MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 17, 2012
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Lodge, Vice Chairman Broadsword, Senators Darrington, Smyser, Heider, Vick, Nuxoll, Bock, and Schmidt
ABSENT/ EXCUSED:	
NOTE:	The sign-in sheet, testimonies, and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
MINUTES:	**Chairman Lodge** called the meeting to order at 3:05 p.m. and welcomed guests.
RS 20897	**Relating to Senate Concurrent Resolution Endorsing the Idaho Alzheimer's Planning Group's Efforts to Create a Statewide Plan. Vice Chairman Broadsword** stated that this resolution seeks to endorse the efforts of the Idaho Alzheimer's Planning Group to create a statewide plan to address the growing problem of Alzheimer's and other dementias that increasingly continue to affect citizens throughout Idaho. She advised that if the Committee agrees to print **RS 20897** it is her intention to come back before the Committee with a full hearing, presenting testimony to explain the need for this plan. She noted there are several co-sponsors on this resolution, including **Senator Schmidt**.
MOTION:	**Senator Schmidt** moved, seconded by **Senator Smyser**, that **RS 20897** be sent to print. The motion carried by **voice vote**.
	Senator Darrington reminded **Chairman Lodge** that when resolutions are printed they automatically go straight to the floor and, therefore, it will be necessary for her to request on the floor that the resolution be returned to the Committee.
GAVEL CHANGE:	**Chairman Lodge** passed the gavel to **Vice Chairman Broadsword** to continue rules review.
DOCKET NO. 16-0309-1108	**Relating to Medicaid Basic Plan Benefits (Pending). Lisa Hettinger**, Bureau Chief, Division of Medicaid Financial Operations, Department of Health & Welfare (Department), stated this proposed rule aligns state rules with federal requirements. The amendments clarify the rules related to Medicaid's reimbursement policies to providers for non-Medicare coordination of benefits when a third party payer (insurance company) reimburses a provider for services, or when the Department determines that a third party liability exists. **Ms. Hettinger** requested that the Committee approve **Docket No. 16-0309-1101**.
	Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #1).
	Senator Schmidt asked if this rule applies to Medicaid benefits that would go to veterans for services provided by a Veteran's Home. **Ms. Hettinger** advised this would not apply to Veteran's Administration benefits.
MOTION:	**Senator Bock** moved, seconded by **Senator Heider**, that the Committee approve **Docket No. 16-0309-1108**. The motion carried by **voice vote**.

DOCKET NO. 16-0309-1101

Relating to Medicaid Basic Plan Benefits (Temporary). Sheila Pugatch, Principal Financial Specialist, Division of Medicaid, Department of Health & Welfare, advised that the purpose of this rule, in accordance with 2011 legislative direction in H 260, is to change pharmacy reimbursement to the Average Actual Acquisition Cost (AAAC) by obtaining cost information through a pharmacy survey process. In addition the dispensing fee payment is changed from a single fee to a tiered fee structure. **Ms. Pugatch** requested that the Committee approve **Docket No. 16-0309-1101**.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #2).

Vice Chairman Broadsword noted the rule indicates that if a pharmacy is nonresponsive to the periodic state cost surveys, it can be disenrolled. She asked if the Department has made sure that every pharmacy provider in the state is aware of that issue. **Ms. Pugatch** advised that the Department had covered that through an information release. **Senator Bock** questioned why this is a temporary rule as opposed to a pending rule. **Ms. Pugatch** advised that the rule was implemented after July 1, 2011, and because of timing issues the Department had to pursue a temporary rule. **Senator Heider** asked for an explanation of how pharmacies were reimbursed in the past and whether we were paying more or less before this rule. **Ms. Pugatch** indicated pharmacies were paid based on the average wholesale price minus 12 percent and that amount was more than it is under this rule. **Senator Darrington** asked what the difference is between a labeler and supplier. **Ms. Pugatch** advised that for the most part they are the same; the labeler is the manufacturer of the drug.

MOTION:

Chairman Lodge moved, seconded by **Senator Nuxoll**, that the Committee approve **Docket No. 16-0309-1101**. The motion carried by **voice vote**.

DOCKET NO. 16-0309-1102

Relating to Medicaid Basic Plan Benefits (Pending). Ms. Pugatch advised that H 260, passed by the 2011 Legislature, repealed, amended, and added statutes that are being referenced in these rules. Changes in effect regarding hospital floor reimbursement percentage and the reduction to outpatient hospital costs include: 1) reimburse most private hospitals at 100% of cost - private hospitals that do not have emergency rooms or are psychiatric hospitals will continue to be reimbursed at 91.7% of their costs; 2) reimburse critical access hospitals at 101% of costs; and 3) reimburse out-of-state hospitals at 87.1% of costs. **Ms. Pugatch** requested that the Committee approve **Docket No. 16-0309-1102**.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #3).

Senator Nuxoll asked why some hospitals are paid less. **Ms. Pugatch** explained that the private hospitals not having emergency rooms, such as psychiatric hospitals, and out-of-state hospitals do not participate in the Hospital Assessment Act, therefore their reimbursement cost is decreased.

MOTION:

Senator Schmidt moved, seconded by **Senator Heider**, that the Committee approve **Docket No. 16-0309-1102**. The motion carried by **voice vote**.

DOCKET NO. 16-0310-1104 **Relating to Medicaid Enhanced Plan Benefits (Pending). Ms. Pugatch** stated that rule changes in this Docket implement legislative intent language in H 260 passed by the 2011 Legislature regarding nursing facilities and intermediate care facilities for people with intellectual disabilities. This rule will: 1) continue the nursing home and intermediate care facility for persons with intellectual disabilities (ICF/ID) rate freeze; 2) remove the efficiency incentive payments to ICF/ID providers; and 3) clarify the definition for patient day for both a nursing facility as well as an ICF/ID and date of discharge as it relates to nursing facilities. The rule also requires cost survey data to be provided periodically by certain providers in order to establish reimbursement rates. **Ms. Pugatch** requested that the Committee approve **Docket No. 16-0310-1104**.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #4).

Senator Schmidt asked how the requirement to provide the survey information had been received by the providers. **Ms. Pugatch** responded that the providers have asked when they will be surveyed and she has advised that on average it would be every five years. They have also inquired if they will be automatically disenrolled from the Medicaid program if they do not participate in the survey. They have been advised that the rule says the Department may disenroll a provider who does not participate, but there is no certainty that they will be disenrolled. **Senator Schmidt** then noted the language of the rule states if a provider refuses or fails to respond to the survey, the provider "can" be disenrolled as opposed to "will" be disenrolled. **Ms. Pugatch** indicated that is right.

TESTIMONY: **Robert Vande Merwe** representing Idaho Health Care Association and Idaho Center for Assisted Living spoke **in opposition** to Sections 235 and 257 of **Docket 16-0310-1104.** He indicated a rate freeze has been in place for nursing facilities for the past three years, while costs are going up. A nursing home assessment for the last two years allowed backfill with federal funds, but those federal funds will not be available this year. He stated they are working with the Department to come up with a compromise to use federal funds to backfill for Fiscal Year (FY) 2012 and 2013.

Senator Heider asked if negotiations with the Department would take a long time or could be accomplished in a few days and what he would like the Committee to do at this point. **Mr. Vande Merwe** responded that he would like the Committee to reject the rule and bring it back after they find an assessment that will allow federal funds for backfill. He anticipates negotiation will take a few weeks, but should be accomplished during this session.

TESTIMONY: **Katherine Hansen**, Executive Director of Community Partnerships of Idaho, representing Vocational Services of Idaho, spoke **in opposition** to **Docket No. 16-0310-1104** stating that her concern is that the rule is unclear related to the cost survey. She recognized the need to make sure the survey has a high degree of representation, but recommended that the Department return to the language that was in a temporary rule for this past year which requires the Department to do a five year study based on statistical representation as opposed to being mandatory.

Senator Darrington asked **Ms. Hansen** to specify the specific part of the rule she is addressing. **Ms. Hansen** advised her objection is to Section 706.04 and 706.05. related to Adult DD Waiver Services.

TESTIMONY: **Greg Dickerson**, Administrator, Human Supports of Idaho, spoke **in opposition** to **Docket No. 16-0310-1104**, Sections 119.03 and 140.09, related to cost survey. He advised these surveys take a great deal of training and time to properly complete. After the 2006 survey, proposed rates were set and several were found to be below what was necessary to meet provider costs. He stated the Department has failed to address the disparities with the Legislature or request budget increases necessary to meet financial needs of providers, and questioned why the providers should be required to go to the time and expense of attending to this empty process.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #5).

TESTIMONY: **Kelly Keele** representing Mental Health Providers Association of Idaho, spoke **in opposition** to **Docket No. 16-0310-1104** saying he concurs with the testimony of **Mr. Dickerson** and requested that the Committee reject Sections 119 and 140 of this Docket.

TESTIMONY: **Jason Lowry**. President, Idaho Association of Developmental Disability Agencies, spoke **in opposition** to **Docket 16-0310-1104**, Section 659.02 related to cost survey. He stated agreement with the Department conducting a survey every five years from a statistical appropriate number of provider association representatives in order to obtain cost data. He does not support the new rule which states the Department can disenroll Medicaid providers if they refuse or fail to respond to the survey, but does support transparency and collaboration with the Department. He requested the Department strike Section 659.02 from this Docket.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #6).

Vice Chairman Broadsword stated that she does not think the Department is planning to eliminate providers but they do need something that requires them to come to the table and talk. She asked **Mr. Lowry** how he would suggest they get the providers to provide the information. He replied he would request that the Department collaborate with the Association so they can help establish some ways to do that.

TESTIMONY: **Michael Wilson**, Secretary, Idaho Residential Supported Living Association, and a Masters Level Social Worker, spoke **in opposition** to **Docket 16-0310-1104**, Section 706.04 and 706.05. He indicated that although the Association supports a rate study, they cannot support the rule as written because it lacks clarity and promotes concern as to what the "Percentage" of the "target reimbursement rate" would be, does not address how data will be collected, and does not provide assurances that participation in the cost survey process will lead to outcomes. The Association would like to see a requirement that the Department submit the findings of the cost survey to the Legislature for review.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #7).

Vice Chairman Broadsword asked if his association members who have received training in how to complete the cost survey would be willing to go out and help other providers who have not been trained. **Mr. Wilson** indicated they had talked about this and would be willing to do so, but noted that the resources of provider agencies are just as strained as those of the Department at this point in time.

Vice Chairman Broadsword requested that **Ms. Pugatch** return to the podium to respond to questions of the Committee. She asked if for some reason this entire docket is rejected, would the temporary rule that had been in place continue to be valid or would the Department have to go to the expense of writing an entirely new rule. **Ms. Pugatch** deferred the question to **Ed Hawley**, State of Idaho, Department of Administration, Administrative Rules Division. **Mr. Hawley** indicated it would require the entire rule be rewritten.

Senator Bock asked if it is the Department's position that they have to promulgate this rule in order to effect some statutory obligation. **Ms. Pugatch** responded not to her knowledge. **Senator Bock** indicated he did not want to see the Department prejudiced in a way that is going to cause injuries to the people we are trying to serve, and asked what the Department would have to fall back on if the rule was to be repromulgated. **Ms. Pugatch** indicated there will be no rules in effect until new rules are promulgated. **Vice Chairman Broadsword** noted **Paul Leary**, Administrator, Division of Medicaid, Department of Health & Welfare, was present and asked if he would respond to **Senator Bock's** question. **Mr. Leary** indicated he feels the Department is on safe ground if rules are rejected at this point, as a lot of the changes are already in statute with H 260. He agreed that the Legislature should have the data collected from the cost survey as well as other information pertaining to providers and access.

The Committee discussed at length with **Mr. Leary** the fact that this is the third year in a row for cutbacks to the providers; the mandatory requirement for participation in the cost survey; that the Department needs to be able to obtain adequate cost analysis; although the Department has budget constraints, it still needs to ensure the financial health of good providers; whether the survey form could be reworked to make it simpler to complete; and whether the Department intends to disenroll providers over the next year who do not participate in the survey. **Mr. Leary** responded that the survey process had been jointly agreed upon with providers and training was provided. He further stated that the Department does need some leverage to get the providers to complete the survey, and that there are no resources in the budget over the next year to do a cost survey, so the language could be worked on.

Senator Vick asked if one of the providers would share with the Committee why they do not answer the survey. **Vice Chairman Broadsword** asked **Ms. Hansen** to respond to the question. **Ms. Hansen** advised that her organization provides employment services, mental health services, and developmental disabilities services and all of those require separate cost studies to determine the cost ratios, so her organization has to figure out what portion of administrative costs are spent in each service area and eliminate any administrative costs that are not reimbursable; this is very time consuming and complex. She advised her organization would like an opportunity to meet with the Department and perhaps a couple of Committee members prior to the rule being voted on and bring back a recommendation.

Senator Vick asked if it would be possible to delay the Committee's decision on this rule, giving the parties an opportunity to come to an agreement. **Vice Chairman Broadsword** asked the parties if they would be able to meet in the near future and received assurances they would. She announced that a **vote on Docket 16-0310-1104 would be delayed and rescheduled at a later date.**

DOCKET NO. 16-0309-1104

Relating to Medicaid Basic Plan Benefits (Pending). David Simnitt, Deputy Administrator, Division of Medicaid, Department of Health & Welfare, advised that the 2011 Legislature, through H 260, provided specific direction on how to reduce health care costs in the Medicaid budget and improve the health care delivery system in Medicaid. He described for the Committee the directions of the Legislature and the actions taken by the Department to comply within the areas of: collateral contact; chiropractic benefits; podiatrist services; audiology benefits; vision services, mental health assessment coverage; and the Healthy Connections program. He stated that the benefit reductions in this docket were not easy to make and there is always risk involved in changing Medicaid coverage and policies. The Department is monitoring the impacts to ensure that participants' health and safety is protected and that there are not cost shifts to more expensive services as a result of these changes. **Mr. Simnitt** requested that the Committee approve **Docket No. 16-0309-1104**.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #8).

Senator Darrington asked if everything in this rule is to comply with H 260. **Mr. Simnitt** responded that is correct. **Chairman Lodge** asked how the Department monitors the program and if the Committee could be provided with results of what has been discovered so far. **Mr. Simnitt** advised that he would provide more detail under the next Docket and that under this docket the Department worked closely with the associations to identify ways that it can make sure that proper benefits are in place and where there are chronic conditions that they are treated. **Senator Schmidt** noted the Healthy Connections plan allows an additional 50 cent increase per member for providers with extended coverage and asked if there has been a move to extended coverage in the community, and the volume per provider. **Mr. Simnitt** advised there are a lot of providers who were either already providing extended coverage or who have chosen to extend coverage to receive the 50 cent incentive payments. He stated he did not have an exact count but could get that information. He added that there are about 1,500 primary care providers that service about 25,000 Medicaid patients.

Senator Darrington asked if this is the rule that provides a 50 cent payback for physicians unless they maintain a 46 hour office week. **Mr. Simnitt** advised that this is the rule that contains that incentive payment for practices that provide 46 hours per week or more. **Senator Darrington** stated that this is not an incentive payment; it is a penalty, and asked if it was in accordance with and called for in H 260. **Mr. Simnitt** advised Healthy Connection providers were receiving $3.50 per month for each Medicaid member and this reduction was part of a cost savings approach to reduce the amount of payments being made to Healthy Connection providers so **Senator Darrington** is right, if a provider is not able to or chooses not to extend hours he will have a cost decrease compared to the past. **Senator Darrington** indicated this is discriminatory against the solo practitioner who takes a lot of Medicaid patients. It is not reasonable to expect this type of practitioner to extend hours; it is a penalty. He further stated that H 260 does not specifically say we must do this. **Mr. Simnitt** indicated H 260 does give specific directions to provide a tiered payment methodology and gives specific directions to provide an incentive payment for extended hours but does not state an amount for that incentive payment.

Vice Chairman Broadsword recognized **Mr. Leary** who advised that H 701 was a Medicaid reform budget reduction in the 2010 session. At that time the Department switched to a tiered system and temporary rules were passed last year with this change in them. **Senator Darrington** again asked what the rationale for 46 hours is when it could be 40 hours and why the solo practitioner is penalized when the clinics are not. **Mr. Leary** advised that a group looked at what would be defined as extended hours. He stated **Senator Darrington** has a good point when looking at an independent practitioner versus a large practice. He stated this is a springboard as the Department moves into medical homes and is a structure that will be better utilized when we get into health homes with much better reimbursement for those physicians. He added the Department looks at all practices and participants but must set rules for the masses and there are always some that do not seem fair. **Vice Chairman Broadsword** commented that the underlying purpose is to save state money. **Mr. Leary** indicated that is correct. **Senator Darrington** commented that he can not support the rule because it is punitive in nature.

MOTION: **Senator Bock** moved, seconded by **Senator Darrington**, to reject **Docket No. 16-0309-1104.**

SUBSTITUTE MOTION: **Chairman Lodge** stated that the Department worked really hard on this legislation trying to work out ways to be as fair as possible, knowing that this was not going to cover every situation with independent providers and especially a doctor that will not be able to do the 46 hours. She suggested PA's might be able to help them extend those hours. She stated that it was important that the Committee approve this docket and made a substitute motion, seconded by **Senator Vick**, to approve **Docket No. 16-0309-1104**.

Senator Darrington spoke against the substitute motion stating he has seldom seen the lack of fairness to the extent of this. It is not reasonable to expect those single practitioners would have PA’s. It is not common throughout the doctors' offices in his community.

Senator Lodge commented that Healthy Connections is an incentive to get our Medicaid people to go to a single provider and also maybe have some hours that would go beyond 8 to 5 so people could go in the evening time.

Senator Bock spoke against the substitute motion and for the original motion stating this rule is discriminatory. Its net effect is that there will be a certain segment of the population who will not receive services. He stated this is contrary to the mission of the Medicaid program and really undermines it.

VOTE SUBSTITUTE MOTION **Vice Chairman Broadsword** called for a Roll Call Vote on the substitute motion to approve **Docket No. 16-0309-1104**. The results of the vote were: **Chairman Lodge,** Aye; **Vice Chairman Broadsword**, Aye; **Senator Darrington**, Nay; **Senator Heider,** Nay; **Senator Vick**, Aye, **Senator Nuxoll**, Aye; **Senator Bock**, Nay; **Senator Schmidt**, Nay. The vote resulted in a tie with 4 "Aye votes," 4 "Nay votes," and 1 absent/excused. The **motion failed.**

VOTE ORIGINAL MOTION **Vice Chairman Broadsword** called for a Roll Call Vote on the original motion to reject **Docket No. 16-0309-1104**. The results of the vote were: **Chairman Lodge,** Nay; **Vice Chairman Broadsword**, Nay; **Senator Darrington**, Aye; **Senator Heider**, Aye; **Senator Vick,** Nay; **Senator Nuxoll**, Nay; **Senator Bock,** Aye; **Senator Schmidt,** Aye. The vote resulted in a tie with 4 "Aye votes," 4 "Nay votes," and 1 absent/excused. The **motion failed.**

DOCKET NO. 16-0310-1105

Relating to Medicaid Enhanced Plan Benefits (Pending): Mr. Simnitt advised that approval of these pending rules will allow the Department to finalize the cost savings approach and policy changes required through H 260. He described for the Committee the directions of the Legislature and the actions taken by the Department to comply within the areas of: collateral contact; intake and functional assessments as well as comprehensive diagnostic assessments; restriction of duplicative skill training provided by a mental health provider and developmental disability provider; elimination of personal care service coordination; partial care benefits; Psycho-social rehabilitation (PSR) coverage; supportive counseling; individual Developmental Disabilities (DD) budget restrictions; and selective contract to provide oversight to Certified Family Homes providing residential habilitation services. **Mr. Simnitt** stated that while benefit changes are never easy, the Department believes that these pending rules comply with the direction provided through H 260 and will help the Medicaid program be sustainable into the future.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #9).

Senator Bock stated he has heard that some people who fall into both the DD and PSR categories are now requiring greater services, and asked if the separation was actually required by H 260 or is a product of policy decisions that can be refined a bit in order to avoid the problems related to it. **Mr. Simnitt** advised that H 260 language was very specific about limiting the duplicative services in mental health and DD. He stated that he has also heard of problems, but when the Department asks for specifics and looks to the data it does not see that. He said he feels there is a possibility to provide coordination and the Department is interested in helping to provide that coordination and look at other services and benefits that would be all right to combine and make this better for participants. **Senator Schmidt** indicated an appreciation for the effort to look for cost shifting and asked if it is possible that some people needing mental health services have moved to indigent services. **Mr. Simnitt** advised that is possible, if they move off the Medicaid roles, then the Department no longer has information. **Vice Chairman Broadsword** noted that indigent people must go through Medicaid first and be proven ineligible before qualifying for indigent benefits.

TESTIMONY:

Amika DuPree, of the Coeur d'Alene area, representing the State Board of the National Alliance of Mental Illness (NAMI) spoke **in opposition** to **Docket No. 16-0310-1105**. Her concern was that Medicaid requires a choice between PSR services and DD therapy. She noted the qualification differences for treatment in each area, with DD therapy requiring a high school degree while PSR therapy requires a minimum of a Bachelor's degree, continuing education requirements, and national certification.

Senator Bock asked, given the fact that these cuts are mandated, what kind of things NAMI is doing to work with the Department to make sure the Department has information to respond to problems in a more creative way. **Ms. DuPree** indicated NAMI is willing to coordinate with the Department and look at different ideas, such as, if someone needs both services, reducing slightly the amount of hours so they can receive both services.

TESTIMONY:

John Tanner, Idaho Falls, representing NAMI, spoke **in opposition** to **Docket No. 16-0310-1105**. His concern was with elimination of collateral contact coverage. He stated he had a son with severe schizophrenia and collateral contact is a very important part of his treatment plan. He added that medications work well, proving the fact that mental illness is a physical brain disease that requires professional help. He indicated he is aware that some PSR providers are continuing to provide this service without reimbursement.

Senator Schmidt noted that **Mr. Tanner** mentioned that some providers continue to provide service and not get paid, and asked if that has been his experience. He indicated he is aware of providers who are doing that and it is a financial strain.

TESTIMONY: **Cassie Mills**, President of Vocational Services of Idaho (VSI) and Employment Director for Community Partnerships of Idaho (CPI), spoke **in opposition** to **Docket No. 16-0310-1105**. She stated her agencies provide pre-vocational, vocational and Community Supported Employment supports to people with disabilities. Her clients have been severely impacted by the reduction in the number of Community Supported Employment hours and supports on the job.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #10).

TESTIMONY: **Marilyn Sword**, Executive Director, Idaho Council on Developmental Disabilities (ICDD), spoke **in opposition** to **Docket No. 16-0310-1105**. She stated she agrees with the previous testimony and provided written testimony for the Committee.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #11).

TESTIMONY: **Nikki Tangen** and her ward **Crystal** spoke **in opposition** to **Docket No. 16-0310-1105**. She stated Crystal has been diagnosed as bi-polar and is mentally retarded. She related her family history and indicated because of budget cuts to her benefits she has had to make some difficult choices regarding services. She chose services for DD over PSR, but Crystal lost a lot of ground in her effort to become independent and ultimately this has cost the state more money for an assisted living facility. She indicated the process to qualify Crystal for self direction services with the Center for Disabilities of Idaho (CDI) was started in October 2011 and she has been scheduled for the end of February 2012.

Vice Chairman Broadsword thanked **Ms. Tangen** for her testimony and for her work with Crystal.

TESTIMONY: **Kelly Keele**, representing Mental Health Providers Association, spoke **in opposition** to **Docket No. 16-0310-1105**. He indicated three sections of the rule need to be corrected: 1) elimination of collateral contact; 2) inability to serve people with a dual diagnosis; and 3) restoration of 5 hours of PSR therapy for adults.

TESTIMONY: **Katherine Hansen**, Vice President, Idaho Association of Developmental Disabilities Agencies and Executive Director of Community Partnerships of Idaho, spoke **in opposition** to **Docket 16-0310-1105**. She provided written testimony and stated that most of the people who have testified support that there should not be duplicative skill training and that mental health providers should not be training on the same skills as DD providers, but the individual who has a dual diagnosis should be able to have that professional provide skills training based on that particular area. She recommended modifying the language to clarify the intent is not to pay for two individuals providing the same type of skill training; the intent is to assure that we are not duplicating services.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see Attachment #12).

Vice Chairman Broadsword extended appreciation for the comments and stated it is not too late to get legislation drafted. She then asked **Mr. Simnitt** to respond to comments of those who provided testimony. **Mr. Simnitt** reminded the Committee that the rule changes in this docket are the result of H 260 and the Department has little discretion. Related to the specific issues raised, he noted the duplicative services issues and indicated a willingness on the part of the Department to discuss specific cases and do some case management consultation on how a participant can use the benefits that are available. He advised that most people, because of the hours that are available under the DD program, tend to choose the DD schedule. Each person has to make a decision on their own on what best meets their needs and that can be revisited as needed. **Vice Chairman Broadsword** asked **Mr. Simnitt** if he would look into why a determination has taken so long for **Ms.Tangen's** ward, **Crystal. Mr. Simnitt** indicated he would do so and follow up with **Ms. Tangen.** He indicated he was surprised by that testimony inasmuch as the Center of Disabilities of Idaho has just 30 days to make an evaluation related to eligibility determination. Regarding collateral contact, he stated this is a piece of legislation put into place with H 701 and originated as a recommendation from the providers association as an opportunity to save money. He noted that there certainly is appropriate use of collateral contact and at some point the Department could revisit that decision.

Senator Heider commented that he feels the Department does a good job, but it seems there is no coordination between the Department and the providers in the field. He feels the Department needs to work out some of these issues with providers prior to presenting rules. **Mr. Simnitt** indicated that it is his feeling that the Department has an excellent working relationship with the providers. They have regular meetings with those providers and associations and for the most part we reach agreement in drafting rules, but there is always going to be some disagreement. He advised that there have been relatively few issues compared to the scope of changes under H 260. **Senator Heider** asked if the Department could take another look at collateral contact and work something out with the providers. **Vice Chairman Broadsword** asked **Mr. Simnitt** if the statute would allow that. **Mr. Simnitt** indicated the statute is very specific. **Vice Chairman Broadsword** suggested **Senator Heider** might like to work with the providers and come up with a statute change. **Senator Heider** responded that it would be his pleasure to do so.

MOTION: **Chairman Lodge** moved, seconded by **Vice Chairman Broadsword**, that the Committee approve **Docket 16-0310-1105**. **Vice Chairman Broadsword** commented that no one likes H 260 very well, but it is the law and we need to have rules in place to provide the working framework for that law.

ROLL CALL VOTE: **Senator Bock** requested a roll call vote. The results of that vote were: **Chairman Lodge**, Aye; **Vice Chairman Broadsword**, Aye; **Senator Darrington**, Nay; **Senator Smyser**, excused; **Senator Heider**, Nay; **Senator Vick**, Aye; **Senator Nuxoll**, excused; **Senator Bock**, Nay; **Senator Schmidt,** Aye. The **motion passed** with 4 "Aye" votes, 3 "Nay" votes, and 2 absent/excused.

GAVEL CHANGE: **Vice Chairman Broadsword** thanked the presenters and returned the gavel to **Chairman Lodge**.

ADJOURN: **Chairman Lodge** thanked **Vice Chairman Broadsword** for her leadership in rules review. She asked for Committee volunteers to work with **Mr. Leary** on the issues in **Docket 16-0310-1104** and adjourned the meeting at 5:18 p.m.

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Senator Lodge
Chairman

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Lois Bencken
Secretary