MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 14, 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: None.

GUESTS: Corey Surber, St. Alphonsus; Mike Brassey, St. Luke's Health System; Kathie Garrett, National Alliance on Mental Illness, Idaho; Toni Lawson, Idaho Hospital Association; Parrish Miller, Idaho Freedom Foundation; Margaret Henbest, Nurse Leaders of Idaho; Matt Malek, Resident; Tony Smith, Benton Ellis; Elizabeth Criner, Idaho State Dental Association, Pfizer.

Chairman Wood(27) called the meeting to order at 9:01 a.m.

RS 21875C1: **Rep. Loertscher** presented **RS 21875C1**, to repeal the Catastrophic (CAT) Fund and county medical indigent statute. He gave a brief history of the fund, statute, first year lack of appropriations, and exponential growth. This legislation repeals the entire county medical indigent responsibility and catastrophic program. The estimated property tax savings is $478M. Implementation begins at the end of this Legislative session, with an effective date of January 1, 2014. The county levying ability is reduced from .1 to .02, which will leave enough funding for county burials and other similar needs.

MOTION: **Rep. Henderson** made a motion to introduce **RS 21875C1.**

Responding to a question, **Rep. Loertscher** explained that this dedicated levy is for specific medically indigent care, which is no longer needed, and changes the mandate to a local option.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to introduce **RS 21875C1. Motion carried by voice vote.**

RS 21973C1: **Rep. Loertscher** presented **RS 21973C1**, proposed legislation that provides expansion of Medicaid existing programs, including the medically needy (benchmark) program. It includes a new part of Medicaid that is 100% federally funded over the first three years. Other areas of the expansion are in the mental health arena. After three years, the funding decreases to 90%. General Fund savings in the first year is $800,000. The Fiscal Note indicates only General Fund dollars, with no reflection of the federal expenditures. The estimated expansion numbers are based on the supposition that everyone eligible will apply. This is a matter of trading funds from the CAT Fund to this program. It arrests CAT Fund costs and provides a property tax savings.

Answering questions, **Rep. Loertscher** said the preponderance of savings is in the early years, which makes expansion now the best choice, so a year of eligibility is not lost. Current 70/30 funding would remain and have no impact on the expansion. Deciding against the expansion maintains the current 70/30 funding, without the 100% possible funding. After three years, the funding decreases to 90/10, indefinitely, since the rate is set in statute. The current 70/30 rate fluctuates. The CAT Fund costs will continue to grow without this type of action. This is not a shift between federal and state dollars.

MOTION: **Vice Chairman Perry** made a motion to introduce **RS 21973C1**.

Rep. Rusche stated federal, property, and sales taxes will continue the same if we do not approve this move. The current CAT Fund is a crisis cost reimbursement program that does not offer preventive care. Mental health in Idaho needs support, and the Medicaid benefit package provides that support for those who are currently under served and must turn to the CAT Fund when in crisis. This may actually improve some of the fatality issues in the state.

Responding to committee questions, **Rep. Loertscher** said the net cost could be viewed as a wash, but the same amount of dollars will be spent. The impact of a mandatory insurance requirement is unknown. The increasing CAT costs are the biggest liability, with funding directly from property taxes.

Rep. Vander Woude stated the net savings has a lot of unknowns, so it is worth having further discussion to see if there is a real savings. A shift from property tax to increased federal income tax is not a cost savings.

Rep. Malek invoked Rule 38 stating a possible conflict of interest.

Rep. Rusche invoked Rule 38 stating a possible conflict of interest, since his wife is a physician with Medicaid patients.

Chairman Wood(27) invoked Rule 38 stating a possible conflict of interest since he is involved in healthcare.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to introduce **RS 21973C1. Motion carried by voice vote.**

H 291: **Ken McClure**, Attorney, Idaho Medical Association, presented **H 291**, legislation that deals with mentally ill teenagers in an emergency hospital situation. This bill provides more clarity and parental control about the disposition of a teenager, who is a present danger to himself or others. A parent has the control, unless or until a policeman, using existing law, says otherwise. The patient may be kept at the Emergency Room (ER) while a law enforcement officer is enroute to mediate the situation with the parent. This protects the vulnerable teenager and those around him, providing a time out to secure the individual.

Answering questions, **Mr. McClure** said physicians have agreed that it is a good idea to include other psychiatric practitioners, since some rural ERs do not have full time or any physicians, relying on Nurse Practitioners with mental health issue training. Every ER has a framework in place for departmental decision making, with hierarchies in every hospital's bylaws. These are not just nurses, they are highly-trained professions who physicians consider more than competent to make such determinations.

Margaret Henbest, Executive Director, Nurse Leaders of Idaho, described her organization and membership. She stated that advanced practice nurses receive graduate or doctoral degrees with specialty area focuses. Nurse practitioners are also registered nurse anesthetists, and nurse midwives. Those who practice in a variety of settings will specialize in geriatric care and psychiatric mental health services. A clinical category, at the master or doctoral level, is applied in hospitals, often utilizing psychiatric and mental health backgrounds. Nurse practitioners are bound by statute to practice only within the scope of their education, training, and national certification. Hospital credentialing and privileging, based on their bylaws, provide another layer that describes their practice. Hospitals consider professional interface for the very best outcomes for each patient. Responding to a question, Ms. Henbest said the hospitals consider credentialing and privileging a serious charge. This group of professions provide an additional assurance that someone with the appropriate skills will be available to make such a serious decision and determination.

Dr. David Kim, ER Physician, was called upon to answer a committee question. He said there is a very formal procedure to assure the scope of practice of everyone working in an ER meets the needs of any individual who comes into the hospital. Physician Assistants are subject to the same oversight and credentialing. He answered that this type of violent patient has a serious mental illness. This would not be someone who is belligerent, antisocial, or under the influence of a substance, although they can be violent, too. Providers can distinguish between the two situations. This legislation provides a tool that was thought to already exist. Most of the time the parents are at the hospital with the child and provide a collaborative partner in differentiating an isolated incident from an underlying mental illness.

Dr. Kim explained that patients are first evaluated for any life threatening injuries that need stabilization. During that process or shortly after, the patient is asked what happened. If alone or uncommunicative, a determination could be delayed. Discussion with family or friends, who may have brought them to the ER, will usually disclose information that helps determine the severity of the situation, since everyone is usually trying to help that person.

Chairman Wood(27) commented that in his many years of ER practice, there was never an instance when a parent, with a truly mentally ill child, disagreed with securing their child. Rather, they immediately wanted the child taken care of by professionals and admitted for help. A seasoned practitioner, whether a physician or physician's assistant, knows in about thirty seconds if this is a seriously mentally ill patient or a kid who got a little methamphetamine. Hospital Boards are in charge of ERs and take community liability very seriously. Rural hospitals have primary care practitioners and no psychiatrists. They would appreciate a qualified nurse practitioner or physicians assistant with mental health specialties. He emphasized that he never had an issue with a parent because they understand that their child is sick.

In response to a question, **Mr. McClure** stated that the process works well around the state. However, the different adult and juvenile mental health Code chapters has become an in the courts when the juvenile health statute is determined the one to follow. This leaves no ability for the hospital to hold a psychotic teenager until law enforcement arrives. Such a teenager could walk out the door and roam the streets, potentially hurting people.

Chairman Wood(27) said when the original legislation was created, there was no judiciary conference to determine where it belonged in Code, leading to this discrepancy.

Mr. McClure stated that police involvement is not always needed. This is a matter of balancing the medical cost to an individual or parent versus the cost to society, especially if the teenager leaves the hospital. This gap in the law does not provide safety for individuals or society and is not a good use of police time.

MOTION: **Vice Chairman Perry** made a motion to send **H 291** to the floor with a **DO PASS** recommendation.

Rep. Rusche stated that additional qualified professionals were included in this legislation as a result of the decline in rural psychiatrist physicians, who may not be available when this type of incident occurs.

Rep. Malek explained that this type of situation is difficult to conceptualize, with a possible assumption that there might be incentives to hold someone not truly in need. Based on his experience, he assured the committee that there is no mistaking this type of incident and the need for immediate control of the individual. With the disruptive consequences, there is no incentive to keep someone in custody, unless it is in the best interest of the individual.

Responding to a question, **Mr. McClure** said the hospital, law enforcement and Department of Health & Welfare, all maintain incident records, of which Ada County reported four last year. He agreed that there are financial implications because most hospitals do not have a place to detain someone for lengthy amounts of time. Transport to psychiatric hospitals or the mental ward at St. Alphonsus are local facility options. The transport costs would be born by parents, insurance, or society, as would costs from any harm done by the child. For those times when a parent is not available, the hospital could legally proceed to hold the child.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to send **H 291** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Chairman Wood(27)** will sponsor the bill on the floor.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10.27 a.m.

Representative Wood(27)
Chair

Irene Moore
Secretary