MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 06, 2013
TIME:	9:00 A.M.
PLACE:	Room EW20
MEMBERS:	Chairman Wood(27), Vice Chairman Perry, Representatives Hancey, Henderson, Hixon, Malek, Morse, Romrell, Vander Woude, Rusche, Chew
ABSENT/ EXCUSED:	Representative(s) Chew
GUESTS:	Fernando Castro, Lori Stiles, Russ Barron, Lori Wolff, Greg Kunz, Elke Shaw-Tulloch, Department of Health & Welfare (DHW); Elizabeth Criner, Pfizer; Mark Johnston, Idaho Bureau of Pharmacies; Stacey Satterlee, American Cancer Society - Cancer Network; Kathie Garrett, Idaho Council on Suicide Prevention; Heidi Low, Ritter; Holly Koole, Idaho Prosecuting Attorneys Association.

Chairman Wood(27) called the meeting to order at 9:00 a.m.

MOTION: **Rep. Hixon** made a motion to approve the minutes of the January 31, 2013, meeting. **Motion carried by voice vote.**

MOTION:` **Vice Chairman Perry** made a motion to approve the minutes of the February 5, 2013, meeting. **Motion carried by voice vote.**

RS 21865: **Kate Haas**, Kestral West, on behalf of The Idaho Society of Health-System Pharmacists, presented **RS 21865**, that clarifies the diversity of pharmacy practice by specifying that one Board of Pharmacy member have substantial retail pharmacy experience and a second member have substantial hospital pharmacy experience. This change causes no impact to the current board, since two members meet the requirement. Responding to questions, Ms. Haas said that there is no definition for the word "substantial," which provides appointment flexibility to include someone with the appropriate experience, who may not be currently practicing in that setting.

MOTION: **Rep. Rusche** made a motion to introduce **RS 21865.**

Rep. Rusche commented that the practice of pharmacy has changed a lot over the past years and this is an appropriate way to recognize that hospital-based pharmacies are different from retail pharmacies.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to introduce **RS 21865. Motion carried by voice vote.**

Dave Taylor, Deputy Director, DHW Support Services, presented the DHW legislative priorities. He discussed the 2014 recommended ongoing and one-time decision units, listed by priority level, number of full time employees, and general and total funding amounts. Mr. Taylor stated that the Governor's $2.52 B state fiscal year (SFY) budget consists of 65.1% ($1.64 B) from federal funding, 24.5% (617.3 M) from general funds, 7.9% ($199.8 M) from rebates and other types of receipts, and 2.5% ($63.4 M) from dedicated funds collected for a particular purpose. 2013 priorities include the Medicaid modernization and readiness, the trustee and benefit impact for anyone currently Medicaid eligible but not enrolled, the operations and workload increases, the foster care stipend increases, the set up of regional mental health (MH) boards, and the electronic health records upgrade.

Mr. Taylor explained that the Affordable Care Act requires new nationally uniform eligibility criteria using the Modified Adjusted Gross Income (MAGI) calculation that is similar to the Internal Revenue Service adjusted gross income calculation. The new MAGI rules require a start up on January 1, 2014, which will sunset the current eligibility determination rules on December 31, 2013. The new system must be operational by October 1, 2013, in order to meet the deadline. To accomplish this, they must develop a rules engine, work processes for an influx of applicants, claims programming systems, a 24/7 application and customer portal to interface with both the insurance exchange and the federal data portal. It is estimated that enrollment for those eligible, but not enrolled, will increase over a six-month period when the insurance is mandated. The MAGI eligibility criteria could also increase enrollment, although recent federal communication indicates they desire no increase. Even with automation improvements, eligibility determination will involve new rules and complex health care decisions. Staffing requests include additional information technology (IT) staff for the 24/7 application and customer portal.

Since Idaho's foster care stipend is one of the lowest in the nation, an increase of $516,000, made up of $148,600 from the general fund and $367,400 from federal funds, is being requested. Startup funding for the regional MH boards comes from the sale of land at the Southwest Idaho Treatment Center (SWITC). A federal program offers one-time incentive funding to Medicaid providers who convert to the electronic health system.

Responding to questions, **Mr. Ross Edmunds**, DHW Administrator, Division of Behavioral Health, said that the one-time MH transformation funding establishes the system, with divisional funds passed on to the regional boards to administer a variety of local programs. With legislative authorization, the volunteer boards will direct the staff. Through two board positions, the DHW will have an ongoing relationship to monitor the boards' duties and assure success.

Mr. Edmunds said that, although he was not involved in the recent MH prison facility decision, they are in constant contact with the Department of Corrections (DOC) to address MH concerns. With the upcoming health care system changes, 90% of the individuals leaving the DOC system will be covered by Medicaid. Additionally, it is important that the appropriate MH treatment occurs in the community to control impulsive actions that could lead to incarceration.

Further defining Medicaid readiness, **Mr. Taylor** stated that the DHW needs to modernize and prepare for necessary changes for the health care reform and the current Medicaid eligibility criteria sunset. He anticipates that some of the projected information will disappear and change the cost of the Medicaid expansion.

Russ Barrons, Administration, Division of Welfare, responded to questions, stating that the new MAGI rules eliminate some income and assets and align with the tax law. An individual must first be ineligible for Medicaid in order to qualify for a subsidy. He said that those individuals in the 20% to 100% poverty level will have to use the county system for assistance. He anticipates the shuffle between participants no longer eligible and new participants to cause an overall zero gain. In keeping with federal requirements, the Medicaid system must connect to an exchange with a two-way seamless system. There is currently no one available to answer questions for a state-based exchange.

Steve Bellomy, Bureau Chief, DHW Audits & Investigations, presented information on the Program Integrity Unit (PIU). Two units share most of the PIU responsibilities: the Medicaid Program Integrity Unit (MPIU) and the Welfare Fraud Investigation Unit (WFIU). Current MPIU initiatives include working with both recovery audit and Medicaid integrity contractors, improving staff training and productivity, implementation of data mining, and improving provider outreach. MPIU challenges are the rapid growth resulting from **H 657**, improved data analysis, the managed care migration, uncollectable overpayments, and electronic records abuse.

WFIU partners include all department programs, local law enforcement, county prosecutors, state agencies, the Inspector General's food stamps group, federal food stamp retailer compliance, and providers. Their investigative regional staff efficiency restructuring has provided a revenue savings to fund four new positions. Their data analysis has exceeded expectations and they anticipate identifying ten thousand potential data leads by FY end. Leads also come from public complaints and internal referrals. A two-year pilot desk review position was so successful that a full time analyst position has been created. The first thirty days of desk reviews shows 70 key actions ($31,271 in overpayments) over the eight key actions ($10,740 in overpayments) from field investigations.

Responding to questions, **Mr. Bellomy** said that, although there is no public reward program, there is a provision in federal rules for a private complaint entitlement of up to three times the overpayment amount. He explained the current data review methods, stating that there is a need to infuse more technology to bring Idaho up to the same technological level as neighboring states to take advantage of quarterly eligibility transmissions of state-by-state matches that generate leads and additional information. They currently attend meetings with private carriers to discuss trends, fraud, and cross-over cases. They appreciate the critical work of the Attorney General's office, and have a cooperative relationship for data analysis and appropriate case referral. The new availability of Medicaid claims data has led to a data warehouse training program.

Mr. Bellomy described some of their collection challenges and the use of provider offsets. He stated that the cases can cover a full range of action, including criminal or intentional activity, with sanctions or administrative action to recover only the overpayment. Most overpayment collection cases are handled administratively, with a penalty assessment that can range up to the termination of the provider's agreement. He said the addition of four staff members will meet their immediate need and capacity. He added that the PIU is very willing to discuss their operation with anyone in the state.

Kathie Garrett, Chairman, Idaho Council on Suicide Prevention, presented an annual report, describing the formation of the council and the history of the Suicide Prevention Hotline. Ms. Garrett shared that suicide rates in Idaho consistently rank among the top ten states, with many suicides being preventable through intervention and increased awareness. She discussed the Idaho Suicide Prevention Plan and cited statistics gathered by the Suicide Prevention Action Network of Idaho (SPAN), one of several dedicated partners.

Ms. Garrett described the statewide activities and continuing momentum of its ten goals: public awareness; elimination of the associated stigma; gatekeeper education; behavioral health professional readiness; community involvement; access to care; survivor support; suicide prevention hotline establishment; activities leadership; and data compilation and review. They have begun distribution of the publication, "Idaho Suicide Prevention Plan: An Action Guide."

To maintain momentum, the Council is suggesting continued action for each goal. They are requesting the exploration of the connection between bullying and suicide, launch of a social marketing campaign, continuing gatekeeper education, development of a strategic approach for evidenced-based assessment and treatment methods, continued encouragement of community involvement, training for additional survivor support and community groups, increasing the Suicide Prevention Hotline to 24/7, and in-state evaluation and pattern review data collection. Current data indicates that rural and frontier suicide rates are very high, with MH care a critical component.

The Suicide Prevention Hotline is both a phone number and a rescue line. The first part of a call assesses immediacy. The next part de-escalates the situation by talking about and looking into the future. The caller is then given resources and a contact safety plan. The fourth part occurs afterwards as a follow-up call to find out how they're doing and if they're following their safety plan. There are forty trained volunteers who cover the phones from nine o'clock to five o'clock, Monday through Thursday, with a provisional national network relationship that handles calls on a 24/7 basis. To provide Idaho with 24/7 Hotline coverage requires ninety volunteers.

In response to questions, **Ms. Garrett** explained that rural suicide rates tend to be higher due to the lack of MH services, unemployment, economic downturn, and cultural issues. Identification of call locations to the Hotline will identify trends for earlier outreach. She said that anyone concerned about another individual can call the Hotline and, in fact, they receive a lot of calls from people asking for help for a friend or relative. High suicide groups include senior men and the American Indian population. Suicide is the second cause of youth deaths and requires a different approach. She described the social media challenges and the opportunity for a dedicated media hotline. Prevention and postvention is offered to all Idaho schools, but there is often a decision that the school's counseling staff can handle any situation that arises, with a concerned reluctance to have someone come in and discuss suicide with the kids.

She explained that the high suicide rates for men over women is, in part their availability to legal means. Although women and girls attempt suicide more often, their completion rate is less. Research identifies reasons for suicide as a perceived sense of not belonging, diminished self-worth, and the ability to take one's life. This ability goes against our instinct to preserve life and must be overcome, which is a part of some professions and situations of high risk. Ninety percent of individuals who commit suicide have a MH or substance abuse issue at the time of the event. The highest rates in the nation are currently in the Intermountain West and are attributed to our rugged individualism, reluctancy to get help, sense of rural isolation, preservation of a given lifestyle, and a perceived ability to problem solve at every level.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10:47 a.m.

Representative Wood(27)
Chair

Irene Moore
Secretary