MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 20, 2013
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Guthrie, Martin, Lakey, 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.

convened: **Chairman Heider** called the meeting to order at 3:00 p.m. and welcomed the audience. He asked the secretary to take a silent roll.

RS 22033 **Chairman Heider** announced that the first item on the agenda is a unanimous consent request that **RS 22033** (relating to Grounds for Medical Discipline by the State Board of Medicine) be printed by a privileged committee (Judiciary and Rules) and sent back to Health and Welfare for further reading and consideration. **Senator Lodge** asked if the committee needed to see the SOP before they voted. **Chairman Heider** responded that was correct, he then tabled **RS 22033**.

S 1063 **Ken McClure,** an attorney for the Idaho Medical Association, presented **S 1063**, relating to Medical Consent and the Natural Death Act. **Mr. McClure** stated that **S 1063** is a bill designed to address an ambiguity in a statute, S 1348, passed last year. That bill was passed late in the session and involved some controversy and several amendments. He stated that last summer, a hospital attorney expressed concern over the scope of a provision regarding advanced directives, which may be broader than intended. An advanced directive is a living will, which is a decision over personal treatment or a Do Not Resuscitate (DNR).

Mr. McClure stated that an advance directive kicks in when the patient becomes unable to speak for himself or herself. In fact, the DNR and a living will pertain to the time when a patient is in a persistent vegetative state. He stated that S 1348 was relating to end of life issues only. One of the last amendments to the legislation included provisions regarding patient surrogates, who are people who can speak for the patient when the patient cannot speak for himself or herself. That may involve situations that are not end of life, but rather circumstances where the patient is not mentally or legally competent or are not conscious. Therefore, where the legislation states healthcare cannot be withdrawn against the wishes of the patient, there is concern that the hospital may have to provide any services the patient surrogate demands. The hospital attorney was concerned about the obligations of the hospital in some situations such as: Would they be required to give organ transplants to patients who are about to die of cancer? Would they be required to perform surgery when the patient, in their medical assessment, is not strong enough to undergo surgery?

Mr. McClure stated that was not the intent of the legislation, but it could be read that way. What **S 1063** deals with is advanced directives. When someone fills out a living will, they must check a box. One box says they want everything humanly possible done to keep them alive; the next box says only provide food and water; and the third box says don't do anything. Therefore, **S 1063** deals with the situation when people check the box that says they want hospitals to do everything medically possible to keep them alive. He asked at what point should medical professionals stop trying.

Mr. McClure likened this to giving CPR to a patient whose heart has failed in that you can't do CPR for a week just to keep the patient alive as long as possible. There comes a time when medical professionals have done all they can. The same types of things happen in other forms of medical care. This bill is designed to say that when a patient indicates they want everything done to keep them alive, hospitals should do everything they can to sustain their life and keep them comfortable, but they do not have to give them unnecessary or inappropriate medical care. **Mr. McClure** offered to go through the bill in more detail. He stated that he believes it is a relatively straightforward fix to an ambiguity. He stated he has discussed this with everyone involved in the previous year's legislation and he is not aware of any objections.

Senator Bock stated that he doesn't see why this language is necessary. He said it troubles him the later part of the amended sentence makes reference to code sections in Idaho Code that lay out specific language for these directives. **Mr. McClure** responded by referencing the codes. He stated that Section 39-4503 is the provision that allows for living wills, 39-4510 is for Physician Order for Scope of Treatment (POST) provisions, and 39-4504 is the information that deals with surrogacy, and that's the problem. A surrogate is someone who is nominated by statute to have the authority to speak for a patient when the patient is unable to speak for himself or herself. A surrogate's authority is not directed or limited by a form.

Chairman Heider read from line 28 in **S 1063**, "Health care necessary to sustain life," and asked what the definition is of necessary to sustain life. **Mr. McClure** responded that it is defined more by what is isn't than what it is. Unnecessary health care that will not keep a patient alive longer does not need to be provided. If a patient indicates on their living will that they want everything done to sustain their life, it is the patient's right to determine the extent of the care they want. Hospitals then must do everything necessary to keep them alive as long as possible, but do not have to give them care that will not sustain their life or that is unrelated to keeping them alive. The hospitals need this clarification in order to ensure they don't have to do things like give heart transplants to patients who are dying of cancer when the patient will very likely not survive a heart transplant surgery.

Senator Hagedorn asked if the options or boxes on the living will form are described to the patient at the time. If a patient chooses to have everything medically possible done, do they understand the limitations, or do they think that every available doctor will be around them until they die. **Mr. McClure** responded that the form is written in simple prose and he hopes the patient understands the choices. He stated that he has walked many clients through the form and has never seen a client confused about the choices. Most people are going to be relatively well informed, particularly if they help. These forms are relatively straightforward, but they are sold in legal form shops and given out for people to do on their own, but he is not sure how fully those people understand the content.

Senator Hagedorn expressed concern that this bill creates a limit to the extent of health care someone receives. If a person has the expectation, even an unreasonable one which may be a result of poor consultation, that extreme measures will be taken to keep them alive, then setting a limit may get them in trouble. **Mr. McClure** responded that if setting a limit gets them in trouble, then they are already in trouble because that is already the law. He is trying to say that there is other care you don't get. He stated most people recognize there will come a time when everything that can be done has been done and they will die. He stated that most people are more comfortable with making end of life decisions for themselves than for their loved ones.

MOTION: **Senator Bock** moved that**S 1063** be sent to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Vice Chairman Nuxoll will carry **S 1063** on the floor.

H 89 **Nancy Kerr**, Executive Director, Board of Medicine, presented **H 89** relating the Physician Assistant Advisory Committee. **Ms. Kerr** stated that **H 89** changes references in Idaho Code § 54-1807A to allow members of the Physician Assistant Advisory Committee to opt out of the Public Employee Retirement System of Idaho (PERSI) by changing code references for committee members from compensation to honorarium. Committee members receive $50 a day for up to four meetings per year. This small amount may exclude them from private retirement plans or affect their ability to take tax reductions from private retirement plans such as Individual Retirement Accounts. **H 89** removes unintended penalties for serving on the Idaho Board of Medicine, Physician Assistant Advisory Committee.

Senator Lakey asked if there are other boards and commissions that have the ability to opt out of PERSI. **Ms. Kerr** responded yes, there are, and this board is the only one that doesn't have that ability.

MOTION: **Senator Lodge** made the motion to send **H 89** to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote**. Senator Lodge will carry **H 89** on the floor.

PRESENTATION: **Steve Bellomy,** Bureau Chief of Audit and Investigations, Department of Health and Welfare, presented Medicaid and Welfare Fraud. First, he introduced the leadership team for the Bureau of Audit and Investigations (Bureau). Dave Taylor is the Deputy Director of Support and the direct supervisor. Fernado Castro is the supervisor of the Criminal History Unit. Brandon Weber is the supervisor of the Internal Audit Unit. Lori Stiles is the supervisor of the Welfare Fraud Investigations Unit. **Mr. Bellomy** stated that he will focus first on the Medicaid Program Integrity Unit and then close with the Welfare Fraud Investigations Unit. The two units share program integrity responsibility.

The Medicaid Program Integrity Unit audits and investigates only Medicaid providers, while the Welfare Fraud Investigation Unit audits and investigates the remaining public assistance providers and all clients. The program integrity staff are located in three offices, most of which are in Boise. He stated it is important to understand that the Medicaid Program Integrity Unit is but one part of a very large and complex integrity effort within the whole Medicaid program. The Division of Medicaid handles both pre- and post-payment activities, while the Medicaid Program Integrity Unit and other partners handle post payment audits, administrative actions, and criminal actions.

In the 2011 session, H 657 authorized the expansion of the Medicaid Program Integrity Unit, essentially doubling the staff, by adding eight analysts. H 260 required us to track this investment. He stated they are pleased to share that the new staff is learning quickly and their overall productivity continues to increase over time. They finished the last quarter identifying $1.4 million in unauthorized payments and have already exceeded last year's entire amount. Meanwhile, the amount of pending overpayments continues to climb. He referenced his slide presentation and stated these are the cases that they have completed, but are under appeal or awaiting the end of appeal rights. In the end, identifying overpayments is only as good as what they can collect. While receipts are growing, they are also lagging behind what they identify.

In many larger cases, they agree to recoup payments over a two year period. They will never collect some; however, when an entity closes or they terminate them administratively, the balance of amounts receivable continues to climb. **Mr. Bellomy** referenced his slide and stated these numbers are net of the amounts they write off due to closure or bankruptcy. In the first year by the fourth quarter, the unit had recovered more than total costs. So far in 2013, their recoveries have more than doubled their cost. He stated that probably the hardest thing to measure is the effect that enforcement has on compliance overall.

After a three year effort focused on some problems in one area of medical services, they were able to see a decline in billing abuse that has resulted in an overall reduction of claims for this one category. This was a very thorough effort that continues today. They have hired a Recovery Audit Contractor that will specialize in hospital billings, durable medical supplies, and medical services in schools. They continue to work with the federally chartered Medicaid Integrity Contractors and their special studies. They continue to their efforts to improve staff training and productivity. They are poised to begin data mining to expand their leads and they are exploring federal funding to enhance their tools. They continue to look for ways to improve outreach to providers.

Their challenges are many; but with each, they find opportunities:

- The rapid expansion created a bigger learning curve than anticipated but they continue to gather speed
- Data analysis techniques in the industry have improved over the last three years and they are just now able to begin using data for mining. They will need to improve their analytical tools to achieve best practices.
- Migration to managed care has resulted in many integrity issues in other states, and they are working closely with the Medicaid Division to make sure it works properly in Idaho.
- They continue to struggle collecting bad debts and complying with those federal rules.
- They are aware that Electronic Records have created more opportunities for waste and abuse and they are actively pursuing that issue.

Mr. Bellomy moved on to the Welfare Fraud Investigation Unit. This unit is responsible for handling all client investigations for all programs and all provider investigations that are not Medicaid Providers. Last year, they had eight field investigators deployed in the seven regions. However, they have restructured the organization to take advantage of workload and to specialize. They have four additional positions as part of a decision unit that was supported by the Governor. They anticipate that additional revenue from restructuring will fully fund these new positions.

Just as in the Medicaid Unit, the Welfare Unit also works with many other partners to improve what they do. They touch many different programs for both clients and providers. The most common client programs are food stamps, Medicaid, child care, cash assistance, energy assistance, women, infants and children. The most common providers programs are food stamp retailers, child care providers, and energy assistance providers.

They touch many different programs for both clients and providers, and the most common are: all department programs (electronic benefits, eligibility, vital statistics, welfare programs), local law enforcement, county prosecutors, state agencies (Department of Insurance, Occupational Licensing, Department of Employment, etc.), Office of Inspector General - food stamps, Federal Food Stamp Retailer Compliance providers. He stated that if he were to sum up their current status in one word, it would be opportunity. They have made a significant structural change that has allowed them to improve productivity, sustain growth, and identify more suspect cases through data analysis. Historically, they have relied on internal referrals and public complaints to identify their cases.

Starting in fiscal year (FY) 2010, they changed that by adding data analysis and the result has far exceeded their expectations. They anticipate that they will identify more than 10,000 potential leads through data analysis by the end of this fiscal year. They have improved quickly to adapt to the new reality that there are many more leads than they can possibly investigate. Their productivity has grown by an average of 32 percent since FY 2006. They lost one position due to holdbacks. They are only just now able to recover that position through the additional receipts they generate by their reorganization and improved productivity. However, the gap continues to grow as they are discovering potential cases faster than they can implement changes to handle them. The specialization will help them make big improvements.

Probably the best example of this is the creation of the new desk review position. This position was tested successfully for two years so they took a risk to hire one full time analyst. In their very first month on the job, the analyst closed nine times the number of cases as the average field investigator, and the overpayments associated with these cases are much more collectable than traditional cases. Also, the provider specialist has proven to be very productive and is covering their cost. For example, in the child care program, they have already tripled the amount of overpayments collected in the first six months, compared to last year and have collected nearly $11,000 in penalties.

In the past, there was never an expectation for the Welfare Fraud Unit to recover costs, because recovery is very difficult. However, they have improved their efforts significantly over the past few years and they believe that will change this year. This fiscal year, they anticipate recovering more than their cost for the first time. In closing, they have come a long way and they believe that their journey has just started. They have a lot of challenges ahead, but even more opportunities. **Mr. Bellomy** stated he knows this information has been at a very high level but they are willing to meet with members of the committee to look at this information in more depth.

Senator Lakey thanked Mr. Bellomy for his presentation and his work. He inquired about slide pages 10 and 9, regarding amounts collected and received. He asked if that shows there is $4 million in fraud that cannot be collected. **Mr. Bellomy** responded that was correct. **Senator Lakey** asked why they couldn't collect that money. **Mr. Bellomy** responded that often they deal with entities that have decided to close or are in bankruptcy, others are in an extended payment agreement, and others are still trying to determine if they are going to file for bankruptcy, dissolve, reorganize, or negotiate for repayment.

Senator Lakey inquired what kinds of common themes they find during data analysis, looking at potential fraud, and what they are they doing to prevent those common themes. **Mr. Bellomy** responded that the programs are very sensitive to what needs to be done up front to determine eligibility and process claims and to make sure the programs are as safe as possible. However, those in business know that losses due to shrinkage are typically around 5 percent and their programs are far less than that. He stated their programs do a good job at establishing controls and making sure claims are paid out only to legitimate medical claims. As far as what more can be done, they are doing the things they need to be doing from a post-payment standpoint, but there are opportunities. They can't make changes too fast, but are beginning to establish improvements with more staff.

Senator Lakey inquired about the meaning of the term post-payment standpoint, if that meant analyzing what has been happening in particular areas to try to determine where there is fraud. **Mr. Bellomy** responded that was correct. It means that the claim has been made, the payment has been issued, and the benefit has been provided to the client. **Senator Lakey** stated that it is good that effort is being made to recover fraudulent claims, but he would like to see some tracking done regarding those that are successful at committing fraud in order to look at opportunities to prevent it from occurring. **Mr. Bellomy** responded that they do look at that and they work very closely with their programs; they give them quarterly reports about the issues they find. The programs are pretty reactive. For example, in the area of household income, looking at the verifications of that income from their banks, they found inconsistencies which they related to the program and they responded by becoming more suspect of that information. **Senator Lakey** stated that he would like continued updates about those kinds of preventative measures.

Senator Schmidt inquired about slide 12, and asked what the blue bars in the graph represent. **Mr. Bellomy** responded that the point is that when they are active in particular provider areas, the abuse in that area is reduced. The graph shows one such example that they tracked for several years. **Senator Schmidt** asked if the blue bars reflect claims, and by paying attention to those claims, they went down. He asked if this was meant to show that there was a reduction in fraud. **Mr. Bellomy** responded that there was some indication of errors and abuse.

Senator Schmidt asked if there was a expected ratio of investigations to claims or a professional standard as to how much should be spent on investigating claims. **Mr. Bellomy** responded that he doesn't actually know, they have looked at some neighboring states and commercial partners, and they find they are fairly well-staffed. He stated that he sees this as an opportunity cost; if they think their efforts will provide a greater return to the taxpayers, then that's where they should go. **Senator Schmidt** inquired if changes in eligibility processes for welfare will affect their fraud investigations. **Mr. Bellomy** responded that any changes in the eligibility requirements create a learning curve for them, but they are aware of them and he doesn't think it will change the nature of the investigations.

Senator Guthrie commented that he understands there is a range of fraud activity and inquired if the sanctions are appropriate to the different types of fraud. He also asked how aggressive do they get when going after monies owed. **Mr. Bellomy** responded that there is a range of fraud and a corresponding range of sanctions. Sometimes there are errors and sometimes there is actual fraud. In the case of errors, if they are not substantially large or repeated offenses, such as billing improperly, then they can recover the overpayment and assess a penalty. In the cases of intentional fraud, when they can gather evidence of the crime, they hand that information over to the Attorney General for criminal prosecution. They have a good relationship with the Attorney General and give them most of their good complaints, which lead to successful prosecution. They also work with U.S. Attorney. Their efforts often lead to collection of overpaid claims and penalties.

ADJOURNED: **Chairman Heider** thanked Mr. Bellomy for his presentation and his efforts to recover millions for the taxpayers of Idaho. There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:45 p.m.

Senator Heider	Linda Hamlet
Chairman	Secretary