Attachment #2
16-0210-1401

Docket 16-0210-1401Talking Points
Dr. Kathryn Turner
Chief, Bureau of Communicable Disease Prevention

Mister Chair, members of the committee, thank you for the opportunity to testify today. My name is Dr. Kathryn Turner. I am Chief of the Bureau of Communicable Disease Prevention within the Division of Public Health. I am here today to present docket number 16-0210-1401, pending rules titled, "Idaho Reportable Diseases." This docket is located behind tab 7 in your binders.

The intent of the changes being proposed to the Idaho Reportable Disease Rules is to provide clarification to language throughout the chapter, ensure disease control measures are consistent with current disease control and prevention practices, and to address specific topics in disease monitoring and control, which I will briefly outline.

First, we want to update chapter language to increase clarification and consistency. To do this, we are proposing small changes in the Definitions sections to clarify Chapter terminology. We are also proposing changes within the disease-specific sections, intended to provide clarification regarding activities that might be undertaken as part of public health investigations. For instance, to align disease control activities with evidence-based practices for enteric diseases like *E. coli* and *Salmonella,* changes proposed improve consistency in how follow-up testing results should be interpreted and when it is safe for a person who has been sick to return to work, school, or daycare without the risk of spreading the disease to others.

Secondly, the pending rule adds one infection to the list of diseases that must be reported to public health agencies in 2015. Echinococcosis is a parasitic disease that is caused by infection with *Echinococcus,* a tiny tapeworm. These tapeworms are one of many disease-causing organisms in our environment that people might come into contact with while enjoying Idaho outdoor activities, like hunting. While it is our understanding that Echinococcosis in Idaho is rare, standardizing the reporting of the infection when it occurs in people will help us better describe the disease and identify risk factors for infection so we can target prevention messages to Idahoans who might be at risk.

Lastly, we are proposing changes to some disease-specific control activities. One change is to reduce the level of lead found in children's blood that must be reported. The current reportable blood lead level in Idaho is 10 micrograms per deciliter of blood in both children and adults. At the time the current level was approved in rule in 1992, there was clear evidence that adverse health effects occurred at those levels. Since then, important new studies have shown a relationship between adverse health effects and lower levels of lead in the blood. The bottom line is that there isn't really any safe level of lead in our bodies; it builds up in soft tissue like our kidneys, liver, and brain and is stored in the bones of our body, including teeth.

Lead is particularly toxic to children's developing nervous systems. At blood levels lower than 10 micrograms per deciliter, children suffer mental and developmental impairments leading to poor outcomes such as poor school performance, a lower IQ, impaired hearing, and reduced growth. As these children grow into adulthood, they are at increased risk for high blood pressure and cardiovascular-related death, decreased kidney function, and a type of tremor affecting the hands.

For these reasons, we are proposing to change the reportable level of blood lead in children to 5 micrograms per deciliter of blood. By doing so, we can identify children who have been exposed to lead earlier than we currently do and work with doctors and parents to determine where the children might have been exposed, and educate parents how to reduce their immediate exposure, and how to prevent future exposures.

We are proposing additional specific changes to three other diseases. These changes consist of clarifying that necrotizing fasciitis is included in the streptococcal disease infections that must be reported to public health, specifying that infections with free-living amoebae, in addition to the specific parasite *Entamoeba histolytica,* should be reported under the reportable condition amebiasis, and simplifying language about work exclusions during infection with Norovirus.

In summary, the proposed changes to the Idaho Reportable Diseases Chapter will improve consistency and clarity of language throughout the chapter. This is important for health care providers, laboratories, and others that report diseases as well as the Public Health District staff that investigate those diseases. In addition, changes ensure disease control measures are aligned with current public health best practice. The changes are being proposed will improve our ability to protect the public's health throughout the state. I ask for the committee's approval of these chapter changes and stand for questions.

Attachment #3
16-0219-1401

Testimony for IDAPA 16.02.19 by Patrick L. Guzzle

- I was approached about one year ago by Jeff Schroeder, Executive Director of Idaho Hunters Feeding the Hungry about a rule that would sanction the donation of legally harvested, wild game meat to the Idaho Foodbank. I was also contacted by representatives from the Idaho Foodbank who indicated that their partner networks of pantries would be interested in a rule that would allow for this kind of donation.
- At the time, there were no rules or policies that prohibited the practice, but neither was there a rule that expressly allowed the practice. This presented a bit of a dilemma as there was an organization wanting to help donate legally harvested game meat (Idaho Hunters Feeding the Hungry) and organizations willing to accept that donation (food pantries) but the rules were, essentially, silent on the issue.
- I researched what other states allow and I worked with Idaho Hunters Feeding the Hungry and the Idaho Foodbank to draft the language that you have in your rule booklet.
- I had a public hearing on October 14. There was no opposition expressed at that meeting and, in fact, the testimony that was received during that meeting was in full support of this proposed rule.

Attachment #4
16-0227-1401
16-0227-1402

[Mr/Madam] Chair, members of the Committee, I'm Dr. Christopher Ball, Chief of the Bureau of Laboratories and it is a pleasure to present two companion dockets for your consideration and adoption this [afternoon/morning]. The first docket is 16-0227-1402, a chapter rewrite of the Idaho Radiation Control rules, which begins on page 8 of your Pending Fee Rules Review Book. The second, docket 16-0227-1401 is a repeal of the existing chapter and it is located on pages 58 and 59 of your Pending Rules Review Book.

Prior to discussing docket 16-0227-1402, I would like to provide you with a very brief summary of the Idaho Radiation Control Program that is housed in the Bureau of Laboratories' Lab Improvement Section. As required by current rule, the Radiation Control program maintains a register of nearly 1600 facilities that utilize x-ray machines in Idaho.

Ninety-three percent (93%) of registered facilities utilize x-ray machines for diagnostic imaging of people and animals. Of those, the greatest proportion (45%) is dental offices, followed by medical, chiropractic, and veterinary practices. Other uses for registered x-ray machines are in industrial and academic settings.

The Radiation Control Program is staffed by two Radiation Physicists who work to ensure that both patients and health care workers are not being overexposed to x-ray radiation. To do this, they perform about 300 onsite facility inspections every year. During these inspections they verify the identity of registered x-ray machines, test the operating parameters of the instrument, evaluate the diagnostic image quality, assess the adequacy of the shielding, and document the safety protocols, qualifications, and training of staff operating x-ray producing devices.

In March of last year, the Program came under new management and special attention was placed on evaluating the current state of the Program to identify opportunities for improvement. Several performance improvement projects were identified. Examples of ongoing projects include: converting paper files into an electronic record keeping system; adjusting staff travel schedules; incorporating new field instrumentation to maximize productivity; assessing the utility of a dental x-ray evaluation by mail process; comparing our current rules and practices with our statutory mandates; and identifying new opportunities for outreach to the regulated community to provide guidance for the safe operation of x-ray devices.

Turning to page 11, the most striking change in the pending fee rule is that 68 pages of technical information from the Council of Radiation Control Program Director's Suggested State Regulations has been incorporated by reference, noting the Idaho specific exclusions where applicable. This incorporation substantially reduces the size and annual publication costs of the rule [78p x $56 = $4,368 vs. 10p X $56 = $560] while improving its organization, readability and usefulness.

When comparing our current rules and practices with our statutory mandates we discovered inconsistencies that needed to be remedied. As stated previously, our current rules require us to register facilities and x-ray machines. Idaho code requires that "*the board of health and*

welfare shall provide, by rule, for general or specific licensing of x-ray producing machines" [I.C. 53-1043]. We brought this discrepancy to the attention of our Deputy Attorney General and he concluded that registration and licensing are not legally synonymous. A license grants permission to do something, whereas, registration is making a list of who is doing it. With this information, it became imperative that we rewrite our rules to comply with our mandate.

If you turn to page 13, Sections 50 through 53, outline the x-ray licensing process, propose licensing fees and renewal periods, and list the application requirements. The transition from a one-time registration process to maintaining an ongoing licensure program will substantially increase the operating costs of the Radiation Control Program. Idaho is one of only a few states that do not charge x-ray licensing fees, and rather than asking for additional state general funds to bolster the Program, we are proposing to charge reasonable fees to offset the new administrative and technical costs associated with licensure. The proposed fees are substantially less than surrounding states and should generate enough receipts to cover the new costs to the program.

Given the scale of change proposed in this pending fee rule, we elected to utilize the negotiated rulemaking process to solicit assistance and comments in re-writing these rules. The Bureau hosted two in-person meetings and two statewide conference calls but had no response. Because we had no involvement in our negotiated rulemaking, we sent letters soliciting feedback and copies of the pending rule to the Idaho Dental, Medical, Veterinary, Chiropractic, and Hospital Boards and Associations, Regional Medical Centers, and Academic Institutions. We have received comments from the Boards of Dentistry, Medicine and Veterinary Medicine and none were opposed to the proposed rules. All three of the Boards expressed some concern about the documentation required to meet the operator qualifications, safety, radiographer training and quarterly audit requirements listed on pages 14-16 in sections 53-04 through 53-06.

It is important to note that these training, safety, and auditing requirements have been in effect since 1998, but were difficult to find within the lengthy and complex information that was republished from the Suggested State Regulations. The comments from these three boards highlight that the rewritten docket has truly improved the clarity of the rules. This also provided the Program with an excellent opportunity to offer technical assistance and outreach to Idaho's x-ray community. To this end, we have started working with the Board of Veterinary Medicine to develop training and documentation templates that may be appropriate for their membership. In fact, our Laboratory Improvement Manager will be attending the January 26th Board of Veterinary Medicine meeting to discuss these requirements with the board and provide some examples of how the requirements may be met.

I will conclude my formal remarks by thanking you for the opportunity to speak on behalf of the State Lab and respectfully ask that you approve this docket.

At this time, I stand available for questions.

#5
16-0301-1401

Mr. Chairman and members of the committee, thank you for the opportunity to come before you today.

I am Camille Schiller, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare.

I will be presenting Docket Number 16-0301-1401 beginning on page 60 of your Health and Welfare Pending Rules Review book.

Pause

This docket covers *three* items that are needed for *clarification* when determining eligibility for the Medicaid program and to *align* with federal regulations.

The *first* item in this docket revises the definition for parents/caretaker relatives to read "child" only, instead of "dependent child". .....Because other areas of eligibility for Medicaid refer to the determination of who is a "tax dependent", ...this change will add clarity to this section of the definitions.

The guidance around who is considered an eligible child for parents and caretaker relatives is not altered with the change.

The *second* item in this docket describes parents and caretaker relatives' Medicaid coverage. The word "adult"

is being changed to "individual" to allow for parents who may still be minors to receive Medicaid under the parent eligibility group. This will ensure consistent and adequate coverage for minor parents and children needing Medicaid.

The *final* item in this docket concerns the eligibility period for individuals determined presumptively eligible by qualified hospitals.

The Federal Regulations state that a person who has been determined to be "presumptively eligible" may continue to be eligible through the month AFTER the month of initial application or until a final eligibility decision has been made by the Department.

This change will clarify language and bring these rules into alignment with federal regulations.

No negotiated rulemaking was done, because these rules are aligning with federal regulations and are of a simple nature
I ask you to approve this Pending rule as Final.

This concludes my presentation and I stand for questions.

#6
16-03 05-1401

Mr. Chairman and members of the committee, thank you for the opportunity to come before you today.

I am Camille Schiller, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare's Self Reliance program.

I will be presenting docket 16-0305-1401 found on page **74** of your Pending Legislative Rules book.

This docket covers two changes that are being requested in the section of the rules regarding patient liability for individuals receiving Nursing Home Assistance or Home and Community Based Services through Medicaid and their financial responsibility towards their cost of care referred to as their "Share of Cost".

The first request is to add to the list of allowable deductions that can be made to the customer's share of cost calculation. This is guidance that is put forth by the Code of Federal Regulations however the rules in this section of IDAPA do not spell out the allowance given for incurred medical expenses that are not covered by Medicaid. It is being requested that this provision be added to the rules while also putting clarification around the types of expenses that are allowed. The term "medically necessary" is also included in this rule and that term is defined in section 16.03.18 Medicaid Cost Sharing.

There is no fiscal impact to the state general fund, or to any other fund, as this rule will align with other sections of IDAPA that already allow these expenses.

The second change that is being requested is in regards to patients who enter the nursing home and seek Medicaid coverage to help pay for these expenses.

The current rule states that those entering a nursing home are assessed a share of cost when they have resided in the nursing home for one full calendar month. For example, if a patient enters the Nursing Home on December 10th they would be charged their "Share of Cost" on January 1st when the facility does their billing. If the patient later leaves the home mid-month in January, the patient's share of cost is not valid since they did not stay the full calendar month. The facility must re-bill with actual costs for the month and issue a refund to the patient for their Share of Cost.

While it would be ideal if all patients entered on the first of the month and stayed for the entire month for bookkeeping purposes, the reality is that many customers enter and exit the nursing home throughout the month. The change of this rule will allow patients to pay for their Share of Cost only AFTER they have resided in a nursing home for one full calendar month. In the example stated before, there would no cause for refunds because the patient was not in the home for the entirety of either of the months of December or January. If the patient continued residence in the nursing home, they would begin paying their Share of Cost on February 1st.

The anticipated annual fiscal impact for this change is a total of $161,058 (one hundred sixty one thousand, fifty eight dollars) of State funding. This increase will accommodate the portion of the costs for these services while the patient is in care for partial months.... and it will alleviate costly billing processes for providers, and refunding obstacles for patients who do not stay a full calendar month

I ask you to approve this pending rule as Final.

Thank you for your time today, I stand for questions.