corrections Health Care	0.1%
CHCs	0.1%
Total	**100.0%**

Ms. Spencer stated that program enrollment has increased in areas of Medicare, Medicaid, CHIP, State Catastrophic Programs, CHSs Adult Corrections and County Corrections. Enrollment has decreased but expenditures have increased in state employee health/dental benefits, local employee health benefits, the high risk pool and juvenile corrections.

Senator Werk asked what the lowering enrollment in state and local health insurance plans reflects since the size of those workforces is not shrinking. **Ms. Spencer** said she was not sure what those numbers reflect. She said that maybe people are just choosing not to sign up for the state insurance plan. **Senator Cameron** said it was highly unlikely that would be the case. He requested more information regarding this.

Task 2: Estimating Private Health Care Expenditures in Idaho

Estimated private health care expenditures were $3.3 billion for 2004. This section of the

presentation includes overviews of health insurance companies offering individual plans in Idaho, the premiums collected and enrollment as well as an overview of those offering group plans.

Uncompensated care by hospitals includes charity care and bad debt. **Ms. Spencer** said that data in Idaho are limited. She said that for 2004-2005 total uncompensated care and community benefits from select hospitals was approximately $143 million. She said that large nonprofit hospitals in Idaho are required to report uncompensated care costs as part of their IRS annual return. Her report reflected data from St. Alphonsus (Boise), St. Marys (Cottonwood), St. Lukes (Boise), St. Joseph's (Lewiston) and Bonner General (Sandpoint).

Senator Werk asked whether the term "costs" for uncompensated care means the "rack" or "retail" rate costs. **Ms. Spencer** said she thinks it is considered charges based on the reports they relied on.

Senator McGee asked for more explanation of "rack" costs. **Mr. Steve Millard, Idaho Hospital Association** said it is his understanding that uncompensated care is reported at cost, not as charges or at the "rack" rate.

Representative Rusche said that bad debt on a financial statement is considered a charge not a cost. **Mr. Millard** said that could be true but that bad debt is reported as a cost also.

Ms. Spencer noted that there have been discussions regarding the reporting format and consistency of reporting across hospitals for this information. There has been discussion of how to standardize this.

In response to a question from **Representative Marriott, Ms. Spencer** said this information is for nonprofit hospitals only.

Task 5: Trends in Health Care Spending in Idaho
Ms. Lynn Blewett stated that an overview of Idaho's personal health care expenditures shows a 41% increase in that spending from 2000 to 2004.

She went on to give the following overview of health care spending and trends.
Idaho spends less on health care as measured by the percent of gross state product in 2004 compared to the U.S. average.

- 13% in Idaho compared to 16% for the U.S.

A greater share of health care spending in Idaho is from private funds compared to US average.

- 58.4% in Idaho compared to U.S. average of 54.9%
- Includes health insurance payments to providers, individual and employer premiums and other individual spending for health care services.

The annual average per capita growth rate of 7.1% in health care spending was slightly higher than the national trend and lower than all six of its neighboring states.

- Average per capita growth rate of 6.0% for U.S. average
- Rand of 7.6% in MT to 8.2% in NV

Idaho's population has been growing faster than five of its six neighboring states and the US overall contributing to the overall growth rate of 9.0 percent.

- Idaho's population grew 7.3%
- US population growth of 4.0%
- Only Nevada had a significantly higher growth rate of 15.6%

While the private sector accounts for more of the health spending in Idaho, spending on public programs (Medicare and Medicaid/SCHIP) continues to grow.

- Public program share in Idaho rose from 39.3% to 41.6%
- Private share of Idaho's health care spending dropped from 61.1% to 58.4%

While spending on public programs is increasing, the cost increases are primarily due to enrollment not on per person spending.

- Example: The per-person increases in Medicaid spending were 4.2% compared to a per capita increases of 9.5% for state employee health benefits

Cost Drivers

Factors contributing to increasing insurance premiums include:

- General Inflation - 27%
- Increases in health care prices in excess of inflation - 30%
- Increased utilization 43%

Ms. Blewett went on to discuss hospital trends from 2001 to 2005.

Hospital volume has increased over time and more of the growth is concentrated in the Boise area.

- Boise-area hospitals accounted for 45.8 percent of discharge activity in 2005 with an average annual growth rate of 11.2%
- Discharges for non-Boise area hospitals grew by 3%

Population changes can account for some of the increases in hospital discharges.

- The Boise area experienced the greatest population growth, growing 12.3% (2000-2004)
- Growth rate was 5.8% for all of Idaho outside of Boise

In response to a question from **Representative Collins, Mr. Mohan** explained that the Boise area studied included Canyon County and that he would get the list of cities included for members.

Boise-area hospitals had higher average net revenue per Medicare discharge in 2005.

- $13,917 per discharge compared to $11,244 for non-Boise MSA hospitals**.**

Ms. Blewett went on to say that increases in the utilization of hospital services and technology and other hospital capital expansions are also drivers of health care spending in Idaho. She noted that the State of Idaho does not collect data on or regulate capital spending in the health care arena. According to data collected, over $350 million in hospital expansion projects are underway in Idaho from public documents. She said there is a correlation between capital expansions and health care spending.

Senator Goedde asked how much of the $350 million was from incurring debt and said that he would be interested to see how much of that amount was paid with cash. **Ms. Blewett** said she was not sure there would be any public documentation available on that. **Senator Cameron** said the Hospital Association should have that and asked **Mr. Mohan** to follow up with them.

Ms. Blewett stated that according to their information, Medicare pays the lowest rates when compared to private payers but represents almost half of all spending in non-Boise area hospitals. In the Boise area, the private sector is the primary payer for hospital services and Medicare is the primary payer for non-Boise area hospitals.

Idaho has Medicare discharge rates higher than the national average for back surgery and hip replacement and certain areas of the state have higher rates than the state average. She said their formal report contains a list of Medicaid procedures and the percentage that is performed in Idaho hospitals compared to the national average.

Senator Cameron asked whether this is suggesting that this is an area of concern regarding the high numbers of hip and back surgeries. **Ms. Blewett** said this would require more discussion with physicians and patients.

Senator Werk asked, since information is available regarding hip and back surgeries from Medicare discharge rates, whether this same trend would carry forward outside of Medicare. **Ms. Blewett** said she was not sure because Medicare is a different population. She did not think this would necessarily be the case.

Senator Goedde asked whether this high amount of hip and back surgeries could be related to the type of workers in Idaho. He suggested comparing back and hip surgeries to worker's compensation claims could be helpful information. He added that in his opinion, since Medicare has a fairly low reimbursement rate the abuse rate, if one exists, would be higher in the private pay area. **Ms. Blewett** said that would be another area of inquiry.

Senator Corder said that if capital expenditures are the most significant cost driver, not disease, he thinks the density of health care providers and the costs of new construction and new technology should be looked at more closely. He said if this is a bigger component of health care costs, this is an area that the state can do something about. **Senator Cameron** asked for data that shows what states have certificates of need and whether that helps control capital costs.

Mr. Mohan said he would check on worker's compensation claims to see if there are large claims for back and hip surgery. **Representative Rusche** pointed out that the data being discussed is Medicare discharge information so that is a different population. He said this is a percentage of discharge. He explained that hospitals such as St. Joseph's in Lewiston that have no cardiac care and thus have no cardiac discharges, will have higher percentages of other types of discharges. **Senator Cameron** agreed but said that if Idaho has a trend toward hip and back surgeries, it would also show up outside of the Medicare arena.

Ms. Blewett went on to discuss physician and prescription drug trends for 2000 to 2004. She stated that growth in Idaho's physician spending was consistent with the national average and lower compared to its six neighboring states. The average annual growth rate in Idaho of 8.2% which was identical to the national average growth rate of 8.2 percent. Neighboring states ranged from a low of 9.1% in Wyoming to a high of 13.5% in Nevada.

Ms. Blewett said that prescription drugs have one of the fastest rates of growth at 12.8% but accounted for a relatively small share (16%) of total spending. Idaho's per capita utilization of prescription drugs of 8.6 prescriptions was lower than the national average of 10.6 prescription drugs per capita.

With regard to consolidation of the payer and provider markets, **Ms. Blewett** stated that Idaho's private payer market is slightly more concentrated in the group market and somewhat similar in the individual markets compared to its neighboring states. Consolidation of private payer market limits competition to keep premium costs down. Consolidation of private payer market has led to increasing concerns about consolidation of the provider market.

She stated that Idaho's private administrative costs are relatively high while public program administrative costs are consistently low. This statement led to general task force discussion as to what specific costs are included in the administrative costs reflected in the consultant's report. The consultants noted that the administrative costs reflected in the report may differ from the administrative costs reported by specific Idaho carriers.

The report includes the following overview of lifestyle trends in Idaho.

- The aging of the population will lead to increased health care spending in Idaho consistent with the US overall.
- Idaho's share of the population aged 65 years and older is projected to increase to 18.3 percent of the total projected population in 2030.
- Idaho has low rates of adult smokers.
    - Idaho ranked third in lowest state smoking rate
    - Health care costs for smokers are as much as 40% higher than for non-smokers
- Adult obesity rates continue to rise.
    - Idaho has adult obesity prevalence of 24.1%
    - Increased costs of heart disease and diabetes related care accounting for as much as 27% of per-capita health spending

She went on to explain that the state catastrophic health care plan provides assistance for episodic, catastrophic care for indigent uninsured Idaho residents. Counties are responsible to provide financial assistance for medical expenses under $10,000 - the state program pays for eligible medical expenses in excess of $10,000. In FY2006 these programs ***combined*** spent **$36.7 million** in medical and related administration expenses, serving 5,249 indigents across the state. State Catastrophic program alone spent approximately **$22.8 million** for indigent care services.

In conclusion the consultants stated that:

- Idaho faces many of the same health reform issues as other states.
    - Rising health care costs
    - Growing number of uninsured adults
    - Aging population
    - Prevalence of obesity
- Baseline Idaho-specific data highlights key cost trends and drivers to help shape state policy.
    - Hospital spending/variation in procedures
    - Medicare as driver for non-Boise area hospitals
    - Consolidated payer market
    - Relatively high private administrative costs
- There does appear to be potential for some savings in the Catastrophic Health Care Program
    - Possible primary/preventive care through a local pilot demonstration of the Catastrophic Health Care Program

The consultants closed with the following list for prioritizing ongoing data needs.

- Are there areas of health care spending with particular relevance to current legislative goals?
- What are the areas of health care spending over which policy makers have more control?
- What is each program's/entity's estimated role in health care spending?
- Where do key health expenditure information gaps exist?
- What level of information is needed?
- What is the feasibility of obtaining and analyzing certain health care expenditure data?

Ms. Lynn Quincy, Mathematica, was introduced to discuss Idaho's Uninsured and Options for Expanding Access to Health Care. This complete Powerpoint is available from the Legislative Services Office. She stated that there are three questions to answer regarding coverage expansions. Those include:

- Who to cover?
- What type of approach?
- How to finance the coverage?

Idaho's uninsured comprise 16% to 18% of the non-elderly population. Those ages 18 to 24 have the highest rate of uninsurance. Her information shows that premium growth rate is outpacing wage growth.

Ms. Quincy said the following possible coverage approaches could be considered:

- Modify the market in which coverage is offered
  - Limited Benefit Plans
  - Increase the Age of Dependency
  - Buy-in to State Health Plan
  - Small Employer Purchasing Pools
  - Insurance Exchange or "Connector"

- Subsidize market-based coverage
  - Subsidies can lower the cost for the employer, the individual or both
  - Subsidies can be prospective, retrospective or embedded in the apparent price of the premium

Ms. Quincy explained that difficulty affording premiums is the most common reason given for being uninsured.

She noted that subsidies can be combined with other strategies.

- Healthy New York: Subsidy + pools together individuals and small groups + modest benefit
- Insure Montana: Subsidy + small employer pool
- Muskegon Three Share: Subsidy + donated care + limited benefit

- Provide direct public coverage
  - Boost enrollment among eligibles
  - Expand eligibility:
    - All Kids program (IL, PA, TN)
    - Parents
    - Childless adults (ME, PA, WA, UT)
- Federal match may be available

- Provide new mechanisms for accessing care

Ms. Quincy explained the following approaches to funding that could help with access to care.

Federal:

Medicaid and SCHIP matching funds
Use of disproportionate share hospital (DSH) funds,
Community health center (CHC) grants
High-risk pool subsidies

State:

Tobacco settlement funds
"Sin" taxes
Insurer assessments
General revenues/tax expenditures

Other:
New employer contributions
Provider discounts and donated care

Ms. Quincy summarized that new coverage options should be part of a comprehensive state vision. This should include clearly articulated goals, data collection and reporting to support policy goals, complementary strategies to address health care cost escalation and complementary strategies to ensure adequate access to providers.

For a more comprehensive update of this information please review the minutes of the December 13, 2007, JLOC meeting and the final report of these presentations that are available on their website at: www.legislature.idaho.gov/ope/jloc/minutes/index.htm.

The next agenda item was a follow up report of medicaid coverage for substance abuse treatment and children's mental health services by **Paul Leary, Division of Medicaid, Department of Health and Welfare, Debbie Field, Office of Drug Policy and Bethany Gadzinski, Department of Health and Welfare.**

This information was requested due to House Bill 322 that was the appropriation for the Department of Health and Welfare. **Mr. Leary** explained that House Bill 322 requested a comprehensive cost-benefit analysis of Medicaid coverage of certain substance abuse treatment. **Mr. Leary's** document includes current coverage and cost to the state of Idaho for Medicaid participants receiving substance abuse treatment through the Division of Behavioral Health's contract with Business Psychology Association (BPA) and the cost-benefit impact of expanding Medicaid services to cover this treatment.

Mr. Leary explained that for the follow up information he developed an outline (that is available at the Legislative Services Office) of Medicaid and Behavioral Health and the Office of Drug Program activities that they need to go forward with. He said there will also be a decision unit in the Department's budget request this legislative session. He also included information on what other states are doing for these programs.

Ms. Bethany Gadzinski, Substance Abuse Disorder Chief for the Division of Behavior Health. She said that one of the first things that was done when they starting looking at the possibility of paying for substance abuse treatment with Medicaid dollars was to look at other states who do this. This was to help decide where Idaho's rates should be. This report is also available from the Legislative Services Office.

Ms. Gadzinski also distributed an handout of the decision unit the department is going forward with this session. The last page of this handout shows the difference using Medicaid for this purpose would have made to the state budget. This funding would have saved the state approximately $2.2 million. This budget request is on-going and is to pay for treatment services through Medicaid at 30% state funds and 70% federal funds.

The Department estimates that approximately 1,300 people out of a total of 9,200 currently receiving substance abuse services will be eligible to receive this benefit through Medicaid. This will include about 41% of the adolescent population and about 16% of the adult population. This number is based on the number of people in fiscal year 2007 who received services through the Department's substance abuse disorder program and who reported that they were Medicaid recipients.

Debbie Field, Director, Office of Drug Policy said that this process has been quite a journey. She said due to the work of the Interagency Committee on Substance Abuse, Prevention and Treatment (ICSA) the state has a better understanding of the delivery of Idaho's substance abuse disorder services. This is some of what has been learned from the data collected through the "Access to Recovery" (ATR) grant years of 2005-2007.

- Total Adults who received treatment: 8,192
- Total Adolescents who received treatment: 1,118

This data gives a good baseline for the number of Idahoans who try to access and receive treatment through the state delivery system. Keep in mind these numbers spread through the three years of ATR, with most receiving treatment through fiscal year 2007. This gives the Office of Drug Policy good baseline data, that allows them to analyze the areas of treatment for saving lives or a "return on our investment".

On the issue of comparing Residential (Res), Intensive Outpatient (IOP) and Outpatient (OP) treatment services, IOP services tip the scale on the best return, both in successful treatment and less relapse. Such data can help make a great case for those who help set policy.

Director Field went on to discuss some of the personal statistics and observations from the Office of Drug Policy (ODP). Since she started this job on January 9, 2007, there have been:

- 791 Office Appointments in the ODP office
- 109 visits to Region 1,2,3,4,5,6,7
- 159 community presentations on the "Idaho Meth Project"
- 239 individuals dropped by the Office of Drug Policy to leave their business card to see how they could help
- And, last but not least, the office tackled tough issues that have put Idaho in the national spotlight for innovation and cooperation between state agencies, local governments, private business, and our federal partners.

Director Field said that the Salt Lake County Substance Abuse Office in Utah, encouraged Idaho

to look at accessing Medicaid for this treatment because it has saved Utah a lot of money. In her opinion, this is not an expansion of Medicaid, it is taking care of those already on Medicaid and saving the general fund over $2 million.

Senator Cameron thanked **Director Field** for her efforts. He stated that the Office of Drug Policy will be used as a reporting mechanism for the Health Care Task Force and that process will be developed over time.

Ross Edmonds and Michelle Britton, Department of Health and Welfare, were introduced to report on the residential treatment and therapeutic foster care programs that are also being developed and will use Medicaid dollars. **Mr. Leary** commented that they had met with **Representative Henbest** to make sure they were moving in the right direction. He stated that these areas are not as clear cut as the substance abuse program. There are some federal regulations in place currently that are making it difficult for Medicaid to cover all therapeutic foster care services as they did before.

Mr. Leary said that some states have covered therapeutic foster care through Title IV-E payments to pay for the room and board while in care. He said the therapeutic care services are bundled services that the state has paid for. In his opinion, this is why the new regulations have been developed because states were "double dipping" and getting these Title IV-E payments as well as Title XIX payments.

He said they have met with the Centers for Medicare/Medicaid Services (CMS) to see what services would be covered and this is outlined on the therapeutic foster care handout that is available in the Legislative Services Office. Out of the nine specific services that have been identified for therapeutic foster care, behavioral management and community based wrap around services have received very positive responses. **Mr. Leary** said that from a Medicaid standpoint, they are talking with other states and are receiving unit costs and comparing what services exist today. He said there is a need to learn how many units of those services are currently being provided outside of Medicaid in order to figure out the fiscal impact.

Mr. Leary explained that it will take them up to the 2009 legislative session to move this forward. He noted that there are a couple of department and legislative decision points that need to be made along the way. (Please see his handout for additional details.)

The first decision point would be to get the actual units to understand what the fiscal impact would be if part of these services were covered by Medicaid. The second part is to figure the cost of building the infrastructure and making sure that it does not morph into something much greater than intended. He said this is true for both therapeutic foster care and residential treatment.

Ms. Britton added that one thing they have observed in the foster care system is that the length of stay for children in care has continued to increase in the last few years. In 2001, length of stay

averaged for residential and foster care was 104 days to114 days. She emphasized therapeutic foster as the maximum intervention needed because it is a much more normal environment in which to live. She said they want to make sure the service does not get overused and are trying to prevent children from rising to this level of need and to keep the length of stay as short as possible.

Ms. Britton said they have observed that foster care rates overall, including residential rates, have increased dramatically in the last six or seven years. Spending was $6 million in 2001 and it is up to $16 million for these two services in 2007. She said they believe that more can be done to prevent high levels of placement when possible and plan to emphasize that. She assured the Task Force that her department is not overusing what might become available through Medicaid.

Senator Cameron noted that the legislature requested that the Department consider using or maximizing the resources by utilizing federal funds, not just General Funds, for therapeutic foster care. He asked for a report as to what progress has been made in that arena. **Mr. Leary** said that is included in the outline/timeline he distributed. He said they have identified the two services or codes he mentioned above for therapeutic foster care. The next move is to determine the cost per unit and to identify how many units are being utilized per code and whether it makes sense to make that a Medicaid covered service at that point.

Senator Cameron asked why the state would not want to utilize the federal match. He asked why they are taking such painstaking steps to make the decision. He said, it would seem to him that unless there were additional federal requirements, it would make no sense not to use the federal funds. **Mr. Leary** said that makes sense where those funds are available. He said that the state will also have to make sure that benefits can be controlled. He said that the therapeutic foster care benefit will probably not be one that morphs into something larger. He said there is some concern with residential treatment, without building the infrastructure, that it could become something more than it is today if it becomes a Medicaid benefit. Looking at what services are being provided today is what is taking the time. Currently those services are bundled so there is not really any knowledge of the specific components.

Senator Cameron said that the only way those services will grow like wildfire is if there is a high demand for those services. He asked what the alternative is to providing those services. In his opinion, the situation would be the same as it is today. He said he understands the concern regarding growth but it sounds like they do not want to use federal dollars because they do not want to provide services to those that need it. He asked for clarification. **Mr. Leary** said he was saying that they do not want to provide services for those who do not need it. Other states have experienced rapid growth in residential treatment due to this change in funding.

Senator Cameron suggested that this would mean they would focus more on the therapeutic foster care first. **Ms. Britton** said the reality is that there is not a lot of infrastructure at this point. Therapeutic foster care will require certain qualifications for the parents who take on children

with severe mental health disorders or severe emotional disturbance. These people will need to be trained. These providers will also need to be able to separate out what is acceptable to Medicaid as treatment versus room and board payments and the like. Currently this is all included in a daily rate that is paid from an automated system.

Representative Marriott asked for the difference between residential care and therapeutic foster care. **Mr. Edmonds** explained that residential treatment is a professionally built service. It is an actual facility with many rooms and is staffed 24 hours a day by professionals. These facilities house between 12 and 30 youths at a time. On the other hand, therapeutic foster care is someone's home in which a child comes to live. These homes only house one or two children at a time.

Senator Werk asked whether residential treatment homes would be akin to facilities such as the "New Hope" facilities that have been in the news recently. **Mr. Edmonds** said other states that have made residential treatment a Medicaid benefit have warned Idaho that can happen. It has created more of these types of facilities in other states.

Representative Wood commended the department for taking their time with this and doing "due diligence." He said he understood where **Senator Cameron** was coming from but that this has the potential of getting out of control if it is not adequately defined. **Senator Cameron** agreed with that but said that since those services are being paid for with General Fund dollars, there ought to be definitions already in place. He said the expansion to Medicaid ought not create more concern. **Ms. Britton** said the residential treatment providers in the state are licensed under one set of rules, therapeutic foster homes are licensed under another set of rules. She said the residential rules contain a lot of requirements in terms of provider qualifications, delivery of medications and so on. She said the bundling of costs and daily rates are the problem because the federal government needs to know specific costs for specific services. She said that by the time therapy components have been figured, Idaho is going to have to meet some Medicaid requirements that may not have been part of the expectations that were set in the bundled rates. That is part of the challenge. **Ms. Britton** said that everyone is very excited about the opportunity, they just want to do it the right way.

In response to a question from **Senator Cameron** regarding the current plan for this legislative session, **Ms. Britton** said they plan to work with their federal partners to change the plan that the state must submit and work to get that approved. At that point, all of these issues will be costed out. Qualifications and rules will be developed and brought forward in the 2009 session. The Department will also ask for a statute change and approval of the infrastructure for implementation in July, 2009.

Senator Cameron clarified that this means the state would still be at least one year away from using any Medicaid funds for these services. He added that it was his understanding that there will not be any Medicaid spending authority requested or sought for in the 2009 budget, consequently making it fiscal year 2010 before this would take place. **Mr. Leary** said that was

correct.

Due to time constraints the Task Force agreed to discuss any potential legislation at the next meeting.

The meeting was adjourned at 12:15 p.m.