MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, January 27, 2014

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: None

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 2:59 p.m., and requested the Secretary take a silent roll call. **Chairman Heider** stated that the Committee will begin the Department of Health and Welfare overview.

PRESENTATION: **Richard Armstrong**, Director of the Department of Health and Welfare, listed out the four main topics in his discussion including: the budget overview for the Department of Health and Welfare (DHW); Medicaid eligibility and systems integration with the Federal Marketplace; three DHW initiatives for state fiscal year (FY) 2015; and "livable wage" impact on public assistance programs. There has been a slight increase in general funds and a decrease in receipts. The main driver here is a reduction in pharmacy receipts in the Medicaid program—many of the brand name drugs are transitioning to generic drugs, which are preferred in Medicaid. However, the Department does not receive rebates on generics. The slight increase in general funds is necessary to replace the loss of receipts. The DHW is at about 96 percent for all of the brand drugs that can be replaced with its generic counterpart and he stated that they will never be at 100 percent since there are some generic brands that are actually more expensive than the brand drugs.

Mr. Armstrong noted to the Committee that in years past, their Medicaid portion was quite large and had an "appetite" that they were uncomfortable with as the Department tried to preserve this safety net without breaking the bank. This year is different however, and is the first year in recent memory where the Medicaid percentage actually declined—and that is huge. Last year, Medicaid was 81.4 percent of the Department's budget, and it is now at 80.6 percent. They have seemed to turn a corner—no longer does the Medicaid budget look totally out of control and unsustainable—"gobbling up" general fund dollars that are desperately needed elsewhere. All the efforts they have made over the years are starting to show results—the Molina Medicaid claims payment system is adjudicating claims extremely accurately, saving millions. The managed care efforts in transportation and dental care have been very successful, and are starting to pay off. There have also been other advancements made to the program over the years.

Mr. Armstrong reminded the Committee of the problems that have been encountered with their managed care contract with OPTUM, and he and representatives from OPTUM will be back before the Committee to address those concerns later in the week. He wanted to assure the Committee that the Department does have their "teeth in the contract" to bring about compliance and they will see that the problems can be resolved fairly quickly.

Returning to the budget, **Mr. Armstrong** said that the vast majority of the money appropriated to their agency is paid directly out to Idaho citizens and health care and social service providers. The recommendation includes 2,848 full-time positions, which is down 270 positions from the 3,119 we had in 2008, before the recession began.

Mr. Armstrong declared that possibly one of the most frustrating challenges the Department faces today concerns the Affordable Care Act. Since Idaho's State Based Marketplace is not yet functional, Idaho consumers currently apply for a tax credit and shop for private insurance through the Federal Marketplace. This means that the Department must electronically share data with the Federal Marketplace through what is referred to as Account Transfers. Idaho delegated authority to the Federal Marketplace to make eligibility decisions for Medicaid when someone applies for a tax credit but ends up being Medicaid eligible. To make this possible, the Department provided Idaho Medicaid eligibility rules to the Federal Marketplace, so that when people began applying for insurance coverage through the Exchange last October, the federal government could accurately determine if they were eligible for Idaho Medicaid. **Mr. Armstrong** said that the Department agreed at the time to accept the federal determinations for Idaho Medicaid and automatically enroll them for January 1st coverage, based on the federal government's assurance that they would accurately calculate Idaho Medicaid eligibility. The Department had been told that they would receive test files in October that they could use to test and that could be used to verify the federal eligibility determinations for Idaho Medicaid. This however, did not happen as promised, and the test files were not received until January, and then there was a significant amount of information missing. Even though the Department did not receive the promised Medicaid test files in October, they did begin getting calls from citizens who were told by the Federal Marketplace they were eligible for Idaho Medicaid. These callers were questioning the federal decision based on their higher incomes. As the Department looked into it further, the citizens appeared to be right, many are not eligible in spite of the Federal Marketplace telling them they are.

This is creating a real quandary for the Department and the citizens of Idaho, **Mr. Armstrong** stated. As the department reviews the information being received they are finding missing information that is critical to make an eligibility determination. If they reject a federally approved application, it can put the family in a Catch-22 situation that will find them going around in endless circles, caught between two bureaucracies, and they have seen that the federal government does not have an escalation process in place. They have been put in the position to continuously go back to the federal government to state why the applications are not accurate, explain the circumstance, and request help in getting the citizens to the right place. The citizens are wanting to buy insurance through the Exchange and do not want to be in Medicaid. He mentioned that the only way out of the quagmire would be to implement our own state-based exchange and get out of the Federal Marketplace as soon as possible. That way the State would own the process on both sides and could talk about building the right solution now to roll out next November allowing an escalation process between the two groups working together.

Mr. Armstrong then went on to discuss the three DHW Initiatives for FY 2015. The first, the behavioral health community crisis centers, was mentioned by Governor Otter in his State of the State. The concept is modeled after successful crisis centers in other states for people with behavioral health disorders. The goal is to reduce incarcerations and hospital ER use, both of which are used inappropriately because there are few alternatives for law enforcement answering behavioral health crisis calls. With this initial request, the Department would pilot three crisis centers in the State with plans to expand to seven based on success and costs.

The next initiative **Mr. Armstrong** discussed was the IV-E pilot, which is a five-year program that is federally funded and could shape the national child welfare model. Currently, federal IV-E funds are available for states when a child enters foster care. The more children in care, the more federal funds a state receives. But what if states were allowed to use this funding to prevent children from coming into foster care? Frequently when a Department representative goes out on a child welfare referral, a child may still be safe with their family, but there may be serious issues that need to be addressed before the family situation spirals out of control. Currently, there are very limited resources to provide intensive in-home services to prevent foster care placements. With this pilot, the federal government is going to allow the DHW to use the funding for specific in-home, preventive services through a waiver. Their goal is to prevent foster care placements that could be avoided, which they believe will result in improved, long-term outcomes for Idaho's children. If this proves successful, there could be a change at the national level for child welfare funding for all states.

The last initiative that **Mr. Armstrong** addressed was the State Healthcare Innovation Plan (SHIP), which is really starting to pick up momentum in the health care field. This is not a DHW program—the federal funding for the planning grant flowed through the agency and they have interest because Medicaid will benefit. But it really is a partnership with health care providers, insurers, and participants to transform the health care model from one that pays for the number of services provided, to one that pays to oversee patients' health care needs within a medical neighborhood, focused on improving patient outcomes. In the SHIP model, all health care providers use electronic health records so there is no duplication of services, while also focusing the providers on improving a patient's health. SHIP also collects treatment and outcome data to identify best practices and encourage the most effective care for health care providers.

The final section of the presentation dealt with the issue of how the "livable wage" in the State has an impact on public assistance programs. **Mr. Armstrong** stated that he has had a number of discussions with several legislators these last few years about the high number of people on public assistance. Some have voiced a genuine concern that Idaho is becoming a welfare state. He then went on to show the enrollment of four public assistance programs over the last dozen years. The first assistance program on the chart is for cash assistance. Over 98 percent of cash assistance goes to people who are elderly, blind, disabled, or children who are being raised by a grandparent or other relative. The vast majority of people on cash assistance receive an average payment of $53 a month. It is very difficult for an able-bodied, working age adult to qualify for cash assistance in Idaho. Out of the 18,300 people receiving a cash benefit, only 270 are able-bodied, working age adults. These are adults with children in the household. Able-bodied, working-age adults without children are not eligible for cash assistance in Idaho.

The next assistance program pointed out showed Medicaid enrollments, which have increased from 10 percent of the population to 15 percent over the last dozen years. The biggest growth in Medicaid has been low-income children. Food stamps, the next assistance program, are probably the most-discussed benefit when it comes to public assistance. Idaho had traditionally seen a low percentage of enrollees until the recession hit. Before the recession, people who would have qualified for food stamps did not apply because they seemed to get by with help from their communities, churches, or families. Some of those resources have undoubtedly dried up with the recession because Idaho is now just below the national enrollment for food stamps. The final assistance program, child care assistance, is the only one that has experienced a decline. The Department attributes this mostly to the

fact that the number of jobs have decreased. If you are not working, you don't need child care. The numbers show that DHW is serving over 20 percent of the State's population in these 4 programs, up from 13 percent a decade ago. This is perhaps what the growing concern is about. At first glance, the numbers may seem to indicate a growing dependence on government welfare.

Mr. Armstrong then went on to point out that the CATO Institute published a report last August that placed a value on welfare benefits available by state. This is a follow-up to a similar study it did in 1995. Its evaluation was for a family of one adult and two children, which it defines as the typical welfare family. The point was to show that in some states, you can earn as much on welfare as working a full-time job. In comparing Idaho with other states, it comes in 50th, with the total benefit package adding up to $5.36 an hour for a full-time worker. The median state was Alaska, at $12.69 an hour, which is still more than double that of Idaho. But there was one measure in the same report that shows Idaho as being number one in the nation. This is for the percentage of adults receiving Temporary Assistance for Needy Families (TANF) benefits who participate in work activities. This measure, along with the low amount of benefits available, shows very plainly that Idaho is not a welfare state.

Going back to the subject of food stamps, **Mr. Armstrong** stated that food stamp enrollments peaked in January 2012, exactly two years ago. During the two years since, Idaho experienced a 9.8 percent reduction in caseload, but even though the numbers are going down, it is not at the rate many would like. They know that people are returning to work, but they still qualify for food stamp benefits. The reason—their new jobs do not pay as much as they were earning prior to the recession. **Mr. Armstrong** point out that the Idaho Department of Labor shared some interesting data when analyzing the high numbers of working people who continue qualifying for public assistance. Their Department learned there has been a fundamental shift in jobs. During the recession, 60,000 jobs were lost, with half in goods production. This would include higher paying construction and manufacturing jobs. The State has regained 40,000 jobs; however, they are heavily weighted to the service industry, which pays an average of about $10,000 a year less. This is quickly becoming the new reality—people are working, but not earning as much.

The sad truth is, as **Mr. Armstrong** declared, that Idaho's median income is the lowest in the nation, at $23,200 a year. For a full-time worker, that's $11.15 an hour. We have become a low-wage state, whether we like it or not. But this is the dilemma—if people are working as hard as ever, but they don't earn enough to make ends meet, what do they do? It is easy to say go get a better paying job. But if the better paying jobs have four applicants for every opening, that means three do not get the higher paying job. Or in rural communities, if there are a limited number of higher paying jobs, what can aspiring workers do? **Mr. Armstrong** said that the answer comes from assistance—whether it's from other family members, their church, a charitable organization, a community action agency, or the Department of Health and Welfare. They need help in filling in the gaps while they learn new job skills to qualify for a better paying job.

Mr. Armstrong noted that this is where the concept of a livable wage comes in. He then called the Committee's attention to an online living wage calculator developed by the Massachusetts Institute of Technology (MIT). The figures estimate basic living costs for CATO's typical welfare family—a household with one adult and two children. Without any assistance, the single parent would need to earn $22 an hour at their job to make ends meet, but if the parent only earns the median Idaho income of $11.15 an hour, how does the family get by? The parent needs to earn an additional $5.78 an hour to bridge the gap between their wage and a livable wage.

Mr. Armstrong is concerned with the fact that the State has 121,000 households in Idaho with collective incomes below the $23,200 median wage. These are Idaho families who are probably going to need some support to get by. This is not due to lack of a strong work ethic. The State may have the lowest individual median income, but in 62 percent of the households both parents work. Idaho also has one of the highest rates in the nation of workers holding down more than one job. And it is a known fact that Idaho's public assistance benefits are among the most meager in the nation. The issue is that workers lack the opportunities to earn a livable wage.

Mr. Armstrong mentioned that some solutions have been put forward recently, including when these figures were placed before the Idaho Economic Outlook and Revenue Assessment Committee, it generated quite of bit of discussion about improving education. Governor Otter's Project 60 has many of the ingredients for fostering business growth. And the Governor's "K Through Career" workforce development initiative provides a fresh and unique approach for maintaining a vibrant workforce. The answer lies, **Mr. Armstrong** stated, in policies to improve wages, work opportunities, and education. When the State can do that, the high utilization of public assistance services will take care of itself.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 1).

DISCUSSION: **Senator Lodge** asked about the amount of hours people were on the line waiting for OPTUM, what was the reasons behind the long wait times, and why couldn't they take a message and get back to the caller. **Mr. Armstrong** responded that there has been a lot of conversation regarding this issue, and there is no good excuse. Their agency knew several months ago that there would be some potential for crisis, so there have been many sessions of feedback with better response, and more people being added to the phone bank. **Senator Lodge** likened this to some of the problems that happened with the Molina Medicaid program, in that they didn't quite understand what the requirements were going to be, and doesn't see how they couldn't have prepared themselves in advance for all of the possible scenarios. **Chairman Heider** confirmed that representatives from OPTUM will be before the Committee on Thursday to address the issues and concerns. **Mr. Armstrong** also noted that, unfortunately, one company or agency doesn't necessarily pay attention to another to learn from their successes or failures. Since every situation is unique, sometimes you can anticipate all of the problems that may arise and other times not, it's all in how one responds to the situation that determines the outcome. As a Department, he felt they have enough "horse power" in their contracts to make sure they get compliance.

Senator Hagedorn wanted to know in regard to the electronic health records, where was that idea initiated from and how is it impacting the physicians we have in our state right now. **Mr. Armstrong** answered that the Health and Welfare Committee authorized the Health Quality Planning Commission back in 2006, and one of the spin-offs of that Commission was the Idaho Health Data Exchange, and has been up and operational for at least five years. It has been the vehicle by which electronic records can be moved between physician offices. This allows a physician to either pull data to his computer or push data to another physician, and has become the requirement to do business with incentives being offered for offices to convert to doing electronic records. It has become the standard, but now the concern is in moving it forward with best practices. The physician has all of the previous information (lab results, imaging) to move forward with the best diagnosis, and there should be no duplication of testing, lab work, imaging, procedures, etc... The idea is that, within a secure environment, the physician will have access to more accurate information which will bring about a less costly diagnosis. **Senator Hagedorn** then asked if this is affecting doctors such that we are losing practices

throughout the State. **Mr. Armstrong** responded that we are not losing practices because of the electronic health record system. He has had several discussions with physicians on how to use this tool effectively for their practice and patients. It requires a change in the way health care is being delivered. There may be some physicians who are coming to the end of their career and are using this as a reason to get out sooner, to avoid the conversion, but those scenarios are very minor as far as the numbers of practices being effected. The average age of primary care physicians in Idaho is 54, so there is a baby boomer component to physicians retiring, but the electronic health recording system is not a driving element to the closing of practices. **Senator Hagedorn** requested to know, as far as the 121,000 Idaho households that were the median, what did that represent as far as the total percentage of Idaho households. **Mr. Armstrong** stated that their Department believes that represents about 25 percent of Idaho households.

Senator Guthrie asked about the federal exchange quagmire addressed by Mr. Armstrong where the State kicked out an applicant for Medicaid since they didn't qualify even though the federal said they did, is that because of something unique between the State exchange employing the federal technology or is this a typical problem with states with federal exchanges. **Mr. Armstrong** answered that they believe it's typical of the technology of the Federal Marketplace, that the logic being used is flawed everywhere. In talking with other states, they seem to be having similar problems with the same scenarios as Idaho, and because of the Children's Health Insurance Program (CHIP), we may have a higher percentage of issues. **Senator Guthrie** wanted some explanation as to why the "family" used in the study is not more the traditional family (2 adults and 2 children). **Mr. Armstrong** noted that it was done intentionally to match the CATO Institute's study model to use to define the global impact for Idaho versus other states. This was the first opportunity to compare what happens in our state with information from other states.

Senator Lakey asked Mr. Armstrong if he could give him a letter he'd received from a provider in the State to prepare for the meeting later in the week with the OPTUM representatives. **Mr. Armstrong** confirmed he would be happy to take the letter in an effort to address all the scenarios.

Senator Schmidt wanted to know about the folks caught in the middle between the State and federal and noted that really isn't the "wood work" that had been mentioned earlier. He wanted to know if we have seen the numbers and identified people that are Medicaid eligible and show an increase in Medicaid enrollment due to the mandate. **Mr. Armstrong** responded that no, he does not feel the numbers represent the "wood work". It is simply a technical complexity with most of the people applying because they wanted to buy private insurance so they weren't intentionally going into the system to get Medicaid. The "wood work" effect hasn't been seen yet, and will take some time to understand since the "noise is rather deafening with statistics right now because of the problems". The enrollment has only been going on for about a month now, and with that there are at least 2,000 that fall into the questionable area of that they're trying to sort through. The enrollment is lower than expected but that should start to pick up. **Senator Schmidt** then asked about the goal for the Behavioral Health Crisis Centers, which is to reduce Emergency Room (ER) visits and incarcerations; do we currently count those now so we will know if we are making our goal? **Mr. Armstrong** answered that yes, they do know from records received from county law enforcement on how many events take place and how many are "holds" and the number that eventually are turned over to the state hospitals. So, he felt confident that the Department would have a good way to show results fairly quickly based on historical information.

Chairman Heider thanked Mr. Armstrong for his time and for the information on what is happening between the State and the federal government.

S 1222 **Relating to Emergency Medical Services (EMS) to Remove a Definition and Add Definitions for the "Practice of Emergency Medical Services" and "Provision of Emergency Medical Services": Wayne Denny**, Chief of the Bureau of Emergency Medical Services and Preparedness of the Division of Public Health in the Department of Health and Welfare. Mr. Denny introduced himself and the Bureau's unique dual role of both supporting and regulating Idaho's Emergency Medical Services (EMS) system. The focus of his comments before the Committee was on how **S 1222** will give them needed clarity in the regulatory role.

Mr. Denny noted that the challenge their agency faces today is that the current definition of EMS in Idaho Code describes the system in which care is delivered, but it does not describe when care provided to a sick or injured person is considered EMS. The lack of clarity in the current definition can potentially allow untrained individuals to provide inappropriate and potentially harmful interventions to sick or injured persons. The "practice of EMS" is being defined to make it clear that EMS is not happenstance, good Samaritan, first aid like would be provided by a bystander at an auto accident or CPR provided by the witness of a cardiac arrest. EMS is specifically defined as responding to a perceived need for care and doing so on an organized basis through an alerting and response mechanism such as the 9-1-1 system. Being prepared to use skills that are beyond the scope of practice associated with advanced first aid as, and being supplied with equipment, which exceeds the scope of practice associated with advanced first aid as described. There is exempting language pertaining to ski patrollers, in cooperation with the National Ski Patrol (NSP) to make it clear that NSP affiliated ski patrollers are exempt from regulation as they are one of a list of individuals, although not holding a license to do so, who may legally practice medicine in Idaho.

Mr. Denny went on to explain the definition of "provision of EMS" as the deployment of an individual, group of individuals, or organization to respond to human medical emergencies, illness or injuries outside of hospitals or clinics. Many of the EMS agencies in Idaho are staffed either in part or in whole by volunteer EMS professionals. The language in lines 38 and 41 through 43 recognizes those EMS agencies that employ volunteer EMS professionals in the same light as an agency that uses paid or compensated EMS personnel. Most of our licensed EMS agencies rely on response vehicles of some sort, be they ambulances, SUVs or fire apparatuses; however, there are several agencies that do not use response vehicles. There are several exemptions in this category, the first exemption concerns other licensed health care providers such as athletic trainers, nurses, mid level practitioners and physicians.

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 Nuxoll wanted to know if this will make it harder or easier to get treatment and first aid attention in other places such as a camps or public swimming pools. Is there anything in the definition that will prevent them from providing first aid immediately? **Mr. Denny** responded that the definition applies to care that is above advanced first aid, so these types of scenarios aren't regulated by the definition. **Vice Chairman Nuxoll** then wanted to know how the definition would apply if someone gave first aid, and the victim wanted to pay them for their services. **Mr. Denny** answered that the scenario is out of the scope of the EMS definition since EMS is not a happenstance event, but one organized through a dispatch, and perhaps an ambulance and not under the "Good Samaritan" situation.

Senator Guthrie commented that this definition looks out of character in looking at the other definitions, and is worried about getting into the minutiae of minor details,

as if the agency struggled to come up with the definition and nail it down so tightly that something is bound to be overlooked. **Mr. Denny** stated that this all can be traced back several years ago while working with the NSP to get ski patrollers in the State exempted. They formed a Licensure Summit inviting all groups that might be affected by this (ski patrollers, smoke jumpers, etc...). They used this input to help build their definition of what EMS is and what it is not. This is only the medical care that their agency feels they have regulatory oversight over, and helps to define where their agency becomes involved and where they do not.

Senator Hagedorn was curious what the impact would be if **S 1222** does not pass. **Mr. Denny** gave a scenario about a vehicle being used to transport individuals, not calling it an ambulance and saying they aren't providing EMS because they have figured out a way to get paid outside of Medicaid. Organizations that want to bill have to be licensed through EMS, but if they've figured out a different way to get paid, his agency has no power to touch them since there's no definition in place. He noted several actual examples that the agency couldn't do anything about because there is no clear definition in place.

Senator Schmidt asked if there are other states that allow their ski patrollers to be exempt from the EMS regulations. **Mr. Denny** responded that the NPS is currently working with other states. The definition of EMS is different state by state.

MOTION

Senator Bock moved to send **S 1222** to the floor with a do-pass recommendation. **Senator Martin** seconded the motion.

Senator Hagedorn declared he would vote against the motion since he could see no compelling need. He sees it more as a protection for existing EMS providers than for those who might just want to offer a service to transport those in wheelchairs. **Senator Schmidt** gave a real example of a small town where private citizens are running a service to transfer people in between hospitals. The hospitals support this, since the volunteer ambulance service can't always handle this type of thing. He wanted to know how would this company get licensed and defined in the current system. This definition will make it easier to tell them where they fit, the licenses needed and the criteria to follow. **Senator Hagedorn** then asked would this then apply to family members who want to transport someone back and forth from a hospital to a nursing home, would they have to be regulated and licensed. **Chairman Heider** noted that, as a former ski patrolman for several years, he feels that **S 1222** is defining those that don't have to be licensed as opposed to those that do. The same exclusions for ski patrollers applies to those transporting loved ones back and forth, they don't need to be licensed to do that since they're not providing the specific level of care as an EMS provider. **Senator Hagedorn** appreciated the explanation, but is concerned that there are no other exclusions other than the ski patrollers, there is no mention of those who just want to run a wheelchair transportation service for example. **Chairman Heider** mentioned that the difference would come if they required some sort of medical care while being transported such as a respirator or heart monitor, then it would fall under EMS, otherwise the driver would not need to be licensed. **Vice Chairman Nuxoll** voiced concern over too many scenarios and not enough exemptions, and it doesn't seem clear enough as to who would be required to be licensed and fall under the EMS regulations.

ROLL CALL VOTE:

Chairman Heider called for a roll call vote on sending **S 1222** to the floor with a do-pass recommendation. **Chairman Heider, Senators Lodge, Martin, Lakey, Bock** and **Schmidt** voted aye, with **Vice Chairman Nuxoll**, **Senators Hagedorn** and **Guthrie** voting nay. The motion carried. Senator Schmidt will carry **S 1222** to the floor. **Senators Lakey, Guthrie** and **Vice Chairman Nuxoll** wanted it noted that they would be interested in hearing more about this when it comes to the floor, which may impact their position on the Legislation.

MINUTES: **Chairman Heider** asked for the approval of the January 13, 2014 Senate Health and Welfare Committee meeting Minutes.

MOTION: **Senator Hagedorn** moved to approve the January 13, 2014 Minutes as written. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**.

MINUTES: **Chairman Heider** asked for the approval of the January 14, 2014 Senate Health and Welfare Committee meeting Minutes.

MOTION: **Senator Guthrie** moved to approve the January 14, 2014 Minutes as written. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business to come before the Committee, **Chairman Heider** adjourned the meeting at 4:17 p.m.

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Senator Heider
Chair

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Linda Hamlet
Secretary

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Linda Harrison
Assistant Secretary