MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE:	Monday, February 24, 2014
TIME:	9:00 A.M.
PLACE:	Room EW20
MEMBERS:	Chairman Wood(27), Vice Chairman Perry, Representative(s) Hancey, Henderson, Hixon, Malek, Morse, Romrell, Vander Woude, Rusche, Chew
ABSENT/ EXCUSED:	Representative Malek
GUESTS:	Kathie Garrett, NAMI Idaho; Mitch Scoggins, and James Aydelotte, IDHW; Susie Pouliot, Idaho Medical Assoc.; Wood Richards, Insurance Companies; Elizabeth Criner, ISDA; Stacey Satterlee, ACS-CAN

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

RS 22865: **Rep. Lynn Luker**, presented **RS 22865**, proposed legislation for medical retainer agreements, also known as concierge services, which are direct patient and medical provider relationships with no insurance involvement, unless submitted by the patient. The Affordable Care Act (ACA) allows qualified direct primary care provider services for individuals who are unable to afford insurance or have personal private care. A medical provider is anyone licensed to provide healthcare services within their scope of practice. The retainer agreement must describe the general scope and services included. The medical provider cannot bill the insurance directly. This is not subject to regulation by the Department of Insurance, since it is not health insurance.

Responding to questions, **Rep. Luker** said the defined medical provider could be with a medical group or corporation. This is a direct relationship between the patient and the provider, and removes the insurance billing step from the relationship. This would be the same as any business-customer relationship, with no appeals process or agency oversight. This type of relationship is the only ACA recognized component outside of the health insurance. It removes the number of people between the patient and provider, restoring a direct relationship.

MOTION: **Rep. Hixon** made a motion to introduce **RS 22865.**

Answering additional questions, **Rep. Luker**, said termination of the agreement is possible by either party or the agreement can be for a specific period of time. He described the various contracts available under the provision.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to introduce **RS 22865. Motion carried by voice vote. Rep. Rusche** requested that he be recorded as voting **NAY**.

S 1224aa: **Ross Edmunds**, Administrator, Division of Behavioral Health, Department of Health and Welfare (DHW), presented **S 1224aa**. This legislation achieves three major steps in the transformation of Idaho's behavioral health system of care. It integrates the existing mental health and substance use disorders systems into a single, unified behavioral health system. It establishes Regional Behavioral Health Boards to provide communities the opportunity to greater influence their local behavioral health system, with increased responsibility, if they choose. It establishes clearly defined roles and responsibilities for the Regional Mental Health Centers, the Regional Behavioral Health Boards, and the State Behavioral Health Planning Council.

Mr. Edmunds described the proposed behavioral health organizational structure that consists of the Executive, Legislative and Judicial branches, which have direct authority and advisory capacity for a variety of boards, councils, commissions, and centers. A Behavioral Health Interagency Cooperative will advise the DHW on behavioral health issues within the criminal justice system. The DHW will provide $45,000 from existing funds, to each Regional Behavioral Health Board and will contract with them for recovery support services.

This legislation provides a safety net for those in need of behavioral health services, develops a recovery support services system, moves leadership and influence to the community level, and articulates the role and responsibility of the DHW in Idaho's behavioral health system of care.

Answering questions, **Mr. Edmunds** said the existing regional development specialists are volunteers who assist the Regional Advisory Boards with substance abuse and behavioral health. This staff is expected to transition over to the Boards, along with their salaries and funds. Growth is expected in the area of recovery support services. The Boards will be funded from the $45,000 base funding, grants, housing assistance, respite, and other sources. Similar to the Health Districts, funds will flow through the DHW out to the Regional Boards.

Anyone in the criminal justice system has an equal opportunity to services. Assessments of individuals can be followed by the judges, who can then order them into behavioral health care services. The DHW has the financial responsibility for the services, if no other source of payment is available.

The $45,000 base funding opens the doors. Grant funding can be as big a part of each Board's overall funding as they choose.

Individuals will continue to need behavioral health services; however, a decline in those accessing ongoing services through the DHW is expected. ACA benefits will not cover recovery support services, which are as important as clinical treatment services, which are covered. People between benefits will need a safety net provider, which is what the DHW becomes under this system, particularly with the nature of mental illness. The Behavioral Health Authority must assure a system is in place to meet the needs of individuals who are not covered. Ongoing care and treatment at the Regional Board level will be funded through the DHW, but the Councils will need sustainability plans.

Regional Behavioral Health Centers is the new name for the existing state-run clinics. This legislation clarifies their roles and responsibilities, including court services treatment delivery. Recovery Centers are community-based efforts. Regional Health Boards could be a champion to help develop community efforts to generate funds.

Responding to a question about membership, **Mr. Edmunds** explained behavioral health care is accessed by many systems with many stakeholders, including criminal and juvenile systems. The Executive Committee is the business end of the Regional Boards.

Kathie Garrett, NAMI Idaho, testified **in support** of **S 1224aa**, stating their previous concerns were addressed during the interim, with changes that improved the legislation. Their main concern was the role and services definition for the DHW addressing severe and persistent mental illness. This is the end stage and the wording would codify it as the only aspect of behavioral health services they would provide.

For the record, no one else indicated their desire to testify.

MOTION: **Rep. Rusche** made a motion to send **S 1224aa** to the floor with a **DO PASS** recommendation. He said this is a good first step toward regionalization; but, it is a bit of rearranging due to advocacy difficulties and one more reason to plead for low income insurance coverage.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to send **S 1224aa** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. Vander Woude** asked to be recorded as voting **NAY. Chairman Wood(27)** will sponsor the bill on the floor.

S 1295: **Sen. Jim Guthrie**, presented **S 1295**, to repeal Chapter 134, Section 2 of the 2010 Idaho Session Laws which stipulates a sunset provision of July 1, 2014. If the sunset provision remains, the Childhood Immunization Policy Commission will dissolve. He described the commission membership, purpose, and accomplishments. Sen. Guthrie emphasized the Commission improves access and quality of vaccines and does not force immunization. The fiscal note of $1,000 is catchall for miscellaneous minor expenses and travel expenses for attending DHW staff. Answering a question, he said the Commission makes recommendations, but does not create provider rules or regulations.

MOTION: **Rep. Rusche** made a motion to send **S 1295** to the floor with a **DO PASS** recommendation. He said it is important to recognize community experts and incorporate their wisdom and knowledge in the state vaccine policy.

Susie Pouliot, Idaho Medical Association, testified **in support** of **S 1295**.

For the record, no one else indicated their desire to testify.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to send **S 1295** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. Thompson** will sponsor the bill on the floor.

S 1263: **James Aydelotte**, Bureau Chief, Bureau of Vital Records and Health Statistics, Department of Health and Welfare Bureau of Records presented **S 1263**. Legislation passed during the previous session changed the term "Advanced Practice Professional Nurse" to "Advanced Practice Registered Nurse." This legislation updates this same terminology in several places in vital statistics law to provide consistency. He emphasized there are no changes to responsibility or scopes of practice.

MOTION: **Rep. Rusche** made a motion to send **S 1263** to the floor with a **DO PASS** recommendation.

For the record, no one indicated their desire to testify.

Responding to a question, **Mr. Aydelotte** said the fiscal estimate is based on changes required to the automated systems and a lower, more accurate estimate has since been received.

VOTE ON MOTION: **Chairman Wood(27)** called for a vote on the motion to send **S 1263** to the floor with a **DO PASS** recommendation. **Motion carried by voice vote. Rep. Chew** will sponsor the bill on the floor.

ADJOURN: There being no further business to come before the Committee, the meeting was adjourned at 10:01 a.m.

Representative Wood(27)
Chair

Irene Moore
Secretary