MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 03, 2014

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 Vander Woude

GUESTS: Michael Farley, Russ Barron, Paul Leary, Elke Shaw-Tulloch, Cameron Gilliland, DHW; Elli Brown, Veritas Advisors; Stacey Satterlee, ACS CAN; Elizabeth Criner, ISDA / ACS-CAN

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

Richard Armstrong, Director, Department of Health & Welfare (DHW), presented the DHW budget overview, Medicaid eligibility or readiness with the federal marketplace integration, three initiatives for State Fiscal Year (SFY) 2015, and the "Livable Wage" impact on public assistance programs.

Director Armstrong explained the federal, general, dedicated, and receipt fund sources that show a budget increase of 1.6%, for a total of $2.54 Billion. He noted the decline of -0.6% Receipt Funds is a result of the introduction of several generic drugs for which the drug companies do not give a receipt, a form of use reimbursement, since their generic profit margins are lower. He explained that generic drugs are added to the preferred drug list only when they are as effective and cost less than their brand name equivalent. Ninety-six percent of the drugs on the preferred list are generic.

Director Armstrong said the state-based exchange enabling legislation was so late that any state technology could not be ready and they had to use federal technology. The federal representatives agreed to use Idaho's Medicaid eligibility rules, send back any records that qualified for Medicaid, and we agreed to send them records that qualified for a tax credit. Unfortunately, the federal system was built with no escalation protocol and has been sending out Medicaid eligibility notices in error, leaving Idahoans caught between two bureaucracies and unable to enroll in anything. Weekly conversations continue, but the sooner Idaho is off the federal technology, the sooner the issues can be resolved and an escalation protocol can be designed. The final vendor selection is underway, with candidates who truly understand how Idaho's Medicaid system works and the errors in the federal system.

Three behavioral health crisis centers are proposed to build community support for people dealing with behavioral health issues. This adds a safe and cost-effective response to law enforcement's request for better ways to help individuals in crisis. The centers would provide immediate needs assessment, serve as hubs for other community-based and peer support services, and be part of the state behavioral health system reform. The initial request for three crisis centers will be modeled after similar facilities in other states. Future statewide expansion is planned, depending on approval, costs, utilization, and sustainability.

The child welfare pilot (IV-E) provides an alternative use of federal funds to reduce foster care entries. The previous financial incentive was based on the quantity of children in foster care. Long-term outcomes for children improve if families can safely remain together as problems are addressed. The five-year pilot could improve the national model of child welfare funding.

The State Healthcare Innovation Plan (SHIP) is a public/private initiative to transform our healthcare system from volume-based to value-based, with improved patient outcomes. SHIP brings together payers, providers, citizens, and communities to discuss the move from paying for services to paying for healthy outcomes. We currently pay for service units no matter the outcome. Together, as a state healthcare system and collection of payers, we will see better outcomes, more efficiency, and lower cost.

The public assistance program has experienced a significant increase in the number of participants. **Director Armstrong** explained that 98.5% of the small amount of state cash assistance goes to the elderly, blind, disabled, or children raised by grandparents. Four out of five recipients receive a monthly payment of $53. Adults receiving cash assistance are required to be engaged in work search or preparedness, have a 24-month service limit, and have no program re-entrance.

Medicaid participation grew from 10.3% in 2001 to 15.5% in 2013. The Food Stamp program increase indicates new applications received during the recession from people using other community sources that dried up. As the recession progressed dual wage earner households became single wage households and were able to provide their own day care, which lowered the child care numbers. Unduplicated participants, those counted in a single program, increased from 13.4% in 2003 to 20.2% in 2013.

Describing the CATO Report, issued in August from the CATO Institute, **Director Armstrong** said it was published under the guise that welfare inhibits people from working. However, the study, using a "typical welfare family" of a single adult and two children, found a dramatic state-to-state variance in benefit values. This has changed the national perception that households can live comfortably on only welfare funds. Idaho was found to offer the lowest welfare benefits that are very stringent. In the same report, Idaho was ranked number one for the highest percentage of adult Temporary Assistance for Needy Families (TANF) recipients participating in work activities.

Food Stamp enrollment peaked in January, 2012, during the recession. Idaho shed 60,000 jobs; half in the manufacturing and production of goods. During recovery, we have regained 40,000 jobs that are heavily weighted to the lower wage service industry.

Lowest in the nation, our median income is $23,200 or $11.15 per hour. The national median income is $29,538 or $14.20 per hour. Many Idaho incomes fall below the minimum standard of living, requiring private, family, or government assistance. Our citizens must earn a "livable wage" to reduce their need for private or public assistance.

Director Armstrong described an Idaho livable wage study using the same typical family as in the CATO Report and the Massachusetts Institute of Technology's Living Wage Calculation. It determined that a hourly wage of $22 provides a livable family income; however, the state's median hourly wage of $11.15, with a tax credit adjustment, leaves a monthly hourly deficit of $5.78. This indicates the need for additional supporting funds to achieve the livable wage point. Nationally, Idaho has one of the highest rates of workers holding down more than one job.

Several projects are being developed to provide a livable wage. Project 60 cultivates a highly skilled workforce, improves the statewide business infrastructure, recruits businesses to Idaho, and markets Idaho products worldwide. The "K-Career" workforce development initiative maintains a continuum of education and training opportunities. Even with progress, **Director Armstrong** emphasized a livable wage cannot be achieved overnight. People will need assistance until the state can rebalance equitable wages.

Responding to Committee questions, **Director Armstrong** said personnel decreases over the last five years had an impact on every division, with the largest at the South West Idaho Treatment Center (SWITC). The free clinics will continue to operate. The merger of the Mental Health and Substance Abuse Boards will provide additional outreach opportunities and add more community-level service. Telepsychology, already proven effective in clinics and health facilities, is a tool to provide more rural mental health services.

Director Armstrong has been in discussions with the federal system referring ineligible people to Medicaid. If they were to accept those ineligibles, 30% of the cost would have to be paid, with a future audit finding noted due to their ineligibility. The Department expects a number of these families will go ahead and enroll their children through the Health Care Exchange, instead of CHIP.

The Food Stamp Program requires that qualified adults participate in job search or job readiness. The Department has used a contractor to engage those individuals for job preparedness. There is a high correlation between Medicaid and Food Stamp benefits, since Medicaid alone doesn't provide for job readiness.

Part of this year's legislation formally addresses peer support specialists in Statute and Rule. There are already individuals who can be certified and trained for these Crisis Center positions. The Crisis Centers assess and determine an individual's needs. **Director Armstrong** described in-home crisis supports used previously during a transition from one type of program to another. This was very successful and highlighted that persons in crisis are not usually on their medications. If they can be engaged to return to their medications, homes, and jobs, they can return to the community quickly for stabilization. The Crisis Centers help build community-based support by turning to community resources, paid or voluntary, that provide the broadest support and the best outcomes so individuals can remain in their homes and productive in their communities. This will be a separate group of individuals who may be working in and out of the facilities, like the Department Caseworkers, depending on the patient in the Crisis Center. The Centers will be a gathering place for multiple disciplines to deal with that individual in that situation.

During the recession reductions occurred in the number of Case Managers; however, the clinics remained open. With the impact of Crisis Centers unknown, statistics will be monitored to determine if outcome changes are occurring. This project will be an ongoing refinement of services and processes. Private industry will increase as reimbursement for services funding becomes available. **Director Armstrong** said he expects this to take a number of years, but anticipates the success will lead to additional centers and build out the system.

Director Armstrong stated that a benefit gap exists for citizens whose income is below 100% of the Federal Poverty Level (FPL). They will continue to be part of the delivery and responsibility of free clinics, Catastrophic Fund, hospital charities, and physician charities. The Crisis Centers will help the entire population assure society is safer, by providing a place where someone feeling in crisis can come and be referred to services. The Centers will provide easier access to help and break down existing stigmas for anyone feeling stressed or challenged. Services and medications will be available through the existing clinics. Getting to everyone at the right moment is addressed better with open and public Crisis Centers.

The Centers are expected to evolve as a solution for the indigent health care delivery system is found. They can become behavioral and mental health clinics. If at that point behavioral health has coverage, then these not-for-profit clinics would have no clients and would evolve into quality behavioral health system management facilities. **Director Armstrong** is of the opinion that the Crisis Centers will continue since someone in crisis may not know what to do and the need for a facility where anyone can go for help. A crisis can happen at any time of the day, often before the individual knows it is occurring. The facilities may evolve into community-based, instead of state-based, centers. The unique combination of frontier, rural, and urban population areas in our state will require different models. Some areas will require a more distributed system, but quality services need to be delivered, no matter where the citizens live.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10:04 a.m.

Representative Wood(27)
Chair

Irene Moore
Secretary