MINUTES

# SENATE HEALTH & WELFARE COMMITTEE

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| **DATE:** | Tuesday, February 14, 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. |
| **S 1294** | **Relating to the Medical Consent and Natural Death Act. Robert L. Aldridge** requested that **S 1294** be held for a day or two. |
| **GAVEL CHANGE:** | **Chairman Lodge** introduced her neighbors, the Sauer family, who are here in support of proposed legislation related to texting while driving. They are testifying before the Transportation Committee on behalf of their daughter, Taylor, who was fatally injured while driving and texting. **Chairman Lodge** asked that she be excused to support the Sauer family and passed the gavel to **Vice Chairman Broadsword**, who announced the next item on the agenda is a status report related to the Children's Benefits Redesign. She stated there would be no testimony from the audience, but the Committee will be allowed to ask questions. |
| **PRESENTATION** | **Department of Health and Welfare - Children's Benefits Redesign Status Report. David Simnitt** Deputy Administrator, Division of Medicaid, Department of Health & Welfare (Department) stated the Department has received the necessary approval from the Centers for Medicare and Medicaid Services (CMS) to implement the rules adopted by the Legislature in 2011. **Mr. Simnitt** provided a brief history of Children's Developmental Disability (DD) services in Idaho, highlighting the fact that prior to 1995 children utilized few Medicaid DD services. In 1996 the Department began to see an increase in the use of developmental therapy and introduced Intensive Behavioral Intervention (IBI) which was originally targeted to the specific needs of children with autism. Because Medicaid rules do not allow targeting services to a specific population group, this was made available to children with DD from birth to 21 years of age. He reviewed the increase in utilization from 1991 through 2011 and advised that as utilization began to increase there were concerns from families, advocates and providers that this therapy program did not always meet the needs of the children.<br><br>In 2009 the Department began to work on the children's benefit redesign package. A Steering Committee and Design Committee were established and meetings were held with families and stakeholders over a two-year period to identify redesign objectives, which he reviewed. He stated the redesign objective is to move from a one-size-fits-all system, that was only able to deliver therapy, to a system that provides a continuum of care based on the child's level of need. |

The Department developed a budget methodology for children with DD based on research and level of care needs. Outside of the budget children can access an array of non DD services to meet individualized needs, including: medical services, pharmacy, physical therapy, occupational therapy, speech therapy, crisis services, and early periodic screening (EPSDT) for medically necessary services. **Mr. Simnitt** provided an example of a child's budget detailing the services that come out of the budget and those that do not.

Realizing it would be impossible to move from the old to the new system all at once, the Department structured a phase-in strategy over the course of a year, based on a child's birth date. This necessitates operating two systems at once which is a challenge for the field staff.

**Mr. Simnitt** introduced **Chad Cardwell**, Field Operations Program Manager, Division of Family and Community Services DD Program, who advised that new benefits became available on October 1, 2011 and currently 119 families are receiving services under the redesign program. Case Management is provided through a combination of Department staff and contractors. The Department has been able to sign contractors in only two areas of the state and Department staff will continue to handle case management while contracts in other areas of the state are pursued.

**Mr. Cardwell** provided an overview of the current program enrollment, indicating 71 percent of families receiving application notices have responded and 12 percent of families have chosen to move to the new redesign services. A contributing factor to the low number of families receiving new services is the inability of the program to secure contracts for case management as intended. As a result, the transition plan portion of the program was delayed on an interim basis to give the Department more time to pursue contracts. During this interim period families were given the option to transition, but were not required to transition until contracts were in place. He reviewed the services being chosen by parents under the redesign and indicated they are choosing an array of services.

**Mr. Cardwell** reviewed the Department's communications with parents and providers and noted the Department's web site, www.redesignforchildren.medicaid.idaho.gov has current information about the program and contact information. He indicated there is some confusion among families who have not yet transitioned regarding what benefits come out of the DD budget, and some families report that providers are advising against transitioning to the new system. He stated as a result the Department is increasing its communication with families. He further stated that among families who are receiving the new services there is strong agreement that their questions are being answered and services are being met. He stated the Department would continue to monitor the program closely.

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 what procedure was used in seeking contracts for case management. **Mr. Cardwell** indicated RFPs were issued in April 2011 for a statewide contractor. There were only two vendor responses, with one vendor being prepared to offer a statewide contract; that bid was beyond the Department's allocated budget, so the contract was not awarded and the RFP was cancelled. The RFP was revised to a regional contract and established a per member per month rate which locked in the allocated budget. Contracts have been awarded in Regions Three and Four. He is optimistic that additional contracts will be awarded in the near future.

In response to questions from **Senator Schmidt**, **Mr. Cardwell** confirmed that there was a good response to the RFP from urban areas, but rural areas did not respond. He stated that the cost for services graph shown to the Committee reflects an increase in spending during the 1990's which is commensurate with the increase in participant levels. There was an additional spike in the early 2000's when the Department noted a move from DD to IBI; the same participants were receiving more expensive services. There are 3200 children with DD in the current system and increases are commensurate with population increases in Idaho. He advised, however, that increases in school based services continue to be a concern. Regarding the simultaneous operation of two systems, he indicated that identifying who is participating in which system is mostly done through communications with families, and that the key to getting families to the services they need is having employees who know everything about both programs.

In response to questions from **Senator Smyser** related to school based services, **Mr. Simnitt** indicated the Department maintains those DD and IBI services in the Medicaid State Plan and the Department is working through a plan so that when those services are moved out of the State Plan it will have the least impact possible on schools. He stated it is hard to make a distinction between these habilitative services in schools and education and the office of the inspector general is looking closely at all school based services. They have not come to Idaho yet, but around the country the federal government has made fairly significant disallowances or recoupment of school based Medicaid services, because those were delivered inappropriately or they were replacing education with Medicaid services. The Department has not identified why these costs are increasing and has an integrity unit looking specifically at what is going on in schools. They are taking a broad look at it and trying to figure out what makes sense from a Medicaid perspective for school providers.

**Vice Chairman Broadsword** asked if the Department has a final deadline for moving everyone to the redesign and if the project will still be budget neutral. **Mr. Simnitt** indicated CMS has recommended cutting the old system off and moving people to the new benefit package. He stated at some point that may be necessary, but the Department is trying to identify some alternative strategies to encourage people to move to the new system so there is not a drop dead date, and they are committed to having this be a smooth transition process. He noted that whenever you operate two systems at once there is an increased cost, but in the long term there is a good plan in place to have a cost neutral initiative so that when they are no longer operating two systems it will be cost neutral.

**Vice Chairman Broadsword** asked if there is a means test for people who can afford to pay for childrens services. **Mr. Simnitt** indicated families with DD children are qualifying for Medicaid in a variety of ways. One way is low income and meeting financial eligibility and additional clinical program requirements – there is no cost sharing or copay for those families. Others qualify through the Katie Beckett program which asks families to make voluntary premiums based on income levels – there is no copay for this program this year, with the exception of some speech therapy.

**GAVEL CHANGE:** **Vice Chairman Broadsword** returned the gavel to **Chairman Lodge**, who thanked the presenters for an informative presentation.

**PRESENTATION** **Methamphetamine Precursor Informational Presentation. Chairman Lodge** introduced her intern, **Todd Rains**, who provided the Committee with the history of pseudoephederine regulation federally and in Idaho. He stated the Methamphetemine Epidemic Act of 2005 (Act), which was signed on March 9, 2006, as part of the USA Patriot Improvement and Reauthorization Act, first regulated pseudoephedrine, the active ingredient of Sudafed and similar decongestants, and the essential ingredient of methamphetamine.

He reviewed the mandates in the Act on retailers to accomplish the intended substance control and also provided a chart showing the number of lab busts from 2004 through 2010 for both national and Idaho incidents. **Mr. Rains** advised that **S 1309** now before the Legislature is an attempt to deal with individuals going to different retailers to exceed the daily or monthly purchase limit of pseudoephederine.

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

**Senator Darrington** asked if the graph presented was done by DEA or Idaho and if it represents all state, county and local busts. **Mr. Rains** responded that the data is from DEA for Idaho busts and National totals. **Senator Schmidt** indicated he has read that instead of large batches, some are mixed in a 2 liter bottle, and asked if one of those were to blow up, would it be considered a lab bust. **Chairman Lodge** recognized **Vice Chairman Broadsword** who responded to that question indicating it might not necessarily be a lab bust, because of the amount involved. She further indicated that law enforcement has informed her that they feel they could make more busts in Idaho if the electronic tracking of Pseudoephedrine is implemented in accordance with **H 1309**.

**Mr. Rains** indicated he would investigate the subject further and provide answers for the Committee to the following questions:

1. It is thought that more Pseudoephedrine is being shipped to Mexico than can actually be used for decongestant medication, is there any evidence the excess is being used for production of Methamphetamine?
2. Why was there an increase in the lab busts nationally from 2007 to 2010, while Idaho busts remained pretty stable, and could this have anything to do with the amount of money that was being put toward law enforcement?
3. Is data available on the prevalence for abuse or health problems resulting from Methamphetamine use?

**ADJOURN:** **Chairman Lodge** thanked **Mr. Rains** for his presentation and adjourned the meeting at 4:25 p.m.

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Senator Lodge
Chairman

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Lois Bencken
Secretary