# AGENDA

**SENATE HEALTH & WELFARE COMMITTEE**  
3:00 P.M.  
Room WW54  
Tuesday, January 07, 2020

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<td>Organizational Meeting</td>
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*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**  
Chairman Martin  
Vice Chairman Souza  
Sen Heider  
Sen Lee  
Sen Harris  

**COMMITTEE SECRETARY**  
Margo Miller  
Room: WW35  
Phone: 332-1319  
Email: shel@senate.idaho.gov
DATE:       Tuesday, January 07, 2020
TIME:       3:00 P.M.
PLACE:      Room WW54
MEMBERS PRESENT:   Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
INTRODUCTION: Chairman Martin welcomed and introduced the new Committee secretary, Margo Miller, and asked her to tell the Committee a little about herself. Chairman Martin explained this was an organizational meeting and they would not be voting on anything. He reported he had put together and handed out binders for each Committee member to help them navigate the rules process on their computer.
PASSED THE GAVEL:   Chairman Martin passed the gavel to Vice Chair Souza.

Vice Chair Souza assigned the 47 omnibus pending rules, section 16, Department of Health and Welfare, among the Committee.

PRESENTATION: Dennis Stevenson, Administrative Rules Coordinator, Division of Financial Management (DFM), gave an overview of the omnibus rules process and answered a few questions from Committee members. He reminded the Committee of the actions they could take on a docket.

PASSED THE GAVEL:   Vice Chair Souza passed the gavel to Chairman Martin.

INTRODUCTION: Chairman Martin welcomed the Committee's new page, Brenna Bolinder. Ms. Bolinder explained where she was from and her future plans.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:37 p.m.

___________________________  ___________________________
Senator Martin                   Margo Miller
Chair                             Secretary
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<td>Department of Health and Welfare, Notice of Omnibus Rulemaking.</td>
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<tr>
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<td>Docket No. 22-0000-1900</td>
<td>Board of Medicine, Notice of Omnibus Rulemaking, Page 1309.</td>
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<td>Department of Health and Welfare, Notice of Omnibus Rulemaking, Pending Fee Rule, Page 5.</td>
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Docket No. 22-0000-1900F  
Board of Medicine, Notice of Omnibus Rulemaking, Page 439.  
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Vice-Chair Souza

Docket No. 27-00001900F  
Board of Pharmacy, Notice of Omnibus Rulemaking, Page 741 27.01.01  
Vice-Chair Souza

Docket No. 16-0000-1900F, Rule 16.02.08  
Department of Health and Welfare, Notice of Omnibus Rulemaking, Page 35 16.02.08  
Vice-Chair Souza

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS  
Chairman Martin  
Vice Chairman Souza  
Sen Heider  
Sen Lee  
Sen Harris  
Sen Burtschaw  
Sen Bayer  
Sen Jordan  
Sen Nelson

COMMITTEE SECRETARY  
Margo Miller  
Room: WW35  
Phone: 332-1319  
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 09, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson.
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 Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 2:59 p.m.
PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza.

DOCKET NOS. 16-0000-1900 AND 22-0000-1900

Department of Health and Welfare, Notice of Omnibus Rulemaking, Page 47; Board of Medicine, Notice of Omnibus Rulemaking, Page 139. Tamara Prisock, Administrator, Division of Licensing and Certification, Department of Health and Welfare (Department), explained the reauthorization of existing non-fee rules was an opportunity to pursue reductions to comply with the Governor’s Executive Order 2019-02. The Department eliminated 20 chapters of rules, reduced its total word count in rule by just under 168,000 words, and reduced the total restrictive language in rule by over 3,300 words.

This process did not change the intent of any requirements or benefits outlined in the rules, with one exception in 16.03.10, Medicaid Enhanced Plan Benefits. The Department made additional changes necessary to implement rate increases resulting from two years of negotiations with providers.

TESTIMONY: Lydia Dawson, Executive Director of the Idaho Association of Community Providers (ICAP), expressed support for the Department of Health and Welfare and the Omnibus Rulemaking, Docket No. 16-0000-1900, IDAPA 16.03.10, Section 038.

MOTION: Chairman Martin moved to approve Docket No. 16-0000-1900: 16.01.02; 16.01.03; 16.01.05; 16.01.06; 16.01.12; 16.02.02; 16.02.06; 16.02.10; 16.02.11; 16.02.12; 16.02.15; 16.02.19; 16.02.23; 16.02.24; 16.03.01; 16.03.02; 16.03.04; 16.03.05; 16.03.06; 16.03.07; 16.03.08; 16.03.09; 16.03.10; 16.03.11; 16.03.13; 16.03.14; 16.03.17; 16.03.21; 16.03.23; 16.03.24; 16.03.25; 16.04.14; 16.04.17; 16.05.01; 16.05.03; 16.05.04; 16.05.07; 16.06.05; 16.06.12; 16.06.13; 16.07.17; 16.07.19; 16.07.25; 16.07.33; 16.07.37; 16.07.39 and Docket No. 22-0000-1900: 22.01.05. Senator Heider seconded the motion. The motion carried by voice vote.

DOCKET NOS. 16-0000-1900F, 22-0000-1900F, AND 27-0000-1900F

Department of Health and Welfare, Notice of Omnibus Rulemaking, Pending Fee Rule, Page 5; Board of Medicine, Notice of Omnibus Rulemaking, Page 439; Board of Pharmacy, Notice of Omnibus Rulemaking, Page 741. Chairman Martin announced they would vote on all three fee docket at once.
MOTION: Chairman Martin moved to approve Docket No. 16-0000-1900F: 16.01.07; 16.02.01; 16.02.08; 16.02.13; 16.02.14; 16.02.25; 16.02.26; 16.02.27; 16.03.03; 16.03.18; 16.03.19; 16.03.22; 16.04.07; 16.05.06; 16.06.01; 16.06.02; 16.07.01; Docket No. 22-0000-1900F: 22.01.01; 22.01.03; 22.01.10; 22.01.11; 22.01.13; and Docket No. 27-0000-1900F: 27.01.01. Senator Heider seconded the motion.

DISCUSSION: Senator Bayer announced that Docket No. 16-0000-1900F Rule 16.02.08 was mistakenly included in the motion. Chairman Martin acknowledged that including Rule 16.02.08 was a mistake and that it would not be included in the motion. Vice Chair Souza confirmed with the Committee that Docket No. 16-0000-1900F, Rule 16.02.08 was not to be considered part of the motion.

Senator Jordan stated her concern about leaving out the rule. She believed it was a standard rule in response to settled law and did not agree that it should be left off this docket. Chairman Martin asked to return to the rule at a later date, as it may be controversial. Senator Jordan responded that she did not want to vote against the other rules and withdrew her opposition to the motion.

VOICE VOTE: The motion to approve Docket No. 16-0000-1900F: 16.01.07; 16.02.01; 16.02.13; 16.02.14; 16.02.25; 16.02.26; 16.02.27; 16.03.03; 16.03.18; 16.03.19; 16.03.22; 16.04.07; 16.05.06; 16.06.01; 16.06.02; 16.07.01; Docket No. 22-0000-1900F: 22.01.01; 22.01.03; 22.01.10; 22.01.11; 22.01.13; and Docket No. 27-0000-1900F: 27.01.01 carried by voice vote.

MOTION: Chairman Martin moved to hold Docket No. 16-0000-1900F, Rule 16.02.08 in Committee. Senator Bayer seconded the motion.

DISCUSSION: Chairman Martin asked to hold the rule so that the whole legislative body, which plans to pass related legislation on this issue, would have the ultimate say on the topic. Similar legislation will come through the Committee at a later time.

Senator Jordan stood in opposition to holding the rule in Committee. She reasoned that the rule is in response to an item decided by the courts and she believed there is no government interest to change it at this point in time.

VOICE VOTE: The motion to hold Docket No. 16-0000-1900F, Rule 16.02.08 in Committee carried by voice vote. Senators Jordan and Nelson requested they be recorded as voting nay.

PASSED THE GAVAL: Vice Chair Souza passed the gavel to Chairman Martin.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:37 p.m.

___________________________
Senator Martin
Chair
___________________________
Margo Miller
Secretary
___________________________
Bryce DeLay
Secretary's Assistant
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<td>Docket No. 24-1201-1900F</td>
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<td>Docket No. 24-1701-1900F</td>
<td>State Board of Acupuncture, Notice of Omnibus Rulemaking, Pending Fee Rule, Page 679</td>
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<td><strong>58-0101-1904F</strong></td>
<td>Department of Environmental Quality</td>
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COMMITTEE MEMBERS
Chairman Martin
Vice Chairman Souza
Sen Heider
Sen Lee
Sen Harris
Sen Burtenshaw
Sen Bayer
Sen Jordan
Sen Nelson

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, January 13, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza.

OMNIBUS FEE RULES:

MOTION: Chairman Martin moved to approve Docket Nos. 19-0101-1900F; 23-0101-1900F; 24-0301-1900F; 24-0501-1900F; 24-0601-1900F; 24-0901-1900F; 24-1001-1900F; 24-1101-1900F; 24-1201-1900F; 24-1301-1900F; 24-1401-1900F; 24-1501-1900F; 24-1601-1900F; 24-1701-1900F; 24-1901-1900F; 24-2301-1900F; 24-2401-1900F; 24-2601-1900F; and 24-2701-1900F. Senator Heider seconded the motion. The motion passed by voice vote.

OMNIBUS RULES:

MOTION: Chairman Martin moved to approve Docket Nos. 15-0100-1900, 15-0200-1900, and 41-0101-1900. Senator Burtenshaw seconded the motion.

DISCUSSION: Senator Bayer asked for clarification from someone in the Commission on Aging. Seeing no one, she commented that there was no negotiated rulemaking on the rules for the Commission on Aging. Vice Chair Souza responded that because there were no changes in the existing rules, negotiated rulemaking was not conducted.

VOICE VOTE: The motion to approve Docket Nos. 15-0100-1900, 15-0200-1900, and 41-0101-1900 passed by voice vote.
DOCKET NO. 23-0101-1901  
Russ Barron, Executive Director, Idaho Board of Nursing, presented Docket No. 23-0101-1901; Rules of the Board of Nursing. Mr. Barron explained the rule was negotiated in the spirit of the Red Tape Reduction Act and there was a public hearing on July 12, 2019. He described the rule change deleted all rules associated or related to the Medication Assistant Certified. This certification was provided to qualified, unlicensed assistants to administer certain kinds of medication under the direction and supervision of a registered nurse. He explained why there was no current need for this in the state.

In response to Committee questions, Mr. Barron explained to the Committee how to view changes in the rule.

MOTION: Senator Lee moved to approve Docket No. 23-0101-1901. Senator Jordan seconded the motion. The motion passed by voice vote.

DOCKET NO. 22-0107-1901  
Anne Lawler, Executive Director, Idaho Board of Medicine, presented Docket No. 22-0107-1901; Rules for the Licensure of Naturopathic Medical Doctors. Ms. Lawler explained the changes and additions to the Docket. She detailed the Fee table in the rule and explained the fee changes. See attachment 1.

DISCUSSION: Chairman Martin requested clarification pertaining to the fee table on page 468. Ms. Lawler explained all the fees are "not to exceed" amounts. If an adjustment is needed, up to the amount listed in the table, they don't need to ask the Legislature for approval.

TESTIMONY: Kris Ellis, Partner, Eiguren Ellis Public Policy Firm, spoke in support of Docket No. 22-0107-1901. See attachment 2.

MOTION: Senator Jordan moved to approve Docket No. 22-0107-1901. Senator Lee seconded the motion. The motion passed by voice vote.

DOCKET NO. 58-0101-1903  
Tiffany Floyd, Air Quality Division Administrator, Department of Environmental Quality (DEQ), presented Docket No. 58-0101-1903; Department of Environmental Quality, Rules for the Control of Air Pollution in Idaho. She explained this rule is in response to the Red Tape Reduction Act. Rules that were duplicative, ineffective, or outdated were removed; specifically, sections 590, 591, 845-848, and 855-859. She noted that federal regulations have superseded these requirements, and they're already incorporated by reference into Idaho's rules. DEQ held one public comment period and one public hearing; overall, the comments received were in support of these changes.

MOTION: Senator Heider moved to approve Docket No. 58-0101-1903. Senator Burtenshaw seconded the motion. The motion passed by voice vote.

DOCKET NO. 58-0101-1905  
Ms. Floyd presented Docket No. 58-0101-1905; Department of Environmental Quality, Rules for the Control of Air Pollution in Idaho. See attachment 3. Ms. Floyd explained the differences in font color.


DOCKET NO. 58-0105-1901  
Michael McCurdy, Waste Management and Remediation Division Administrator, DEQ, presented Docket No. 58-0105-1901; Department of Environmental Quality, Rules and Standards for Hazardous Waste. He explained this rulemaking was to ensure state rules remained consistent with federal regulations. See attachment 4.

MOTION: Senator Burtenshaw moved to approve Docket No. 58-0105-1901. Senator Heider seconded the motion. The motion passed by voice vote.
John Tippets, Director, DEQ, spoke to the context of Docket No. 58-0101-1904; Department of Environmental Quality, Rules of Control of Air Pollution in Idaho. He specifically addressed how Idaho Code § 39-107D, applies to DEQ and the provisions stated therein.

DISCUSSION: Ms. Floyd introduced Mr. Carl Brown, Air Quality Rules Coordinator to help her answer questions; however, there were none. She then presented Docket No. 58-0101-1904, pending fee rule. She explained these rules were necessary to ensure the State of Idaho remained the implementing authority of the Clean Air Act and maintained primacy over the federal programs. The primary purpose was to provide the required structure to implement the national ambient air quality standards and to implement an air quality operating permit program in lieu of the Environmental Protection Agency. These rules regulated activities not regulated by the federal government. There were two rules: the Toxic Air Pollutant Rules and The Fluoride and Vegetation Limit, which were promulgated prior to Idaho Code § 39-107D. They required further research to ensure they met the requirements of Idaho Code § 39-107D.

MOTION: Senator Burtenshaw moved to approve Docket No. 58-0101-1904. Senator Harris seconded the motion. The motion passed by voice vote.

PASSED THE GAVEL: Vice Chair Souza passed the gavel to Chairman Martin.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:12 p.m.

___________________________  _______________________
Sen. Martin            Margo Miller
Chair                  Secretary

___________________________
Carol Cornwall
Assistant Secretary
BOARD OF MEDICINE – DOCKET NO. 22-0107-1901

Mr. Chairman, Members of the Committee, thank you for the opportunity to be here today.

My name is Anne Lawler and I am the Executive Director of the Idaho State Board of Medicine. I am here on behalf of the Board of Medicine to present pending rule docket No. 22-0107-1901, Rules for the Licensure of Naturopathic Medical Doctors, which starts on page 463 of your Pending Fee Rules Review Book.

The Idaho State Board of Medicine is a self-governing agency operated with dedicated funds from licensure fees. The Board has primary responsibility for licensure and regulation of physicians (including both MDs and DOs), physician assistants, athletic trainers, dietitians, respiratory therapists, and soon, Naturopathic Medical Doctors.

The Board’s mission is to protect and enhance the public’s health, safety and welfare by establishing and maintaining standards of excellence used in regulating the practice of medicine and ensuring quality health care for the citizens of Idaho through licensure, discipline, and education.

To recap the Naturopathic Medical Doctor licensure law that came into effect July 2019, Title 54, Chapter 51, the Board of Medicine is authorized to license Naturopathic Medical Doctors who have completed an accredited four-year, post-graduate naturopathic medical school. There are seven such programs accredited in North America. In addition, all successful applicants for licensure will have passed the NPLEX, the National Board Examination for naturopathic medical doctors.

The naturopathic medical doctors licensed under this statute and under these rules will provide primary care services to the citizens of Idaho, expanding access to primary care across the state.
Turning to the Docket before you, number 22-0107-1901, this pending rule provides more detail to the new law.

1) Subsection 010 defines relevant organizations for accreditation and the national qualifying examination, along with defining “primary care”;
2) Subsections 020 and 021 set forth the requirements for licensure;
3) Subsection 022 outlines the authority to prescribe, dispense, administer and order medications, lab tests, and diagnostic procedures, along with defining the naturopathic formulary and exceptions thereto;
4) Subsection 032 outlines grounds for discipline or denial of a license, consistent with the Board of Medicine’s other rules chapters;
5) Subsection 033 defines continuing medical education requirements; and
6) Subsection 041 provides the fee table.

In keeping with the Red Tape Reduction Act, these rules do not repeat any language that is already set forth in the authorizing statute.

Three negotiated rulemaking sessions were conducted by the Board on August 12, September 16, and October 7, 2019. The proposed rules were approved by the Naturopathic Board in an open meeting on October 7, 2019. The complete text of the proposed rules was published in the November 6, 2019 Bulletin.

Negotiations continued through the comment period. Several meetings were conducted with stakeholders and the draft rules were available on the Board of Medicine website for review and comment. The Board of Medicine conducted a formal public hearing on these rules on November 7, 2019, during which it heard testimony from the public. Following the November public hearing, the Board adopted the final version of these Pending Rules. The updated Pending Rules were published in the January 1, 2020 Bulletin with the following changes:

1) Removing the waiver option for taking the national pharmacology exam; and
2) Removing language regarding determining if an applicant is lawfully present in the U.S., which has now been deleted by the Board in all its rules.

The Board sought input on these and all the Board’s pending rules from the Idaho Chapter of the American Association of Naturopathic Physicians (IDAANP), Idaho Medical Association, the Idaho Academy of Physician Assistants, the Idaho Hospital Association, the Idaho Boards of Nursing, Pharmacy, and Dentistry, along with the Bureau of Occupational Licenses and the public.

There is no fiscal impact to the General Fund and there will be a modest increase in the agency’s dedicated fund as a result of issuing licenses beginning July 1, 2020.

Mr. Chairman, Members of the Committee, on behalf of the Board of Medicine, I respectfully ask that the Committee approve pending rule docket 22-0107-1901.

Thank you for your time today and I am happy to stand for any questions.
Good Morning Mr. Chairman, Committee

My name is Kris Ellis Representing the Idaho Chapter of the American Association of Naturopathic Physicians.

We are strongly in support of these rules that will allow the NMDs licensed under last years HB 244 to practice what they have been trained and practice to the community standard of care.

- This will allow them to better care for their patients,
- it will save patients money-as they won’t have to see another primary care doctor for labs, imaging and prescriptions,
- The formulary is very similar to the formulary allowed in our neighboring states which will allow patients to receive their naturopathic care in Idaho instead of having to travel out of state, AND
- It will improve access to primary care in general

We very much appreciate the effort of Anne and Board of Medicine and the many negotiated rule hearings.

Happy to stand for questions.
Overview of Incorporations by Reference for the DEQ Air Quality Program
Docket No. 58-0101-1905
Required by Idaho Code § 67-5223(4)

An efficient way to implement new or updated federal regulations is to incorporate them by reference into state rule. Reproducing the Code of Federal Regulations in state rule is impractical and costly. Therefore when possible, and as supported by Idaho industry, DEQ incorporates federal regulations by reference. Sections with no changes are also incorporated to ensure the state rules are consistent with federal regulations and to provide one set of rules for industry to follow. Idaho industry is required to comply with all applicable new and updated federal rules regardless of whether DEQ incorporates them by reference.

In addition, for DEQ to be the implementing authority for the Clean Air Act in the state of Idaho, the agency is required to (1) implement the National Ambient Air Quality Standards (NAAQS) and (2) implement an air quality operating permit program for facilities with significant emissions.

(1) **National Ambient Air Quality Standards Implementation**—If an area in Idaho exceeds a NAAQS, DEQ will develop a state plan to improve air quality in that area. Whenever EPA updates a federal standard, DEQ also must demonstrate to EPA that it can implement the new standard. To obtain the appropriate authority to implement a new standard, DEQ incorporates by reference the following sections from the Code of Federal Regulations: Parts 50, 51, 52, 53, and 58.

(2) **Operating Permit Program**—Operating permit requirements are outlined under Parts 64 and 70 of the Code of Federal Regulations. To write these permits in Idaho, DEQ must have the authority to include all of the applicable federal requirements. These requirements are contained in the Code of Federal Regulations Parts 52, 60, 61, 62, 63, 73, and 82.

To maintain authority for implementing the Clean Air Act in Idaho, DEQ is required to continually demonstrate that our air quality program meets minimum federal requirements.

Note, if DEQ’s air program does not meet EPA’s minimum requirements, EPA could impose sanctions on Idaho as outlined in the Clean Air Act (42 USC § 7509). Under certain circumstances, these sanctions could include withholding federal highway funds or DEQ operating funds.
The following parts were revised:

National Ambient Air Quality Standards (NAAQS) Implementation

The NAAQS implementation rules promulgated by EPA in this time period are mostly administrative in nature. These rules mostly affect DEQ, e.g. updates to state implementation plan (SIP) requirements that DEQ will need to follow, or EPA actions in response to DEQ’s SIP submittals. Most notably, EPA redesignated Pinehurst from nonattainment to attainment for the PM\textsubscript{10} standard.

A more detailed summary of the Code of Federal Register changes that impact NAAQS implementation is given below.

Part 51: Requirements for preparation, adoption, and submittal of implementation plans
- States are required to have a state implementation plan, which includes the rules and area-specific plans that address NAAQS. This section outlines the state implementation plan requirements for state environmental agencies.
- There were four actions in this section: one exempted a chemical from being designated as a volatile organic carbon compound (FR-2018-11-28), one updated compliance testing methods for industry (FR-2019-11-14), one implemented the 2015 Ozone NAAQS (FR-2018-12-06), and one revised the 1998 regulations for nitrogen oxides. (FR-2019-03-08).

Part 52, Subparts A and N and Appendices D and E: Approval and promulgation of implementation plans
- This section contains general provisions associated with state implementation plans and Idaho-specific state implementation plan actions.
- Subpart N - Idaho: EPA promulgated four changes in this section focused on Idaho’s state implementation plan. One approved Idaho’s incorporation by reference rulemaking and the removal of an expired interim regulation (FR-2018-08-20), one approved the Pinehurst PM\textsubscript{10} redesignation and limited maintenance plan and approved an emissions inventory for the West Silver Valley PM\textsubscript{2.5} nonattainment area (FR-2018-08-11), one approved Idaho’s interstate transport analysis for the 2012 PM\textsubscript{2.5} NAAQS (FR-2018-09-24), and one approved a rule revision focused on Kraft pulp mills (FR-2019-04-08).

Operating Permit Program Implementation

Most of the updates to the subparts associated with DEQ’s operating permit program do not impact Idaho facilities. The source category that does impact Idaho facilities is the surface coating of wood building products. The updates to this rule are minimal, affected facilities in Idaho are Woodgrain Millwork and Teton Sales Company.

A more detailed summary of the Code of Federal Register changes that impact DEQ’s operating permit program is given below.
Part 62, Subpart HHH: Federal plan requirements for hospital/medical/infectious waste incinerators constructed on or before December 1, 2008
- This section describes the requirements for hospital/medical/infectious waste incinerators. DEQ took delegation of these federal plan requirements.

Part 64: Compliance assurance monitoring
- This section outlines the compliance assurance monitoring requirements for emission units at major sources of pollution.

Part 70: State operating permit programs
- This section describes the minimum requirements for state permitting programs.

Part 72: Permits
- This section establishes permit requirements under the Acid Rain Program.

Part 73: Sulfur dioxide allowance system
- This part establishes the requirements and procedures for an SO₂ pollutant trading program.
- Idaho currently does not have any sources participating in a pollutant trading program.
Overview of Incorporations by Reference for the DEQ Hazardous Waste Program - Docket No. 58-0105-1901
Required by Idaho Code § 67-5223(4)

Rulemaking Docket No. 58-0105-1901 describes incorporation by reference of final federal hazardous waste regulations promulgated with effective dates from July 1, 2018, through June 30, 2019.

Incorporation by reference of federal hazardous waste regulations is a routine procedure that DEQ performs annually to: 1) satisfy the consistency and stringency requirements of the Hazardous Waste Management Act (HWMA – Idaho Code § 39-4404); 2) meet the legislative intent to avoid the existence of duplicative, overlapping or conflicting state and federal regulatory systems; and 3) provide authority for DEQ to maintain primacy and authorization to operate the federal Resource Conservation and Recovery Act (RCRA) program in lieu of EPA.

This proposed rule is neither broader in scope nor more stringent than federal regulations, and does not regulate an activity that is not regulated by the federal government.
The following parts were revised and may have an impact on Idaho facilities:

Parts 260, 261, and 262

Safe Management of Recalled Airbags: In this rule, EPA provides an exemption for the collection of airbag waste from hazardous waste requirements. Specifically, the rule addresses the public health issue posed by management and disposal of defective Takata airbags. In May 2015 the US Department of Transportation (DOT) issued a national recall of airbag inflators manufactured by Takata due to a defect in their propellant. Discarded airbags meet the definition of ignitable hazardous waste and reactive hazardous waste. Under this rule, airbag waste is exempt from hazardous waste requirements as long as certain requirements are met. This exemption will provide a more expedited removal of defective airbags from vehicles at dealerships, salvage yards and other locations for safe and environmentally sound disposal.

This provision should have little to no impact on Idaho Facilities.
IDAPA 58 – DEPARTMENT OF ENVIRONMENTAL QUALITY
58.01.05 – RULES AND STANDARDS FOR HAZARDOUS WASTE
DOCKET NO. 58-0105-1901
NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the Idaho Board of Environmental Quality (Board) and is now pending review by the 2020 Idaho State Legislature for final approval. The pending rule will become final and effective immediately upon the adjournment sine die of the Second Regular Session of the Sixty-fifth Idaho Legislature unless prior to that date the rule is rejected in whole or in part by concurrent resolution in accordance with Idaho Code Sections 67-5224 and 67-5291.

Upon legislative approval of this pending rule the amendments made in this docket will overwrite those sections of the reauthorized rule promulgated under docket no. 58-0000-1900F, which will also be filed for review for final approval during the upcoming legislative session.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that the Board has adopted a pending rule. This action is authorized by Chapters 44 and 58, Title 39, Idaho Code. In addition, 40 CFR 271.21(e) and Section 39-4404, Idaho Code, require DEQ to adopt amendments to federal law.

DESCRIPTIVE SUMMARY: A detailed summary of the reason for adopting the rule is set forth in the initial proposal published in the Idaho Administrative Bulletin, August 7, 2019, Vol. 19-8, pages 147 through 153. DEQ received no public comments, and the rule has been adopted as initially proposed. More information regarding this rule docket is available at www.deq.idaho.gov/58-0105-1901.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on questions concerning the rulemaking, contact Caroline Moores at caroline.moores@deq.idaho.gov or (208) 373-0554.

Dated this 14th day of November, 2019,

Paula J. Wilson
Department of Environmental Quality
1410 N. Hilton Street
Boise, Idaho 83706
Phone: (208) 373-0418
Fax No.: (208) 373-0481
paula.wilson@deq.idaho.gov

S – HEALTH & WELFARE COMMITTEE PAGE 1359 2020 PENDING RULE BOOK
## AGENDA
### SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.  
Room WW54  
Tuesday, January 14, 2020

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<th>SUBJECT</th>
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<td>Docket No. 16-0102-1901</td>
<td>Department of Health and Welfare, EMS - Rule Definitions, Page 1121</td>
<td>Wayne Denny, Bureau Chief</td>
</tr>
<tr>
<td>Docket No. 16-0103-1901</td>
<td>Department of Health and Welfare, EMS - Agency Licensing Requirements, Page 1126</td>
<td>Mr. Denny</td>
</tr>
<tr>
<td>Docket No. 16-0107-1901</td>
<td>Department of Health and Welfare, EMS - Personnel Licensing Requirements, Page 1129</td>
<td>Mr. Denny</td>
</tr>
<tr>
<td>Docket No. 16-0504-1901</td>
<td>Department of Health and Welfare, Rules of the Idaho Council on Domestic Violence &amp; Victim Assistance Grant Funding, Page 1278</td>
<td>Nicole Fitzgerald, Executive Director</td>
</tr>
</tbody>
</table>

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

### COMMITTEE MEMBERS
- Chairman Martin  
- Vice Chairman Souza  
- Sen Heider  
- Sen Lee  
- Sen Harris  
- Sen Burtenshaw  
- Sen Bayer  
- Sen Jordan  
- Sen Nelson

### COMMITTEE SECRETARY
- Margo Miller  
- Room: WW35  
- Phone: 332-1319  
- Email: shel@senate.idaho.gov
DATE: Tuesday, January 14, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza.

DOCKET NO. 16-0102-1901

MOTION: Senator Heider moved to approve Docket No. 16-0102-1901. Senator Nelson seconded the motion. The motion carried by voice vote.

DOCKET NO. 16-0103-1901
Wayne Denny, Bureau Chief, Emergency Medical Services (EMS), Department of Health and Welfare, presented Docket No. 16-0103-1901, Department of Health and Welfare, EMS - Agency Licensing Requirements. Mr. Denny stated there were two changes: one was a housekeeping change, the other was in the Time Sensitive Emergency (TSE) Manual, to add TSE designation to hospitals and EMS agencies, and this designation was not mandatory.

DISCUSSION: In response to Committee questions, Mr. Denny explained agencies desiring the TSE Designation would have to attend meetings. The goal of EMS is for every hospital and EMS agency to desire TSE designation; he doesn't foresee it becoming mandatory in the future.

MOTION: Senator Bayer moved to approve Docket No. 16-0103-1901. Senator Heider seconded the motion. The motion carried by voice vote.

DOCKET NO. 16-0107-1901
Mr. Denny presented Docket No. 16-0107-1901, Department of Health and Welfare, EMS Personnel Licensing Requirements. Mr. Denny noted three changes or additions: Section 103, Recognition of EMS Personnel Licensure Interstate Compact (REPLICA); Section 107, Licensure of Members of the Military, Veterans, and Spouses; and Section 131, Reinstatement of a Lapsed EMS Personnel License, specifically competency certification. Mr. Denny explained the continuing education (CE) and criminal history requirements were kept, but the examination requirement was removed.

DISCUSSION: In response to Committee questions, Mr. Denny indicated a person who has not been an emergency medical technician (EMT) for several years would have two years to meet the reinstatement requirements. There are national standards that have to be met, and a National Registry of EMT's exam must be passed. Currently, there are 17 states with reciprocity agreements.
MOTION: Chairman Martin moved to approve Docket No. 16-0107-1901. Senator Heider seconded the motion. The motion carried by voice vote.


Ms. Fitzgerald clarified the term "share a child in common" included a family or a household. Another clarification was the term "victim" regarding the terms of sexual and psychological abuse that were added. Ms. Fitzgerald explained the terms were added as a result of comments received during the comment period and not due to any federal requirement.

MOTION: Senator Jordan moved to approve Docket No. 16-0504-1901. Senator Lee seconded the motion. The motion carried by voice vote.

PASSED THE GAVEL: Vice Chair Souza passed the gavel to Chairman Martin.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:36 p.m.

_________________________________________________   ______________________________
Senator Martin                                          Margo Miller
Chair                                                  Secretary
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<tr>
<th>SUBJECT</th>
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<tr>
<td>Docket No. 19-0101-1901 fee</td>
<td>Rules of Idaho State Board of Dentistry, Dental Therapy Fee Rule, Page 428</td>
<td>Susan Miller, Executive Director, Board of Dentistry</td>
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<td>Docket No. 16-0309-2001 temp</td>
<td>Department of Health and Welfare, Medicaid Basic Plan Benefits, Page 3</td>
<td>David Welsh, Bureau Chief, Division of Medicaid</td>
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<td>Docket No. 16-0309-1803</td>
<td>Department of Health and Welfare, Medicaid Basic Plan Benefits, Page 1145</td>
<td>Michael Case, Program Manager, Division of Medicaid</td>
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<td>Docket No. 16-0310-1806</td>
<td>Department of Health and Welfare, Medicaid Enhanced Plan Benefits, Page 1175</td>
<td>Mr. Case</td>
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<tr>
<td>Docket No. 16-0318-1901</td>
<td>Department of Health and Welfare, Medicaid Cost-Sharing, Page 1212</td>
<td>Ali Fernandez, Bureau Chief, Division of Medicaid</td>
</tr>
</tbody>
</table>

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin
Vice Chairman Souza
Sen Heider
Sen Lee
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
**MINUTES**

**SENATE HEALTH & WELFARE COMMITTEE**

**DATE:** Wednesday, January 15, 2020  
**TIME:** 3:00 P.M.  
**PLACE:** Room WW54  
**MEMBERS PRESENT:** Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson  
**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 Martin called the Senate Health and Welfare Committee (Committee) meeting to order at 3:06 p.m.  
**PASSED THE GAVEL:** Chairman Martin passed the gavel to Vice Chair Souza.  
**DOCKET NO.** 19-0101-1901  
**DISCUSSION:** Rules of the Idaho State Board of Dentistry, Dental Therapy Fee Rule. Susan Miller, Executive Director, State Board of Dentistry (Board), presented the docket for approval. Ms. Miller gave a PowerPoint presentation, along with her remarks.

In response to questions from the Committee regarding the written collaborative agreement as referenced at the top of page 433, section 035(b), who has the agreement and where it is, Ms. Miller responded the agreement is maintained by the dentist and the hygienist. It is provided to the Board initially and with each successive renewal. The Board doesn't see the agreement unless there is an investigation. Ms. Miller explained the role of the Board is to protect the public through licensure and dentistry; to provide good and safe care for the public. On the Board, there are four licensed, practicing dentists out of seven filled positions, with one vacancy. The Idaho State Dental Association is an association of professional dentists.

The Committee and Mr. Miller discussed the subject of a dental therapist performing tooth extractions. Mr. Miller explained that the dental therapist also has to perform 500 hours of supervised practice before becoming licensed or certified and performing extractions on his or her own.

**TESTIMONY:** Taylor Wilkins, Dental Director for the Coeur d'Alene Tribe, testified in support of the rule and stated that it is not a new model and is being done in other states. Elizabeth Criner, Idaho State Dental Association (ISDA), indicated there are problems with sections 035 and 036 and requested they be rejected.

Tyrel Stevenson, Legislative Director for the Coeur d'Alene Tribe, provided page 2 of a bill that was signed last year and passed into law. See attachment 1. He then explained that a private dentist cannot open a practice on tribal reservations because he or she needs to be a part of the Indian Health Services Clinic. Mr. Stevenson says he feels confident with the model as presented.

Tim Olsen, representing the Nez Perce Tribe, said there has been an issue of access to health care for the tribe and it continues to be a problem. However, he is in support of the rule.
Dr. Steve Bruce, ISDA member and practitioner of dentistry in Idaho for 41 years, remarked that it looks like a plan for failure for the dental therapist. Dr. Bruce stated that someone needs to be on-site if teeth are extracted.

Dr. John Cres, a practicing Boise dentist for more than 40 years, is in support of the scope of practice being placed into the rules.

**MOTION:** Senator Harris moved to approve Docket No. 19-0101-1901, with the exception of sections 035 and 036. Senator Lee seconded the motion.

**DISCUSSION:** Senator Harris commented he does not see full industry support.

**SUBSTITUTE MOTION:** Senator Jordan moved to approve Docket No. 19-0101-1901 in its entirety.

**DISCUSSION:** Senator Jordan stated that by removing sections 035 and 036, the entire rule is affected.

**AMENDED SUBSTITUTE MOTION:** Chairman Martin moved to approve Docket No. 19-0101-1901, striking section 036, sub paragraph 04, b, i, and ii; and renumbering subsequent lines. Vice Chair Souza seconded the motion.

**ROLL CALL VOTE:** Senator Bayer called for a roll call vote on the motions. Vice Chair Souza announced they would vote on the amended substitute motion first. Vice Chair Souza and Chairman Martin voted aye. Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson voted nay. The motion failed.

**ROLL CALL VOTE:** Vice Chair Souza announced they would vote on the substitute motion. Senators Heider, Bayer, Jordan, and Nelson voted aye. Vice Chair Souza, Senators Lee, Harris, Burtenshaw, and Chairman Martin voted nay. The motion failed.

**ROLL CALL VOTE:** Vice Chair Souza announced they would vote on the original motion. Vice Chair Souza, Senators Lee, Harris, Burtenshaw, and Chairman Martin voted aye. Senators Heider, Bayer, Jordan, and Nelson voted nay. The motion carried.

**PASSED THE GAVEL:** Vice Chair Souza passed the gavel to Chairman Martin.

**ADJOURNED:** There being no further business at this time, Chairman Martin adjourned the meeting at 4:56 p.m.

__________________________________________
Senator Martin
Chair

Margo Miller
Secretary

__________________________________________
Juanita Budell
Assistant Secretary

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 15, 2020—Minutes—Page 2
54-902A. DEFINITION -- PRACTICE OF DENTAL THERAPY. The practice of
dental therapy is the doing by one (1) person for a direct or indirect con-
sideration of one (1) or more of the following with respect to the teeth or
dental health of another person, namely, identifying oral and systemic con-
ditions, performing dental prophylaxis, dispensing and administering non-
narcotic analgesics, anti-inflammatory and antibiotic medications as pre-
scribed by a licensed dentist, applying preventive agents, preparation and
placement of direct restorations in primary and permanent teeth, indirect
direct pulp capping on permanent teeth, indirect pulp capping on primary
teeth, and other dental services as specified by the supervising dent-
ist and for which the dental therapist is trained unless prohibited by the
board in its adopted rules. The board shall enter into negotiated rulemaking
to establish the appropriate levels of supervision for each authorized ser-
vice or procedure. Except as otherwise specified in this chapter, such ser-
services and procedures shall be limited to the discharge of official duties on
behalf of the United States government, including through the United States
public health service, the Indian health service, or tribal health programs
contracted to perform services on behalf of the United States government in a
practice setting within the exterior boundaries of a tribal reservation.

SECTION 3. That Section 54-903, Idaho Code, be, and the same is hereby
amended to read as follows:

54-903. GENERAL DEFINITIONS. As used in this chapter:
(1) "Association" means the Idaho state dental association and the
Idaho dental hygienists' association.
(2) "Board" means the state board of dentistry.
(3) "Conviction" or "convicted" means a finding of guilt by a judge
or jury, an entry of a guilty plea by a defendant and its acceptance by
the court, a forfeiture of a bail bond or collateral deposited to secure a
defendant's appearance, a judgment of conviction, a suspended sentence,
probation, a withheld judgment, or a finding of guilt under the uniform code
of military justice.
(4) "Dental assistant" is a person who need not be licensed under this
chapter, but who is regularly employed at a dental office, who works under
a dentist's supervision, and is adequately trained and qualified according
to standards established by the board to perform the dental services permit-
ted to be performed by assistants by this chapter and applicable rules of the
board.
(5) "Dental hygienist" is a person both qualified and licensed by the
laws of Idaho to practice dental hygiene.
(6) "Dental specialist" is a dentist who has graduated from a board-ap-
proved postgraduate program in the dentist's specialty and is a person both
qualified and licensed by the laws of Idaho to practice a dental specialty
recognized by the board.
(7) "Dental therapist" is a person both qualified and licensed by the
laws of Idaho to practice dental therapy.
(8) "Dentist" is a person both qualified and licensed by the laws of
Idaho to practice dentistry.
(9) "Direct supervision" is supervision of a dental therapist, dental
assistant, or dental hygienist requiring that a dentist diagnose the condi-
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<td>Relating to Nurses; New Section</td>
<td>Vice-Chair Souza</td>
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<td>RS27293C1</td>
<td>Relating to Amending Sections of Title 37</td>
<td>Representative Dorothy Moon</td>
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<td>RS27382</td>
<td>Relating To Nursing Home Administrators; Amending, Revising</td>
<td>Senator Mark Harris</td>
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<td>Camille Schiller, Program Manager, Medicaid Eligibility</td>
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<td>Docket No. 16-0319-1901</td>
<td>Department of Health and Welfare, Rules Governing Certified Family Homes, Page 1217</td>
<td>Steve Millward, Program Manager</td>
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<td>Docket No. 16-0322-1901</td>
<td>Department of Health and Welfare, Residential Care or Assisted Living Facilities in Idaho, Page 1222</td>
<td>Tamara Prisock, Administrator, Division of Licensing and Certification</td>
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<td>Docket No. 16-0506-1901</td>
<td>Department of Health and Welfare, Criminal History and Background Checks, Page 1289</td>
<td>Fernando Castro, Program Manager, Criminal History Unit</td>
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<td>Department of Health and Welfare, Criminal History and Background Checks, Page 1294</td>
<td>Mr. Castro</td>
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<td>Docket No. 16-0612-1901</td>
<td>Department of Health and Welfare, Rules Governing the Idaho Child Care Program (ICCP), Page 1304</td>
<td>Ericka Rupp, Program Manager, Idaho Child Care Program</td>
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If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin       Sen Burtenshaw
Vice Chairman Souza  Sen Bayer
Sen Heider            Sen Jordan
Sen Lee               Sen Nelson
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, January 21, 2020
TIME: 3:00 P.M.
PLACE: Room WW54

MEMBERS PRESENT: Chairman Martin, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson

ABSENT/EXCUSED: Vice Chair Souza

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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:03 p.m.

RS 27367 Relating to Nurses; New Section. There were no testimonials or questions.

MOTION: Senator Lee moved to send RS 27367 to print. Senator Heider seconded the motion. The motion carried by voice vote.

RS 27293C1 Relating to Amending Sections of Title 37. Representative Dorothy Moon presented RS 27293C1, which removes hemp from the definition of marijuana, and then removes hemp from Schedule 1, to conform with the Farm Bill of 2018. There were no testimonials or questions.

MOTION: Senator Bayer moved to send RS 27293C1 to print. Senator Jordan seconded the motion. The motion carried by voice vote. Senator Burtenshaw asked to be recorded as voting nay.

RS 27382 Relating to Nursing Home Administrators; Amending, Revising. Senator Harris announced that RS 27382, pertaining to Nursing Home Administrator licensing, was before the Committee.

MOTION: Senator Heider moved to send RS 27382 to print. Senator Lee seconded the motion. The motion passed by voice vote.

DOCKET NO. 16-0301-1901 Department of Health and Welfare, Eligibility for Healthcare Assistance for Families and Children. Camille Schiller, Program Manager for Medicaid Eligibility, Department of Health and Welfare, explained the docket addresses changes to the Medicaid Program for the families and children's chapter under the Idaho Administrative Procedures Act (IDAPA). The rulemaking is in compliance with the Red Tape Reduction Act.

Ms. Schiller told the Committee the first change adds a rule regarding Medicaid eligibility for an inmate during the time inpatient services are needed in a hospital. Services that are covered are only those that are provided during the time the inmate is in the hospital. The second change is in Section 400, where the intention was to create a more organized chapter. They added the criteria used to evaluate eligibility and income limits that apply to adults. In Section 545, the wording was changed for simplicity.

DISCUSSION: In response to a question from Senator Lee, Ms. Schiller explained the inmates specified included those from both county and state facilities.

MOTION: Senator Nelson moved to approve Docket No. 16-0301-1901. Senator Lee seconded the motion. The motion carried by voice vote.
DOCKET NO. 16-0319-1901
Department of Health and Welfare, Rules Governing Certified Family Homes.

Steve Millward, Program Manager for the Certified Family Home Program, Department of Health and Welfare, said the changes add protections to vulnerable adults living in certified family homes. He explained this rulemaking is in compliance with the Red Tape Reduction Act. The entire chapter was rewritten in 2017-2018 with strong stakeholder involvement, equating to a simplified revision. There were no major changes made in this docket. See attachment 1.

TESTIMONY: Richelle Tierney, Policy Analyst, Idaho Council on Developmental Disabilities (ICDD), said ICDD is authorized by federal and state law to monitor systems and policies and advocate for improved services that enable Idahoans with disabilities to live meaningful lives. ICDD supports this docket. See attachment 2.

MOTION: Senator Heider moved to approve Docket No. 16-0319-1901. Senator Jordan seconded the motion. The motion carried by voice vote.

DOCKET NO. 16-0322-1901
Department of Health and Welfare, Residential Care or Assisted Living Facilities in Idaho
Tamara Prisock, Administrator of the Division of Licensing and Certification, Department of Health and Welfare, said this docket is a complete rewrite of the chapter of rules that contain the licensing requirements for residential assisted living facilities in Idaho. They aligned the rules with legislation that was passed in the 2019 session, enabling assisted living facilities to become accredited by a nationally-recognized accreditation agency in place of regular licensure surveys. In compliance with the Red Tape Reduction Act, they clarified the chapter and industry requirements, relaxed some licensure requirements, strengthened resident safety, reduced the total word count, and eliminated 61 restrictive words. See attachment 3.

DISCUSSION: Chairman Martin queried if Ms. Prisock wanted the Committee to adopt the docket but exclude Rule 16.03.22.152.03.b.xvi, found on page 1,240. Ms. Prisock confirmed this and explained the rule was an error; it’s a requirement that they eliminated in negotiations with stakeholders. They intended to remove the reference, but it was overlooked.

TESTIMONY: Richelle Tierney, Policy Analyst, Idaho Council on Developmental Disabilities (ICDD), said ICDD supports Docket No. 16-0322-1901. See attachment 4. Senator Jordan asked if ICDD has any issue rejecting section 152.03,b.xvi. Ms. Tierney replied they have no objection.

Kris Ellis, Idaho Health Care Association, supported the exclusion of section 152.03.b.xvi from the docket.

MOTION: Senator Jordan moved to approve Docket No. 16-0322-1901 with the exception of section 152.03.b.xvi. Senator Lee seconded the motion. The motion carried by voice vote.

DOCKET NO. 16-0506-1901
Department of Health and Welfare, Criminal History and Background Checks.

Fernando Castro, Program Supervisor of the Criminal History Unit, Department of Health and Welfare, said the docket is in compliance with the Red Tape Reduction Act. He said they sought to make permanent the authority of the Department to complete background checks of the citizen review panel members, formed during the revision of the 2018 Child Protection Act. The intent is to make the rule more user friendly and easier to read. See attachment 5.

DISCUSSION: Mr. Castro explained the changes to the rule. He added that they did not hold formal negotiated rulemaking meetings with stakeholders, because the rule change is being made to conform with existing law.

MOTION: Senator Nelson moved to approve Docket No. 16-0506-1901. Senator Heider seconded the motion. The motion carried by voice vote.
DOCKET NO. 16-0506-1902  
Department of Health and Welfare, Criminal History and Background Checks.  
Mr. Castro said the first change was requested by the FBI because state law cannot oppose a requirement on a federal entity. The Department will continue to have access to the authorized FBI criminal archives, with the exception of the FBI sex offender registry and the warrants file. It will continue to check the registries that are available by other means. The thoroughness of their background check will be minimally affected by this limitation. Mr. Castro explained the other changes to the rule. See attachment 6.

MOTION: Senator Jordan moved to approve Docket No. 16-0506-1902. Senator Heider seconded the motion. The motion carried by voice vote.

DOCKET NO. 16-0612-1901  
Department of Health and Welfare, Rules Governing the Idaho Child Care Program (ICCP). Ericka Rupp, Program Manager of the Idaho Child Care Program, Department of Health and Welfare, said the changes were made in compliance with the Red Tape Reduction Act and focus on two categories: eligibility for families and requirements for providers. She explained the changes and noted that they ensured compliance with federal requirements; therefore, there was no negotiated rulemaking.

MOTION: Senator Heider moved to approve Docket No. 16-0612-1901. Senator Jordan seconded the motion. The motion carried by voice vote.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:25 p.m.

___________________________
Senator Martin  
Chair

___________________________
Margo Miller  
Secretary

___________________________
Bryce DeLay  
Assistant to the Secretary
Mr. Chairman and members of the Committee, good morning and thank you for the opportunity to present this rule docket. I am Steve Millward, program manager for the Certified Family Home Program in the Division of Licensing and Certification. Rule Docket 16-0319-1901 adds protections to vulnerable adults living in certified family homes. You can find this docket on Page 1217 in your pending rules review book. <<PAUSE>>

This docket was developed with the goals of the Governor’s *Red Tape Reduction Act* in mind. There was a net increase of only 23 words, including an increase of 3 restrictive words. This entire chapter was recently rewritten in 2017-2018 with very strong stakeholder involvement, through which the rules were clarified, simplified, and streamlined, so no major changes were made in this docket.

The purpose of the Certified Family Home Program is to provide care in a homelike, family-styled setting for between one (1) and four (4) vulnerable adults who live in their care provider’s personal residence. A certified family home provides care to adults who are elderly, or who have mental illness, developmental disabilities, or physical disabilities, and whose mental, emotional, and physical needs can be met by the care provider. Certification as a certified family home allows the provider to receive financial compensation for care given to such residents as an alternative to more expensive institutional care. There are currently over 2500 certified family homes in operation statewide.

This past spring, the Department offered opportunities for stakeholders to engage in negotiated rulemaking. Sessions were held in all seven regions across the state. Although the Department did not receive any feedback through the negotiated rulemaking process, these proposed rule changes were discussed on multiple occasions in 2019 with the Community Care Advisory Council, which is
comprised of 20 stakeholders representing various interests in the certified family home and residential care or assisted living settings. This council voted unanimously to support the rule changes presented before the Committee today.

These pending rules will do two things: (1) require that the provider, substitute caregivers, and other adults in the home (besides the vulnerable adult residents) renew their clearance of a Department criminal history and background check at least every five years; and (2) allow the Department to deny the application for a certificate when the applicant has had disciplinary action on a child care or foster care license.

Regarding criminal history and background checks, the more frequent the clearance renewal, the safer it is for the resident, but also the higher the expense to the provider. While this rule change does not impact the Department financially as providers pay for these checks themselves, the Department is sensitive to balancing operating costs for providers while keeping residents safe. The policy for licensed child care workers is renewal of criminal history clearances every five years. The Certified Family Home Program agrees that a five-year renewal period is frequent enough to regularly screen out bad actors without putting too high a cost burden on the provider. The Department retains the right to require a provider to renew his clearance prior to the five-year minimum timeframe when it becomes aware of issues that may impact the status of the clearance.

Moving on from criminal history and background checks, collaboration between the Divisions of Licensing & Certification and Family & Community Services identified a blind spot in thoroughly checking the history of certified family home applicants who previously cared for children. There are currently no barriers
preventing an individual whom the Department will not license to care for children to be certified as a certified family home provider.

Section 113 of certified family home rules list reasons for denying an application. This list in its current form omits consideration of issues with foster or child care licenses. Because vulnerable adults receiving services in certified family homes are often as susceptible to abuse, neglect, and exploitation as children, the Department seeks to be consistent in preventing those who are not allowed a license to care for children to be certified to care for vulnerable adults. This rule change will help accomplish this objective.

This concludes my presentation of the pending rule changes. I respectfully ask that you approve as final Rule Docket 16-0319-1901, and I am happy to stand for questions.
January 21, 2020

Senator Martin, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: Docket No. 16-0319-1901 Rules Governing Certified Family Homes

Dear Chairman Martin and Members of the Committee:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their schools and communities. The Council is comprised of 23 volunteers appointed by the Governor.

The DD Council supports the proposed rules Docket No. 16-0319-1901 Rules Governing Certified Family Homes. The Council sits on the Community Care Advisory Council which oversees Residential Assisted Living Facilities and Certified Family Homes, these rules were presented to the advisory committee twice in the past year for its review, input and recommendations.

The DD Council applauds the Division of Licensing and Certification for the additional protections included in Section 9 and Section 113:

1) Section 9, Criminal History and Background Check Requirements, outlining requirements that care providers, substitute caregivers, and other adults living in certified family homes (excluding residents receiving care) clear a recurring criminal history and background check through the Department of Health & Welfare at least every five (5) years; and

2) Section 113, Denial of Application for Certificate, adding language within this section that allows the department to deny the application for a certified family home certificate when the applicant has had a child care or foster care license denied or revoked in the past.

The Certified Family Home (CHF’s) program is intended to provide a safe, family-style living environment for adults who need some assistance with the activities of daily living but do not require a more restrictive institutional setting. 2018 data shows there are 3,425 Certified Family Homes beds. These CFHs are limited to no more than four individuals, but generally 1-2 people reside there. Approximately 72% of the residents of CFHs are people with developmental disabilities.
The Idaho Council on Developmental Disabilities appreciates the vigilance for which the Division of Licensing and Certification acts upon in ensuring the safety and protection of individuals who are at high risk of abuse and exploitation.

Thank you for your time and consideration of the Council's comments.

Sincerely,

[Signature]

Richelle Tierney
Idaho Council on Developmental Disabilities
Presentation Notes for Docket 16-0322-1901
Senate H&W Committee – January 21, 2020

Mr. Chair and committee members, my name is Tamara Prisock. I am the Administrator for the Division of Licensing and Certification in the Department of Health and Welfare. I am presenting Rule Docket 16-0322-1901, which represents a complete rewrite of the chapter of rules that contain the licensing requirements for Residential Assisted Living Facilities in Idaho. You will find this docket in your Pending Rules Review Book starting on page 1200.

The work we did to rewrite this rule chapter helped us accomplish several objectives; namely,

- Align the rules with legislation that was passed in the 2019 session enabling assisted living facilities to become accredited by a nationally-recognized accreditation agency in place of regular licensure surveys (Idaho Code §39-3355(7));
- Clarify requirements that the industry found unclear or confusing;
- Re-organize the chapter for clarity and ease of locating specific requirements;
- Delete obsolete and duplicative language and update references;
- Relax some licensure requirements;
- Strengthen resident safety;
- Comply with the Governor’s Red Tape Reduction Act. We were able to reduce the total words in this chapter by 6,385 words, and we also eliminated 61 restrictive words.

Next, I will review substantive changes we made to licensing requirements in this docket:

- In section 130.03, we added language to allow accreditation to be accepted in lieu of regular licensure surveys.

- In section 130.09, we eliminated the requirement for facilities to submit evidence of resolution.
• In section 155.01, we changed the requirement for disaster plans to require two separate locations for evacuation.
• In section 155.03, we clarified that emergency generators, when installed, must comply with National Fire Protection Association standards.
• In section 215, we removed much of the criteria that had been in rule for administrators over multiple facilities.
• In section 215.08, we changed the rule to require reportable incidents be reported within 1 business day, rather than within 24 hours.
• In section 250.13, we modified the rule to require a secured environment only for residents at risk for elopement, not all residents with cognitive impairments.
• In section 260.07, we modified the rule to require facilities to store chemicals in locked storage area only when serving residents with cognitive impairments.
• In section 300.02, we relaxed the requirement to allow LPNs to respond to changes of condition instead of only RNs.
• In section 305.01, staff other than RNs can now report medication concerns to a resident’s physician. The RN is still responsible to ensure those notifications occur.
• In section 330.06.b.ii, we relaxed the requirement so facilities can review behavior interventions as appropriate rather than requiring a review after 72 hours.
• In section 460.2d, we now require fluids to be offered to residents between meals and at bedtime.
• In sections 510 through 525, we require the facility’s policies and procedures related to abuse, neglect, exploitation, and inadequate care to be posted in the facility, available upon request, and shared annually with residents.
• In section 920.01, we revised the rule to state that a ban on admissions will no longer be imposed for repeat non-core deficiencies.
• In section 925.01, we revised the rule to state that the Department will not impose civil monetary penalties for first time deficiencies. In practice, we do not impose civil monetary penalties for first-time deficiencies even
though the previous version of the rule allowed the Department to impose those penalties.

In developing this rule chapter, we conducted negotiated rulemaking in July 2019 and negotiated the changes with the Idaho Health Care Association. We also sent the draft rule docket to all assisted living providers and invited them to review and comment on the draft chapter rewrite.

We presented the rule docket to the Community Care Advisory Council, a council established in Idaho Code to advise the Department on issues related to assisted living facilities and certified family homes. At its October 2019 meeting, the Council voted to support the rule docket.

In addition, the Board of Health and Welfare approved the rule docket at its November 2019 meeting.

After the presentation of this rule docket to the House Committee on January 13th at which time the House committee approved the docket as final, members of the Idaho Health Care Association discovered an error in the docket. Section 16.03.22.152.03(b)xvi, found on page 1240, lists a requirement that we eliminated in our negotiations with stakeholders. Although we revised the fire safety requirements starting in section 400 to eliminate the requirement, we missed removing the reference to the requirement in section 152. We respectfully ask this committee to reject this subsection in the approval of the docket, and we plan to notify the House Committee of this error as well.

Mr. Chair, thank you for the opportunity to present this rule docket to the committee. That concludes my presentation, and I am happy to stand for questions.
January 21, 2020

Senator Martin, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: Docket No. 16-0322-1901 Rules Governing Residential Assisted Living Facilities

Dear Chairman Martin and Members of the Committee:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their schools and communities. The Council is comprised of 23 volunteers appointed by the Governor.

The DD Council supports the proposed rules Docket No. 16-0322-1901 Rules Governing Residential Assisted Living Facilities. The Council sits on the Community Care Advisory Council which advises the Division of Licensing and Certification on Residential Assisted Living Facilities and Certified Family Homes, these rules were presented to the advisory committee twice in the past year for its review, input and recommendations. These rules have been well-vetted.

The following sections highlight the extensive precautions put into place for resident safety:

1) Section 9, Criminal History and Background Check Requirements clearly outlines staff to resident contact while there is a waiting period for a facility to receive the results a criminal history background check of a newly hired staff. Also, the addition of language requiring direct line of sight supervision for all staff until the criminal history check is completed and the facility is in possession of is recognized as a positive step in protecting vulnerable individuals.

2) Section 153, Financial Requirements, these protections are a welcome addition to this set of rules and clearly outlines the safeguarding of residents and the requirement of distinct resident accounts separate from that of the facility.

3) Section 155, Emergency Preparedness, this additional section requires each facility to have an emergency preparedness plan to follow in the event of fire, flood, earthquake, high wind or any other emergency. In addition to this the DD Council is pleased to see the requirement of written agreements between the facility and at least two separate locations to which residents may be relocated in case of emergency.
Thank you to the Division of Licensing and Certification for the significant work they have done on these rules and thank you for your time and consideration of the Council's comments.

Sincerely,

[Signature]

Richelle Tierney
Idaho Council on Developmental Disabilities
Idaho Department of Health and Welfare
Senate
Criminal History Unit Presentation

IDAPA 16.05.06, “Criminal History and Background Checks”
RE: Criminal History and Background Check Rule Changes
Docket 16-0506-1901
Pending Rule

January 16, 2020

Mister Chairman / Madam Chair, members of the Committee:

My name is Fernando Castro and I am the supervisor for the Criminal History Unit. Our unit is part of the Department of Health & Welfare’s Bureau of Audits and Investigations. Thank you for allowing me to present the rule change in docket # 16-0506-1901, Criminal History and Background Checks. We developed this rulemaking in compliance with the Red Tape Reduction Act. Changes in this docket reduced the overall word count for this chapter by 382 words total, and the number of restrictive words was reduced by 26. You may find this docket in Page 1,289 of your Pending Rules book.

The Criminal History Unit completes over 30,000 background checks a year. These checks help the Department protect those that are vulnerable by screening employees of providers and individuals that participate in certain Department programs such as foster care, adoption and certified family homes. Each year, nearly 500 applicants are denied or voluntarily withdraw from their background checks because of disqualifying elements.
The purpose of this docket is two-fold. First, we are seeking to make permanent the authority of the Department to complete the background checks of the Citizen Review Panel members that were formed when the state revised the Child Protection Act during the 2018 Legislative Session with Senate Bill 1341. And secondly, we are attempting to meet Governor Little’s mandate expressed in the "Red Tape Reduction Act". That is, we are making the necessary changes to make this rule more user-friendly by eliminating restrictive language and changing the presentation of the information to an easier to read format.

The first change that you will see starts in the bottom half of page 1,291 and ends in page 1,292. What you are seeing there is a complete conversion of the current bulleted list in Section 100 into a table presenting the same information with these proposed changes. Other changes visible in this table show the repeal of other Department chapters of rules that remove the requirement for those types of providers from being cleared by the Department.

The second change in this docket can be found in page 1,293. The change consists of adding to the Department Enhanced Clearance requirement persons that are associated with a Children's Agency and the Citizen Review Panel members as well. This is being done at the request of the stakeholders involved in the operation and oversight of said agencies and activities which articulated the desire to screen these persons at a higher standard.
There is no fiscal impact to the State General Fund or to the dedicated funds with this rule change. The costs of modifying the Department’s web-based system will be performed by Department staff and will be covered with the allocated system maintenance funds of our unit.

I would also like to note that we did not hold formal negotiated rulemaking meetings with our stakeholders for this docket because this rule change is being made to conform with existent law; and, because the background checks requirements for our applicants are already present in other chapter of rules.

We believe that these proposed changes improve the protection of the vulnerable population of our state. I ask that you approve this docket as a Final rule.

This concludes my prepared remarks. Thank you for your time. I stand now for questions.
Mister Chairman / Madam Chair, members of the Committee:

My name is Fernando Castro and I am the supervisor for the Criminal History Unit. Thank you for allowing me to present the rule changes in docket # 16-0506-1902, Criminal History and Background Checks. We developed this rulemaking in compliance with the Red Tape Reduction Act. Changes in this docket increased the overall word count for this chapter by 310 words total, and the number of restrictive words was reduced by six. You may find this docket in Page 1,294 of your Pending Rules book.

In contrast to my previous presentation, this docket is the result of negotiated rulemaking efforts seeking stakeholder participation and support to clarify processes and expectations of all parties involved in the Department’s background check process. I am happy to report that we did receive their support and I am excited to present the fruits of that labor with this docket.

The first change that you will see starts at the bottom of page 1,296 and goes on through page 1,297. As the docket shows, we are removing references to the National Crime Information Center throughout this rule. This change is being requested by the FBI and the
reason for this is that in the realm of law and subordination of state to Federal law, a state law cannot impose a requirement on a Federal entity. In the opinion of the FBI Criminal Justice Information Law Unit, the FBI unit that is tasked with the review and approval of state laws for compliance with federal criminal justice mandates, the rule as it was written was requiring the FBI to give us access to the entire National Crime Information Center archive of criminal histories to complete our background checks. Access to this resource requires a federal law stipulating so. And, the only law that is currently giving us access to portions of the NCIC is the Child Care and Development Block Grant of 2014. This provision only applies to the background checks that we are completing for our children’s daycare workforce as of today. In practice, this means that we will continue to have access to the authorized FBI criminal archives except the FBI’s National Sex Offender Registry and Warrants file. However, we will continue to check federal and state Sex Offender Registries that are available by other means. So, the thoroughness of our background check will be minimally affected by this new limitation on our work.

Staying in page 1,297, near the center of the page, at Subsection 010.04. where we define what is a Conviction for the purposes of this rule, you will see a renumbering of references that were erroneously included in prior versions of the rule. This renumbering is our correction to those past errors.

Moving on to page 1,298, you will see that we have included the definition of what is a Direct Patient Access Employee as a new SubSection 010.09. This change is needed so that our state can meet one of the National Background Check Program (NBCP) milestones
for background checks of Long Term Care providers employees. The NBCP is a federal Centers for Medicaid and Medicare Services program that provides grants to states to enhance their current background check systems. Since we are the recipients of one of those grants we are simply attempting compliance with it by adding this definition to our program.

In the same page, near the bottom, you can see that we have made changes to clarify what are the expectations that the Department has for our providers. In Subsection 060.02, in addition to making some changes to the text in to comply with the Red Tape Reduction Act, we are clarifying that a provider must update their information in the Department's background check system to ensure that as ownership of their facilities changes, the Criminal History Unit has accurate information for that provider or facility after the transaction is completed.

In the upper half of page 1,299, in Subsection 061.02, we have rewritten it to clarify what background check related documents must be retained by the provider and for how long they should do so. Our stakeholders had asked for this clarification because some of them were retaining unnecessary documentation or, where retaining them longer than necessary. We believe that this change will provide them some relief on that administrative burden.
At the bottom of the same page, in Section 150 of the rule, we are taking the first steps to help our providers comply with the requirements of this rule and protect the vulnerable. Unfortunately, up to this point the Department did not have a clear policy as to how long an employee should be allowed to work with the vulnerable without being fingerprinted and having their background check work initiated. There are multiple and valid reasons for applicants to not be fingerprinted as soon as possible ranging from personal hardships to not being physically present in the state. However, it became apparent that some applicants would postpone their fingerprinting for dubious reasons. With the creation of a 60-day deadline to the applicant to provide their fingerprints to the Department we are effectively creating a definitive point for them to be removed by their employer from any position where they access the vulnerable.

In page 1,300, throughout Section 210 we removed some text to reduce the size of this rule and, at the same time, we are taking this opportunity to add two new permanent disqualifying crimes. Those are Assault and Battery with intent to commit a serious felony. A serious felony in this case can be murder, rape, the infamous crime against nature, mayhem, robbery or lewd and lascivious conduct with a minor child. Being that convictions of these two crimes are indicative of the applicant proclivity to commit grievous crimes against a person, the Department believes that they should be disqualifying.
Finally, in Section 300, in page 1,302 of this docket, we are clarifying what background checks actions are required for rehired staff. Without this clarification, an employee could be re-hired without being subjected to a new background check unless the employer would require it voluntarily. And, because the Department does not have a recurring background check requirement for most provider staff, it is easy for unscrupulous persons to remain undetected should they engage in criminal activity after they are cleared by the Department. Even though we believe that the nearly all our providers expend effort and resources to have the highest qualified staff possible, we think that setting this new requirement would further assist them in doing so.

There is no fiscal impact to the State General Fund or to the dedicated funds with this rule change. The costs of modifying the Department’s web-based system to accommodate these changes will be performed by Department staff and will be covered with the allocated system maintenance funds of our unit. These proposed changes improve the ability of the Department in its efforts to protect the vulnerable population of our state. I ask that you approve this docket as a Final rule.

This concludes my prepared remarks. Thank you for your time. I stand now for questions.
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, January 22, 2020

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<td>Dave Jeppesen, Director, Department of Health and Welfare</td>
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<td>Department of Health and Welfare, Update on Licensing and Certification</td>
<td>Tamara Prisock, Administrator, Division of Licensing and Certification</td>
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<td>Department of Health and Welfare, Update on Non-Emergent Medical Transportation (NEMT)</td>
<td>Matt Wimmer, Administrator, Division of Medicaid</td>
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<td>Department of Health and Welfare, Update on Southwest Idaho Treatment Center (SWITC)</td>
<td>Miren Unsworth, Administrator, Division of Family and Community Services (FACS)</td>
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<td>Presentation</td>
<td>Department of Health and Welfare, Medicaid Expansion and the Status of Waivers</td>
<td>Lori Wolff, Deputy Director</td>
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If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin
Vice Chairman Souza
Sen Heider
Sen Lee
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, January 22, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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: Senator Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:03 p.m. He welcomed the presenters and said that Dave Jeppesen, Director of the Department of Health and Welfare (Department), would provide an overview of today's meeting.

PRESENTATION: Mr. Jeppesen informed the Committee there were four presenters representing four different divisions in the Department pertaining to the 2018 recommendations of the Office of Performance Evaluations (OPE). In response to a question about how many people were being served by Medicaid expansion, Mr. Jeppesen replied there are just under 58,000 people.

PRESENTATION: Tamara Prisock, Administrator of the Division of Licensing and Certification, Department of Health and Welfare, gave an update to the January 2018 OPE recommendations on residential care facilities. The study focused on 3 of the 18 facility types overseen by Ms. Prisock's Division which are: nursing homes, assisted living facilities, and children's residential care facilities. See attachment 1.

In response to Committee questions, Ms. Prisock explained she has increased coaching of staff and is monitoring processes and progress much more carefully than in the past. She informed the Committee that February 3, 2020, OPE will provide a follow-up report to its January 2018 recommendations. She reported there was a shortage of surveyors last year for skilled nursing facilities and explained surveyors need to be registered nurses on the long term care team. It wasn't a question of additional positions; rather, to fill the positions they had and retain them. Regarding the time lag for new facilities, Ms. Prisock explained the Centers for Medicare and Medicaid Services (CMS) considered new facility surveys lower in importance, if they were behind in higher level surveys. She stated there was only one new facility this year, and it was completed within 90 days as promised.

PRESENTATION: Matt Wimmer, Administrator of the Division of Medicaid, Department of Health and Welfare, provided an update to the January 2018 OPE recommendations for non-emergent medical transportation (NEMT). This included a review of the brokerage which examined effectiveness of models and compared models with respect to: costs; rates; requirements; structure; and, national standards. See attachment 2. Mr. Wimmer explained NEMT was a required Medicaid benefit, and they provided approximately 1.7 million trips in 2019. OPE's first recommendation was to analyze service delivery costs to make sure appropriate rate methodologies are used in the NEMT program. Other recommendations were to proactively plan for annual rate adequacy reviews, and implement a robust contract monitoring process.
Committee questions concerned stakeholder involvement, healthcare providers, rate adjustments, cost studies and how the Legislature can help to address these continuing needs. Mr. Wimmer responded these issues make his job very difficult. He noted that sometimes the one who gets the best rate increase depends on who has the best lobbyist or where the crisis is. Mr. Wimmer stated NEMT must stay customer-focused.

PRESENTATION: Miren Unsworth, Administrator of the Division of Family and Community Services (FACS), Department of Health and Welfare, reported update information on the Southwest Idaho Treatment Center (SWITC). See attachment 3. The SWITC population has decreased from 75 clients in 2008 to 17 clients in 2018. The mission of SWITC also changed from being a long-term home for clients to a short-term stabilization and treatment center for individuals in crisis. All of SWITC's residents have significant developmental disabilities, often in combination with mental diagnoses.

OPE made two core recommendations for SWITC: develop a strategic plan and a formal quality improvement process, and develop a long-term vision for Idaho's system of crisis care and its role as provider of last resort for those with intellectual disabilities. A strategic plan was developed to address priority areas of improvement. It included staff safety, facility improvements and management, and professional development. SWITC has improved staffing, which has resulted in a decrease in workers' compensation injuries, and staff turnover has been reduced. The long-term vision identified services for individuals with a developmental disability and acute or subacute needs. The new model includes a more robust continuum of care for those who currently reside at SWITC.

PRESENTATION: Lori Wolff, Deputy Director in the Department of Health and Welfare, updated the Committee on Medicaid expansion and the status of waivers. She stated that Medicaid expansion provides coverage to non-disabled adults with an annual household income up to 138 percent of the federal poverty level. The Expansion State Plan Amendment was approved and coverage began January 1, 2020. As of January 16, 2020, the enrollment was 57,794. See attachment 4. Applicant information had to be verified and, if they did not want the coverage, an opt-out option was available. New participants select a primary care provider; however, should they not select one, Medicaid assigns one within 90 days. Ninety percent of primary care providers are enrolled with Idaho Medicaid.

Ms. Wolff said there are several waivers:

- Work requirement waiver: requires that individuals work at least 20 hours per week as an eligibility requirement. This waiver was submitted September 27, 2019, and is awaiting federal approval.
- Idaho behavioral health transformation/IMD waiver: allows individuals to receive inpatient treatment for mental health and substance use disorders in a freestanding psychiatric hospital. This waiver was submitted January 3, 2020, and is awaiting federal approval.
- Family planning services waiver: requires individuals seeking family planning services to have a referral from their assigned medical home if the family planning service providers are outside the patient's established medical home. This waiver was submitted October 21, 2019, and is awaiting federal approval.
- Coverage choice waiver: allows Idahoans the choice to maintain their private insurance with the tax credit rather than enrolling in Medicaid. This waiver was determined incomplete and will be resubmitted.
In response to Committee questions, Ms. Wolff discussed at which hospitals the IMD waiver could be used, and how gross income for adult coverage was set.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:25 p.m.

___________________________  __________________________
Senator Martin               Margo Miller
Chair                         Secretary

___________________________  __________________________
Juanita Budell                Senator Martin
Assistant to the Secretary    Chair

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 22, 2020—Minutes—Page 3
Presentation Notes
Update on 2018 OPE Report on Residential Care

Mr. Chair and members of the Committee—my name is Tamara Prisock, and I am the administrator for the Division of Licensing and Certification in the Department of Health and Welfare. Thank you for the opportunity to update you on our division’s progress in implementing the recommendations contained in the 2018 report on Residential Care released by the Office of Performance Evaluations, or OPE. The study OPE conducted focused on three of the 18 facility types my division oversees—nursing homes, assisted living facilities, and children’s residential care facilities.

In the report released in January 2018, OPE made several recommendations. To date, we have fully implemented or are close to implementing all but one of the recommendations.

OPE made recommendations for improving the survey process for children’s residential care facilities. We have implemented all recommendations, including implementing an abbreviated application process, for which we have received positive feedback from facilities. In late 2018, we began sending more than one surveyor to large facilities in order to reduce the amount of time the survey team is on-site at the facility. That change is also working well. We have also implemented anonymous customer feedback cards and an informal dispute resolution process for facilities to be able to challenge citations.

We have also implemented OPE’s recommendations related to the division’s assisted living team. To help manage the workload in a growing industry, we now offer national accreditation to assisted living facilities in lieu of regular licensure surveys.

To address the recommendation to provide more support for the Assisted Living team supervisor, the division worked with the Department’s Human Resources Office to establish the role of Field Supervisor, and we appointed two seasoned individuals to fulfill the role on a permanent basis. Establishing the new role has provided relief to the Assisted Living Program Supervisor.

The most serious concerns in the 2018 OPE report revolved around workplace issues and deteriorating provider relationships with the division’s Long-term Care Team, the team that surveys skilled nursing facilities, or nursing homes. During the OPE study, morale was low, and surveyors told OPE team members about unprofessional and even hostile conduct coming from other surveyors and from the two Long-term Care supervisors. The Department Director at the time immediately directed the Department’s Human Resources Office to conduct a workplace assessment to identify specific issues. In the course of that assessment, both supervisors resigned.
NEMT Update
January 2020
Matt Wimmer
Medicaid Division Administrator

IDAHO DEPARTMENT OF HEALTH & WELFARE
Non-Emergency Medical Transportation

Program Overview

- Non-emergency medical transportation (NEMT) is a required Medicaid benefit.
- Designed to get individuals to and from medical appointments
- Transportation and lodging for medically necessary long-distance/out-of-state travel are covered.

About 1.7 Million trips provided in 2019.
Non-Emergency Medical Transportation

Brokerage
- Idaho's NEMT program is administered through a brokerage model (since 2010).
- The broker contracts with a network of transportation providers.
- The current NEMT broker is Medical Transportation Management (MTM).
- The broker is paid on a per-member per-month basis.
Non-Emergency Medical Transportation

History

- Previous broker Veyo terminated contract in 2017.
- Under state purchasing regulations, the contract passed to MTM in March 2018.
- Rapid transition was challenging.
- Provider rates had stagnated.
- Requested rate increase in 2019; delivered in July 2019.
- Amended contract to retain broker and increase rates.
During the 2019 Legislative Session, the Joint Legislative Oversight Committee requested that the Office of Performance Evaluation review the NEMT brokerage to:

- Examine effectiveness of model
- Compare models with respect to:
  - Costs
  - Rates
  - Requirements
  - Structure
  - National standards
"The division can strengthen its management of the risks inherent to a capitated payment structure through three key improvements:"

1. Analyze program cost drivers
2. Plan for rate adjustments
3. Develop a contract monitoring process that includes independent verification

Other recommendations: Incorporate lessons from IBHP review and University of Illinois report
NEMT program initiatives

OPE recommendation #1
Analyze service delivery costs to make sure appropriate rate methodologies are used in the NEMT program.

Medicaid actions
- Work with an accounting firm to examine costs
- Analyze service utilization by geographic region and member eligibility category
OPE recommendation #2
Proactively plan for annual rate adequacy reviews.

Medicaid actions

- Conduct annual rate reviews to ensure actuarial soundness
- Development of Request for Proposal (RFP) with provisions for annual rate adjustments based on use, cost, and quality of services
OPE recommendation #3
Improve a robust contract monitoring process.

Medicaid actions

- Strategic leadership changes to improve accountability, ownership, oversight, and quality.
- Work with managed care consultants to refine contract monitoring and data analysis activities.
- Amended contract to include additional performance metrics and to outline financial penalties associated with performance metrics.
OPE recommendation #3
Implement a robust contract monitoring process.

Medicaid actions

- Develop an independent complaint database that includes a web-based submission form for customers and stakeholders to quickly submit concerns to Medicaid
- Consult other states’ NEMT programs
- Conduct independent complaint investigations
2019 Complaints Data

The NEMT team has analyzed complaints submitted through various channels during calendar year 2019.
Performance monitoring

2019 Total Complaints and Escalated Complaints

January: 204
February: 166
March: 189
April: 167
May: 163
June: 186
July: 169
August: 175
September: 137
October: 183
November: 124
December: 134

January: 21
February: 26
March: 23
April: 18
May: 19
June: 31
July: 28
August: 23
September: 25
October: 7
November: 18
December: 134
2019 Complaints Data

% of Complaints to Total Trips

January: 0.14%
February: 0.13%
March: 0.14%
April: 0.11%
May: 0.11%
June: 0.14%
July: 0.11%
August: 0.12%
September: 0.10%
October: 0.12%
November: 0.09%
December: 0.10%
Current procurement activities

- Contract ends April 4, 2021
- Projected RFP release – Spring 2020
- Compiling RFI responses received Dec. 2, 2019
- Planning stakeholder engagement
- Incorporating University of Illinois and OPE recommendations
- Working with managed care experts on model contract language
- Researching NEMT best practices used in other states
Matt Wimmer, Administrator
Department of Health and Welfare
Division of Medicaid
matt.wimmer@dhw.idaho.gov
(208) 364-1831
Southwest Idaho Treatment Center

Legislative Report 2020

JANUARY 21, 2020

Idaho Department of Health and Welfare
Division of Family and Community Services
Contents

Introduction/Historical Reminder

Strategic Plan and Quality Improvement
   Staff Safety
   Client Safety
   Facility and Staffing Improvements
   Management and Professional Development

Long Term Vision for Individuals with Developmental Disabilities and Complex Needs
   New Treatment Model
   Implementation Plan

Appendices
   Report Highlights
   Advisory Board Bylaws
Introduction/Historical Reminder

Transition of Mission and Goals: In 2009, the Southwest Idaho Treatment Center (SWITC), was directed by the legislature to reduce the population at SWITC. This direction resulted in SWITC downsizing rapidly from a population of 75 clients in 2008 to 17 clients in 2018. The purpose for this transition was to support individuals with developmental disabilities in their communities whenever possible. At that time, the mission of SWITC also changed from being a long-term home for clients to a short-term stabilization and treatment center for individuals in crisis.

SWITC fulfills its mission of a short-term treatment center. The population at SWITC continues to decrease.

The state was effective in reducing placements at SWITC, however, with that reduction, the profile of the population that remained and their treatment needs also changed. Residents at SWITC are individuals with developmental disabilities who have the most complex, behavioral needs in the state.

All of SWITC's residents have significant developmental disabilities, often in combination with mental illness, and aggressive and/or self-abusive behaviors that preclude them from being supported in the community for extended periods of time. Residents only come to SWITC and remain at the facility when there are no community options or placements currently available to them.

The licensure and treatment at SWITC must address the changing behavioral and service needs of our clients. SWITC is licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The ICF/IID license is designed for the general population of people with developmental disabilities for long-term residential care. Although this licensure is very effective in treating the general population with Developmental Disabilities, SWITC has "grown out" of this licensure as this type of license is not designed to effectively deal with the acute mental illness, aggressive behaviors, or significant self-abusive behaviors exhibited by the residents at SWITC.

The residents at SWITC all have unique and complex needs.

100% of the residents have the following:

- Intellectual Disability (mild, moderate, severe or profound impairment)
- Mental Health Diagnosis (bipolar, psychosis, major depression, anxiety)
- Dangerous Behavior (physical aggression or self-injurious behavior)
History of Facility Issues: In 2015, the department attempted to sell the land at SWITC and rebuild the facility in another location, but the land sale was not completed, and the project was abandoned. In 2017, SWITC administration discovered that a small group of SWITC staff had engaged in acts that were abusive to clients and corresponding investigations resulted in six staff either being terminated for cause or resigning from the facility. The investigations brought scrutiny to the facility in the form of licensure investigations and findings requiring improvements over the next year and a half. In the fall of 2018, both Disability Rights Idaho (DRI) and the Office of Performance Evaluation (OPE) released reports and recommendations to address issues at the facility.

OPE Recommendations: The Office of Performance Evaluations made recommendations to address system-wide issues and issues with SWITC’s operations and treatment standards. The Office of Performance Evaluations believed the key to making long -term progress rested with two core recommendations. Those recommendations were for the Department of Health and Welfare to:

- Develop a strategic plan and a formal quality improvement process at SWITC.
- Develop a long-term vision for Idaho’s system of crisis care and its role as provider of last resort for those with intellectual disabilities.

The Department Seeks Solutions: As reported in the OPE report, addressing the issues at SWITC ultimately comes down to finding an appropriate treatment model for the very small sub-set of individuals with developmental disabilities that have the complexity of treatment needs as the residents at SWITC.

Today 99.8 percent of DD clients in Idaho are effectively and successfully served in community placements or in their own homes with resources and services through Home and Community Based Services. Less than one percent of the population have not been successful in a long-term community setting because of the complex and difficult behaviors and trauma they have faced. This small group of individuals who would be well supported by a new model of care.

Over the past year, the department has had over 60 meetings with stakeholders, experts, department leaders and community partners to develop a strategic plan and to identify a long-term vision for the population currently served at SWITC. The department welcomes this opportunity to provide you with our progress on our Strategic Plan, Quality Improvement, and Long-Term Vision for Individuals with Developmental Disabilities and Complex Needs.
Strategic Plan and Quality Improvement

In 2019, the department developed a Strategic Plan to proactively address priority areas of improvement. These areas included staff safety, facility improvements and management and professional development. The department is pleased to report our successes in these areas.

Staff Safety

Staff trauma and injury: SWITC has seen a decrease in Worker Compensation injuries and claims over the past two years. The following improvements related to staff trauma and injury have been made:

- SWITC formed a safety workgroup that includes direct care staff. This workgroup reviews staff injuries and safety issues to reduce injuries and threats at the facility.
- Self-Care and Employee Assistance Provider information is provided and promoted weekly.
- A 24-hour Response Team has been hired and is being trained to react to and deescalate client behaviors and prevent injury. The team will be deployed in February 2020.

Understaffing: SWITC has improved staffing in both quality and quantity. SWITC is currently at or above our ideal staffing and over the last nine months, SWITC has hired more staff than it has lost. The following improvements related to understaffing have been made:

- Direct Care staff have moved to four ten-hour shifts which allows for flexibility in scheduling and better overall shift coverage. According to a recent staff survey, staff also like this schedule.
- A full-time recruiter was hired to help fill key direct care and supervisory positions.
- Pay schedule changes in 2018 provide incentives for staff to continue developing their skills through training and certifications and staff are rewarded for performance and longevity.
- SWITC hired more employees than it lost in five of the past nine months.

SWITC is currently at or above ideal staffing.
Facility and Staffing Improvements

Shift to proactive approach to treatment: SWITC has made strides to become less reactive to crisis and move towards more proactive, organized methods of improvements. In 2019, the following improvements related to a proactive approach to treatment have been made.

- A Sensory Room was created for each unit. These areas are places where residents can calm and work on sensory processing needs as identified by assessment.
- The department has approved the installation of key card access to the units. This safety measure will not prevent egress from the buildings but will limit who can enter.
- The department hired a Recreational Therapist to improve day to day client activities and learning. Additionally, a therapy dog is being trained to work with our clients as a new feature this spring.
- The department has hired additional Board Certified Applied Behavioral Analysts to improve expertise and informed care models for Active Treatment planning.
- Four Licensed Practical Nurse positions have been reclassified and filled with Registered Nurses to improve medical oversight and treatment.
- An Investigator was hired in May of 2019. He received certification training and pursuing certification as a Certified Forensic Interviewer.
- A Licensed Clinical Social Worker was hired to provide counseling to families and clients.
- SWITC’s Qualified Intellectual Disabilities Professional attended national certification training and is in the process of completing certification requirements.
- Two clinical staff were trained to teach advanced Crisis Prevention Interventions.
- Client to staff ratio supports active treatment goals at an average of two direct care staff for every three residents.

Discharge process: SWITC continues to fulfill its mission to transition individuals to effective community placements for long-term services as quickly as possible. The average number of residents serviced, and their average length of stay, has declined since 2011. In 2019, the department coordinated across programs to improve the discharge process for residents transitioning to the community. Coordination activities included:

- SWITC and the DD Crisis Prevention and Court Services Team worked together to develop outcome measures that will be used in post discharge plans of care.
- Improved availability of Crisis and SWITC staff to the residents and private providers after the resident has discharged from the facility.
- Meetings with the Division of Medicaid to develop a long-term plan on how to expedite discharge and access to community service once a client is ready to transition.
Management and Professional Development

Leadership and management: SWITC has made improvements to the leadership and management of staff at the facility. In 2019, the following improvements related to management have been made:

- The management team formed specialized workgroups with crisis teams and treatment teams to conduct individualized analysis of client population.
- An extensive Quality Management program was adopted with two staff assigned quality assurance/quality improvement as their primary duty.
- With the addition of five Board Certified Behavioral Analysts, SWITC is now able to offer direct care staff supervision, and national certification of direct care staff as Registered Behavioral Technicians.

Increased training and supervision

- Staff received additional training from the National Association of Dual Diagnosis around providing trauma informed services.
- All staff and clients are trained on abuse and neglect identification and prevention.
- New staff orientation training increased to two weeks of class time followed by a full week of job shadowing.
Long-Term Vision for Individuals with Developmental Disabilities and Complex Needs

The director of the department convened a SWITC Advisory Board in the fall of 2018 and tasked it with making recommendations and exploring options for the right treatment model to serve SWITC’s unique population. The Advisory Board membership is comprised of members of the Idaho Legislature, a representative of the Governor’s office, a parent of an individual residing at SWITC, advocacy groups, law enforcement, corrections, and the courts.

This Board met several times throughout the past year to explore current systems and ideas related to individuals with disabilities and complex needs. Through this exploration, the Board identified that the developmental disability system in Idaho needs clearly identified services or structures for individuals with a developmental disability and acute or subacute needs.

Based on this conclusion, the Board created a new treatment model for individuals with developmental disabilities and complex needs at SWITC. The new model includes a more robust continuum of care and will better serve the population of individuals who currently reside at SWITC.

**New Treatment Model**

Three new components will be added to Idaho’s continuum of care at SWITC; an assessment and observation unit, a step-down facility and enhanced community placements.
**Assessment, Observation and Stabilization Unit:** This unit will serve clients in crisis, often who need extensive and urgent psychiatric and behavioral intervention. This new acute level of care may feature some restrictive elements as determined individually by patient need. Clients may stay at this level of care until they can tolerate a lower level of services, but the length of stay is intended to last approximately three to six months.

**Step Down Treatment:** As a client’s acute needs stabilize, they will move to this step-down facility. The step-down facility will model community living with residents living in small apartment-like units with one or two individuals per units. These units would be on a shared campus so that staff resources could be shared. Significant psychiatric and behavioral services will be available to residents, but the primary focus in this subacute level of care will be to assist residents in developing skills that are necessary to live in the community. Clients will stay in the step-down facility until they can safely move to the community, but the length of stay is intended to last less than three years.

**Community Capacity Building:** There are two subsets of residents currently living at SWITC that can be served in the community with the development of specialized providers. Currently, a few clients with significant communication limitations and behaviors often associated with autism, and clients who have specialized skilled nursing needs along with significant behaviors cannot be served safely in the community. The Advisory Board recommended capacity building of private providers to enable safe and effective care in the community. Capacity building efforts may include the development of new services with specially trained and resourced providers.

Below is a visual representation of the Advisory Board’s recommended treatment model with the new components to Idaho’s continuum of care represented by boxes with dashed lines.
Implementation Plan

Implementing an effective system of care for individuals with developmental disabilities and complex needs is one of the department's Strategic Objectives. Over the past year, the department has worked with the Advisory Board, stakeholders, department leaders, and community advocates to develop the proposed treatment model. Based on that work, we know what services should be added, but must now grapple with how to provide these services under new licenses, funding streams, possibly in new locations and with new staff expertise.

A cross-divisional department project team has been developed to address these needs. Sponsorship of the project comes from the Divisions of Behavioral Health, Medicaid, Family and Community Services, and Licensing and Certification. Under their direction, the implementation of the new treatment model will require significant policy and operational work such as stakeholder engagement, provider negotiations, construction of buildings and communication with federal partners. This work will occur within each of the three prongs of development:

1. Assessment Observation and Stabilization Unit
2. Step-Down Treatment
3. Community Capacity Development

The department's goal is to bring a plan and foundation that establishes the new treatment model to the 2021 Legislative Session. With legislative approval, the department can move forward with its plan to transition to the new model of care. Many factors will affect future timelines including:

- The possible use of private providers
- The building of facilities
- Whether solutions will require federal approval
The Southwest Idaho Treatment Center is a short-term stabilization and treatment center for individuals with developmental disabilities who are in crisis.

Residents at SWITC have unique and complex needs.

- Intellectual Disability (mild, moderate, severe or profound impairment)
- Mental Health Diagnosis (bipolar, psychosis, major depression, anxiety)
- Dangerous Behavior (physical aggression or self-injurious behavior)

100% of the residents have the following:

Residents at SWITC represent less than 1% of individuals who receive DD services in Idaho.

In 2019, the Department developed a Strategic Plan to proactively address priority areas of improvement.

Plan implementation has resulted in the following:

- Workers Compensation claims are decreasing.
- SWITC is currently at or above ideal staffing.
- SWITC hired more employees than it lost.
- Key positions were filled. Staff census increased.
- Staff turnover has reduced.
- Client to staff ratio supports active treatment.
- Resident census continues to decline.
- Resident length of stay continues to be low.

Over the past year, the Department worked with:

- An Advisory Board,
- Community Stakeholders,
- Department Leaders, and
- Disability Advocates

...to develop a new treatment model for individuals with developmental disabilities and complex needs.

Treatment Model Components

<table>
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<tr>
<th>Community Services</th>
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<tr>
<td>Community Residential Habilitation</td>
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<td>Community Facilities</td>
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<tr>
<td>Adult Autism Services</td>
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<tr>
<td>Specialized Skilled Nursing</td>
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More than 60 meetings were held to identify a long-term vision.
Medicaid Expansion Update

Wednesday, January 22, 2020

Lori Wolff
DHW Deputy Director
Medicaid Expansion in Idaho

Overview
Enrollment
Waivers
Providers
Website
Questions
Medicaid Expansion OVERVIEW
The Expansion State Plan Amendment was approved, and coverage began Jan. 1., 2020. Medicaid expansion provides coverage to non-disabled adults with an annual household income up to 138 percent of the Federal Poverty Level.

Implementation of SB1204 required four waivers to be filed with CMS and CCIIO:

- Coverage Choice
- Work Requirements
- Family Planning Services
- Idaho Behavioral Health Transformation/IMD
## Expanded Medicaid income eligibility

### Gross Income for Adult Coverage

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<td>$4,486</td>
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<td>8</td>
<td>$4,994</td>
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<tr>
<td>Each additional member</td>
<td>+ $508</td>
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</table>
Enrollment and eligibility

Enrollment methods
1. SNAP Re-evaluations beginning July 2019
2. Specialized Enrollment for target populations (Behavioral Health)
3. Applications submitted beginning Nov. 1, 2019
4. APTC renewal process beginning October 2019

Eligibility Process
1. Signed application
2. Verification of information (interface or manual)
3. Mailed notices outlining eligibility
4. Ability to opt out of Medicaid
## Current Medicaid Expansion enrollment

57,794 Enrolled

*Updated Thursday, Jan. 16, 2020*

### EXPANSION ENROLLMENT BY COUNTY

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<td>VALLEY</td>
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<td>WASHINGTON</td>
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### EXPANSION ENROLLMENT BY DISTRICT

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<td>35</td>
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Federally required Medicaid benefits

Ambulatory Medical Services: primary care, specialist care, outpatient surgery, and other outpatient medical services
Emergency Services: emergency room services and ambulance
Hospital Services: inpatient services, including physician, surgery, and radiation therapy
Maternity and Newborn Care: prenatal, postnatal, and maternity care
Mental Health and Substance Use Disorder Services: individual, family, and group counseling, and other outpatient and inpatient mental health and substance use disorder services
Prescription Drugs: all FDA approved drugs required under federal coverage provisions
Rehabilitative and Habilitative Services and Devices: physical, occupational, and speech therapy, durable medical equipment and supplies, rehabilitative nursing facility services, and other habilitative services
Laboratory Services: diagnostic lab tests and imaging such as X-rays and CT/PET/MRI
Preventive and Wellness Services: includes preventive screenings, immunizations, diabetes education, tobacco cessation
Pediatric Services: routine eye exams, medically necessary orthodontia, eyeglasses, dental services

Additional Idaho Medicaid Services

• Optometrist Services
• Podiatrist Services
• Chiropractic Services
• Dental Services
• Preventive Health Assistance
Primary Care Enrollment

- About 13% (~7,400) of new participants have already chosen their primary care provider
- During their first 90 days of enrollment, participants can go to any provider without referral
- If they don’t select a primary care provider within 90 days, Medicaid will assign one
- Provider survey indicates strong availability of primary care throughout Idaho
- 90+% of Primary Care Providers are enrolled with Idaho Medicaid
Idaho Medicaid healthcare providers

Idaho Physicians, Nurse Practitioners and Physician Assistants Enrolled per Insurance Plan

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<th>Insurance Plan</th>
<th>Unique Count of National Provider Identifiers</th>
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<td>Idaho Medicaid</td>
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<td>Select Health</td>
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<td>Pacific Source</td>
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<tr>
<td>BCI</td>
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</table>
Percent of Idaho Physicians, Nurse Practitioners and Physician Assistants Enrolled per Insurance Plan and Idaho Medicaid

- BCI: 84% (84%), 16% (16%)
- Pacific Source: 85% (85%), 15% (15%)
- Select Health: 71% (71%), 29% (29%)
- MHC: 64% (64%), 36% (36%)

Key:
- ■ Percent of Providers Enrolled in Idaho Medicaid and Other Insurance
- ● Percent of Providers Enrolled in Other Insurance and not in Idaho Medicaid
Medicaid Expansion WAIVERS
<table>
<thead>
<tr>
<th>Coverage Choice</th>
<th>Draft application 8 weeks</th>
<th>Tribal/Public Notice and comment 30 days</th>
<th>Review comments and submit application 1 - 2 weeks</th>
<th>Review letter of completion from CMS 1 - 2 weeks</th>
<th>Negotiate terms and conditions 6 - 12 weeks</th>
<th>Wait for Federal approval 8 - 16 weeks</th>
<th>Implement waivers 6 months</th>
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<tr>
<td>Work Requirements</td>
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<td>Family Planning</td>
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</table>
Work Requirements Waiver

Requires that individuals are working at least 20 hours a week as a condition of being eligible.

Status: Submitted Sept. 27, 2019 and awaiting federal approval.

National Status:
10 States approved
6 states have lawsuits
10 states have submitted applications/pending
No state currently has work requirements implemented for Medicaid
Idaho Behavioral Health Transformation/IMD Waiver

Allows individuals with Medicaid coverage to receive inpatient treatment for mental health and substance use disorders in a freestanding psychiatric hospital.

Status: Submitted on Jan. 3, 2020 and awaiting federal approval.

26 states have received similar waivers for substance use disorder. Washington D.C. and Indiana have received a waiver for both substance use disorder and serious mental illness treatment. Idaho expects to be the first state approved for substance use disorder coverage through a State Plan Amendment.
Family Planning Services Waiver

Requires individuals seeking family planning services to have a referral from their assigned medical home if the family planning service providers is outside the patient's established medical home.

**Status:** Submitted Oct. 21, 2019 and awaiting federal approval.

South Carolina, Tennessee, and Texas have applied for family planning waivers and all are pending a federal decision.
Coverage Choice Waiver

Allows Idahoans the choice to maintain their private insurance with the tax credit rather than enrolling in Medicaid.

Status: Determined incomplete. DHW and the Department of Insurance are working to resubmit the application.

A challenging approval path: Consumer Information and Insurance Oversight (CCIIO at CMS) and Treasury (IRS) must approve.

Idaho’s waiver request is the first of its kind. Idaho’s waiver must prove budget neutrality.
QUESTIONS & OPEN DISCUSSION
# AMENDED AGENDA #1

**SENATE HEALTH & WELFARE COMMITTEE**

3:00 P.M.

Room WW54

Thursday, January 23, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
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<td>RS27420C1</td>
<td>Relating to Hemp and FDA-Approved Medical Cannabis.</td>
<td>Senator Mary Souza</td>
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<tr>
<td>Docket No.</td>
<td>Department of Health and Welfare, Medicaid Basic Plan Benefits,</td>
<td>David Welsh, Bureau Chief, Division of Medicaid</td>
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<tr>
<td>16-0309-2001</td>
<td>Page 3</td>
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<tr>
<td>Temp</td>
<td>Department of Health and Welfare, Medicaid Basic Plan Benefits,</td>
<td>Michael Case, Program Manager, Division of Medicaid</td>
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<tr>
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<tr>
<td>Docket No.</td>
<td>Department of Health and Welfare, Medicaid Enhanced Plan Benefits,</td>
<td>Mr. Case</td>
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<tr>
<td>16-0310-1806</td>
<td>Page 1175</td>
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<tr>
<td>16-0318-1901</td>
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</table>

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**

Chairman Martin Sen Burtenshaw
Vice Chairman Souza Sen Bayer
Sen Heider Sen Jordan
Sen Lee Sen Nelson
Sen Harris

**COMMITTEE SECRETARY**

Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 23, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Burtenshaw, Bayer, Jordan, and Nelson
ABSENT/EXCUSED: Senators Lee and Harris

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.

CONVENE: Chairman Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:00 p.m.

RS 27420C1 Vice Chair Souza presented RS 27420C1, which allows for cannabidiol (CBD) oil, a derivative of hemp with 0.3 percent tetrahydrocannabinol (THC) or less, that Idahoans may use for possible pain relief. It also recognizes that there are currently available in Idaho, by prescription, several legal, FDA-approved, cannabinoid medications offering high levels of THC or CBD for the treatment of various conditions.

MOTION: Senator Jordan moved to print RS 27420C1. Senator Bayer seconded the motion. The motion carried by voice vote, with Senator Burtenshaw requesting he be recorded as voting nay.

PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza.

DOCKET NO. 16-0309-2001 Department of Health and Welfare, Medicaid Basic Plan Benefits. David Welsh, Bureau Chief over Care Management, Division of Medicaid, Department of Health and Welfare (Department), stated the Department is asking for an extension on this temporary rule. The purpose of this docket is to remove all IDAPA references to the Institutions for Mental Diseases (IMD) exclusion. This docket supports S 1204 (2019) which required the Director of the Department to research options and to apply waivers for substance abuse and/or mental health services in IMDs. Historically, IMDs have not been eligible to receive Medicaid payment for services provided to individuals aged 21-64. In recent years, the federal government has provided new mechanisms and authorities for states to finance IMD services for non-elderly adults through Medicaid in certain situations. Mr. Welsh stated the Department did not engage in negotiated rulemaking because this is a temporary rule; however, the public comments received were overwhelmingly positive. Without a waiver in place, the only option for patients with serious mental illness is admission to the psychiatric unit of an acute hospital, which is the most expensive setting of all for psychiatric treatment. See attachment 1.

Mr. Case said, given the mandate, the Department chose to move all children's intervention services (not just those for children with autism spectrum disorder) out of the 1915(c) waivers, cover the intervention services as State Plan Basic Plan Benefits, and allow the 1915(c) children's waivers to expire on June 30, 2019. To align Idaho's administrative rules with these coverage changes, the descriptions of intervention services were moved from IDAPA 16-03-10 into IDAPA 16-03-09 where State Plan Basic Plan Benefits are described.

Mr. Case indicated that without these changes, the Department would not be able to offer intervention services to children under the State Plan or revert back to offering those services under the 1915(c) waiver, because they would have expired.

DISCUSSION: Committee discussion referred to interventions and that stimuli not be painful. An inquiry was made regarding vocational and educational services.

MOTION: Chairman Martin moved to approve Docket No. 16-0309-1803. Senator Nelson seconded the motion. The motion carried by voice vote.

DOCKET NO. 16-0310-1806

Department of Health and Welfare, Medicaid Enhanced Plan Benefits. Mr. Case said this is a companion docket to the one previously presented. The previous docket made changes to support services, and this docket will describe the deletions and restructuring that were required in order to accomplish the changes. The 1915(i) support services were revised concerning respite, family education, community-based supports, and family-directed community supports. Mr. Case said that the changes in these two dockets are dependent upon one another, and the stakeholder engagement was the same. It included stakeholder engagement for more than four years and a Children's Enhancement Project Team was formed. Meetings were held monthly to discuss needed changes. The draft rule was published July, 2018 and nine public meetings were held to gather public feedback. The draft rule was revised and presented between September 2018 and March 2019. The temporary rule went into effect July 1, 2019. See attachment 3.

DISCUSSION: Senator Jordan asked about the reference to "restrictive words" and if that would affect quality or delivery of services. Mr. Case replied that they would not affect services; rather, the removal of "restrictive words" would make it less burdensome on the providers of the services.

MOTION: Senator Heider moved to approve Docket No. 16-0310-1806. Senator Jordan seconded the motion.

DISCUSSION: Chairman Martin read the analysis from the Legislative Services Office. It stated: "These temporary and proposed rules transfer some children's intervention services from a waiver to the Medicaid's State Plan. These changes are necessary for Idaho to continue to receive federal financial participation for these services. The Governor finds that the temporary rules are justified because the rules confer a benefit and are necessary for continued federal funding."

VOICE VOTE: The motion to approve Docket No. 16-0310-1806 carried by voice vote.
DOCKET NO. 16-0318-1901

Department of Health and Welfare, Medicaid Cost-Sharing. Ali Fernandez, Bureau Chief for the Bureau of Long Term Care, Division of Medicaid, Department of Health and Welfare, presented this docket. The rules are being amended to accomplish two objectives associated with participating cost sharing for home and community-based services. They are to clarify exemptions and to update the personal needs allowances used in the cost-sharing calculation to align with federal requirements. Exempt participants are Native Americans and Alaskan Native participants, as well as participants who are eligible via the Medicaid for Workers with Disabilities program. This rule simplifies the calculation for cost-sharing by streamlining the personal needs allowance figures and ensures that a member retains enough disposable income to cover living expenses not covered by Medicaid, such as rent, utilities, and food. This change will result in ongoing savings of up to $46,606.20 per year. These savings are realized from the corresponding increase in cost-sharing that some participants will experience due to their personal needs allowance decreasing. Approximately 30 participants currently receiving services will experience an increase. See attachment 4.

A negotiated rulemaking session was hosted on June 18, 2019, and a public hearing on October 8, 2019. Three comments were received. One comment was in support for both components of this rule change and two expressed concerns. Aligning the personal needs allowance will ensure the Centers for Medicare and Medicaid Services (CMS) continues to authorize the administration of Idaho's home and community-based services programs.

DISCUSSION: Ms. Fernandez discussed the extra costs due to more participants and the total number of program participants.

MOTION: Chairman Martin moved to approve Docket No. 16-0318-1901. Senator Heider seconded the motion. The motion carried by voice vote.

PASSED THE GAVEL: Vice Chair Souza passed the gavel to Chairman Martin.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:45 p.m.

__________________________________________  ________________
Senator Martin  Margo Miller
Chair  Secretary

Juanita Budell
Assistant to the Secretary
Chairman Martin (Senate) / Wood (House) and members of the committee, my name is David Welsh and I am the Bureau Chief over Care Management in the Division of Medicaid. The Department is asking you to EXTEND the temporary rule in docket number 16-0309-2001. This docket is in your rules review book on pages 350 – 354.

PAUSE

The Division of Medicaid developed this rulemaking in compliance with the Red Tape Reduction Act. Changes in this docket reduced the total word count for this chapter by 59, and the number of restrictive words was reduced by 1.

The purpose of this docket is to remove all IDAPA references to the Institutions for Mental Diseases (IMD) exclusion. This docket supports Senate Bill 1204, enacted in the 2019 Legislative session. Senate Bill 1204 requires the Director of the Department of Health and Welfare to “research options and apply for federal waivers to enable cost-efficient use of Medicaid funds to pay for substance abuse and/or mental health services in IMDs.”

The institutions for mental diseases (IMD) exclusion has been in place in Medicaid statute since 1965. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes substance use disorders (SUDs).

Historically, IMDs have not been eligible to receive Medicaid payment for services provided to individuals aged 21-64. However, in recent years, the federal government has provided new mechanisms and authorities for states to finance IMD services for nonelderly adults through Medicaid in certain situations.

In response to the legislative direction in Senate Bill 1204, the Division of Medicaid submitted applications to CMS for two new authorities that waive the IMD exclusion in federal law and allow reimbursement for IMD services:

1. A Section 1915(l) state plan option, which would allow reimbursement for IMD services related to a substance use disorder (SUD) diagnosis. This state plan option was submitted to CMS on September 30th. CMS intends to approve this authority with an effective date of January 1, 2020.

2. A Section 1115 demonstration waiver, which will cover both mental health and SUD services in IMDs. The Department submitted this waiver on January 3, 2020 and received a letter of completeness for this submission on January 9, 2020. We are working with closely with our partners at CMS to expeditiously review and approve this waiver.
This temporary docket has an effective date of January 1, 2020. This effective date was required in order to coincide with the effective date of the 1915(I) state plan option. By aligning these dates, the Division of Medicaid was able to begin reimbursing SUD services provided in an IMD on the same day as expanding Medicaid to the new adult population.

Because these are temporary rules, the Department did not engage in negotiated rulemaking. The public comment period for the 1115 IMD waiver opened on November 22nd and closed on December 24th. Public hearings were held in Boise on December 2nd and 3rd, with an available conference line for those unable to attend in person. This provided stakeholders an opportunity to give feedback on the proposed changes. The public comments received about this waiver are overwhelmingly positive.

These rule changes are not expected to have any fiscal impacts on the State General Fund. During the 2019 legislative session, action by the Joint Finance Appropriations Committee shifted budget dollars from the Division of Behavioral Health and the Department of Correction to the Division of Medicaid to pay for costs of Medicaid Expansion, including the costs of the waivers set forth in Senate Bill 1204. Additionally, Idaho Medicaid was required to demonstrate cost neutrality of this 1115 waiver to CMS.

The Department anticipates the 1115 waiver will have significant positive impacts on the Idaho behavioral health continuum of care. This waiver will be instrumental in helping to reduce opioid overdoses and suicide rates in Idaho. Without a waiver in place, the only option for patients with serious mental illness is admission to the psychiatric unit of an acute hospital, which is the most expensive setting of all for psychiatric treatment.

The Department asks that the committee EXTEND these temporary rules.

Thank you – I stand for your questions.
Legislative Presentation - 16-0309-1803 – Children’s Habilitation Intervention Services

INTRODUCTION
Mr. Chairman/Madam Chair, members of the Committee, thank you for the opportunity to come before you today. My name is Michael Case and I am a Policy Program Manager for the Division of Medicaid within the Department of Health and Welfare. I am here today to present two companion docket related to children’s intervention services and supports. At this time, I will present docket 16-0309-1803 that begins on page 1145 of your Pending Rules Review Book.

The Department would like the committee to approve these pending rules as final which were implemented as temporary rules with an effective date of July 1, 2019.

DESCRIPTION
During this presentation I will be referring to the State Plan and to 1915(c) waivers. The State Plan is our agreement with the Centers for Medicare and Medicaid Services (CMS) about Medicaid eligibility, medically necessary services and supplies, provider payment, and federal financing. Federal law requires that services included in the State Plan must be made available to any Medicaid participant that has a need for the service. These services are included in the State Plan Basic Plan Benefits described in IDAPA 16.03.09.

However, section 1915(c) of the Social Security Act allows CMS to waive this requirement. With an approved 1915(c) waiver, a state may provide home and community-based services (not otherwise available under the State Plan) to a targeted population. These waiver services are described in IDAPA 16.03.10.

In 2014, CMS issued an Informational Bulletin directing states to move intervention services for children with autism spectrum disorder from a Home and Community-Based 1915(c) waiver into the State Plan. These rules are being revised to comply with this mandate.

Prior to July 2019, Idaho’s approved 1915(c) children’s waivers targeted children with a developmental disability who also qualify for an institutional level of care because of identified functional and/or behavioral limitations. Because Idaho Statute includes autism in its definition of developmental disabilities, children with autism spectrum disorder received intervention services under the same 1915(c) waivers as children with other developmental disabilities.

All children receiving 1915(c) waiver services were assigned a budget to purchase all supports and services needed by the child, including intervention services. The amount and frequency of intervention services may have been decided more by the child’s
budget than by the child’s need. That is, they may have chosen to forego needed intervention services for less costly supports to stay within budget.

Given the mandate, the inclusion of autism in Idaho’s statutory definition of developmental disability, and the Department’s desire to ensure all Medicaid eligible children with an identified need were able to access intervention services, the Department chose to (i) move all children’s intervention services (not just those for children with autism spectrum disorder) out of the 1915(c) waivers, (ii) cover the intervention services as State Plan Basic Plan Benefits, and allow the 1915(c) children’s waivers to expire on June 30, 2019. To align Idaho’s Administrative rules with these coverage changes, the descriptions of intervention services were moved from IDAPA 16.03.10 (where waiver services are described) into IDAPA 16.03.09 where State Plan Basic Plan Benefits are described.

Specifically, children’s habilitation intervention services are medically necessary therapeutic techniques based on applied behavior analysis. These services include Habilitative Skill Building, Behavioral Intervention, Interdisciplinary Training, and Crisis Intervention. The revised rule provides for these services to be delivered in both evidence-based and evidence-informed service delivery models.

Additionally, a tiered provider reimbursement structure was also created to improve access and service quality. Under this structure, existing providers may continue to provide services, and all existing and new provider types are able to seek reimbursement in accordance with their credential. This structure also allows for the addition of an independent provider type. The Department believes these changes will create an environment that maintains existing providers, allows for professional growth within the field, and encourages recruitment of new providers.

Without these changes, the Department would not be able to offer intervention services to children under the State Plan and is not able to revert back to offering those services under the 1915(c) waiver because they have expired.

PUBLIC INVOLVEMENT
The Department conducted extensive stakeholder engagement for more than four years. Prior to drafting the initial rule changes, the Department formed a Children’s Enhancement Project Team. Workgroups composed of Department staff, participant families, community professionals, community providers, school-based service providers, advocacy groups, and other interested stakeholders were established. These workgroups included a Clinical Advisory Group, a Provider Advisory Group, two Family Advisory Groups – Traditional and Family Directed – and a Fiscal Workgroup. Meetings were held at least monthly to discuss needed changes, conduct research, and suggest language for revised or new rules.
Based on the work of the advisory groups, draft rule language was prepared and presented to stakeholders in May of 2018. The Department published a Notice of Negotiated Rulemaking in the July 2018 Administrative Bulletin and held nine (9) public meetings to gather feedback. Based on the feedback received during those meetings, the Department chose to continue the negotiation process.

The draft rule was revised and then presented to stakeholders, section by section. Between September 2018 and March 2019, the Childrens Enhancement Project Team traveled to each region of the state each month and presented a section of the revised rule, sought feedback, and responded to questions. Rule language was then revised based on stakeholder input, and a new section of rule was presented the next month. Once all sections were reviewed, a full draft was compiled and presented to stakeholders across the state.

A Notice of Temporary and Proposed Rulemaking was published in the July 2019 Administrative Bulletin, and the Temporary Rule went into effect July 1, 2019. The Public Hearing for the Proposed Rule was held July 17, 2019. Feedback was received and updates were made, resulting in the pending rule before you.

FISCAL IMPACT
Because these rules were implemented as temporary rules, the fiscal impact analysis was completed, and the cost increase was requested for Medicaid’s 2020 Budget and approved for funding by the 2019 Legislature.

CONCLUSION

RED TAPE REDUCTION STATEMENT
In accordance with the Red Tape Reduction Act, efforts were made to simplify language and remove redundancies during the drafting of these rules. Additions in this docket, together with deletions in the companion docket I will be presenting, have resulted in a decrease of 738 words overall, including the reduction of 48 restrictive words.

I ask you approve this Pending rule as final.

Mr. Chairman/Madam Chair, members of the Committee, this concludes my presentation. Thank you for your time. I stand for questions.
Legislative Presentation - 16-0310-1806 – Children’s Habilitative Support Services

Mr. Chairman/Madam Chair, members of the Committee, thank you for the opportunity to come before you today. My name is Michael Case and I am a Policy Program Manager for the Division of Medicaid within the Department of Health and Welfare. I will now present docket 16-0310-1806 that begins on page 1175 of your Pending Rules Review Book. This is the companion docket mentioned in my previous presentation.

The Department would like the committee to approve these pending rules as final which were implemented as temporary rules with an effective date of July 1, 2019.

DESCRIPTION
In my previous presentation I discussed moving children’s intervention services out of the approved 1915(c) children’s waivers and into the State Plan – that is, out of IDAPA 16.03.10 and into IDAPA 16.03.09. In this presentation, I will describe the deletions and restructuring in IDAPA 16.03.10 that were required in order to accomplish this change.

In my previous presentation I explained how services covered in the State Plan must be made available to any Medicaid participant that has a need for the service, and how Section 1915(c) of the Social Security Act allows the Centers for Medicare and Medicaid Services (CMS) to waive this requirement so states can deliver home and community-based services (not otherwise available under the State Plan) to a targeted population.

Similarly, Section 1915(i) of the Social Security Act provides states the option to offer home and community-based services through the State Plan to a targeted population but does not require the more stringent institutional level of care determination needed for a 1915(c) waiver. That is, 1915(i) State Plan Option Benefit services may be offered to a specific population (like individuals with a developmental disability diagnosis), while State Plan services must be made available to any Medicaid participant. Additionally, children are assigned a budget based upon identified level of need. The assigned budget is utilized to pay for services under the 1915(i) State Plan Option Benefit. The 1915(i) State Plan Option Benefit support services are described in IDAPA 16.03.10.

As indicated in my previous presentation, CMS directed states to move intervention services for children with autism spectrum disorder from a 1915(c) waiver into the State Plan. The majority of the changes required by this federal mandate were made in docket 16-0309-1803. This companion docket addresses rule changes needed to delete obsolete 1915(c) waiver language and to clarify support services offered through the 1915(i) State Plan Option Benefit which cannot be offered as part of the State Plan. This ensures children previously accessing support services through the 1915(c) children’s waivers (which have now expired) can continue to access those services through the 1915(i) State Plan Option Benefit.

Specifically, the 1915(i) support services were revised, as follows:

Respite: Certain restrictions to this service were removed to allow Respite to be provided while an unpaid care giver is receiving Family Education, and to allow an independent provider (who is related to the child participant) to provide respite to a sibling group.

Family Education: Certain restrictions to this service were removed to allow Family Education to be provided to anyone who participates in caring for the eligible child participant to help them better meet the needs of the participant.

Community-Based Supports: The name of this service was changed to eliminate potential confusion with Habilitation Intervention Services – the service that was moved into the State Plan

The Family-Directed Community Supports option, commonly referred to as Family-Directed Services, continues to be available through the 1915(i) authority.

Without these changes, the Department would not be able to ensure children who qualified for the now-expired 1915(c) children’s waivers would be able to continue to receive those services offered in the 1915(i) State Plan Option Benefit.
PUBLIC INVOLVEMENT
This docket, 16-0310-1806, is a companion docket to the one I presented previously, 16-0309-1803. Because the changes in these two dockets are dependent upon one another, the stakeholder engagement was the same. In the interest of time, I would like to ask the committee if they would like me to repeat the details of the stakeholder engagement process or continue with the remainder of my presentation?

- [If no, move to “Fiscal Impact” section of presentation.]
- [If yes, repeat the following:

The Department conducted extensive stakeholder engagement for more than four years. Prior to drafting the initial rule changes, the Department formed a Children’s Enhancement Project Team. Workgroups composed of Department staff, participant families, community professionals, community providers, school-based service providers, advocacy groups, and other interested stakeholders were established. These workgroups included a Clinical Advisory Group, a Provider Advisory Group, two Family Advisory Groups – Traditional and Family Directed – and a Fiscal Workgroup. Meetings were held at least monthly to discuss needed changes, conduct research, and suggest language for revised or new rules.

Based on the work of the advisory groups, draft rule language was prepared and presented to stakeholders in May of 2018. The Department published a Notice of Negotiated Rulemaking in the July 2018 Administrative Bulletin and held nine (9) public meetings to gather feedback. Based on the feedback received during those meetings, the Department chose to continue the negotiation process.

The draft rule was revised and then presented to stakeholders, section by section. Between September 2018 and March 2019, the Childrens Enhancement Project Team traveled to each region of the state each month and presented a section of the revised rule, sought feedback, and responded to questions. Rule language was then revised based on stakeholder input, and a new section of rule was presented the next month. Once all sections were reviewed, a full draft was compiled and presented to stakeholders across the state.

A Notice of Temporary and Proposed Rulemaking was published in the July 2019 Administrative Bulletin, and the Temporary Rule went into effect July 1, 2019. The Public Hearing for the Proposed Rule was held July 17, 2019. Feedback was received and updates were made, resulting in the pending rule before you.]

FISCAL IMPACT
As with the previous docket, because these rules were implemented as temporary rules, the fiscal impact analysis was completed, and the cost increase was requested for Medicaid’s 2020 Budget and approved for funding by the 2019 Legislature.

CONCLUSION
RED TAPE REDUCTION STATEMENT
In accordance with the Red Tape Reduction Act, efforts were made to simplify language and remove redundancies during the drafting of these rules. Deletions in this docket, together with additions in the companion docket I previously presented, have resulted in a decrease of 738 words overall, including the reduction of 48 restrictive words.

I ask you approve this Pending rule as final.

Mr. Chairman/Madam Chair, members of the Committee, this concludes my presentation. Thank you for your time. I stand for questions.
Legislative Presentation - 16-0318-1901 – Medicaid Cost Sharing

Mr. / Madam Chair and Members of the Committee,

My name is Alexandra Fernández, and I am the Bureau Chief for the Bureau of Long Term Care within the Division of Medicaid under the Department of Health and Welfare.

I am here today to present docket number 16-0318-1901, which can be found on pages 1190 - 1194 of your electronic Pending Rules review book. The Department asks the committee to approve these pending rules as final.

We developed this rulemaking in compliance with the Red Tape Reduction Act. Changes in this docket reduced the overall word count for this chapter by 96 words, and there was no change in the number of restrictive words. The rules in this chapter are being amended to accomplish two objectives associated with participant cost sharing for home and community-based services: to clarify exemptions; and to update the Personal Needs Allowances used in the cost-sharing calculation to align with federal requirements.

First, this rule change identifies populations that are exempt from cost-sharing, including Native American and Alaskan Native participants, as well as participants who are eligible via the Medicaid for Workers with Disabilities program. These groups are categorically exempt from incurring a share of cost for home and community-based waiver services. The purpose of explicitly outlining these exemptions is to align rule to existing program operations. The Division of Medicaid has participated on the Medicaid for Workers with Disabilities workgroup with the State Independent Living Council, Disability Rights Idaho, Division of Vocational Rehabilitation, Commission for the Blind, Division of Self Reliance, and other stakeholders over the last year to improve access to the Medicaid for Workers with Disabilities program. This rule change is a recommendation from that workgroup and carries no fiscal impact.

Second, this rule change simplifies the calculation for cost-sharing by streamlining the Personal Needs Allowance figures. For context: the Personal Needs Allowance is a figure used in the financial eligibility determination process that determines how much a participant must pay towards the cost of their home and community-based services. The function of the Personal Needs Allowance is to ensure that a member retains enough disposable income to cover living expenses not covered by Medicaid, such as rent, utilities, food, etc.

Previously, the Personal Needs Allowance figures varied based on marital status and the participant’s obligation to pay rent or mortgage expenses. The impetus for simplifying the allowance figures was a request from our federal partner, the Centers for Medicare and Medicaid Services, or CMS, to validate that any variations to the cost-sharing calculation meet certain federal criteria. CMS determined that a variation based on marital status does not meet federal standards for establishing reasonable differences in how cost-sharing is calculated.

The proposed change to differentiate the Personal Needs Allowance only based on a member’s obligation to pay rent or mortgage simplifies the cost-sharing calculation and meets CMS requirements. This change will also result in ongoing savings of up to $46,606.20 per year. These savings are realized from the corresponding increase in cost-sharing that some participants will experience due to their Personal Needs Allowance decreasing. At the time of this presentation, approximately 30 participants currently receiving services will experience an increase in their share of cost as a result of this rule change.

The Department sought both informal and formal input on this rulemaking. Informal input was solicited as part of the Medicaid for Workers with Disabilities workgroup; the group supported incorporating the exemptions but did not provide comment on the Personal Needs Allowance component.

Formal public input included a negotiated rule making session hosted on June 18, 2019 and a public hearing on October 8, 2019 in Boise and via teleconference for remote attendees to join. During these comment opportunities the Department received a total of three comments from stakeholders. One commenter expressed support for both components of this rule change. Two commenters expressed concerns about potential negative impacts to participants associated with the change to the Personal Needs Allowance figures. The Department responded to these concerns by
identifying all participants that would possibly be negatively affected and validating whether those members were correctly identified as having no rent or mortgage obligation. Aligning the Personal Needs Allowance will ensure that CMS continues to authorize the administration of Idaho’s home and community-based services programs.

In summary, these rule changes are being proposed to clarify and simplify the cost sharing rules for home and community based waiver participants. I appreciate your consideration of this docket and respectfully ask the committee to approve these pending rules as final. Thank you for your time. I am happy to review the rule changes by section if the Chair and Committee would like; otherwise I stand for your questions.
# AMENDED AGENDA #1
## SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, January 27, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>MINUTES APPROVAL:</td>
<td>Minutes of January 9, 2020</td>
<td>Senator Heider</td>
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</table>

### DOCKET NO.: 16-0201-1901
  - Presenter: Christopher Way, Chairman Time Sensitive Emergency System Council

### S 1240
- Relating to Nurses; Amending and Adding
  - Presenter: Colleen Shackelford, MSN, APRN, BSN, Nurse Practitioners of Idaho

### S 1242
- Relating to Nursing Home Administrators; Amending and Revising
  - Presenter: Kris Ellis, Idaho Health Care Association

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*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

### COMMITTEE MEMBERS
- Chairman: Martin
- Vice Chairman: Souza
- Sen: Heider
- Sen: Lee
- Sen: Harris
- Sen: Burtenshaw
- Sen: Bayer
- Sen: Jordan
- Sen: Nelson

### COMMITTEE SECRETARY
- Margo Miller
- Room: WW35
- Phone: 332-1319
- Email: shel@senate.idaho.gov
DATE: Monday, January 27, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:00 p.m.

MINUTES APPROVAL: Senator Heider moved to approve the Minutes of January 9, 2020. Vice Chair Souza seconded the motion. The motion carried by voice vote.

PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza for the rules presentation.

DOCKET NO. 16-0201-1901: Christopher Way, Chairman of the Time Sensitive Emergency (TSE) System Council, and Chief of Emergency Medical Services (EMS) for Kootenai County, presented the rules of the Idaho TSE System Council (Council). He explained the rule docket had been revised and updated to a more current standard in the TSE Standards Manual. He summarized the changes which relate to designated facilities, redundant or burdensome criteria, heart attack and stroke criteria, and fall prevention. The Council responded to public comments by clarifying the criteria. In compliance with the Red Tape Reduction Act, no new restrictive language was added to this rule. The updates to the TSE manual will make applying for TSE designation easier for facilities.

DISCUSSION: Senator Martin and Mr. Way discussed the yellow dot program. Mr. Way expressed he was not ready to endorse it in Idaho.

Senator Nelson and Vice Chair Souza requested clarification on whether fee rules were applicable, and if they were included in this section. Mr. Way responded there have always been fees in the original rules for the hospitals to apply for designation. There are no changes to the fee structure, and since there is no chance of increased revenue to EMS as a result of this, there will be no fees for EMS to apply for TSE designation. Vice Chair Souza added that the rule is listed under pending rules, not pending fee rules in the rule chapter.

MOTION: Senator Heider moved to approve Docket No. 16-0201-1901. Chairman Martin seconded the motion. The motion passed by voice vote.

PASSED THE GAVEL: Vice Chair Souza passed the gavel to Chairman Martin.
Colleen Shackelford, who holds a B.S. and an M.S. in nursing and is an advanced practice registered nurse, presented S 1240 Relating to Nurses. She represents over 1,700 nurse practitioners (NPs) in the state and serves as the legislative chair for the Nurse Practitioners of Idaho. She explained that this bill provides authority of an NP’s signature in current physician-only statutes. NPs were recognized to provide quality care, and Idaho became the first state in the nation to approve NPs to practice on their own. Without signature authority, NPs face limitations in providing comprehensive care to patients. S 1240 will not expand NPs' scope of practice; it will authorize NPs to more completely serve their patients by allowing their signature on multiple forms that would be expected in a primary care office.

Ms. Shackelford provided several examples of forms this will apply to.

Ms. Shackelford explained that the bill uses global language modeled after several other states that authorizes all current and future forms that use 'only physician' in their language and fall within the NP scope of practice. There are 33 independent NP practices with thousands of patients in Idaho. In some rural areas the NP is the only access to care. NPs now account for over 40 percent of primary care providers in Idaho. The NP workforce has increased by 30 percent in the last five years.

DISCUSSION: Senator Lee asked about the scope of practice. Ms. Shackelford assured the Committee if the form needing a signature did not fall within the NP’s scope of practice, the patient would have to have a physician sign it. Chairman Martin asked if Idaho had many certified nurse midwives (CNM). Ms. Shackelford stated there were about 50 CNMs within the state. Chairman Martin asked if a CNM is a nurse, an RN, trained in midwifery. Ms. Shackelford affirmed his comment. She said all these rules pertained to advanced practice registered nurses, so they are advanced practice nurses with a master's degree or doctorate. Vice Chair Souza commented on a visit she had with an advanced practice cardiac nurse and affirmed the signing authority is only for items within the NP's scope of practice.

TESTIMONY: Michael McGrane, Idaho Nurses Association and Nurse Leaders of Idaho, spoke on behalf of the Idaho Centers for Nursing. He expressed his support for the bill. He stated there are 11 communities in the state where an NP is the only provider, and this bill eliminates barriers for the patients, particularly in rural areas.

MOTION: Senator Bayer moved to send S 1240 to the floor with a do pass recommendation. Senator Heider seconded the motion. The motion passed by voice vote. Vice Chair Souza volunteered to carry the bill.

Kris Ellis, Idaho Health Care Association, presented S 1242, Relating to Nursing Home Administrators. Ms. Ellis explained this bill is co-sponsored by the Idaho Hospital Association. This legislation cleans up and clarifies language, and makes it easier to become a nursing home administrator. The change to become a nursing home administrator in Idaho is from an emphasis in long term care to an emphasis in healthcare. Often, nursing homes are attached to a hospital, and the hospital administrator is qualified to be the nursing home administrator. This bill states that a hospital administrator who has one year of experience in his/her patient care facility can become the nursing home administrator as well.

TESTIMONY: Brian Whitlock stated that he represents the Idaho Hospital Association, comprised of 46 member hospitals throughout the state, all in rural or urban settings. Twelve of those 46 hospitals have nursing homes or skilled nursing facilities attached. He said hospital administrators who had a master's level in health administration or business administration with an emphasis in healthcare were both valuable, and that the change was a simple but important change, especially to the rural parts of Idaho. See attachment 1.
DISCUSSION: Senator Harris commented that he has five rural hospitals in his district, and four of them have nursing homes attached to them. He stated this is a good bill, and will help in the difficulty of finding nursing home administrators.

MOTION: Senator Heider moved to send S 1242 to the floor with a do pass recommendation. Senator Harris seconded the motion. The motion passed by voice vote. Senator Harris volunteered to carry the bill.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:29 p.m.

___________________________  ________________________
Senator Martin               Margo Miller
Chair                         Secretary
Mr. Chairman and Members of the Committee, my name is Brian Whitlock, and I am the President of the Idaho Hospital Association. We represent 46 member hospitals all across the state – in urban and rural settings.

12 of those hospitals also operate a nursing home or have skilled nursing facility beds. (Bear Lake, Bingham, Boundary, Caribou, Franklin, Minidoka, Nell J. Redfield, Power County, St. Luke’s Elmore, St. Luke’s Rehab, Idaho State – South, and the VA.)

In some of those facilities, the hospital CEO wears two hats – hospital CEO and nursing home administrator.

Idaho Code 54-1605 spells out the requirements for obtaining a nursing home administrator’s license – which includes completion of 1000 hours in an “administrator-in-training” program.

Later in Chapter 1610, the statute grants two exemptions to that 1000 hour training program -- if you have a Masters Degree in Health Administration with an emphasis in long-term care, or, if you have a MHA and one year of management experience in long-term care.

Senate Bill 1242 adds one additional exemption. On Line 28 of the bill before you, it allows you to waive the 1000 training program if you have a Masters Degree – like an MBA -- with an emphasis in health care, along with one year of management experience in an inpatient facility.

Again, this could be an MHA – or it could be a Masters in Business Administration with an emphasis in health care.

While a Masters in Health Administration is more immersive in healthcare, the Masters in Business Administration, with an emphasis in health administration, recognizes the increased role of technology, changes in reimbursement, the rise in consumerism, and the diversified ways healthcare is delivered today as having changed health care, and thus, healthcare administration.

Both the MHA and MBA with an emphasis in health administration include course work in:
This bill recognizes that both an MHA and an MBA with an emphasis in health care, combined with at least a year’s management experience in an inpatient setting, are both valuable prerequisites that should adequately prepare a nursing home administrator applicant to sit for the nursing home administrator licensing exam.

This is a simple, but important change that will allow us to continue to attract qualified administrators to the state – especially in the more rural parts of Idaho.

I encourage your yes vote to send this to the floor with a do pass recommendation.

I’d stand for questions.
# AMENDED AGENDA #1

**SENATE HEALTH & WELFARE COMMITTEE**

3:00 P.M.

Room WW54

Thursday, January 30, 2020

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<thead>
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<tr>
<td>MINUTES APPROVAL:</td>
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<td>Senator Bayer</td>
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<td></td>
<td>Minutes of January 13, 2020</td>
<td>Senator Harris</td>
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<td>Minutes of January 14, 2020</td>
<td>Senator Jordan</td>
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<tr>
<td>PRESENTATION:</td>
<td>Idaho Resilience Project</td>
<td>Roger Sherman, Executive Director</td>
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<td>Idaho Children's Trust Fund</td>
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<tr>
<td>PRESENTATION:</td>
<td>Catastrophic Health Care Cost Program Annual Report</td>
<td>Kathryn Mooney, Program Director</td>
</tr>
</tbody>
</table>

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**

Chairman Martin  
Vice Chairman Souza  
Sen Heider  
Sen Lee  
Sen Harris  

*Sen Burtenshaw  
Sen Bayer  
Sen Jordan  
Sen Nelson*

**COMMITTEE SECRETARY**

Margo Miller  
Room: WW35  
Phone: 332-1319  
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 30, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, and Nelson
ABSENT/EXCUSED: Senator Jordan

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 Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 2:59 p.m.

MINUTES APPROVAL: Senator Bayer moved to approve the Minutes of January 7, 2020. Vice Chair Souza seconded the motion. The motion carried by voice vote.

Senator Harris moved to approve the Minutes of January 13, 2020. Senator Heider seconded the motion. The motion carried by voice vote.

Chairman Martin announced the Minutes of January 14, 2020, would be approved at the next meeting, when Senator Jordan would be present.

PRESENTATION: Roger Sherman, Executive Director, Idaho Children's Trust Fund, presented a report about the Idaho Resilience Project. The information was a collective effort of Kaiser Permanente and the Centers for Disease Control and Prevention. The most commonly reported adverse childhood experiences (ACEs) in Idaho are poverty, divorce and broken homes, substance use, and mental illness. Only four states have a higher prevalence than Idaho of children with three or more ACEs. The ACE study provides a paradigm shift from what's wrong with a child to what happened to a child. The economic impact is significant: $124 billion worth of lost work days. Nearly 65 percent of children are impacted by a learning disability, 54.6 percent are diagnosed with ADHD, and just over 47 percent have to repeat a grade. The Idaho Department of Juvenile Corrections reports the average ACE score is 4.2 among those in its care; of those, 62 percent reported over 4 ACEs, and 16 percent reported over 7 ACEs.

Jeff Myers, MD, Idaho Youth Ranch; Jack Varin, retired judge; and, Jane Mutchie, representing St. Luke's, presented a short film on toxic stress. Abuse, neglect, and household dysfunction are considered ACEs. They impact behavior and health, as well as our ability to think and reason in adulthood. See attachment 1.

DISCUSSION: Vice Chair Souza asked if girls are considered more vulnerable than boys in these situations. Mr. Varin explained that boys are just as vulnerable as girls, as far as things that happen to them.

In response to questions from Senator Heider, Mr. Sherman explained the population of Idaho children affected by ACEs and noted efforts to disseminate that information to the public.

Vice Chair Souza and Ms. Mutchie discussed the impacts of cortisol on children and ways to mitigate its negative effects.
PRESENTATION: Kathryn Mooney, Program Director of the Catastrophic (CAT) Health Care Cost Program, presented the annual report to the Committee. See attachment 2. She explained that the program is based on emergencies. She described the process and timelines involved in handling cases. Since January 1, 2020, the CAT Program has not seen a cut-off due to Medicaid expansion; however, the hospitals are seeing a slowdown.

DISCUSSION: In response to Committee questions, Ms. Mooney discussed the timing of applications to the CAT Program and a case involving a disability determination. Ms. Mooney continued her presentation, explaining reimbursement. Payments are received from patients and liens are filed against real and personal property; but, patients can settle if they sell a house, for example. She explained that there are no payoff arrangements and no set amounts; they receive whatever the patient can afford to pay. Administering the program is expensive, and counties spend millions due to the appeal processes. The 2019 cost per case was $23,541. Ms. Mooney stated that the CAT Program should begin to see a slowdown in the fourth quarter of the fiscal year.

Ms. Mooney was asked to provide scenarios where the CAT Program will be needed even with Medicaid expansion. She explained that applications are received from people who are above the Medicaid eligibility limit.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:21 p.m.
SHAPING HEALTHY AND RESILIENT COMMUNITIES ACROSS IDAHO
The Things We Carry

https://www.adsoftheworld.com/media/film/center_for_youth_wellness_and_evolution_bureau_the_things_we_carry
Adverse Childhood Experiences (ACE) Study

- Collective effort of Kaiser Permanente and Centers for Disease Control and Prevention (CDC)
- The largest study of its kind to examine the health, social and economic effects of ACEs over the lifespan (over 17,000 participants)
- Examined past history of abuse, family dysfunction and current health status
- Retrospective cohort study of an HMO population with average of 57 years

acestudy.org
Adverse childhood experiences

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother Treated Violently
- Substance Abuse
- Divorce
BEHAVIORAL IMPACT OF ACES

Increased likelihood (x times more likely)

- More Likely to consider themselves alcoholic
- More likely to smoke
- More likely to have used illicit drugs
- Missed 14 days or more of work in a month

- 2 ACES
- 3 Aces
- 4 Aces
HOW IT AFFECTS US

According to a study by Vincent Felitti, a person with 4 or more ACEs is:

- 4.6x more likely to report feeling depressed for 2 weeks or more in a year
- 2.2x more likely to develop heart disease
- 12.2x more likely to attempt suicide
- 2.4x more likely to have a stroke
- 1.9x more likely to have cancer
- 1.6x more likely to have diabetes
- 7.4x more likely to be an alcoholic
- 3.9x more likely to have chronic bronchitis or emphysema
Health Impact > Behavioral

- "When you look at ACEs they're actually a stronger predictor of heart disease than any of the traditional risk factors...and yet I was never trained on this in one day in Medical School." - Dr. Nadine Burke Harris, Center on Youth Wellness

- People with an ACE score of 7 who: don't drink, don't smoke, are not diabetic, do not have high cholesterol, still have a 360% greater risk of heart disease
ACE STUDY PROVIDES A PARADIGM SHIFT
FROM 'WHAT'S WRONG WITH YOU' TO 'WHAT HAPPENED TO YOU'
The CDC’s Vital Signs report key takeaways

- At least 5 of the top ten leading causes of death are associated with ACEs
- Preventing ACEs could help prevent poor health and life outcomes.

- ACEs are preventable & treatable
ACEs In Idaho & Local Impact
Preventing ACEs in Idaho could result in:

- Over 30,000 fewer people experiencing depression
- Keeping 60,000 people from smoking
- Preventing nearly 30,000 cases of Asthma
- Even reducing unemployment by nearly 15%

*Extrapolated from CDC Vital Signs report, November 2019*
ACES in Idaho

- Most commonly reported ACEs are poverty, divorce and broken homes, substance use and mental illness
- Only four states have a higher prevalence of children with three or more ACEs than Idaho
- US data for kids with a score of 3 or more is 11%; Idaho is 15%
- Idaho is in the early process of collecting more broad ACEs data
Only four states have a higher prevalence of children with three or more ACEs than Idaho.

Children in Idaho are more likely than other children in the US to experience:

Economic Impact is Significant

- 1 in 5 children live in poverty in Canyon County.
- ACE score contributes to 200 million lost work days each year.
- Each year, ACEs cost US employers $17 to $44 billion in lost work days.
- Each ACE a child experiences increases their score. Higher score = greater risk.
- People with a high ACE score can die 20 years younger than average.
- ACEs contribute to 200 million lost work days each year.
- Children with an ACE score over 4 are 10x more likely to abuse drugs as adults.

30.1
Risk of death by suicide among people experiencing 4 or more ACEs.

$124 Billion
The annual cost of ACEs in the US (CDC estimate)

7:1
Return on Investment: For every $1 spent on preventing ACEs, society receives a $7 ROI over a person’s lifetime.

$100,000 + More in Lifetime Earning
$15,000 + More in Taxes Paid
$20,000 + Healthcare Savings
$7,000 + Public Services Savings

Centerforchildcounseling.org
Education Is Focus In Idaho – Consider

How ACEs impact school performance in Idaho


Population Attributable Fraction: In epidemiology, attributable fraction for the population is the proportion of incidents in the population that are attributable to the risk factor.
ACEs are a Pipeline to Prison

- In a study of 64,329 juvenile offenders in Florida: (Epps, 2014)

- Juvenile offenders are 13 times less likely to report zero ACES

- Juvenile offenders are four times more likely to report four or more ACES

- ACEs not only increase the chances of involvement in the juvenile justice system, but increase the risk of re-offense.
## ACEs among Idaho Youth in Juvenile Detention versus General Population

<table>
<thead>
<tr>
<th>Number of Aces</th>
<th>% in Justice Involved Sample</th>
<th>% in Adolescents Ages 12-17</th>
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<tbody>
<tr>
<td>None</td>
<td>7.8</td>
<td>45.8</td>
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<tr>
<td>One</td>
<td>15.7</td>
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<tr>
<td>Four</td>
<td>12.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Five or more</td>
<td>38</td>
<td>4.7</td>
</tr>
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*The Center for Health Policy, Boise State University*
Mean ACE Score by Juvenile Detention Center

- Ada = 3.82
- Bannock = 3.95
- Bonneville/3B = 3.41
- **Canyon = 4.21**
- Fremont/5C = 3.28
- Kootenai = 4.12
- Nez Perce = 3.57
- Nez Perce = 3.57
- Twin Falls = 3.65

= highest  = lowest

Source: The Center for Health Policy, Boise State University
Aces In Juvenile Detention

• Juveniles in Idaho’s JDCs have had a much higher level of trauma exposure than similarly aged juveniles in the general population across the nation.

• Most juveniles entering detention in JDCs in Idaho have been exposed to multiple forms of trauma and should be treated accordingly.

• If the State of Idaho is to make substantial progress in reducing trauma exposure in juveniles, and preventing or reducing mental health and substance abuse problems in them as well, dedicated efforts need to be made much further ‘upstream’ than in the juvenile justice system.

• Dr. Theodore MacDonald, BSU, Year Eleven Assessment of the Idaho Department of Juvenile Corrections’ Clinical Services Program
Aces In Juvenile Justice

- IDJC reports average ACE score is 4.2
  - Of those – 62% 4 or greater, 16% over 7
- 25 years ago a paradigm shift to Balanced and Restorative Justice
- Perhaps time for another paradigm shift to Restorative and Resilience Based Justice.
- ACEs has real world consequences and healing trauma takes a different approach then current programing.

FROM ‘WHAT’S WRONG WITH YOU’ TO ‘WHAT HAPPENED TO YOU’
• Implications for ACEs Juv Justice etc. goes here...
Idaho Resilience Project
To shape and create an environment in Idaho that allows all to thrive and be resilient in the face of adversity; engage individuals, organizations, leaders, and communities.

What must we do to create a resilient Idaho?

OUR FOCUS AREAS:

1. AWARENESS & EDUCATION
2. PREVENTION AND RESILIENCY-FOCUSED STRATEGIES
3. HEALING AND COPING STRATEGIES
4. COMMUNITY SUPPORT
BUILDING RESILIENCE

Resilience can be the antidote to ACEs. Through positive relationships and appropriate support, adversity can be conquered, crucial coping skills can be developed and healing can take place.

Note typo in text should be antidote not anecdote

<table>
<thead>
<tr>
<th>KEY INGREDIENTS</th>
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<tr>
<td>The relationships children have with others who care about them</td>
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<tr>
<td>Social connections</td>
</tr>
<tr>
<td>Knowledge of adolescent development</td>
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<tr>
<td>Concrete support in times of need</td>
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<td>Cognitive and social-emotional competence</td>
</tr>
<tr>
<td>Reduce stressors</td>
</tr>
<tr>
<td>Safe, stable and nurturing environments</td>
</tr>
</tbody>
</table>
The Growing Idaho Network, Focus Areas and Score Card
Regionalizing Efforts
Local leaders launch 2C Kids Succeed, a push to help children build resiliency against adverse experiences

By EMILY LOWE elowe@idahopress.com
Nov 20, 2018

A panel held at the Nampa Civic Center Tuesday focuses on the 2C Kids Succeed initiative, focused on building resiliency among youth against adverse childhood experiences.

A Canyon County wide initiative committed to building healthy, resilient communities.
Commitment Themes

- Advocacy
- Awareness and education
- Continued learning
- Engaging youth
- Mentorship
- Partnership and collaboration
Local Idea in Progress

SET YOUR CHILD UP FOR SUCCESS

Adverse Childhood Experiences (ACEs) have a tremendous impact on lifelong health, well-being, and opportunity. Working together, we can help create neighborhoods, communities, and a world in which every child thrives. The work starts at home.

10 Ways to Help a Child Feel Secure:
1. Dedicate time
2. Give affection
3. Praise them
4. Consistently hold boundaries
5. Listen to them
6. Laugh with them
7. Honor and honor their talents
8. Provide balance
9. Give unconditional love
10. Meet their needs

3 Keys to Success:
1. Safety: It’s important children feel secure and do not fear physical or psychological harm within their social, physical, and work environments.
2. Stability: Predictability and consistency are important for children. This includes their social, emotional, and physical environments.
3. Nurturing: Parents and children need to have access to individuals who are able to sensitively and consistently respond to and meet their needs.

RESOURCES FOR PARENTS:
You may still be dealing with your own Adverse Childhood Experiences. Visit 2cKidsSucceed.org for more information or call the Idaho Careline at 2-1-1.
'Rebellions are built on hope. Maybe Canyon County is ripe for a rebellion to eliminate adverse childhood experiences.'

-Bryan Taylor, Canyon County Prosecuting Attorney
What Can Be Done About Adverse Childhood Experiences?

- Parent support programs for teens and teen pregnancy prevention programs
- Mental illness and substance abuse treatment
- High quality child care
- Sufficient economic supports for families with lower incomes
- Home visiting to pregnant women and families with newborns
- Parenting training programs
- Intimate partner violence prevention
- Family-friendly work

CDC – Veto Violence
Survival Services

- Food
- Housing
- Medical/Dental Care
- Behavioral Health Care
- Transportation

Thriving Services

- Parent Supports
- Early Childhood Learning
- Community Schools
- Youth Mentors
- Job Training

There Are Many Different Models – But They All Start With Our Kids In The Middle Surrounded With Support
Four Thoughts To Takeaway

1. Adverse Childhood Experiences are common & the resulting trauma impacts everyday Idahoans.
2. Awareness of the impacts can inform legislative decisions on family support, foster care, education, health care, corrections, etc.
3. This is an approach not a program. The Legislature can provide support to communities to develop programs that strengthen families.
4. There are a variety of public policy decisions that can strengthen Idaho families, build resilience and mitigate the impact of childhood adversity.
CATASTROPHIC HEALTH CARE COST PROGRAM

ANNUAL REPORT
FISCAL YEAR 2019

To
MEMBERS OF HEALTH & WELFARE COMMITTEES
IDAHO STATE LEGISLATURE
FEBRUARY 2020

CATASTROPHIC HEALTH CARE COST PROGRAM
BOARD OF DIRECTORS
700 W. WASHINGTON ST.
BOISE, ID 83702
(208) 345-1966

ROGER S. CHRISTENSEN
CHAIRMAN OF THE BOARD
ANNUAL REPORT OF
THE CATASTROPHIC HEALTH CARE COST PROGRAM
Fiscal Year 2019

Pursuant to Idaho Code §31-3517, the following is the annual report of the Catastrophic Health Care Cost Program.

TO: All Members of the Health & Welfare Committees
FROM: Administrative Board of the Catastrophic Health Care Cost Program

HISTORY
The state catastrophic health care cost program was established by the Idaho Legislature in 1991 and commenced operations on October 1, 1991. The state-funded catastrophic health care cost program (CAT fund) is a continuation of the previously county-funded indigent program. The state assumed funding responsibility for the program effective October 1, 1991, as a means of providing property tax relief to Idaho residents.

During fiscal year 2019 the catastrophic program was administered by a board of directors consisting of six county commissioners, one from each IAC district, one member appointed by the director of the department of health and welfare, four legislators, one member appointed by the governor as follows: District 1, Dan McDonald, Bonner County; District 2, Greg Johnson, Lewis County; District 3, Rick Visser, Ada County; District 4, Kent McClellan, Minidoka County; District 5, William Lasley, Power County; District 6, Roger Christensen, Bonneville County; H&W Director David Jeppesen, Senators Jim Guthrie, and Maryanne Jordan, Rep. Steve Harris, and the governor’s appointee, David High. Late in the fiscal year, there was an appointment from the minority caucus of the House of Representatives to fill a vacancy, created in January 2017. Rep. Mat Erpelding served on the board of directors for a short time during this fiscal year and the first half of fiscal 2020 before leaving the legislature. The administrative board governs all activities of the CAT fund and meets approximately every eight to ten weeks to consider pending cases and claims and to provide oversight for program management.

Beginning in fiscal 2010, after nearly 20 years with the same contractor, the administrative board negotiated a new contract with the Idaho Association of Counties (IAC) to serve as program administrator. The association hired a program director and staff to handle the day-to-day operations of the CAT program. The IAC is currently retained on an annual contract running through September 2020.

The contract between the association and the CAT fund has proven to be an effective cost mitigating tool for both the CAT fund and Idaho’s 44 counties. The hospitals asked for consistency within the counties and to facilitate such, the CAT program office and the IAC provides training
for county social services directors and staff in the procedures and processes implemented to standardize billing, records transfer, and countless other tasks for efficient case submission to the CAT program for payment consideration.

Catastrophic Health Care Cost Program board of directors takes very seriously their responsibility to be accountable for the funds provided by the state taxpayer. The administrator reviews each case to ensure statutory compliance by the all counties. The cases are then presented to the board for their review.

From July 1, 2018 to June 30, 2019, the CAT board approved the payment of 744 cases and spent $17,515,092 on medical claims for those new cases as well as ongoing claims from previously approved cases. (Exhibit A)

From July 1, 2019 to December 31, 2019, (FYTD 2020) the CAT board approved 323 new cases, as well as continuing to pay ongoing claims for cases previously approved and has paid providers during this time period in the amount of $8,446,094. (Exhibit B)

As required, the board provides the state controller’s office with annual audits, which have consistently shown responsible management of the program in an efficient manner with minimal administrative costs. (Exhibit C)

In an effort to provide both local government and the state with effective information and for the board’s continued effort toward responsible accountability to the taxpayer, a program was implemented in early fiscal 2011 to provide medical reviews for the county commissioners to use during their determination process. Statute dictates only claims which are deemed to be medically necessary shall be paid by taxpayers’ funds, pursuant to Idaho Code 31-3501 et seq. The counties and the CAT program continue their contract with a medical professional whose primary practice is the review of services and charges to ensure the most cost effective service for the residents of Idaho. Commercial insurance companies use reviews for claims and pre authorization of services and our reviewer has extensive experience in this segment of the medical profession.

Traditionally, those medically indigent residents who use financial assistance via the CAT program are individuals who are ineligible for Medicaid or other government assistance programs. They tend to be those faced with a catastrophic illness or injury who have chosen not to get insurance, or do not qualify for Medicaid. With the implementation of expanded Medicaid in Idaho, it is presumed at the time of printing the hospitals will continue to rely on the county indigent program and therein, the CAT fund for those patients.

A statutory lien is filed on each patient for both real and personal property. All medically indigent residents incur a debt when their case is approved by the county and they are required to reimburse both the county and, if included, the state of Idaho for monies paid out on their behalf. The reimbursement report shows those payments received by the state. Reimbursements to the state for their portion typically represent approximately $3 million of the annual revenue collected by the state. From July 1, 2018 through June 30, 2019, the fund received reimbursement payments of $3,515,740 (Exhibit D).

The indigent program is set up as a financial assistance program and not a medical services program. The counties shoulder all of the collection and administration responsibilities in
seeking reimbursements from those who use the program. Some counties contract with collection agencies. Results vary depending on each county's contract and demographics.

Beginning in FY 2004, the Catastrophic Health Care Cost Program began receiving from the counties $5.00 for every seat belt fine collected from violations imposed under Idaho Code §49-673. The fund received $59,470 for the fiscal year 2019.

Pursuant to Idaho Code §31-3503A(4) the CAT board has requested information from hospitals, to report to the legislature. This request for information was sent to thirty-two (32) hospitals across the state of Idaho. (See Exhibit E) We emphasize to them each year this reporting is required by law however, as there is no penalty to the providers for failing to respond, cooperation is tenuous at best. The blanks are hospitals which received a report form to fill out but did not return it to us. The hospitals that respond make every effort to provide accurate information.

The board for the catastrophic health care cost program annually requests information from the 44 counties of the state of Idaho to report to the legislature as required by Idaho Code §31-3503A(4). The totals presented herein are broken out into 2 separate formats. One shows the data broken out by county and on the last page, all dollars spent for indigent medical care is shown by diagnosis category. Both reports show county and state funds added together in this final 2 page report. (Exhibit F.)

Should you have any further questions concerning the catastrophic health care cost program, please feel free to contact any member of the catastrophic program administrative board, or the Program Director, Kathryn Mooney at 208-345-1366.
## EXHIBIT A

**PROVIDER PAYMENTS Made by the CAT Fund**

**Fiscal Year 2019**

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>PROVIDER PAYMENTS</th>
<th>COUNTY</th>
<th>PROVIDER PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA</td>
<td>$4,627,789</td>
<td>GOODING</td>
<td>$265,503</td>
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<tr>
<td>ADAMS</td>
<td>$336,231</td>
<td>IDAHO</td>
<td>$184,091</td>
</tr>
<tr>
<td>BANNOCK</td>
<td>$900,104</td>
<td>JEFFERSON</td>
<td>$35,736</td>
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<tr>
<td>BEAR LAKE</td>
<td>$40,803</td>
<td>JEROME</td>
<td>$430,965</td>
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<tr>
<td>BENEWAH</td>
<td>$27,932</td>
<td>KOOTENAI</td>
<td>$990,080</td>
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<tr>
<td>BINGHAM</td>
<td>$65,374</td>
<td>LATAH</td>
<td>$259,661</td>
</tr>
<tr>
<td>BLAINE</td>
<td>$529,898</td>
<td>LEMHI</td>
<td>$131,247</td>
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<tr>
<td>BOISE</td>
<td>$185,647</td>
<td>LEWIS</td>
<td>$27,691</td>
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<tr>
<td>BONNER</td>
<td>$123,757</td>
<td>LINCOLN</td>
<td>$294,963</td>
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<tr>
<td>BONNEVILLE</td>
<td>$1,069,094</td>
<td>MADISON</td>
<td>$286,367</td>
</tr>
<tr>
<td>BOUNDARY</td>
<td>$14,314</td>
<td>MINIDOKA</td>
<td>$235,502</td>
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<tr>
<td>BUTTE</td>
<td>$13,079</td>
<td>NEZ PERCE</td>
<td>$304,392</td>
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<tr>
<td>CAMAS</td>
<td>$0</td>
<td>ONEIDA</td>
<td>$132,731</td>
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<tr>
<td>CANYON</td>
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<td>OWYHEE</td>
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<td>CASSIA</td>
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<td>POWER</td>
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<td>$1,268,497</td>
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<td>$189,124</td>
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<td>FREMONT</td>
<td>$5,811</td>
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<tr>
<td>GEM</td>
<td>$16,817</td>
<td>TOTAL</td>
<td>$17,545,465</td>
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**EXHIBIT B**  
**CAT Cases & Total State Dollars**  
**July 1, 2019 to December 31, 2019**  
**FYTD 2020**

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>NO. OF CASES</th>
<th>PROVIDER PAYMENTS</th>
<th>COUNTY</th>
<th>NO. OF CASES</th>
<th>PROVIDER PAYMENTS</th>
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<td>9</td>
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<td>JEFFERSON</td>
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<td>$103,715</td>
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<td>JEROME</td>
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<tr>
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<td>KOOTENAI</td>
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<td>MADISON</td>
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<td>$72,597</td>
<td>MINIDOKA</td>
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<tr>
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<td>ONEIDA</td>
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<td>$0</td>
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<td>FREMONT</td>
<td>2</td>
<td>$83,990</td>
<td>TOTAL</td>
<td>323</td>
<td>$8,446,094</td>
</tr>
</tbody>
</table>
EXHIBIT C

2019 ANNUAL AUDIT
STATE OF IDAHO – STATE FUNDED
CATASTROPHIC HEALTH CARE
COST PROGRAM
BASIC FINANCIAL STATEMENTS
with
INDEPENDENT AUDITOR’S REPORT
For the Fiscal Year Ended June 30, 2019
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Item</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Auditor’s Report – Basic Financial Statements</td>
<td></td>
</tr>
<tr>
<td><strong>BASIC FINANCIAL STATEMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Governmental Funds Balance Sheet and Statement of Net Position</td>
<td>1-2</td>
</tr>
<tr>
<td>Governmental Funds Revenues, Expenditures and Changes in Fund Balance and Statement of Activities</td>
<td>3-4</td>
</tr>
<tr>
<td>Notes to the Financial Statements</td>
<td>5-8</td>
</tr>
<tr>
<td><strong>REQUIRED SUPPLEMENTARY INFORMATION</strong></td>
<td></td>
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<tr>
<td>Statement of Revenues, Expenditures and Changes in Fund Balance – Budget and Actual (With Budget to GAAP Differences) – General Fund</td>
<td>9-10</td>
</tr>
<tr>
<td><strong>OTHER SUPPLEMENTARY INFORMATION</strong></td>
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<tr>
<td>Independent Auditor’s Report on Compliance and on Internal Control Over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards</td>
<td>11-12</td>
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</tbody>
</table>
INDEPENDENT AUDITOR'S REPORT

Administrative Board
Catastrophic Health Care Cost Program
Boise, Idaho

Report on the Financial Statements

We have audited the accompanying financial statements of the governmental activities of the Catastrophic Health Care Cost Program, an agency of the state of Idaho, as of and for the year ended June 30, 2019, and the related notes to the financial statements, which collectively comprise the program's basic financial statements as listed in the table of contents.

Management’s Responsibility for the Financial Statements

The Catastrophic Health Care Cost Program’s management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor’s Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities of the Catastrophic Health Care Cost Program, an agency of
the state of Idaho, as of June 30, 2019, and the respective changes in financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

**Emphasis of Matter**

As discussed in Note 1, the financial statements of the Catastrophic Health Care Cost Program, an agency of the state of Idaho, are intended to present the financial position, and the changes in financial position and cash flows, where applicable, of only that portion of the governmental activities of the state of Idaho that is attributable to the transactions of the Catastrophic Health Care Cost Program. They do not purport to, and do not, present fairly the financial position of the state of Idaho as of June 30, 2019, and the changes in its financial position and its cash flows, where applicable, for the year then ended in accordance with accounting principles generally accepted in the United States of America.

**Other Matters**

**Required Supplementary Information**

Accounting principles generally accepted in the United States of America require supplementary information, such as management’s discussion and analysis and budgetary comparison information to be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s response to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted management’s discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of the financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

**Other Reporting Required by Government Auditing Standards**

In accordance with Government Auditing Standards, we have issued our report dated September 25, 2019, on our consideration of the Catastrophic Health Care Cost Program’s internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of the audit performed in accordance with Government Auditing Standards in considering the Catastrophic Health Care Cost Program’s internal control over financial reporting and compliance.

**Beard Hart & Associates, PC**

Idaho Falls, Idaho
September 25, 2019
BASIC FINANCIAL STATEMENTS
STATE OF IDAHO - STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
GOVERNMENTAL FUNDS BALANCE SHEET AND
STATEMENT OF NET POSITION
June 30, 2019

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>General</th>
<th>Totals</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and investments</td>
<td>$10,193,141</td>
<td>$10,193,141</td>
<td>$</td>
</tr>
<tr>
<td>Refunds and reimbursements receivable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>10,193,141</td>
<td>10,193,141</td>
<td></td>
</tr>
</tbody>
</table>

| DEFERRED OUTFLOWS                   |         |          |             |
| TOTAL ASSETS AND DEFERRED OUTFLOWS  | $10,193,141 | $10,193,141 |             |

| LIABILITIES AND FUND BALANCES       |         |          |             |
| LIABILITIES                         |         |          |             |
| Benefits payable                    |         |          |             |
| TOTAL LIABILITIES                   |         |          |             |
| DEFERRED INFLOWS                    |         |          |             |
| FUND BALANCES                       |         |          |             |
| Restricted                          | 10,193,141 | 10,193,141 | (10,193,141) |
| TOTAL FUND BALANCES                 | 10,193,141 | 10,193,141 | (10,193,141) |

| TOTAL LIABILITIES, DEFERRED INFLOWS AND FUND BALANCES | $10,193,141 | $10,193,141 | (10,193,141) |

| NET POSITION                         |         |          |             |
| Restricted                           |         |          |             |

The notes to the financial statements are an integral part of this statement.
<table>
<thead>
<tr>
<th>Statement of Net Position</th>
</tr>
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<tbody>
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<tr>
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<tr>
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<tr>
<td>$</td>
</tr>
<tr>
<td>10,193,141</td>
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<tr>
<td>$</td>
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<tr>
<td>10,193,141</td>
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<td>10,193,141</td>
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<tr>
<td>10,193,141</td>
</tr>
<tr>
<td>EXPENDITURES/EXPENSES:</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Health and sanitation:</td>
</tr>
<tr>
<td>Contract administration</td>
</tr>
<tr>
<td>Other professional services</td>
</tr>
<tr>
<td>Board travel</td>
</tr>
<tr>
<td>Indemnity payments</td>
</tr>
<tr>
<td>Health care payments</td>
</tr>
<tr>
<td>Miscellaneous - overhead allocation</td>
</tr>
<tr>
<td>Trustee/benefit payments</td>
</tr>
</tbody>
</table>

**TOTAL EXPENDITURES/EXPENSES**

<table>
<thead>
<tr>
<th>PROGRAM REVENUES:</th>
<th></th>
<th></th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges for services</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Operating grants and contributions</td>
<td>-</td>
<td>-</td>
<td>11,999,700</td>
</tr>
<tr>
<td>Capital grants and contributions</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**TOTAL PROGRAM REVENUES**

**NET PROGRAM REVENUE (EXPENSE)**

**GENERAL REVENUES:**

| Interest on investments | 379,221 | 379,221 | - |
| Gain (loss) on investments | - | - | - |
| Other revenues | - | - | - |
| Seat belt income | 59,470 | 59,470 | - |
| Refunds and reimbursements | 3,515,740 | 3,515,740 | - |
| Other sources (uses) | - | - | - |
| Intergovernmental appropriation | 11,999,700 | 11,999,700 | (11,999,700) |
| Intergovernmental appropriation reclassification | - | - | - |

**TOTAL GENERAL REVENUES OTHER SOURCES (USES)**

**EXCESS OF REVENUES OVER (UNDER) EXPENDITURES AND OTHER FINANCIAL SOURCES (USES)**

| -1,754,518 | -1,754,518 | -1,754,518 |

**CHANGES IN NET POSITION**

**RESTRICTED FUND BALANCE/NET POSITION - July 1, 2018**

| 11,947,659 | 11,947,659 | - |

**RESTRICTED FUND BALANCE/NET POSITION - June 30, 2019**

| 10,193,141 | 10,193,141 | - |

The notes to the financial statements are an integral part of this statement.
<table>
<thead>
<tr>
<th>Statement of Activities</th>
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<tbody>
<tr>
<td>$</td>
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<tr>
<td>397,544</td>
</tr>
<tr>
<td>13,480</td>
</tr>
<tr>
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<tr>
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<td></td>
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<tr>
<td>8,038</td>
</tr>
<tr>
<td>17,289,587</td>
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<tr>
<td>17,708,649</td>
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<tr>
<td>11,999,700</td>
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<tr>
<td>11,999,700</td>
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<tr>
<td>(5,708,949)</td>
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</tr>
<tr>
<td>379,221</td>
</tr>
<tr>
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<tr>
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<tr>
<td>59,470</td>
</tr>
<tr>
<td>3,515,740</td>
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<tr>
<td></td>
</tr>
<tr>
<td>3,954,431</td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>(1,754,518)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>11,947,659</td>
</tr>
<tr>
<td>$</td>
</tr>
<tr>
<td>10,193,141</td>
</tr>
</tbody>
</table>
STATE OF IDAHO – STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
NOTES TO THE FINANCIAL STATEMENTS
For the Year Ended June 30, 2019

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES
The basic financial statements of the Catastrophic Health Care Cost Program have been prepared in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP), as applied to government units.

The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The more significant part of the Catastrophic Health Care Cost Program’s accounting policies are described below.

A. Reporting Entity
For financial reporting purposes, the Catastrophic Health Care Cost Program contains a General Fund. The management of the Catastrophic Health Care Cost Program does not have oversight responsibility or governing authority to significantly influence operations of any component units. The Catastrophic Health Care Cost Program is considered an agency of the state of Idaho.

B. Significant Accounting Policies
It is the Board’s policy to use the state’s accounting system to maintain its books and records. The state’s accounting system will allow the state to report on a modified accrual basis of accounting.

Much of the accounting is done on a statewide centralized accounting system. As the constitutional officer responsible for the state’s accounting, the state controller pre-audits payment vouchers initiated by departments before paying claims. Transactions for receipts are initiated by departments and recorded in state records by the state controller and the state treasurer. A monthly, summary-level reconciliation of all receipts and expenditures must be approved by the departments and returned to the state controller. Certain other functions — including purchasing, insurance, telephone and communications, and public works — are centralized in the Department of Administration. Agencies are billed their proportionate share of these costs.

Idaho Code, Section 67-3521, allows agencies and departments to encumber appropriations for a specific product or service due and payable prior to or as of the end of the current year. There were no encumbrances outstanding at the beginning of the year. There were no encumbrances at the end of the current fiscal year for invoices from pre-authorized cases dated and received through June 30, 2019.

C. Basis of Presentation
Government-Wide Statements – The Statement of Net Position and the Statement of Activities display information about the Catastrophic Health Care Cost Program of the state of Idaho. All funds reported are considered governmental type activities as opposed to business type activities. These funds are financed through state appropriations, safety restraint citations, interest earnings and refunds and reimbursements.

Fund Financial Statements – The fund financial statements provide information about the Catastrophic Health Care Cost Program’s funds. The Catastrophic Health Care Cost Program consists of a General Fund.
1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Fund Accounting - The Catastrophic Health Care Cost Program uses funds to report on its financial position and the results of its operations. Fund accounting is designed to demonstrate legal compliance and to aid financial management by segregating transactions related to certain government functions or activities.

**Governmental Funds**

General Fund — The General Fund is the general operating fund of the Catastrophic Health Care Cost Program. It is used to account for all financial resources except those required to be accounted for in another fund.

Special Revenue Fund — The Special Revenue Fund is established to account for the proceeds of specific revenue sources other than assessments, expendable trusts, or major capital projects that are legally restricted to expenditures for specified purposes. There were no special revenue funds as of June 30, 2019.

D. **Basis of Accounting**

Government-Wide Financial Statements - The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues, expenses, gains, losses, assets, deferred outflows of resources, liabilities, and deferred inflows of resources are recognized when earned or at the time when the liabilities are incurred, regardless of when the related cash flows take place.

Fund Financial Statements - The modified accrual basis of accounting is used by all governmental fund types. Under the modified accrual basis of accounting, revenues, expenditures, transfers, assets, deferred outflows of resources, liabilities and deferred inflows of resources are recognized when susceptible to accrual (i.e., when they become both measurable and available or payable.) "Measurable" means the amount of the transaction can be determined and "available" means collectible within the current period or soon enough thereafter to be used to pay liabilities out of the current appropriation. "Payable" indicates whether and to what extent the liability has matured, independent of the method and timing of resource accumulation.

E. **Budgets**

Budgets are adopted on a basis consistent with generally accepted accounting principles. An annual appropriated budget is adopted for the General Fund.

2. CASH AND INVESTMENTS

All cash balances shown on the basic financial statements are held and invested by the Idaho state treasurer. All interest earned and reported on this financial statement is deposited to the Catastrophic Health Care Cost Program account and is the property of the board.

Idaho Code provides authorization for the investment of funds as well as specific direction as to what constitutes an allowable investment.
STATE OF IDAHO -- STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
NOTES TO THE FINANCIAL STATEMENTS
For the Year Ended June 30, 2019

2. CASH AND INVESTMENTS (Continued)
The state is limited to the following general types of investments:

1. Certain revenue bonds, general obligation bonds, local improvement district bonds, tax and revenue
   anticipation notes and registered warrants of state and local governmental entities.

2. Time deposit accounts.

3. Bonds, treasury bills, interest-bearing notes, debentures, or other similar obligations of the United
   States Government and the Farm Credit System and its agencies and instrumentalities.

4. Repurchase agreements.

5. Banker’s acceptance and prime commercial paper.

Deposits and investments are included in the state of Idaho Investment Pool Funds, an unrated fund, and
are under the direction of the state treasurer. These investments are included in the state of Idaho’s
Comprehensive Annual Financial Report which is available through the state controller’s office.

3. REFUNDS AND REIMBURSEMENTS RECEIVABLE
There were no material refunds or reimbursements receivable noted as of June 30, 2019.

4. BENEFITS PAYABLE
Benefits are accrued on a modified accrual basis of accounting for the fund financial statements and on a
full accrual basis on the government-wide financial statements. Invoices for pre-authorized cases dated
through June 30, 2019 which will be paid in the 2020 fiscal year, if any, are reflected as benefits payable.

5. RELATED PARTY TRANSACTIONS
The Catastrophic Health Care Cost Program has not been involved in related party transactions that would
violate the Idaho Code or federal regulations.

6. SUBSEQUENT EVENTS
Subsequent events have been considered through the report date of September 25, 2019.

7. SEAT BELT INCOME
Idaho Code 49-673 allows for a citation of $10 for violation of safety restraint use laws of which $5 of
each citation is apportioned to the Catastrophic Health Care Cost Fund. For the fiscal year ended June
30, 2019, $59,470 was apportioned as set forth in this code section.

8. CAPITAL ASSETS
There are no capital assets to be accounted for in this program.
9. RESTRICTED FUND BALANCE/NET POSITION
The fund balance/net position should be reported as restricted when constraints placed on the use of resources are either externally imposed by creditors, grantors, contributors, or laws or regulations of other governments or are imposed by law through constitutional provisions or enabling legislation. Constraints have been placed on the use of the resources of the Catastrophic Health Care Cost Fund by enabling legislation. Therefore, the entire fund balance/net position has been reported as restricted. If the fund had both restricted and unrestricted fund balance/net position available, the restricted fund balance/net position would be spent first.

10. RISK MANAGEMENT
The Catastrophic Health Care Cost Program is exposed to various risks related to torts, theft of assets, and errors and omissions. The fund’s risk management program encompasses various means of protecting the fund against loss including liability coverage through commercial insurance carriers through the state of Idaho.

11. STATE APPROPRIATIONS
For the 2019 fiscal year, the state of Idaho appropriated $11,999,700 for the Catastrophic Health Care Cost Program’s use.
REQUIRED SUPPLEMENTARY INFORMATION
STATE OF IDAHO - STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE
BUDGET AND ACTUAL (WITH BUDGET TO GAAP DIFFERENCES) - GENERAL FUND
For the Year Ended June 30, 2019

<table>
<thead>
<tr>
<th>REVENUES</th>
<th>Original Budget</th>
<th>Final Budget</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on investments</td>
<td>$</td>
<td>- $</td>
<td>$379,221</td>
</tr>
<tr>
<td>Gain (loss) on investments</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seat belt income</td>
<td>-</td>
<td>-</td>
<td>59,470</td>
</tr>
<tr>
<td>Refunds and reimbursements</td>
<td>2,500,000</td>
<td>2,500,000</td>
<td>3,515,740</td>
</tr>
<tr>
<td>TOTAL REVENUES</td>
<td>2,500,000</td>
<td>2,500,000</td>
<td>3,954,431</td>
</tr>
</tbody>
</table>

| EXPENDITURES                  |                 |              |         |
| Health and sanitation:        |                 |              |         |
| Contract administration       | 367,034         | 367,034      | 397,544 |
| Other professional services   | 10,023          | 10,023       | 13,480  |
| Board travel                  | -               | -            | -       |
| Indemnity payments            | -               | -            | -       |
| Health care payments          | -               | -            | -       |
| Miscellaneous                 | 9,843           | 9,843        | 8,038   |
| Trustee/benefit payments      | 12,112,800      | 12,112,800   | 17,289,587|
| TOTAL EXPENDITURES            | 12,499,700      | 12,499,700   | 17,708,649|

| EXCESS OF REVENUES OVER (UNDER) EXPENDITURES |                 |              |         |
| (9,999,700)                                   | (9,999,700)     | (13,754,218) |

| OTHER FINANCIAL SOURCES (USES) |                 |              |         |
| Intergovernmental appropriations | 9,999,700       | 9,999,700    | 11,999,700|
| Intergovernmental appropriation recission | -              | -            | -       |
| TOTAL OTHER FINANCIAL SOURCES (USES) | 9,999,700       | 9,999,700    | 11,999,700|

| EXCESS OF REVENUES OVER (UNDER) EXPENDITURES AFTER OTHER FINANCIAL SOURCES (USES) | $ | $ | (1,754,518) |

| ADJUSTMENTS                  |                 |              |         |
| Net (increase) decrease in expenditure accruals | - | - | - |
| Net increase (decrease) in revenue accruals    | -               | -            | -       |

| EXCESS OF REVENUES OVER (UNDER) EXPENDITURES-MODIFIED ACCRUAL BASIS | (1,754,518) |

| RESTRICTED FUND BALANCE/NET POSITION - July 1, 2018 | 11,947,659 |

<p>| RESTRICTED FUND BALANCE/NET POSITION - June 30, 2019 | $10,193,141 |</p>
<table>
<thead>
<tr>
<th>GAAP Differences</th>
<th>GAAP Basis</th>
<th>Notes to the Required Supplementary Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$ 379,221</td>
<td>1. The Catastrophic Health Care Cost Program budgets on a modified accrual basis.</td>
</tr>
<tr>
<td></td>
<td>$ 59,470</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 3,515,740</td>
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<tr>
<td></td>
<td>$ 3,954,431</td>
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<td></td>
<td>$ 397,544</td>
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<td>$ 17,708,649</td>
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<td>$ (13,754,218)</td>
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<td>$ 11,999,700</td>
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<td></td>
<td>$ (1,754,518)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$ 10,193,141</td>
<td></td>
</tr>
</tbody>
</table>
Report on Internal Control Over Financial Reporting and on Compliance and
Other Matters Based on an Audit of Financial Statements Performed in
Accordance With Government Auditing Standards

INDEPENDENT AUDITOR’S REPORT

Administrative Board
Catastrophic Health Care Cost Program
Boise, Idaho

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the financial statements of the governmental activities of the Catastrophic Health Care Cost Program, an agency of the state of Idaho, as of and for the year ended June 30, 2019, and the related notes to the financial statements, which collectively comprise the program’s basic financial statements, and have issued our report thereon dated September 25, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Catastrophic Health Care Cost Program’s internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Catastrophic Health Care Cost Program’s internal control. Accordingly, we do not express an opinion on the effectiveness of the Catastrophic Health Care Cost Program’s internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity’s financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control, as defined above, that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Catastrophic Health Care Cost Program’s financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a
direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dearle Hart & Associates, PLLC
Idaho Falls, Idaho
September 25, 2019
<table>
<thead>
<tr>
<th>County</th>
<th>Reimbursements</th>
<th>County</th>
<th>Reimbursements</th>
</tr>
</thead>
<tbody>
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<td>Ada</td>
<td>$826,594</td>
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<tr>
<td>Adams</td>
<td>$51,670</td>
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<td>$149,099</td>
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<td>$16,310</td>
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<tr>
<td>Bear Lake</td>
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<td>Jerome</td>
<td>$60,206</td>
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<td>Benewah</td>
<td>$17,134</td>
<td>Kootenai</td>
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<td>Bingham</td>
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<td>Minidoka</td>
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<td>Nez Perce</td>
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<td>Canyon</td>
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<td>Custer</td>
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<td>Fremont</td>
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<td>Total</td>
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<td>Gem</td>
<td>$70,624</td>
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<tr>
<td>Providers</td>
<td>No. Patients</td>
<td>Total Amt of Billed Charges</td>
<td>Amount Received</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Bear Lake Memorial Hospital</td>
<td>5</td>
<td>115,957</td>
<td>$35,273</td>
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<tr>
<td>Benewah Community Hospital</td>
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<tr>
<td>Bingham Memorial Hospital</td>
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<td>313,252</td>
<td>$66,538</td>
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<td>Bonner General Hospital</td>
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<td>$46,862</td>
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<td>Boundary Community Hospital</td>
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<td>$3,033</td>
</tr>
<tr>
<td>Caribou Memorial Hospital</td>
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<td>$12,991</td>
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<td>Cascade Medical Center</td>
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<td>$1,066</td>
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Exhibit F
TOTALS FOR COMBINED STATE & COUNTY
Fiscal Year 2019

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<th>COUNTY</th>
<th>NO. OF CASES</th>
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### CAT and County Medical Costs Combined

**2019**

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**Total Administrative Costs:** $8,017,909 incurred by the counties only, the state spends considerably less to administer the CAT program.

*Resident- Refers to documented US citizens vs. undocumented persons.*
# AGENDA

**SENATE HEALTH & WELFARE COMMITTEE**  
3:00 P.M.  
Room WW54  
Monday, February 03, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
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<tr>
<td>H 314</td>
<td>Relating To The Deaf and Hard of Hearing</td>
<td>Steven Snow, Executive Director, Council for the Deaf and Hard of Hearing</td>
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<tr>
<td><strong>RS27462</strong></td>
<td>Relating to Dentists; Amending Section 54-901 Idaho Code</td>
<td>Elizabeth Criner</td>
</tr>
<tr>
<td>H 315</td>
<td>Relating to Controlled Substances; to mirror the Drug Enforcement Administration (DEA) scheduling decisions for 2019.</td>
<td>Nicki Chopski, PharmD, BCGP, ANP, Executive Director, State Board of Pharmacy</td>
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<td>H 316</td>
<td>Relating to Pharmacy; updates provisions of the Uniform Controlled Substances Act as it relates to forfeitures and discipline.</td>
<td>Nicki Chopski, PharmD, BCGP, ANP, Executive Director, State Board of Pharmacy</td>
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<tr>
<td>H 311</td>
<td>Relating to the treatment and care of the Developmentally Disabled</td>
<td>Blake Brumfield, Program Manager for DD, CPCS, Department of Health and Welfare</td>
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</table>

**MINUTES APPROVAL:**  
Minutes of January 14, 2020  
Senator Jordan

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**  
Chairman Martin  
Vice Chairman Souza  
Sen Heider  
Sen Lee  
Sen Harris  
Sen Burtenshaw  
Sen Bayer  
Sen Jordan  
Sen Nelson

**COMMITTEE SECRETARY**  
Margo Miller  
Room: WW35  
Phone: 332-1319  
Email: shel@senate.idaho.gov
MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 03, 2020
TIME: 3:00 P.M.
PLACE: Room WW54

MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
ABSENT/EXCUSED: Senator Heider

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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:07 p.m.

Chairman Martin stated he would like to recognize and welcome Neva Santos, Executive Director of the Idaho Academy of Family Physicians, and several resident students who are touring the Capitol and visiting the Committee meeting today.

H 314 Steven Snow, Executive Director, Council for the Deaf and Hard of Hearing, presented H 314 which relates to the deaf and hard of hearing. This bill revises and updates archaic language found in Title 67, Chapter 73 of Idaho Code. There are five agencies this change would impact and they are in agreement with this change. They are: Bureau of Occupational Licenses; State Department of Education; Idaho Educational Services for the Deaf and Blind; Idaho Public Utilities Commission; and the Council for the Deaf and Hard of Hearing.

He explained that terms being deleted are "hearing-impaired" and "hearing-impairment," and they are being replaced with "deaf or hard of hearing" or "hearing loss." The reference to a national representative on the Council is also being deleted.

DISCUSSION: Vice Chair Souza asked about using the word "impairments." Director Snow explained that the term "impairments" has a negative connotation and indicates that someone is broken. "Deaf and dumb" and "deaf and mute" are also considered inappropriate. Senator Lee asked about the composition of the Council and the removal of the word "national." Director Snow replied that the local board is comprised of two "hard of hearing" representatives and by removing the word "national," Council members may be from other "hard of hearing" organizations.

MOTION: Senator Burtenshaw moved to send H 314 to the floor with a do pass recommendation. Senator Jordan seconded the motion. The motion carried by voice vote. Senator Ward-Engleking will carry the bill.

RS 27462 Elizabeth Criner, representing the Idaho State Dental Association, presented RS 27462. This legislation would amend the Dental Practice Act to accommodate the advancement of teledentistry. Teledentistry is transparent, enhances patient protection, and preserves the standard of care. See attachment 1.

MOTION: Senator Lee moved to send RS 27462 to print. Vice Chair Souza seconded the motion. The motion carried by voice vote.
Nicki Chopski, Executive Director, State Board of Pharmacy, presented H 315. She explained that the State Board of Pharmacy administers the regulatory provisions of the state’s Uniform Controlled Substances Act. This bill relates to controlled substances and mirrors the Drug Enforcement Administration (DEA) scheduling decisions for 2019.

MOTION: Senator Harris moved to send H 315 to the floor with a do pass recommendation. Senator Bayer seconded the motion. The motion carried by voice vote. Senator Harris will be the floor sponsor.

H 316 Ms. Chopski presented H 316, relating to controlled substances. She stated it updates the provisions of the Uniform Controlled Substances Act as it relates to forfeitures and discipline. Ms. Chopski also indicated the bill updates and modernizes provisions of the Pharmacy Act. Drug destruction is under the supervision of the Idaho State Police and a representative of the State Board of Pharmacy will no longer be required to witness the destruction. Language has been simplified relating to continuing education and counseling, both of which are important.

MOTION: Senator Jordan moved to send H 316 to the floor with a do pass recommendation. Senator Lee seconded the motion. The motion carried by voice vote. Senator Jordan will carry the bill.

Blake Brumfield, Program Manager of the Developmentally Disability Crisis Prevention and Court Services Program, Division of Family and Community Services, Department of Health and Welfare, presented H 311, Relating To The Treatment And Care Of The Developmentally Disabled. He explained that the bill would allow a licensed independent practitioner to be used in place of a physician. This would allow the workload to be spread more effectively among the staff.

TESTIMONY: Richelle Tierney, Policy Analyst, Idaho Council on Developmental Disabilities, stated the Council supports H 311. The Council is comprised of 23 volunteers, appointed by the governor, and they applaud the efforts that are being made. See attachment 2.

MOTION: Senator Nelson moved to send H 311 to the floor with a do pass recommendation. Vice Chair Souza seconded the motion. The motion carried by voice vote. Senator Nelson will carry the bill.

MINUTES APPROVAL: Senator Jordan moved to approve the Minutes of January 14, 2020. Senator Harris seconded the motion. The motion carried by voice vote.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:37 p.m.
Good afternoon, my name is Elizabeth Criner and I am here today on behalf of the Idaho State Dental Association for the introduction of RS 27462.

This legislation amends the Dental Practice Act in two sections of Idaho Code -- 54-901 and 54-924 -- to accommodate the advancement of teledentistry in a manner that is transparent to patients, enhances patient protection and preserves the community standard of care provided to patients whether delivered in person or via teledentistry.

In section 54-901 - Language is added to the practice of dentistry to ensure that dentists practicing telehealth or teledentistry are doing so in accordance with the Telehealth Access Act (Title 54, Chapter 57), as well as in accordance with the community standard of care.

The bill also adds language requiring dentists to provide a patient with licensure and contact information.

The practice of dentistry is different from the practice of medicine, and in most instances a patient will need in-person care at some point. We want to make sure the patient is clearly informed and understands what they are paying for, what may be needed, and what may or may not be provided by the dentist they are working with via teledentistry. Therefore, the bill allows a dentist to either provide referral options for the patient or obtain a signed statement from the patient that they understand in-person care may be needed from another dentist.

In section 54-924 – the bill ensures parity between the provision of telehealth and in-person dental services. Regardless of the delivery method, these services must be provided in keeping with the community standard of care when a dentist is authorizing or performing dental procedures to correct the malposition of human teeth.

The bill also ensures a dentist cannot represent, contract with or be employed by an entity that would limit a patient’s right to file a complaint with the State Board of Dentistry.

FISCAL NOTE

The Dental Practice Act is enforced by the Idaho State Board of Dentistry, which is self-funded; therefore, there is no fiscal impact to the state general fund or local government funds.
February 3, 2020

Senator Martin, Chairman
Senate Health & Welfare Committee
Statehouse
Boise, ID 83720

Dear Chairman Martin and Members of the Committee:

The Council on Developmental Disabilities is authorized by federal and state law to monitor service systems and policies and to advocate for improved services that enable Idahoans with developmental disabilities to live meaningful lives, included in their home communities. The Council is comprised of 23 volunteers appointed by the Governor.

The Council supports House Bill 311.

The replacement of a Licensed Independent Practitioner in place of a physician is a practical solution to an increasingly common problem for the guardianship evaluation committees. As you are already aware, it is difficult to find a physician in our rural areas.

This legislation is also consistent with the direction the state is moving with respect to guardianships for individuals with intellectual and developmental disabilities. I would like to recognize the work this division has done to help transition from a medical model of treatment, as in viewing people with developmental disabilities as sick, broken, or in need of “fixing.” Our state is moving to the practice of using “Supported Decision Making,” which is an alternative to guardianships. Supported decision making is a way for an adult with a disability to make their own decisions by using friends, family members, and other people they trust to:

- Help understand issues and choices
- Ask questions
- Receive explanations in a way that makes sense to the person

The division has provided training to all staff on supported decision making and alternatives to guardianship. When evaluation committee members review individual guardianship cases, they are using the supported decision-making framework to evaluate the necessity of continued guardianship.

The Idaho Council on Developmental Disabilities applauds the efforts the division is making to assist adults with intellectual and developmental disabilities to make informed decisions. The division is working to create a culture that supports the individual’s ability to exercise their rights to make important life decisions.

Thank you for considering the Council’s comments.

Sincerely,

Richelle Tierney
Policy Analyst
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, February 04, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
<th>PRESENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESENTATION:</td>
<td>Youth Vaping Epidemic</td>
<td>Dr. Bonnie Halpern-Felsher</td>
</tr>
<tr>
<td>PRESENTATION:</td>
<td>Red Cross Blood/Biomed Program</td>
<td>Roy Eiguren</td>
</tr>
<tr>
<td><strong>H 310</strong></td>
<td>Relating to Criminal History and Background Checks</td>
<td>Fernando Castro, Program Manager, Criminal History Unit</td>
</tr>
</tbody>
</table>

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**
- Chairman Martin
- Vice Chairman Souza
- Sen Heider
- Sen Lee
- Sen Harris
- Sen Burtenshaw
- Sen Bayer
- Sen Jordan
- Sen Nelson

**COMMITTEE SECRETARY**
- Margo Miller
  - Room: WW35
  - Phone: 332-1319
  - Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 04, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:00 p.m.

PRESENTATION: Bonnie Halpern-Felsher, Ph.D., Developmental Psychologist, presented information on the youth vaping epidemic. She stated that her presentation would include information regarding national and local tobacco usage rates, an introduction to e-cigarettes/vaping/cannabis and what e-cigarettes are, how they work, and what is in them. See attachment 1. While cigarette use has decreased, e-cigarette use has significantly increased, especially from 2017-2018. Approximately one in five students uses e-cigarettes. Idaho's youth is at 41 percent for usage in the past month.

Dr. Halpern-Felsher described the five generations of vaping products and how they work. Many of these products are easy to hide, and that appeals to young people.

Dr. Halpern-Felsher then explained the amount of nicotine in these products, the effect of the chemicals on the brain, and their impact on the heart and lungs. Youth use anywhere from one to three pods a day and do not know the amount of nicotine contained in them. The Juul label indicates it has 5 percent strength, but the label doesn't explain that equals 41 milligrams of nicotine.

E-cigarette, or vaping, product use associated lung injury (EVALI), caused 60 deaths from January 1, 2020, through January 21, 2020. There were 2,711 hospitalized cases of severe lung damage linked to vaping. All vaped THC, nicotine, or both. Sixteen percent were under 18 years of age, and 38 percent were 18 to 24 years of age.

Dr. Halpern-Felsher said there are some things that can be done. First of all, e-cigarettes should be considered a tobacco product as identified on the books, because nicotine comes from tobacco products. Second, a permit system is needed for all vape shops, and compliance checks need to be in place. Presently, those shops do not card youths. The lower cost of e-cigarettes compared to traditional cigarettes is appealing to youths. Prices should be equalized and all tobacco products should cost the same. Also, there is insufficient evidence to prove that adults who are using e-cigarettes are being helped to stop smoking traditional cigarettes. The fact is, adults are just switching products, not quitting.
DISCUSSION: Senator Jordan referred to the 2,700 who were hospitalized, but the CDC only tested 100 lungs and there is no definitive data. She asked what would be definitive data. Dr. Halpern-Felsher replied that she didn't know. Senator Heider inquired if "regulate" refers to a penalty, and how that would occur. Dr. Halpern-Felsher said she doesn't view regulating as a youth penalty at all. It is up to adults to regulate the industry. She explained there should not be fines or penalties, but rather support for youths and limited access to e-cigarettes. Senator Bayer asked about the damage that is done to the lungs. The reply was that pneumonia and asthma are directly linked to e-cigarettes and nicotine. Vice Chair Souza said that she had been told that marijuana can be made into a paste and also can become odorless and inquired if that was true. Dr. Halpern-Felsher replied in the affirmative.

PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza.

Vice Chair Souza asked if the Committee could now hear H 310, followed by the Red Cross presentation. There were no objections.

H 310 Fernando Castro, Supervisor for the Criminal History Unit, Department of Health and Welfare (Department), presented H 310. He stated that this bill charges the Department to conduct background checks on individuals who provide care or services to vulnerable adults or children. Section 4(c) of the statute refers to the Federal Bureau of Investigation's (FBI) National Crime Information Center (NCIC) as being a source of information. The FBI has asked that specific references to the NCIC be removed from the statute because the FBI has never had access to the entire NCIC. The current language suggests that it does. See attachments 2 and 3.

MOTION: Senator Lee moved to send H 310 to the floor with a do pass recommendation. Senator Harris seconded the motion. The motion carried by voice vote. Senator Heider will carry the bill.

PRESENTATION: Roy Eiguren, of Eiguren Ellis Public Policy Firm and Chairman of the American Red Cross of Greater Idaho, presented information about the Blood/Biomed Program. Mr. Eiguren noted that Steve Carr from Idaho Falls has served on the Global Red Cross Board which is based in Geneva Switzerland and is the only Idahoan to do so.

One hundred percent of funding for the Red Cross comes from the private sector and the organization has more than 500 volunteers across Idaho. The Red Cross helps people affected by disaster; supports members of the military and their families; provides health and safety training programs; conducts blood collection and distribution; and runs an international relief and development program. See attachment 4.

Nicole Siewack Erwin, CEO of the American Red Cross, explained how the programs of the Red Cross work. They serve over 100,000 people throughout the state, and this is done by 539 volunteers who donate more than 34,000 hours. The value of this service is $856,000 per year which is a great savings to taxpayers. Idahoans donate approximately 60,000 pints of blood each year and each pint saves up to three lives. See attachment 5. Volunteers are installing smoke alarms in high-risk neighborhoods across Idaho and Ms. Erwin stated that home fires kill up to seven people each day. CPR is also taught and 1,275 people were trained in CPR. Vice Chair Souza inquired if CPR could be taught to the Committee, and Ms. Erwin answered affirmatively.
Senator Jordan asked about the requirements for smoke detector installation. Ms. Erwin stated there is a website, an 800 number, and campaigns throughout the state canvassing mobile home parks.

ADJOURNED: There being no further business at this time, Vice Chair Souza adjourned the meeting at 3:51 p.m.
The Vaping Phenomenon: What it is, Why it happened, and What you can do about it

Bonnie Halpern-Felsher, PhD
Professor, Adolescent Med/Peds
Founder & Executive Director, TPT and CAPT
What I Will Cover

• National and local tobacco usage rates
• An introduction to e-cigs/vaping/Cannabis
  – What they are
  – How they work
  – What is in them
• Health effects
• Why youth are using vapes
• Policies to consider
National 2019 Data

NATIONAL YOUTH TOBACCO SURVEY*:
HIGH SCHOOL STUDENT USE OF E-CIGARETTES CONTINUES TO CLimb

Source: U.S. Department of Health and Human Services, 2019
Idaho Rates

- 43% of high school students have used e-cigarettes at least once
  - 2019 YRBS survey
Product After Product

E-Cigarettes (Formal/Scientific)
Vapes (Colloquial)

1st Generation
• Resembles a cigarette
• Disposable

2nd Generation
• Pen-shaped
• Larger
• Rechargeable

3rd Generation
• Refillable
• Customizable
• Aka “MODs”
Product After Product

E-Cigarettes (Formal/Scientific)
Vapes (Colloquial)

1st Generation
- Resembles a cigarette
- Disposable

2nd Generation
- Pen-shaped
- Larger
- Rechargeable

3rd Generation
- Refillable
- Customizable
- Aka “MODs”

Pod-Based Devices
- Sleek/discreet
- High-tech design
- High in nicotine
The Rise of Juul

Monthly E-Cigarette Sales

- Market Total
- JUUL
- Reynolds/BAT
- Altria
- Imperial/Fontem/Lorillard
- Logic/JTI
- NJoy

1/23/2019
Pod-Based Products
5th Generation: Disposables
E-Cigs = Tobacco

E-cigs/JUULs=Nicotine
Nicotine comes from Tobacco
E-cigs/JUULs=Tobacco Products

Nicotine=Nicotine Dependence
E-cigs are addictive!

For more information, visit: www.tobaccocontroltoolkit.stanford.edu

E-cigs/JUULs=Nicotine
Nicotine comes from Tobacco
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Cigs in a Pod

1 Pack of Cigarettes ≈ 20 mg of nicotine
1 JUUL pod ≈ 41.3 mg of nicotine
1 PHIX pod ≈ 75 mg of nicotine
1 Suorin pod ≈ 90 mg of nicotine

=20 CIGARETTES
≈ 41 CIGARETTES
≈ 75 CIGARETTES
≈ 90 CIGARETTES

tobaccopreventiontoolkit.stanford.edu
### Which Chemicals Are Found in E-Cig/Pod-Based Aerosol?

<table>
<thead>
<tr>
<th>Compounds</th>
<th>Compounds</th>
<th>Compounds</th>
<th>Compounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propylene glycol</td>
<td>Chlorobenzene</td>
<td>Benzo(ghi)perylenne</td>
<td>Cadmium</td>
</tr>
<tr>
<td>Glycerin</td>
<td>Crotonaldehyde</td>
<td>Acetone</td>
<td>Silicon</td>
</tr>
<tr>
<td>Flavorings (many)</td>
<td>Propionaldehyde</td>
<td>Acrolein</td>
<td>Lithium</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Benzaldehyde</td>
<td>Silver</td>
<td>Lead</td>
</tr>
<tr>
<td>NNN</td>
<td>Valeric acid</td>
<td>Nickel</td>
<td>Magnesium</td>
</tr>
<tr>
<td>NNK</td>
<td>Hexanal</td>
<td>Tin</td>
<td>Manganese</td>
</tr>
<tr>
<td>NAB</td>
<td>Fluorine</td>
<td>Sodium</td>
<td>Potassium</td>
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<td></td>
<td>Titanium</td>
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<td>Ethylbenzene</td>
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<tr>
<td>Benzene</td>
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<td>Toluene</td>
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<td>Cobalt</td>
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<tr>
<td>Naphthalene</td>
<td></td>
<td></td>
<td>Rubidium</td>
</tr>
<tr>
<td>Styrene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzo(b)fluoranthene</td>
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</tr>
</tbody>
</table>

All of these have been found in e-cigarette/pod-based aerosol

Compounds in orange are from FDA 2012, Harmful and Potentially Harmful Substances – Established List
The Body When Vaping

- Rewires and changes the brain
- Heart beats faster due to “fight or flight” response
- Trouble breathing & damage to lungs
- Increased acid reflux
The Body When Vaping

Rewires and changes the brain

Heart beats faster due to “fight or flight” response

Trouble breathing & damage to lungs

Increased acid reflux
Cannabis and Respiratory Illness

E-cigarette, or Vaping, product use Associated Lung Injury (EVALI)

Healthy lungs  Vape-injured lungs  17yo victim

Tryston Zohfeld, TX
◆ 18 days in hospital
◆ 10 days medically-induced coma
Cannabis and Respiratory Illness: EVALI

2,711 hospitalized cases of severe lung damage linked to vaping
60 deaths confirmed (as of Jan 21, 2020)

16% under 18 years old
38% 18-24 years old

All vaped THC, nicotine or both

_Vitamin E acetate suspected in many but not all cases_

Symptoms: coughing, shortness of breath, chest pain, nausea, vomiting, abdominal pain, diarrhea, fever, chills, weight loss

Youth Appeal: Not a Mistake
Hidden in Plain Sight
Hidden in Plain Sight
Misleading Product Packaging
How Much is That?

They want you to be confused!
How much nicotine do JUULs have…

- **The SAME amount of nicotine as a pack of cigarettes**
- **MORE amount of nicotine as a pack of cigarettes**
- **LESS amount of nicotine as a pack of cigarettes**

35.9%  
39.7%  
24.5%
How much nicotine do you think each product contains?

- **Juul**
- **Suorin**
- **Drop**

Choices:
- 0 mg/ml
- 3 mg/ml
- 12 mg/ml
- 36 mg/ml
- 59 mg/ml
- Don't know
- 5 mg/ml
- 72 mg/ml
Flavors
Flavors of Vapes

15,500 tobacco flavors and counting

What’s Your Taste?

Chicken & Waffles

Tastes your Mouth Cave For, Which Flavor you Sneke?
Widely used e-cigarette flavoring impairs lung function

Date: May 23, 2018
Source: American Thoracic Society

E-cigarette use, flavorings may increase heart disease risk, study finds

E-cigarette flavorings damage human blood vessel cells grown in the lab even in the absence of nicotine, Stanford researchers and their colleagues found. Cinnamon and menthol flavors were particularly harmful.
Cool and Youth-Focused Ads

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Cool and Youth-Focused Ads

tobaccopreventiontoolkit.stanford.edu
Social Media Targeting

tobaccopreventiontoolkit.stanford.edu

• Problematic memes and cartoons are also distributed via Twitter or Instagram, which give youth the impression that using is okay.
Access
Access
Cost
COST: Juul vs Cigarettes

- 4 JUUL pods: $14.99 (Vapor Lounge)
- Cigarettes: $5.41 per pack x 4 = $21.64
- $14.99 vs. $21.64

JUUL pods cost LESS than cigarettes!!!
Disposables Even Less!

• Many are sold for $1
But Don’t Vapes Help Adults Quit Smoking Cigarettes?
What Policies Can Help: Federal Level

• Flavored, **cartridge-based** e-cigs (except for tobacco or menthol flavored)

• Other e-cig products for which the manufacturer has failed to take adequate measures to prevent minors' access

• **NOT** prioritizing “open systems” such as Suorin or disposal systems such as the Puff Bar, which are both very popular with youth, and come in attractive colors, flavors, and packaging
What Policies Can Help: State and Local Levels

- Definitions (parity across tobacco products):
  - E-cigarettes are tobacco products; therefore, fold e-cigarettes into all tobacco policies
  - Any new/emerging tobacco or nicotine product to come on the market → tobacco
What Policies Can Help

• **Access:**
  – Need a permit system for all vape shops; compliance checks
  – Youth are price sensitive. Equalize price points; tax e-cigarettes like all other tobacco products
Thank you!

Bonnie.halpernfelsher@Stanford.edu
Idaho Department of Health and Welfare
Criminal History Unit Presentation
House Bill No. 310

IC 56-1004A, “Criminal History and Background Checks”
RE: Amending statute to eliminate references

February 4, 2020

Mister Chairman, members of the Committee:

My name is Fernando Castro and I am the supervisor for the Department of Health and Welfare Criminal History Unit. Our unit is part of the Bureau of Compliance. Thank you for inviting me to present this legislative proposal identified as House Bill 310, concerning the amendment of Idaho Code 56-1004A, Criminal History and Background Checks.

First, let me tell you about ourselves. The Criminal History Unit completes over 30,000 background checks a year. These checks help the Department protect those that are vulnerable by screening employees of providers and individuals that participate in certain Department programs such as foster care, adoption and certified family homes. Each year, nearly 500 applicants are denied or voluntarily withdraw from their background checks because of disqualifying elements.

This statute change simply seeks to eliminate subsection 4 (c) of the statute – line 38 of the changed text document –, which makes reference to the National Crime Information Center.

I would like to share with you why this change is being made. When the Department makes changes to its background check rules, we must send our draft proposed rule changes to the FBI to ensure that those changes are not contrary to existing federal mandates, or, to make sure that they do not bestow upon the Department greater powers than authorized by federal law. Accordingly, when the Department considers making such changes, we send them to the FBI for their review. The goal of this exercise is that when this body convenes on Regular Session, we can affirm to you that those rule changes have received the FBI’s approval and are ready for your consideration, review and approval.

Last year, as we engaged our stakeholders in negotiated rulemaking, and we submitted those rule changes to the FBI for their review, they pointed out to us that there was language in those rules that was indeed conferring the Department access to more information than allowed by federal law. The Department recognized that similar language was present in this statute and asked the FBI to review it as well. Consequently, they requested that the language in subsection 4 (c) be removed from this statute so that it would accurately represent the scope of the FBI information that federal law authorizes the Department to receive. I would like to let you know that in our companion administrative rule changes that you have already reviewed, we have already removed similar language to the one that we are striking through in this Legislative proposal.
Ultimately, what this statute change will accomplish is enable the Department to continue to process background checks by removing the language that the FBI does not approve. I would like to reiterate to you that even though it appears that we are getting less from the FBI with this statute change, we still have access to all their resources as authorized by both US Public Laws 92-544 and 113-186. That is, we will continue to receive information from the Interstate Identification Index and the National Sex Offender Registry as authorized by those laws and as appropriate. In cases where information contained in the National Sex Offender Registry information cannot be given to us directly from the FBI, the Department can access other resources that provide literally the same information.

Finally, this statute change does not reduce or add applicant or Department costs. The applicant fees that the Department currently charges for the processing of its background check are adequate to fund the operation of the program. Therefore, there is no fiscal impact to the State with this statute change.

I ask that you send this statute change to the floor with a do pass recommendation so that the Department can continue to receive the FBI criminal history information that is authorized to receive as per federal law to continue to process the background checks that is required to complete under this statute.

This concludes my prepared remarks. Thank you for your time. I stand now for questions.
Talking Points

- It is necessary to remove references to the FBI National Crime Information Center (NCIC) to assure that DHW continues to receive the information that it currently receives.
  a. The NCIC is the FBI criminal information clearing house. It is composed of 21 separate files. US Law 92-544 and 113-186 only authorize DHW access to two components of this clearing house: The Interstate Identification Index (III) and the National Sex Offender Registry (NSOR)
    i. US PL 92-544 authorizes access to the III
    ii. US PL 113-186 authorizes access to the III and the NSOR only if the background check is for persons that work in a children's daycare environment/setting
- Failure to remove the references to the NCIC will likely result in suspension of the current criminal history information exchanges between the Department and the FBI. If these exchanges are suspended due to the failure to change the statute, they will be restored once the statute is changed to satisfy the FBI request. DHW has until September 30, 2020 to change the statute
- Currently, DHW has unrestricted access to individual state Sex Offender Registries online and the US Department of Justice Dru Sjodin Sex Offender Registry. Therefore, loss of access to the FBI NSOR for the background checks of applicants that are not part children's daycare workforce is mitigated by the availability of these other resources
- As long as the FBI remains mentioned in the statute – Section 4 (b) -, DHW will continue to receive any and all FBI information that is authorized as per federal law. Making this change now will likely eliminate the need to make further statute changes if future federal legislation confers or rescinds access to any FBI resources to DHW

---

1 The USDOJ Dru Sjodin National Sex Offender Registry website can be found at this location: https://www.nsopw.gov/
The Department and the Bureau
The Department oversees $2.5 Billion in spending for Idaho Citizen’s Health and Welfare. The Bureau of Audits and Investigations, part of Support Services, provides critical integrity efforts to ensure public safety and to fight waste, abuse, and fraud. The Bureau of Audits and Investigations has four units which provide very different services.

- Internal Audit provides Management with independent feedback on critical controls.
- Criminal History processes background checks to protect vulnerable adults and children.
- Medicaid Program Integrity audits Medicaid providers.
- Welfare Fraud Investigation audits and investigates recipients of public assistance and Non-Medicaid providers.

The Criminal History Unit
The Criminal History Unit is staffed by 18 dedicated professionals that cover the entire state of Idaho needs for the Department background check. The unit is self-funded and completes over 30,000 background checks per year. These background checks help the Department protect those who are vulnerable from harm by screening employees of providers and individuals that participate in certain Department programs such as foster care, adoption and certified family homes. Each year, nearly 500 applicants are either denied or voluntarily withdraw from their background checks because of disqualifying elements in their background checks. The current average turnaround time for the background check is 15 days.

Providers that were Background Checked

<table>
<thead>
<tr>
<th>Provider Types</th>
<th>SFY2016</th>
<th>SFY2017</th>
<th>SFY2018</th>
<th>SFY2019</th>
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<tbody>
<tr>
<td>Medicaid Providers</td>
<td>12,319</td>
<td>14,008</td>
<td>12,709</td>
<td>14,365</td>
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<tr>
<td>Long Term Care Providers</td>
<td>8,880</td>
<td>8,030</td>
<td>11,201</td>
<td>11,407</td>
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<tr>
<td>Foster Care and Adoption Candidates</td>
<td>3,460</td>
<td>3,005</td>
<td>4,236</td>
<td>3,998</td>
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<tr>
<td>Day Care/Child Care Providers</td>
<td>2,994</td>
<td>4,224</td>
<td>3,443</td>
<td>3,720</td>
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<tr>
<td>EMS Employees and Volunteers</td>
<td>904</td>
<td>825</td>
<td>949</td>
<td>986</td>
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<tr>
<td>Behavioral Health Providers</td>
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<td>915</td>
<td>1,901</td>
<td>4,161</td>
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<tr>
<td>Department Employees/Volunteers</td>
<td>490</td>
<td>994</td>
<td>466</td>
<td>1169</td>
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<tr>
<td>Court Appointed Guardians/Conservators</td>
<td>599</td>
<td>598</td>
<td>600</td>
<td>566</td>
</tr>
</tbody>
</table>

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- How We Have Progressed 2
- Our Finances 3
- What’s Next 4

Bureau Mission
Although each of our four units has a distinctly different mission, we all share a common vision.

- We will maximize the value of our services to the Department by improving our effectiveness and efficiency
- We will pursue “best practices” within our own areas of operations
- We will reach out and become excellent communicators with each other, our leaders, customers, and the public
- We will develop and maintain a highly skilled and knowledgeable cadre of experts in our fields

Unit Mission
To protect the vulnerable citizens involved in the many Department programs by administering a criminal history background check system.
2019 Accomplishments

- Obtained federal grant funds to improve the customer experience of the applicant with the background check system online application system and to replace fingerprint collection and submission equipment.

- In response to an ever-increasing demand for the Department background check, we transformed the unit's business model by increasing walk-in fingerprinting opportunities state-wide. At some locations, volume of applicants seen has increased by almost 40% due to the changes implemented.

- Actively listened to stakeholders concerns by changing administrative rules, business practices and improving web-based services to meet their business needs.

Some of the measures reported on this report were included in the Facts Figures and Trends Report which is published annually by the Department of Health and Welfare at the following address: http://www.healthandwelfare.idaho.gov/AboutUs/Facts FiguresTrends
Our Finances

What are the costs of the Criminal History Unit and how are those costs paid?

Unlike other state agencies, 90% of our revenue consists of fees collected from the applicant to process their background check. The remaining 10% of the total revenue comes from a near even split from the state General Fund and corresponding federal match. State statute requires that our applicants pay for their background check. Some of our stakeholders do pay for their employees’ background check as a recruiting and retention measure. The Department pays for the background checks of its employees and those of persons that participate in programs that benefit directly children at risk such as adoption and foster care. The current fee for the background check is $65.00 per person.

Revenue by Source (in thousands)

<table>
<thead>
<tr>
<th>Source</th>
<th>SFY2016</th>
<th>SFY2017</th>
<th>SFY2018</th>
<th>SFY2019</th>
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<tbody>
<tr>
<td>Applicant fees</td>
<td>$1,491.0</td>
<td>$1,599.0</td>
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<td>General Fund &amp; Federal Match</td>
<td>$141.0</td>
<td>$93.0</td>
<td>$178.0</td>
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<tr>
<td><strong>Total revenues</strong></td>
<td>$1,632.0</td>
<td>$1,692.0</td>
<td>$1,952.0</td>
<td>$1,961.0</td>
</tr>
</tbody>
</table>

Expenditures by Area (in thousands)

<table>
<thead>
<tr>
<th>Area</th>
<th>SFY2016</th>
<th>SFY2017</th>
<th>SFY2018</th>
<th>SFY2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fingerprint Processing</td>
<td>$877.1</td>
<td>$890.5</td>
<td>$921.9</td>
<td>$869.6</td>
</tr>
<tr>
<td>Personnel Costs</td>
<td>$639.0</td>
<td>$715.2</td>
<td>$831.1</td>
<td>$946.8</td>
</tr>
<tr>
<td>Other Operating Expenses</td>
<td>$115.4</td>
<td>$93.0</td>
<td>$198.7</td>
<td>$123.5</td>
</tr>
<tr>
<td><strong>Total expenditures</strong></td>
<td>$1,698.7</td>
<td>$1,698.7</td>
<td>$1,951.7</td>
<td>$1,959.9</td>
</tr>
</tbody>
</table>

Independent Audit

Independent audits of the State of Idaho can be found at [http://legislature.idaho.gov/audit/statewidereports.htm](http://legislature.idaho.gov/audit/statewidereports.htm).
Website Continuous Improvement

We will continue to invest in the Department Background Check website to increase its value to our stakeholders. We will keep an eye out for emerging technologies and make changes to the website when possible to ensure that it remains a useful tool to its users. We will listen to them and implement their feedback.

Appointment Availability

We will continue to prudently allocate our resources to satisfy the demand for the Department background check state-wide. Our goal is to maximize access to us for the applicant as soon as they submit their application for the background check online.

Reduce Background Check Costs

We will continue to look for ideas to help us improve our work processes to find savings that will reduce the cost of our background checks. We will continue to partner with the Idaho State Police to deploy and use electronic criminal history information exchange systems to render the process completely paperless.

Accelerate Completion of Background Checks

We will continue to explore ways to leverage electronic data in our systems to ensure that we allocate our resources to resolve background checks that take longer to resolve. Examples of why completion of a Department background check may be delayed are:

- A person may have low quality fingerprints requiring submission of a second set of fingerprints to be compared with federal/state criminal files
- Resolution of research of criminal dispositions in jurisdictions outside of Idaho and, their conversion to an Idaho equivalent depends on the speed of those states’ responses affecting the timely completion of our background check
- Reliability of the fingerprint transmission infrastructure and systems is occasionally interrupted for technical reasons which delay the processing of the background check
Greater Idaho Chapter
Fiscal year 2019
FAST FACTS

When disaster strikes, the Red Cross of Greater Idaho stands at the ready, delivering food, shelter, comfort and hope when families need it most. But the organization does so much more. From providing lifesaving blood to supporting military members and their families, the Red Cross truly lives its mission of turning empathy into action each and every day.

None of this would be possible without the generosity of our donors and the dedication of our volunteers. They not only respond to current disasters but help us prepare for future emergencies as well. To everyone who supports us and our mission, we would like to express our gratitude. Learn more at redcross.org/idaho.

Our 539 volunteers contributed 34,247 hours.

Disaster Action Teams gave 708 people food, shelter, and other support following a disaster.

We collected 62,846 units of blood at 2,473 blood drives. Each unit can save up to three lives.

We installed 1,648 free smoke alarms, making 710 homes safer.

Red Cross provided services to 1,110 military families.

More than 12,875 people learned lifesaving skills like CPR in our health and safety classes.

For more information visit redcross.org/idaho or call 800-853-2570.

www.facebook.com/RedCrossIdaho | twitter.com/RedCrossIdaho
www.instagram.com/idaho.montana.redcross
‘SO FULL OF LIFE’

Blood donors give young Idaho girl a second chance

Around the time she turned 2, Eloise Lawrence couldn’t seem to stay healthy. But when she woke up one afternoon and the blood vessels around her feet and ankles appeared to be bursting, her parents knew it was serious.

“The doctor took one look at her that day and sent us to the emergency room,” Eloise’s mom Jenica said.

Eloise and Jenica were rushed by ambulance to St. Luke’s Children’s Hospital in Boise, where Eloise was eventually diagnosed with leukemia.

She would undergo treatment for the next two and a half years, receiving multiple blood transfusions along the way.

Some four years later, Eloise is a healthy, “feisty” 6-year-old, thanks in large part to the generosity of blood donors.

“She’s so full of life,” Jenica said. “She loves skate boarding and dancing and wants to be a veterinarian when she grows up.”

Jenica has a heartfelt message to all those who helped give a little girl they didn’t even know a second chance.

“Thank you for letting me keep my family,” she said. “Our family wouldn’t be the same; our life wouldn’t be the same. We get to watch her live her dreams for her-
### AGENDA

**SENATE HEALTH & WELFARE COMMITTEE**

**3:00 P.M.**

**Room WW54**

**Wednesday, February 05, 2020**

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
<th>PRESENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRESENTATION:</strong></td>
<td>Department of Health and Welfare, Budget Report</td>
<td>Dave Jeppesen, Director</td>
</tr>
<tr>
<td><strong>RS27492</strong></td>
<td>Senate Concurrent Resolution Stating Findings In Developing And Implementing A Statewide Strategic Plan To Improve The Idaho Behavioral Health System.</td>
<td>Dave Jeppesen, Director, Department of Health and Welfare</td>
</tr>
<tr>
<td><strong>PRESENTATION:</strong></td>
<td>Preschool Development Grant Birth to Five (PDG B-5); overview, history, and targeted outcomes of the grant.</td>
<td>Beth Oppenheimer, Executive Director, Idaho Association for the Education of Young Children</td>
</tr>
</tbody>
</table>

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

<table>
<thead>
<tr>
<th>COMMITTEE MEMBERS</th>
<th>COMMITTEE SECRETARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman Martin</td>
<td>Margo Miller</td>
</tr>
<tr>
<td>Vice Chairman Souza</td>
<td>Room: WW35</td>
</tr>
<tr>
<td>Sen Heider</td>
<td>Phone: 332-1319</td>
</tr>
<tr>
<td>Sen Lee</td>
<td>Email: <a href="mailto:shel@senate.idaho.gov">shel@senate.idaho.gov</a></td>
</tr>
<tr>
<td>Sen Harris</td>
<td></td>
</tr>
</tbody>
</table>


MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 05, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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.

CONVENE: Chairman Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:01 p.m.

PRESENTATION: Dave Jeppesen, Director of the Department of Health and Welfare (Department), presented the budget report, strategic plan, and overall update on where they are as a Department. The mission of the Department is to protect and promote the safety of Idahoans.

Mr. Jeppesen described the past year, which included visiting with Department employees and at each office location throughout the state.

Mr. Jeppesen said one of the things he focused on during the summer was to create a strategic plan and for the Department to be held accountable. See attachment 1. Four goals and objectives were defined within the plan and they are reviewed each month, starting with goal one the first week, goal two the second week, and so on. This has kept them focused, and they have accomplished 34 percent of the tasks that are in the plan. The four goals are as follows:

1. Ensuring affordable, available health care that works
2. Protecting children, youth, and vulnerable adults
3. Helping Idahoans become as healthy and self-sufficient as possible
4. Strengthening the public's trust and confidence in the Department

Goal 1 is to have the cost of Medicaid increase at or below the increase of tax revenues. The objective of Goal 2 is to ensure all children who have experienced abuse or neglect have safe and permanent homes. Mr. Jeppesen stated that one objective of Goal 3 is in regard to suicide prevention. The Department is also working with schools on the lifelong resiliency and well-being program called "Sources of Strength." Also regarding self-sufficiency, there are employment and training programs provided by the Supplemental Nutrition Assistance Program (SNAP) for the people who are eligible to work. In Goal 4, the Department has made progress toward compliance with the Red Tape Reduction Act, but more work needs to be done to simplify, to make less restrictive, and to make it easier for businesses and citizens to operate, but not at the expense of safety.
Mr. Jeppesen continued his presentation by giving an overview of the budget. Personnel costs and operating expenditures account for 12.5 percent of the fiscal year 2020 original appropriation. Trustee and benefit payments account for about 87 percent of the original appropriation. Mr. Jeppesen told the Committee there were two items not presently in the budget which could possibly be requested in the future. They are ambulatory surgical centers and upgrading the technology systems. See attachment 2.

In closing, Mr. Jeppesen talked about the home visitation program and relayed a story about a young man and his family's experience with the program. He said the Department is committed to delivering services that provide for the safety and well-being of Idaho's families as effectively and efficiently as possible.

DISCUSSION: Several Committee members commented on the Director's enthusiasm for his job, the exceptional job he is doing, and the focus he brings to his job. Other discussion was related to the budget, with Senator Lee explaining the need for funding.

RS 27492 Mr. Jeppesen presented RS 27492, a Senate Concurrent Resolution, that highlights the need to improve the Idaho Behavioral Health System. This resolution recognizes the requirement for collaboration among all three branches of state government, local governments, and community partners, and endorses the creation of a 13-member Idaho Behavioral Health Council that will be tasked with developing a statewide strategic plan. It will include action-oriented, time-bound recommendations to the Legislature, to the Governor, and to the Idaho Supreme Court, by October 31, 2020. The action-oriented recommendations will utilize the significant amount of resources that the state already invests in behavioral health by creating a more coordinated, integrated, and collaborative model with the goal of effective behavioral health outcomes for Idahoans and a better return on the investment of public resources. Since the Idaho Behavioral Health Council will have representatives from all three branches of state government, it will be created by an executive order from the Governor, and officially recognized by the Idaho Supreme Court through a proclamation.

MOTION: Vice Chair Souza moved to send RS 27492 to print. Senator Heider seconded the motion. The motion carried by voice vote.

Chairman Martin welcomed several family medicine resident students and asked them to stand and be recognized.

PRESENTATION: Beth Oppenheimer, Executive Director, of the Idaho Association for the Education of Young Children (AEYC), reported on the Preschool Development Grant Birth to Five (PDG B-5). Governor Little authorized Idaho AEYC to apply for the federal grant on November 5, 2019; on December 18, 2019, it was awarded in the amount of $3.3 million. This one-year grant will focus on research, planning, collaboration, and coordination on early childhood systems across the state. Five specific activities must be addressed, per federal requirements:

1. A statewide needs assessment plan;
2. A statewide strategic plan;
3. Maximizing parental choice and knowledge;
4. Sharing best practices; and,
5. Improving overall quality of early childhood care and education.

Ms. Oppenheimer said their overall expected outcome is to better align the current systems and identify areas of improvement in the early childhood program and to better support the youngest children as they enter kindergarten. See attachment 3.
DISCUSSION: Senator Heider inquired about the grant that is funded for just one year. Ms. Oppenheimer replied that President Trump has increased funding for preschool development grants in his budget and she is hopeful that they will have the opportunity to apply for some implementation over the next couple of years.

Senator Jordan inquired if the implementation goal was to put a child in the third grade, and would the third grade reading assessment be applicable. Ms. Oppenheimer said they would be looking at the needs assessment to see what is working and what is not working.

Senator Lee asked about home visitation, what resources are available to measure it, and if the information would be available by the end of the year. Ms. Oppenheimer replied that the needs assessment should be completed by July-August 2020. They hope to align all the different systems so that they can get the research and the data that is needed to effectively and efficiently move forward.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:07 p.m.

________________________________________
Senator Martin
Chair

________________________________________
Margo Miller
Secretary

________________________________________
Juanita Budell
Assistant to the Secretary
**Objective:** Control Medicaid costs by financially rewarding providers and organizations that deliver measurably better care to our participants.

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Medicaid dollars that are paid under a value-based payment.</td>
<td>Actual 12%</td>
<td>12%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target 12%</td>
<td>14%</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Objective:** Improve the children’s mental health system in Idaho for children with serious emotional and behavioral disorders.

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children/youth under the Youth Empowerment Services system of care.</td>
<td>Actual *</td>
<td>3,308</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target *</td>
<td>3,308</td>
<td>3,639</td>
</tr>
<tr>
<td>Number of children/youth whose functional impairment has improved.</td>
<td>Actual *</td>
<td>950</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target *</td>
<td>950</td>
<td>1,045</td>
</tr>
</tbody>
</table>

* New for Fiscal Year 2019

**Allocated Funds**

**Objective:** Ensure children who have experienced abuse or neglect have safe, permanent homes.

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of months to achieve permanency through reunification.</td>
<td>Actual *</td>
<td>8.2</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target *</td>
<td>8.2</td>
<td>8.2</td>
</tr>
<tr>
<td>Number of months to achieve permanency through adoption.</td>
<td>Actual *</td>
<td>27.3</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target *</td>
<td>27.3</td>
<td>27.3</td>
</tr>
<tr>
<td>Number of months to achieve permanency through guardianship.</td>
<td>Actual *</td>
<td>17.9</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target *</td>
<td>17.9</td>
<td>17.9</td>
</tr>
</tbody>
</table>

* New for Fiscal Year 2019

**Public Health Objectives**

**Objective:** Reduce suicide attempts and deaths in Idaho by collaborating with multi-sector stakeholders.

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Zero Suicide Health System Partners that have developed and/or implemented Zero Suicide action plans.</td>
<td>Actual 21 partners committed to implementation, no funding available</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>Maintain partnerships</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Actual 10 schools trained</td>
<td>17 schools trained</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target 10 schools trained</td>
<td>Train 17 schools trained</td>
<td>-</td>
</tr>
</tbody>
</table>

**Objective:** Provide job training and education to low-income adults receiving state assistance, to help them gain stable, full-time employment and eventually move to self-sufficiency.

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of individuals who become employed or gain additional training or education as a result of working in the Employment and Training Program.</td>
<td>Actual *</td>
<td>42%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target *</td>
<td>42%</td>
<td>52%</td>
</tr>
</tbody>
</table>

* New for Fiscal Year 2019

**Welfare Objectives**

**Objective:** “Live Better Idaho” website updates.

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>All divisions within the Department of Health and Welfare will make relevant services available to customers on the Live Better Idaho site.</td>
<td>Actual 80%</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Target 100%</td>
<td>100%</td>
<td>Task Completed</td>
</tr>
</tbody>
</table>
**Medicaid Objectives**

**Objective:** Control Medicaid costs by financially rewarding providers and organizations that deliver measurably better care to our participants.

- Percentage of Medicaid dollars that are paid under a value-based payment.

**Goal 1**

**Objective:** Improve the children’s mental health system in Idaho for children with serious emotional and behavioral disorders.

- Number of children/youth under the Youth Empowerment Services system of care.
- Number of children/youth whose functional impairment has improved.

**Goal 1**

**Child Welfare Objectives**

**Objective:** Ensure children who have experienced abuse or neglect have safe, permanent homes.

- Number of months to achieve permanency through reunification.
- Number of months to achieve permanency through adoption.
- Number of months to achieve permanency through guardianship.

**Goal 2**

**Public Health Objectives**

**Objective:** Reduce suicide attempts and deaths in Idaho by collaborating with multi-sector stakeholders.

- Number of Zero Suicide Health System Partners that have developed and/or implemented Zero Suicide action plans.
- Number of middle and high schools trained in life-long resilience and well-being trainings.

**Goal 3**

**Welfare Objectives**

**Objective:** Provide job training and education to low-income adults receiving state assistance, to help them gain stable, full-time employment and eventually move to self-sufficiency.

- Percent of individuals who become employed or gain additional training or education as a result of working in the Employment and Training Program.

**Goal 3**

**Objective:** “Live Better Idaho” website updates.

- All divisions within the Department of Health and Welfare will make relevant services available to customers on the Live Better Idaho site.
## Comparative Summary

<table>
<thead>
<tr>
<th>Decision Unit</th>
<th>FTP</th>
<th>General</th>
<th>Total</th>
<th>Governor's Rec</th>
<th>FTP</th>
<th>General</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annualizations</td>
<td>0.00</td>
<td>13,349,300</td>
<td>191,622,300</td>
<td>0.00</td>
<td>2,806,100</td>
<td>191,644,100</td>
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</tr>
<tr>
<td>Change in Employee Compensation</td>
<td>0.00</td>
<td>829,300</td>
<td>1,929,000</td>
<td>0.00</td>
<td>1,586,800</td>
<td>3,692,400</td>
<td></td>
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<tr>
<td>Nondiscretionary Adjustments</td>
<td>0.00</td>
<td>42,710,300</td>
<td>98,220,200</td>
<td>0.00</td>
<td>41,707,300</td>
<td>93,208,200</td>
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</tr>
<tr>
<td>Endowment Adjustments</td>
<td>0.00</td>
<td>(286,200)</td>
<td>0</td>
<td>0.00</td>
<td>(286,200)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>FY 2021 Program Maintenance</strong></td>
<td><strong>2,917.11</strong></td>
<td><strong>924,662,800</strong></td>
<td><strong>3,683,954,200</strong></td>
<td><strong>2,917.11</strong></td>
<td><strong>911,570,000</strong></td>
<td><strong>3,676,412,900</strong></td>
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<tr>
<td>Line Items</td>
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<td></td>
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</tr>
<tr>
<td><strong>Child Welfare</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Child Welfare Initiative</td>
<td>0.00</td>
<td>5,348,000</td>
<td>10,696,000</td>
<td>0.00</td>
<td>5,348,000</td>
<td>10,696,000</td>
<td></td>
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<tr>
<td>2. Child Welfare Staffing</td>
<td>5.00</td>
<td>199,700</td>
<td>399,400</td>
<td>5.00</td>
<td>198,100</td>
<td>396,200</td>
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<tr>
<td>Independent Councils</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>13. VOCA Staffing</td>
<td>1.00</td>
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<td>77,800</td>
<td>1.00</td>
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<td>77,100</td>
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<td>14. Use of VOCA Funds</td>
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<td>2,600,000</td>
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<td>2,600,000</td>
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<td>Indirect Support Services</td>
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<td>4. Regional Office Relocation</td>
<td>0.00</td>
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<td>702,000</td>
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<td>73,800</td>
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<td>Division of Medicaid</td>
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<td>3. NEMT Contract Increase</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
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<tr>
<td>5. Electronic Visit Verification</td>
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<td>545,700</td>
<td>2,374,400</td>
<td>0.00</td>
<td>545,700</td>
<td>2,374,400</td>
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<tr>
<td>9. Health Data Exchange Connections</td>
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<td>8,300,000</td>
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<td>0</td>
<td>8,300,000</td>
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<tr>
<td>16. Ambulatory Surgical Centers</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
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<tr>
<td>17. MMIS Re-Procurement</td>
<td>0.00</td>
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<td>0</td>
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<tr>
<td>Mental Health Services</td>
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<td></td>
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<tr>
<td>6. State Hospital West Adolescent</td>
<td>(1.00)</td>
<td>(64,700)</td>
<td>(64,700)</td>
<td>(1.00)</td>
<td>(64,700)</td>
<td>(64,700)</td>
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<td>Psychiatric Hospitalization</td>
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<tr>
<td>6. State Hospital West Adolescent Unit</td>
<td>50.33</td>
<td>3,000,000</td>
<td>3,000,000</td>
<td>50.33</td>
<td>2,966,600</td>
<td>2,966,600</td>
<td></td>
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<td>7. SHS Nursing Home Bond Payment</td>
<td>0.00</td>
<td>1,000,000</td>
<td>4,335,400</td>
<td>0.00</td>
<td>1,000,000</td>
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<tr>
<td>Public Health Services</td>
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<tr>
<td>8. Move HPI to Health</td>
<td>2.00</td>
<td>284,200</td>
<td>1,134,200</td>
<td>2.00</td>
<td>284,600</td>
<td>1,132,600</td>
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<td>10. Home Visitation Program</td>
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<td>2,000,000</td>
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<td>11. Advance Care Directive Registry</td>
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<td>0</td>
<td>0.00</td>
<td>500,000</td>
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<tr>
<td>Substance Abuse Treatment &amp; Prevention</td>
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<td>1. Community Recovery Centers</td>
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<td>Health Care Policy Initiatives</td>
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<tr>
<td>8. Move HPI to Health</td>
<td>(2.00)</td>
<td>(284,900)</td>
<td>(1,134,200)</td>
<td>(2.00)</td>
<td>(284,600)</td>
<td>(1,132,600)</td>
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<td>Multi-Agency Decisions</td>
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<td>OITS 1 – Operating Costs</td>
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<td>23,700</td>
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<td>OITS 2 – Servers and Licensing</td>
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<td>OITS 4 – Agency Billings</td>
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<td>0</td>
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<td>Budget Law Exemptions</td>
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<td>(17,300,700)</td>
<td>(17,300,700)</td>
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<td><strong>FY 2021 Total</strong></td>
<td><strong>2,972.44</strong></td>
<td><strong>937,041,800</strong></td>
<td><strong>3,718,374,500</strong></td>
<td><strong>2,972.44</strong></td>
<td><strong>906,351,500</strong></td>
<td><strong>3,692,983,200</strong></td>
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<td>Chg from FY 2020 Orig Appropr.</td>
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<td>71,744,300</td>
<td>298,278,600</td>
<td>55.33</td>
<td>41,084,000</td>
<td>272,887,500</td>
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<td>% Chg from FY 2020 Orig Appropr.</td>
<td>1.9%</td>
<td>8.3%</td>
<td>8.7%</td>
<td>1.9%</td>
<td>4.7%</td>
<td>8.0%</td>
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Personnel costs and operating expenditures account for 12.5% or $429,119,800 of the $3,420,095,900 FY 2020 Original Appropriation. In comparison, trustee and benefit payments account for about 87% of the FY 2020 Original Appropriation.
Preschool Development Grant (PDG B-5) Highlights

Governor Brad Little authorized the Idaho Association for the Education of Young Children (Idaho AEYC) to apply for the federal Preschool Development Grant Birth through Five (PDG B-5) on Nov. 5, 2019 and designated Idaho AEYC as the lead agency to administer the grant. On Dec. 18, 2019, Idaho AEYC was awarded $3,343,592.00. The one-year grant (Dec. 31, 2019 – Dec. 30, 2020) will focus on research, planning, collaboration and coordination on early childhood systems across the state. Idaho was one of six states and territories awarded funding for this planning grant.

In addition, Governor Little re-established the Idaho Early Childhood Advisory Council and designated Idaho AEYC to coordinate the council’s efforts. Idaho AEYC will collaborate with various federal, state and local agencies and partners to support the Governor’s goals to improve early literacy and school readiness, prepare low-income and disadvantaged children to enter kindergarten with foundational skills needed to be successful and to improve transitions into elementary schools. The PDG B-5 is an opportunity to bring resources into Idaho that will empower parents and early childhood educators and offer a mixed delivery system that includes private, public and community based approaches.

Per federal requirements, five specific activities must be addressed. Below you will find those activities with strategies we have put forth to accomplish the goals.

Activity One: Statewide Needs Assessment Plan
- Define the scope and develop a work plan.
- Collect, compile and present data.
- Complete a systems and facilities validation study, inventory and analysis.
- Finalize a written Needs Assessment.

Activity Two: Statewide Strategic Plan
- Define the scope of the strategic plan.
- Review needs assessment data and stakeholder input to create goal and strategy statements.
- Conduct a literature and best practice review.
- Incorporate stakeholder feedback and submit a final plan for approval.

Activity Three: Maximizing Parental Choice and Knowledge
- Conduct an outreach and recruitment campaign for early childhood program participation in the IdahoSTARS Steps to Quality.
- Recruit and incentivize child care professionals to start a new high-quality child care business.
- Conduct an outreach campaign and training for parents and early childhood educators on the CDC’s Learn the Signs, Act Early developmental monitoring, screening and referrals for early intervention services.
• Utilize the *Ages and Stages Questionnaire* for developmental screenings within Idaho’s star-rated *Steps to Quality* programs.
• Conduct a feasibility study to explore telehealth models that will improve access to speech pathology and other services for children in rural areas.
• Conduct an outreach and education campaign through Idaho Public Television’s *Parent Engagement Initiative* to engage families and improve school readiness.
• Expand the Idaho Commission for Libraries’ outreach campaign and *Read to Me* project through Kindergarten Readiness Grants.
• Empower parents to facilitate smoother transitions through a partnership of parents, children and kindergarten teachers in four high-need school districts via a pilot of the *Countdown to Kindergarten* program.
• Extend the English and Spanish version of the *Ready! for Kindergarten* program throughout the state to empower parents with resources and training to prepare their child for kindergarten.
• Provide *Block Fest* opportunities focusing on STEM activities for families in partnership with school districts and libraries.

**Activity Four: Sharing Best Practices**
• Expand the early childhood local collaborative structure (*Preschool the Idaho Way*) to establish a local governance structure; conduct a local B-5 needs assessment; conduct a local early childhood strategic plan; and engage in transition practices between early childhood programs and elementary schools.
• Share best practices in early childhood through seven regional Early Learning Academies focusing on strengthening early childhood educator’s knowledge of language and early literacy practices. Included in the academies will be professional development in trauma informed care, creating inclusive settings and conducting early screenings for developmental delays, and how to interpret Idaho Reading Indicator scores.
• Support early childhood classrooms with materials designed to enhance early language and literacy development.
• Provide early childhood educator social service training and materials at the Head Start Collaboration Office *Early Years Conference*.
• Produce four one-hour course modules developed by Idaho Public Television and Lee Pesky Learning Center highlighting best practices in early literacy.

**Activity Five: Improving Overall Quality of Early Childhood Care and Education**
• Build capacity for quality early childhood classroom assessments and improvement through the *CLASS* assessment tool.

**Program Performance Evaluation Plan**
• Develop a plan to monitor ongoing processes and the progress towards the goals and objective of the project.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
<th>PRESENTER</th>
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</thead>
<tbody>
<tr>
<td>MINUTES APPROVAL:</td>
<td>Minutes of January 15, 2020</td>
<td>Senator Nelson</td>
</tr>
<tr>
<td>DOCKET NO. 16-0202-1901</td>
<td>Rules of the Emergency Medical Services (EMS) Physician Commission; Page 1137, Pending Rules</td>
<td>Dr. Curtis Sandy, Chairman, Idaho Physician Commission</td>
</tr>
<tr>
<td>GUBERNATORIAL APPOINTMENT CONSIDERATION:</td>
<td>Reappointment of John R. MacMillan, Ph.D., to the Board of Environmental Quality. Committee will vote at the next Committee meeting.</td>
<td>Dr. John MacMillan</td>
</tr>
<tr>
<td>RS27527</td>
<td>Relating to Psychologists; Amending Section 54-2317, Idaho Code, To Revise A Provision Regarding Supervision Agreements And To Make Technical Corrections.</td>
<td>Kris Ellis, Idaho Psychological Association</td>
</tr>
</tbody>
</table>

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 06, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:08 p.m.
MINUTES APPROVAL: Senator Nelson moved to approve the Minutes of January 15, 2020. Senator Harris seconded the motion. The motion carried by voice vote.
DOCKET NO. Rules of the Emergency Medical Services (EMS) Physician Commission; Pending Rules Book. Dr. Curtis Sandy, Chairman, Idaho EMS Physician Commission, reported that changes proposed were to update their standards manual from version 2019-1 to 2020-1. In most cases these changes were to simplify and clarify scope of practice. He said they did not conduct formal negotiated rulemaking, because they had extensive stakeholder input. The changes are in compliance with the Red Tape Reduction Act.
MOTION: Senator Heider moved to approve Docket No. 16-0202-1901. Senator Jordan seconded the motion. The motion carried by voice vote.
GUBERNATORIAL APPOINTMENT: Reappointment of John R. MacMillan, Ph.D., to the Board to Environmental Quality (Board). Dr. MacMillan shared his qualifications, which included a Ph.D. and a position as a senior research associate in the Department of Pathology at the University of Washington's medical school. He detailed his work at Mississippi State University, at Clear Springs Foods in Buhl, and on various environmental associations. He described how he formed the Southern Idaho Water Quality Coalition, a group of industry stakeholders with a mission to improve water quality in the Middle Snake River. He has been on the Board since its inception in 2000.
RS 27527 Relating to Psychologists; To Revise A Provision Regarding Supervision Agreements And To Make Technical Corrections. Kris Ellis, representing the Idaho Psychological Association, presented RS 27527. She explained that RS 27527 is a small change to legislation from several years ago to allow psychologists to prescribe psychotropic medications. This legislation eliminates specialized training and adds two years of experience in the management of psychotropic medications. She said stakeholders agreed with the legislation.
MOTION: Senator Harris moved to send RS 27527 to print. Senator Jordan seconded the motion. The motion carried by voice vote.
ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:28 p.m.
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, February 10, 2020

SUBJECT | DESCRIPTION | PRESENTER
--- | --- | ---
MINUTES APPROVAL: | Minutes of January 21, 2020 | Senator Burtenshaw
| Minutes of January 22, 2020 | Senator Lee
GUBERNATORIAL REAPPOINTMENT VOTE: | Vote on the reappointment of John R. MacMillan, Ph.D., to the Board of Environmental Quality. | Matt Wimmer, Administrator, Department of Health and Welfare
H 351 | Relating To Medicaid; Amending Chapter 1, Title 56, Idaho Code; Amending Section 56-265, Idaho Code; Amending Section 56-1505, Idaho Code. | Senator Crabtree
RS27645 | Relating to Ambulance Services Districts | Senator Lee
RS27537 | Stating Findings, Expressing support For Military And Veteran Caregivers, And Proclaiming May As Hidden Heroes Month In Idaho | Senator Lee
RS27693 | Relating to Creation Of The Board Of Naturopathy | David Lehman, Primus Policy Group
RS27576 | Relating to Pregnant Women And Children - Medicaid Eligibility | Mr. Lehman
RS27686 | Relating to Clinical Nutrition - Chiropractic Practice Act | Caroline Merritt, Idaho Association of Chiropractic Physicians

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin | Sen Burtenshaw
Vice Chairman Souza | Sen Bayer
Sen Heider | Sen Jordan
Sen Lee | Sen Nelson
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 10, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson

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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:00 p.m.

MINUTES APPROVAL: Senator Burtenshaw moved to approve the Minutes of January 21, 2020. Senator Lee seconded the motion. The motion carried by voice vote.

GUBERNATORIAL APPOINTMENT VOTE: Senator Heider moved to send the Gubernatorial reappointment of Dr. John MacMillan to the Board of Environmental Quality to the floor with a recommendation that he be confirmed by the Senate. Senator Nelson seconded the motion. The motion carried by voice vote. Senator Heider will carry the reappointment to the floor.

H 351 Matt Wimmer, Administrator of the Division of Medicaid, Department of Health and Welfare (Department), presented H 351. See attachment 1. Mr. Wimmer explained that the bill presents two challenges. The first challenge is to manage Medicaid spending in the short term by reducing General Fund needs for fiscal years 2020 and 2021, as requested by Governor Little. The bill would allow reductions in hospital payments and temporarily increase assessments for nursing facilities. See attachment 2. The second challenge of the bill addresses the need for better budget management for Medicaid. Currently, both hospitals and nursing facilities are paid based on their costs and Medicaid is legally obligated to pay those costs. Mr. Wimmer said payments will take into account patient needs, quality of care, reasonable cost, and state budget limitations. More importantly, the bill establishes a payment structure that gives the Department better management tools and gives the Legislature better visibility and control over these elements of Medicaid spending.

DISCUSSION: In response to questions from Senators Harris, Lee, and Nelson, Mr. Wimmer discussed plan implementation, going over the budget, the timeframe for the new payment methodology, risk to nursing homes, and critical care hospitals.

TESTIMONY: Steve LaForte, Chairman of the local Idaho Health Care Association's (IHCA) Legislative Committee and Director of Strategic Operations for Cascadia Healthcare, testified in support of H 351. He stated he was excited for and committed to the work ahead in the coming months to craft a new reimbursement system and feels the current work has set the foundation to make Idaho a leader in value-based care delivery. Mr. LaForte also said he was appreciative of Mr. Wimmer and his team.
DISCUSSION: Vice Chair Souza inquired if Mr. LaForté was comfortable with the changes and losses. Mr. LaForté replied that his overall operating revenue will be decreased, but it was something he could work within. Senator Lee stated that in the past, the Legislature has struggled to implement provider increases, particularly in the rural areas with regard to employment. Mr. LaForté said he was excited about the new reimbursement system that will reward operators for doing what they need to do and to provide quality care for vulnerable adults.

TESTIMONY: Jeff Morrell, CEO of Intermountain Hospital, testified in support of this bill and the value-based reimbursement strategy. He said a bill was passed and signed by the Governor in 2015 that allowed them to have their cost based upon a percentage of Medicare funding and it seemed like a very stable methodology. He would like to see that continue.

MOTION: Senator Nelson moved to send H 351 to the floor with a do pass recommendation. Senator Jordan seconded the motion.

DISCUSSION: Senator Bayer said she supports the bill, but reserves the right to change her mind on the floor. Senator Lee stated that she supports the motion and understands the implications to the state budget if some changes are not made. She also expressed her appreciation for everyone coming together to try to get a solution to address the problem. Senator Harris said that he also appreciates the work that has been done; however, he questions the value-based payment system but supports the motion.

VOICE VOTE: The motion to send H 351 to the floor with a do pass recommendation carried by voice vote. Senator Bair will be the floor sponsor.

RS 27645 Senator Crabtree said RS 27645 relates to ambulance service districts. This legislation grandfathers any existing ambulance district and will only affect ambulance service districts formed after July 1, 2020. It mimics the current process in Idaho Code for fire districts and would require a vote of the people within a proposed district during the May or November election dates. This legislation would remove governance by the Board of County Commissioners and put in place an independent commission which would allow ambulances to operate across county boundaries.

DISCUSSION: Vice Chair Souza questioned why there were so many new sections on a simple bill. Senator Crabtree explained it was because of grandfathering in existing districts and mirroring another system.

Senators Harris and Crabtree discussed provisions regarding crossing state lines. Senator Crabtree also addressed Senator Jordan’s concerns related to the independent commission, and existing cross jurisdictional agreements.

MOTION: Vice Chair Souza moved to send RS 27645 to print. Senator Lee seconded the motion. The motion carried by voice vote.

RS 27537 Senator Lee presented RS 27537. This resolution proclaims the month of May as Hidden Heroes Month in conjunction with Idaho’s current recognition of Military Appreciation Month in May. It states findings and expresses support for military and veteran caregivers.

MOTION: Senator Harris moved to send RS 27537 to print. Senator Heider seconded the motion. The motion carried by voice vote.
RS 27693  
**David Lehman** presented **RS 27693** on behalf of his client, The West Clinic, located in Pocatello. **Mr. Lehman** stated **RS 27693** creates a new board with two subspecialties: one being naturopathic doctors and the other, a registered naturopathic providers group. The reasoning for this is to have equal representation. The Board of Naturopathy, under the Bureau of Occupational Licenses, encompasses naturopathic doctors and practitioners not currently licensed under the Board of Medicine. He explained that this is to create a standard for naturopathic doctors that doesn’t require a separate accreditation. This bill will enact a license on July 2021 so as to have time to promulgate rules.

**DISCUSSION:** In response to questions from Senator Bayer and Vice Chair Souza, **Mr. Lehman** discussed definitions and terminology of naturopaths, and reimbursements for certain titles.

**Senator Lee** said she thought it was agreed last year to regulate those who wanted to be under the Board of Medicine and those who did not, and asked why this is being heard again this year. **Mr. Lehman** said the people he represents do no want to be licensed under the Board of Medicine, but prefer to be under the jurisdiction of the Board of Occupational Licenses.

**Chairman Martin** stated that a promise was made last year to allow the Committee to consider this legislation again this year.

**MOTION:** **Senator Bayer** moved that **RS 27693** be held in Committee. **Senator Heider** seconded the motion. The motion carried by **voice vote**.

**RS 27576**  
**Mr. Lehman** presented **RS 27576** and stated he represented Idaho Voices for Children. The purpose of this RS is to have a hearing and begin the process to improve prenatal care. See attachment 3. This legislation would increase Medicaid coverage for children and for pregnant women. Idaho’s rate of uninsured children is on the rise.

**DISCUSSION:** Comments from the Committee included suggestions that an informational hearing should be held, and that the data presented is no longer relevant.

**Senator Nelson** said he went to a conference on Medicaid for new legislators, and Idaho really is at the bottom of the ladder. He believes we should be making incremental progress. We’re addressing the people on the exchange, not in Medicaid expansion and he would like to see the Committee move forward on this. **Senator Bayer** felt it would give false hope by printing a bill. It was suggested that Mr. Lehman schedule a presentation.

**MOTION:** **Vice Chair Souza** moved that **RS 27576** be held in Committee. **Senator Burtenshaw** seconded the motion. The motion carried by **voice vote**, with **Senators Jordan** and **Nelson** requesting they be recorded as voting nay.

**RS 27686**  
**Caroline Merritt**, on behalf of the Idaho Association of Chiropractic Physicians, stated **RS 27686** would allow a chiropractic physician to obtain patient-specific prescriptions for office use from a licensed, Idaho compounding pharmacy. Presently, chiropractic physicians certified in clinical nutrition must use an outsourcing facility or a 503B pharmacy to obtain the prescription drug products which they may administer.

**DISCUSSION:** **Senator Harris** asked if this is happening in other states. **Ms. Merritt** replied that she hasn’t heard of this being an issue in other states; however, it came about because licensed Idaho chiropractic physicians were having trouble obtaining the medications they were requesting both in-state and out-of-state.

**MOTION:** **Vice Chair Souza** moved to send **RS 27686** to print. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.
ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:25 p.m.

____________________________________
Senator Martin
Chair

____________________________________
Margo Miller
Secretary

____________________________________
Juanita Budell
Assistant Secretary
House Bill 351 Hearing Notes

House Bill 351 addresses two challenges for the Department and the State of Idaho.

The first challenge is to manage Medicaid spending in the short term by reducing general fund needs for state fiscal year 2020 and 2021, as requested by Governor Little for most state agencies. The bill allows us to address that challenge by making reductions to hospital payments and by temporarily increasing assessments for nursing facilities.

The second challenge the bill addresses is the need for better budget management for Medicaid. Currently, both hospitals and nursing facilities are paid based on their costs, and Medicaid is legally obligated to pay those costs. Nursing facilities and hospitals together represent over one third of overall Medicaid spending – about $850 million dollars in SFY 2019. Idaho is the last state Medicaid program in the nation to pay hospital providers under this cost-settlement methodology.

With Medicaid expansion now in place, that amount would increase to nearly a billion dollars in combined state and federal spending outside of the control of the Governor or the Legislature. This bill changes the basis for payment to allow the Department to effectively manage those costs and gives ultimate control of their growth to the Legislature. If Medicaid general fund needs outstrip state general fund revenue growth, the Legislature has a difficult choice to make – either raise taxes or pull funds from other state programs to fund Medicaid. This bill, along with other Department efforts, will make possible a third path of effective management within state budget constraints while preserving access to quality services for patients.

I will briefly walk through each section of the bill to explain how each of these objectives are accomplished.

Section 1 of the bill directs the Department to work with nursing facility providers to establish a new payment methodology for nursing facility providers, that takes patient needs, quality of care, provider costs, and the state budget into consideration.

That new payment methodology will set a budget for nursing facility payments prior to the start of each fiscal year. Medicaid will incorporate that budget as a line item within its request for
funding to the legislature for consideration by next year’s legislature. The new payment methodology would go into effect July of 2021.

We have met with the Idaho Health Care Association and discussed this provision at a series of weekly meetings we established when we first began working on this bill in November. We will continue to work closely with these providers to establish a new methodology that will allow fair reimbursement and to maintain access to services for Idahoans with Medicaid coverage. Our goal will be to manage our budget in a way that supports providers and preserves or improves the quality of care for Medicaid participants.

Section 2 of the bill addresses hospital reimbursement. It removes limitations for institutions for mental diseases (freestanding psychiatric hospitals with greater than 16 beds) to allow payment under Medicaid. That change is in keeping with the direction from 2019’s Senate Bill 1204 for the Department to pursue federal approval for that coverage. It revises the definition for clarity and allows payment of a temporarily reduced rate for those hospitals.

Subsection 6 defines reimbursement for critical access, out of state, and state-owned hospitals. Medicaid reimbursement for rural critical access hospitals is codified but not impacted under this bill. Out of state hospital reimbursement remains at current levels. Reimbursement for out of state IMD’s is established at 95% of cost. Reimbursement for state-owned hospitals is set at 100% of cost to make the most efficient use of state general funds.

Subsection 7 directs a reduction in hospital reimbursements by $3.1M in general funds in SFY 2020 and by $8.7 million in general funds in SFY 2021. In total funds that represents a $13.6 M reduction in SFY 2020 and a $38.2 M reduction in SFY 2021.

Subsection 8 directs the Department to work with hospitals to establish new value-based payment methods for hospitals. Like the approach for nursing facilities, the new payment methodology will set a hospital budget before the start of each fiscal year, and Medicaid will request funding from the legislature through the budget process. The new payment methodology would go into effect in July of 2021. As with nursing facilities, the goal is to create
House Bill 351 Hearing Notes

a payment methodology that supports providers and that improves the quality of care for Medicaid patients.

In keeping with that goal, Subsection 9 directs the Department to establish a quality payment program to allow payments to hospitals to be contingent on the quality of care that they deliver.

Section 3 of the bill amends existing Idaho code to allow temporary increases to assessments for privately owned nursing facilities. The Department has worked extensively with the Idaho Health Care Association on this approach. Initially, we had proposed straight reductions to payments like those described for hospitals. That would have been extremely challenging for smaller facilities, and the IHCA asked that we revise our approach to decrease that impact.

This allows us to increase the assessment by about $1.8M in SFY 2020 and $5M in SFY 2021. It also allows additional increases to the assessment to temporarily increase rates for nursing facilities to draw down federal dollars to offset the assessment increase. Should the legislature pass this bill, we will be working closely with nursing facilities to change how we make assessments and payments to address cash flow needs.

While this remains a challenge for nursing facilities in the short term, we have done everything possible to mitigate the impact for residents and avoid negative outcomes resulting from the increased assessment.

Section 4 is an emergency clause to allow the bill to go into effect immediately. This is necessary to achieve general fund spending reductions for SFY 2020.

In summary, the bill before you gives the Department the ability to achieve the Governor’s spending re-set. More importantly, it establishes a payment structure that gives the Department better management tools and the Legislature better visibility and control over these elements of Medicaid spending. Thank you for printing and hearing this bill, and I ask that you send it forward with a do pass recommendation.
Dear Senator Heider,

In Idaho, we all share the goal of ensuring that our kids have access to health coverage early, so they have a better chance to be healthy, do well in school, and succeed in life. Unfortunately, Idaho is falling behind.

Starting last year, Idaho Voices for Children identified a troubling trend in health coverage for children. Between 2017 and 2018, Idaho had the highest increase in the rate of uninsured children in the country, with approximately 7,200 children losing health coverage. We tracked this trend and investigated possible causes for this sharp decline. Following years of steady progress, Idaho’s declines are part of a national trend where the number of uninsured children in the country increased from 4.7 percent in 2016 to 5.2 percent in 2018.

As we continued to investigate this decline, we learned that Idaho saw the steepest child enrollment decline in Medicaid and the Children’s Health Insurance Program (CHIP) in the nation. Between December 2017 and February 2019, Idaho’s Medicaid/CHIP child enrollment dropped 11 percent. While private coverage rates in Idaho remained steady in 2018, this drastic decrease in public coverage indicates enrollment declines in Medicaid/CHIP are driving up Idaho’s rate of uninsured kids.

The significant drop of insured children in Idaho is extremely troubling and likely due to federally required changes in the enrollment and renewal processes in Idaho’s Medicaid programs that have put new barriers in place for children and families. Families with children on Medicaid are now required to submit more paperwork and overcome additional red tape to access or maintain health coverage for their children.

In spite of this alarming trend in kids’ coverage in Idaho, the state is poised to stem this tide in the coming years. Idaho expanded Medicaid in January, resulting in more families and children becoming insured. States without Medicaid expansion are seeing three-times the rate of increases in uninsured children as states that expanded Medicaid. Children in non-expansion states are almost twice as likely to be uninsured as those in states that closed the coverage gap.

I encourage you to look at Idaho Voices for Children’s full report on this issue, and I seek your partnership to implement the following recommendations to further mitigate declines in kids’ coverage:

1) Increase income eligibility thresholds for both children and pregnant women in Idaho. Nationally, Idaho’s current income eligibility thresholds in both categories rank at the bottom.

2) Streamline the renewal process for families with children on Medicaid so they can access the services they need and deserve. This will help eliminate unnecessary gaps in coverage, reduce expensive emergency room visits, increase efficiencies in the program, and ensure better value.

We look forward to working with you to turn these trends around and ensure more Idaho children get the care they need to grow healthy and succeed in life.

Best,

Liz Woodruff, Co-Director
Idaho Voices for Children
1607 W Jefferson St. Boise, ID 83702
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Healthy children are critical to thriving communities in Idaho. Having health insurance increases the likelihood that children will get necessary medical services and even be more likely to graduate from high school, creating ripple effects that benefit us all. Following years of steady progress, newly released data shows Idaho’s child uninsured rate changed direction in 2018 – resulting in thousands of additional kids going without essential health coverage in Idaho.

Coverage losses appear to be driven by new administrative barriers to renewal for Medicaid and the Children’s Health Insurance Program (CHIP). These coverage losses are particularly concerning because they occurred during a period of economic growth when children should have been gaining health coverage. It is time for lawmakers to turn their attention to policies that increase health coverage instead of adding more red tape to programs that help Idahoans make ends meet.

Idaho’s Child Uninsured Rate Increase Worst in the Nation

Idaho is at the top of a concerning national trend in children’s health coverage. For the second year in a row, the national uninsured rate among children has gone in the wrong direction, rising to 5.2 percent in 2018, or more than one in 20 kids. States that did not expand Medicaid to parents and other adults saw their uninsured rate increase three times as much from 2016 to 2018 as states that did, according to the Georgetown Center for Children and Families.

Idaho’s child uninsured rate increased at a considerably faster pace than any other state from 2017 to 2018. Reversing years of coverage gains, the number of Idaho children without any health insurance increased by 7,200 in 2018. Before then, Idaho had not seen an increase since comparable data started being collected in 2008.

Idaho also saw the largest uninsured rate increase across all ages in 2018. The number of Idahoans without health coverage rose to 192,600 in 2018, an increase of 20,600 people compared to the year prior. Disturbingly though, uninsured rates among children increased more than any other age group in Idaho. For example, for every 10 uninsured young adults (19-34 yrs) in 2017, just under one additional young adult went uninsured in 2018, but for every 10 uninsured children (<19 yrs) in 2017, more than 3 additional children went uninsured in 2018.
**Drops in Medicaid and CHIP Coverage Drive Child Uninsured Rate Increase**

While some have argued that the strong economy led children to move to employer sponsored insurance, private coverage rates in Idaho remained consistent while public coverage decreased last year. Idaho experienced the steepest child enrollment decline in Medicaid and CHIP in the nation, dropping 11 percent from December 2017 to February 2019 according to Georgetown University's Center for Children and Families. This decline is driving an increase in Idaho's child uninsured rate.

Medicaid and CHIP provide health coverage to children who live with disabilities and in families facing low wages. The uninsured rate barely moved for children living in higher income households but nearly doubled among children with family incomes below 200% of the federal poverty level (FPL). This is deeply concerning given the additional barriers these families already face and the serious economic consequences of being exposed to medical debt or bankruptcy.

**Figure 2: Uninsured Rates for Idaho Children Under 19**

<table>
<thead>
<tr>
<th>Household Income as Percentage of Poverty Level</th>
<th>2017</th>
<th>2018</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 200% FPL (&lt;$50,200 annual income for a family of four)</td>
<td>3.6%</td>
<td>7.1%</td>
<td>+ 3.5% pts</td>
</tr>
<tr>
<td>Over 200% FPL (&gt;=$50,200 annual income for a family of four)</td>
<td>5.0%</td>
<td>5.3%</td>
<td>+ 0.3% pts</td>
</tr>
</tbody>
</table>

Source: American Community Survey 1-Year Estimates

**Hispanic/Latinx Idahoans Continue to Face More Barriers to Health Coverage**

Hispanic/Latinx Idahoans face additional barriers to health coverage like lower wages, having an employer that doesn't offer health insurance, and recent policy changes that deter eligible families from seeking coverage through Medicaid. Idaho Hispanic/Latinx children have a higher uninsured rate than their white peers, at 8.0 and 5.9 percent respectively.

Children in both demographic groups saw an increase in their uninsured rate in 2018 compared with the year prior. However, the change is only statistically significant for white children – in part because changes are harder to detect among Idaho's relatively small communities of color.

**Figure 3: Health Insurance Coverage Among Idahoans by Age and Demographics, 2018**

<table>
<thead>
<tr>
<th></th>
<th>Number Uninsured</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children Under 19</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Alone, Non-Hispanic/Latinx</td>
<td>21,000</td>
<td>5.9%</td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>6,900</td>
<td>8.0%</td>
</tr>
<tr>
<td><strong>Non-Elderly Adults 19-64</strong></td>
<td>110,100</td>
<td>13.9%</td>
</tr>
<tr>
<td>White Alone, Non-Hispanic/Latinx</td>
<td>42,300</td>
<td>34.3%</td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>131,500</td>
<td>9.3%</td>
</tr>
<tr>
<td><strong>All Ages</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Alone, Non-Hispanic/Latinx</td>
<td>49,400</td>
<td>22.6%</td>
</tr>
</tbody>
</table>

Source: American Community Survey 1-Year Estimates

**Recent Policy Changes Leading to Harmful Coverage Losses Among Idaho Children**

Most uninsured children are eligible for Medicaid or CHIP but are not currently enrolled. A key to reducing the child uninsured rate is for federal and state policies to make it easier for families to enroll and retain their public coverage. Changes over the last two years appear to have made it harder for families to enroll and renew their eligible children in Medicaid and CHIP. Families in Idaho continue to report new red tape barriers and mounting confusion over how to receive or maintain health coverage for their children. Harmful changes included requiring families to submit more paperwork to maintain their health coverage, cuts in various funding sources for outreach to eligible children and families, eliminating the individual mandate penalty, and dozens of policy choices creating a pervasive climate of fear and confusion for eligible immigrant families.
Recommendations

Medicaid and CHIP enrollment continues to decline this year, raising the threat of a continued increase in the child uninsured rate. State officials can help stem the tide. Idaho has several clear opportunities to get back on the right track and keep kids covered.

Ensure families understand the re-enrollment process and eliminate unnecessary paperwork burdens. Recent changes now force families to jump through additional hoops to verify their incomes and prove their eligibility for programs. Idaho should require more advanced notification or alternate ways of reaching out to families before they lose coverage by improving the rules governing the process in Idaho Administrative Code 16.03.01.

Raise Medicaid/CHIP eligibility for children from 185% FPL to 255% FPL. Idaho has one of the lowest income eligibility levels for children in the nation, leaving low-wage working families with few options to cover their children. Coverage is often out of reach for children in this income range because premium assistance is based on ensuring the employee’s coverage is affordable, not coverage for the entire family. Lawmakers could raise child eligibility to the national average of 255% FPL to help children who are experiencing the largest uptick in uninsured rates.

Raise Medicaid/CHIP eligibility for pregnant women from 138% FPL to 200% FPL. Providing more women with access to health coverage during pregnancy is an important step to making sure children are born healthy and stay healthy. Raising Idaho’s eligibility to the national average would help counteract recent coverage losses because when mothers have health coverage their children are more likely to as well.

Expand Medicaid without additional barriers to coverage. The rate of uninsured children grew three times as fast from 2016 to 2018 in states that did not expand Medicaid compared to states that expanded Medicaid. Idaho’s now implemented Medicaid expansion should prove very helpful to curb recent declines in health coverage among kids, because when parents are covered, kids are more likely to be covered. To realize the full benefits of Medicaid expansion for families, Idaho should continue to fund it without imposing barriers to coverage.

Continuous health coverage is critical for Idaho’s children and strengthens our communities. Health coverage not only improves children’s health and educational outcomes, but also improves their earning potential when they grow up and protects their families from medical debt and bankruptcy. Idaho is now moving backwards on this key child health metric of children’s insurance rates. Idaho’s sudden drop in children’s health coverage can only be stopped if policy makers rally around our shared goal of ensuring that all children have access to affordable, comprehensive health insurance.

Endnotes
1 Levine and Schanzenbach’s page summarizes some of this evidence well.

Note: The term white is used for simplicity in this report to refer to white non-Hispanic/Latino people.
Grady’s Story
Star, Idaho

Despite Grady relying on Medicaid for the specialized care he needs, the eleven-year-old’s coverage was unexpectedly terminated in December. The devastating surprise left Grady and his parents out in the cold.

Kimberly and Tim are a veteran family living in Star with their four children. They manage a ranch and run a treatment program that combines equine therapy, psychotherapies, and whole food nutrition for kids with disabilities and veterans with post-traumatic stress disorder. Their son Grady receives Medicaid health coverage through the Youth Empowerment Services (YES) Program in Idaho, a strengths-based and family-centered approach to providing individualized care for children.

Medicaid is a critical lifeline for Grady. It provides treatments he needs to address his Serious Emotional Disturbance disorder and makes it possible for him to be healthy and successful. Nevertheless, Kimberly discovered that Grady lost his Medicaid coverage on December 31, 2019.

Kimberly was stunned to learn about the coverage termination while Grady waited for one of his regular services. Kimberly didn’t receive a notice from the Department of Health and Welfare until two weeks later, indicating Grady had lost Medicaid coverage because of issues with the online renewal system. Kimberly thought she was doing everything correctly, but stated that she was never informed up front about new steps she needed to take to make sure her son’s coverage was renewed.

Kimberly explained:

“When you have a child that suffers from a serious emotional and behavioral disorder, it is incredibly stressful on families and even more so trying to jump through hoops to keep the coverage we qualify for. Access to the care my son needs is so crucial and we work so hard to stay on top of everything. We work hard to do everything right so there aren’t lapses in coverage or treatment. Yet, we still lost coverage.”

After a long and time-consuming reapplication process, Grady finally regained the same Medicaid coverage he suddenly lost. Lapses in coverage, like Grady’s, mean potential setbacks for him and his ability to function in his home and community. Idaho must ensure its renewal process is streamlined and clear for families like Grady’s, so children in Idaho are able to access the health coverage they need to thrive.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
<th>PRESENTER</th>
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<tbody>
<tr>
<td>GUBERNATORIAL APPOINTMENT CONSIDERATION:</td>
<td>Reappointment of Kevin C. Boling, Coeur d'Alene, Idaho, to the Board of Environmental Quality. No vote today.</td>
<td>Kevin Boling, via telephone</td>
</tr>
<tr>
<td>GUBERNATORIAL APPOINTMENT CONSIDERATION:</td>
<td>Reappointment of Leonard &quot;Nick&quot; Purdy, Picabo, Idaho, to the Board of Environmental Quality. No vote today.</td>
<td>Nick Purdy, via telephone</td>
</tr>
<tr>
<td>S 1305</td>
<td>Relating To Psychologists; To Revise A Provision Regarding Supervision Agreements And To Make Technical Corrections.</td>
<td>Kris Ellis, Idaho Psychological Association</td>
</tr>
</tbody>
</table>

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**
- Chairman Martin
- Vice Chairman Souza
- Sen Heider
- Sen Lee
- Sen Harris

**COMMITTEE SECRETARY**
- Margo Miller
- Room: WW35
- Phone: 332-1319
- Email: shel@senate.idaho.gov
MINUTES  
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 11, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:01 p.m.

The Committee called Kevin C. Boling, Coeur d’Alene, Idaho, regarding his reappointment to the Board of Environmental Quality (Board). Unable to reach him, Chairman Martin suggested proceeding with the next gubernatorial reappointment.

GUBERNATORIAL REAPPOINTMENT: Reappointment of Leonard "Nick" Purdy, Picabo, Idaho, to the Board of Environmental Quality (Board). Mr. Purdy was interviewed via phone. Mr. Purdy stated that he owns small businesses in Picabo, and had received a few national accolades for his work on the environment. He indicated that as a small business owner, he is knowledgeable on the code, rules, and standards of the Department of Environmental Quality (DEQ) which will help him give good recommendations to the Board. He expressed his aim to make the Board procedures more efficient, and at the same time protect the environment.

In response to Senators Harris’ and Heider’s questions, Mr. Purdy attested that the Board has done its due diligence to serve the public and the environment efficiently, but acknowledged that there are a few issues the Board should discuss this year. He articulated his satisfaction to see the general public enjoy Idaho surroundings.

S 1305 Relating to Psychologists; To Revise A Provision Regarding Supervision Agreements And To Make Technical Corrections. Kris Ellis, Idaho Psychological Association, stated that S 1305 amends a section of Idaho Code § 54-2317. This legislation adds family physician to the list of approved supervisors who help in managing the prescription of psychotropic medications. It also eliminates the specialized training language, and replaces it with a minimum of two-years experience as one of its requirements. She emphasized that these amendments have been discussed with Idaho State University and the Idaho Medical Association.
In response to Senator Lee's question, Ms. Ellis recognized that the current language allows physicians to administer the management of psychotropic medications but does not specifically include family physicians in the roster. She introduced Ken McClure, Idaho Medical Association and Idaho Psychiatric Medicine, to elaborate on S 1305. Mr. McClure assured the Committee that this legislation is not a change in the scope of practice but merely a clarification of the prior law. With the recent advent of The Idaho College of Osteopathic Medicine, there is a significant demand for preceptors in Idaho. This legislation would allow the appropriately trained instructors to oversee all prescribing psychology students.

MOTION: Vice Chair Souza moved to send S 1305 to floor with a do pass recommendation. Senator Heider seconded the motion. The motion carried by voice vote.

GUBERNATORIAL REAPPOINTMENT: Reappointment of Kevin C. Boling, Couer d'alene, Idaho, to the Board of Environmental Quality (Board). Mr. Boling was interviewed via phone. Mr. Boling introduced himself and stated that this will be his third reappointment to the Board. He mentioned that he had worked with DEQ to oppose regulations imposed by Idaho's neighboring states, and as a result, Idaho had developed better environmental rules and regulations. With his background in forestry and manufacturing, Mr. Boling ensured that he will act on behalf of Idaho citizens to design efficient rules and regulations related to the environment.

Vice Chair Souza and Senator Harris applauded Mr. Boling for his broad affiliations, efforts, and experiences, and asked him to expound on how those experiences will help him as a member of the Board. Mr. Boling answered that over a period of time, he had learned a lot of things, particularly finding common grounds with fellow board members, but still holding his own position and point of view in some issues.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:30 p.m.
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, February 12, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
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<tr>
<td>H 342</td>
<td>Relating To TeleHealth; Amending Section 54-5703, Idaho Code; Amending Section 54-5705, Idaho Code; and Amending Section 54-5711, Idaho Code.</td>
<td>Tim Olson, Teledoc Health</td>
</tr>
<tr>
<td>S 1295</td>
<td>Dental Practice Act</td>
<td>Elizabeth Criner, Idaho State Dental Association</td>
</tr>
</tbody>
</table>

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin Sen Burtenshaw
Vice Chairman Souza Sen Bayer
Sen Heider Sen Jordan
Sen Lee Sen Nelson
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 12, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
ABSENT/EXCUSED: Vice Chair Souza

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 Martin called the meeting of the Senate Health and Welfare Committee (committee) to order at 3:01 p.m.

H 342 Relating to Telehealth; Amending Section 54-5703, Idaho Code; Amending Section 54-5705, Idaho Code; and Amending Section 54-5711, Idaho Code. Tim Olson, representing Teladoc Health, deferred his time to Representative Megan Blanksma who presented H 342. Representative Blanksma reported that out of 44 counties, 42 face healthcare provider shortages, and noted that currently Idaho Statute has the most restrictive technological language of all states. She alleged that H 342 will provide increased access to quality health care for Idahoans currently with limited access to care. Representative Blanksma explained patients could seek treatment under the Idaho community standard of care including:

• informed consent;
• identification of patient and treating provider;
• adequate and appropriate patient evaluation and diagnosis; and
• an appropriate treatment plan.

She emphasized that this could occur without statutory interference that would arbitrarily dictate the type of technology used, and that H 342 maximizes patient and care provider choice.

DISCUSSION: Senator Burtenshaw asked how far Teladoc can go. Representative Blanksma replied that providers are still supervised by their respective boards. Senator Lee asked for the reasons behind redefining asynchronous or synchronous, and why the audio requirement is being removed. Representative Blanksma replied there is not always a need for audio, but whatever is convenient and comfortable with both parties is available.

TESTIMONY: Marc Bernard Ackerman, DMD, MBA, Executive Director of American TeleDentistry Association, submitted written testimony in support of H 342 (see Attachment 1).
Dr. Donna Campbell, board certified emergency medical physician, board certified ophthalmologist, Texas State Senator, and subject matter expert for Teladoc, testified in support of H 342. Dr. Campbell referred to the physician shortage nationwide, and declared that Teladoc increases care for rural areas. She stated she was quite comfortable with telephone access especially if patient records are in front of her, and noted that video requirement is arbitrary. She asserted that barriers to available care should not be put up, but should be removed.

Robert Baratta, national consultant for Teladoc, testified in support of H 342 stating the main purpose of the bill is to increase access to care. He explained how Teladoc achieves this purpose (see attachment 2), and how telehealth can benefit Idaho (see attachment 3). Regarding the opioid issue, Mr. Baratta pointed out that federal law prohibits telehealth dispensing opioids without an in-person examination. Asynchronous treatment is often used today in behavioral health, especially for veterans with post-traumatic stress disorder. Senator Lee asked what the appropriate establishment of a patient-caregiver relationship would be. Mr. Baratta replied that the establishment of care is written in the medical board rules.

Francoise Cleveland, representing AARP Idaho, reported that AARP Idaho supports H 342. She indicated AARP Idaho is in favor of three specific elements:

- remote patient monitoring;
- allowing the patient's home as an option for originating site; and
- expanding the type of provider-patient encounter allowed in telehealth to include technologies sufficient to conduct a patient evaluation and to diagnose and treat the patient.

Anne Lawler, Executive Director for the Board of Medicine (BOM), stated that BOM is not opposed to the changes to the law. She explained that BOM has never interpreted this statute as requiring audio-visual connection for ongoing telehealth services, only for establishing a relationship for the first time. She asserted that a real-time synchronous communication, as simple as a phone call, is needed in establishing a provider-patient relationship to protect the public and provide quality care.

DISCUSSION: Senator Nelson asked if other qualifiers indicate you don't have to have a phone call. Ms. Lawler explained that BOM felt establishing the relationship was better accomplished by phone rather than by text or email. She commented that synchronous communication sets a standard of care that some physicians who prefer to practice online may not think is necessary. Discussion continued regarding amending the bill now rather than changing it by rule later.

TESTIMONY: Elizabeth Criner, Idaho State Dental Association (ISDA), indicated ISDA is concerned that this legislation creates grey areas creating conflict in the code language and putting patient standard of care at risk. She commented that when the provider-patient relationship is established, it is important to be done by telephone.

Ken McClure, Idaho Medical Association (IMA), asked the Committee to be cautious about this bill and pointed out that the Health Care Transformation Council is studying this issue and will complete the study by the end of the year. He stated the IMA would agree to an audio or an audio-visual component to create a provider-patient relationship. Mr. McClure stressed that the way this legislation is written does not meet the standard of care of a real-time communication in establishing the provider-patient relationship. He suggested a change in wording on lines 13, 14, and 15, page 2, to say two-way audio or audio-visual interaction.
Representative Blanksma responded that the suggested amendments take out some of the best parts of the bill. She explained that statutes are broad and the rules can add specifics at a more fluid rate.

**MOTION:** Senator Bayer moved to send H 342 to the floor with a do pass recommendation. Senator Heider seconded the motion.

**DISCUSSION:** Senator Lee wanted to work on establishment of the provider-patient relationship. Senator Heider was concerned that sending the bill for amendment may change the outcome. Senator Bayer concurred with Senator Heider and rejected sending it to the 14th Order of Business. Senator Jordan supported the substitute motion. Chairman Martin was involved in writing the original bill and looked forward to improvements.

**SUBSTITUTE MOTION:** Senator Lee moved to send H 342 to the 14th Order of Business for possible amendment. Senator Jordan seconded the motion.

**ROLL CALL VOTE:** Chairman Martin called for a roll call vote on the substitute motion. Senators Lee, Burtenshaw, Jordan, Nelson, and Chairman Martin voted aye. Senators Heider, Harris, and Bayer voted nay. The substitute motion carried.

**S 1295** The Dental Practice Act. Elizabeth Criner, Idaho State Dental Association (ISDA), presented S 1295 noting that it amends the Dental Practice Act in two sections of Idaho Code to accommodate the advancement of teledentistry. This is done in a manner that is transparent to patients, enhances patient protections, and preserves the community standard of care whether services are provided in person or by telehealth technology. Ms. Criner reported there have been complaints from patients that teledentistry procedures have been unclear on how to contact the dentist, and the only contact is with customer service representatives who are not licensed dental or oral health care providers. She explained that S 1295 will require dentists to provide licensure and contact information, as well as communication regarding the possible need for in-person care. Ms. Criner explained the needs involved in using aligners on a patient's teeth and meeting the standard of care.

**TESTIMONY:** Dr. Laura Lineberry, Lineberry Orthodontics, spoke in favor of S 1295, providing information regarding "do-it-yourself" dentistry and "direct-to-consumer" orthodontics with regard to problems caused by these treatment processes. She shared three examples of patients who:

- never had X-rays taken;
- were not allowed to talk to their treating dentist or orthodontist; and
- did not receive the results they were offered or wanted.

Dr. Lineberry went on to explain the processes needed to provide appropriate dental treatment (see attachment 4).

Dr. Kathleen Beaudry, periodontist, spoke in support of S 1295. Dr. Beaudry described the results of inappropriate treatment of a patient. She noted that one patient had no oral exam or X-rays, nor did he ever see a dentist or be given the name of the prescribing dentist or orthodontist (see attachment 5). Senator Nelson inquired if this case violates the standard of care for dentistry in Idaho. Dr. Beaudry replied that it does. Senator Nelson asked if the Board of Dentistry was out of line in not proceeding with an investigation. Dr. Beaudry stated that the patient needs to go to the Board of Dentistry with any complaints, but some patients are too embarrassed to do so.

Dr. Steve Bruce, State Dental Association, Legislative Committee Chairman, spoke in favor of S 1295 stating that direct consumer dentistry doesn't follow the standard of care for Idaho.
Brooke Fukuoka, DMD, and owner of Your Special Smiles, PLLC, submitted written testimony in support of S 1295 (see Attachment 6).

Norman Nagel, DDS, MS, representing the American Association of Orthodontists submitted written testimony in support of S 1295 (see Attachment 7).

Robert Barratta, representing the Smile Direct Club, spoke against S 1295. Mr. Barratta stated that Smile Direct Club is a national non-clinical administrative support group for licensed dentists. Clear aligner therapy delivers care at 60 percent savings and eliminates approximately 30 orthodontist visits. He reported that to date a million patients have been served. He noted that traditional dentistry opposes this least intrusive of all dentistry, and notes that Idaho Code takes care of all the problems we've seen. Mr. Barratta emphasized that if there are practitioners who are not providing proper care, they should be adjudicated according to Idaho Code.

DISCUSSION: Discussion ensued between Mr. Barratta, Senator Heider, Senator Lee, and Senator Jordan regarding the handling of cases like those presented, Smile Direct Club's role in the process, the stipulation on page 3 requiring the patient to sign a form that limits him/her from complaining against the treating dentist, and the use of dental records, or lack thereof.

Elizabeth Criner stated the proponents of S 1295 are here because Idaho dentists are seeing patients who have been injured because there is no standard of care being upheld. She stressed that current law disallows the use of a questionnaire by the dentist. Ms. Criner emphasized that decay, bone density, and periodontal disease cannot be seen using a scan (picture) rather than an X-ray.

MOTION: Senator Harris moved to send S 1295 to the floor with a do pass recommendation. Senator Jordan seconded the motion.

DISCUSSION: Senator Bayer stated her belief that people need to be given the chance to use teledentistry. Senator Nelson stated these examples given by Dr. Beaudry and Dr. Lineberry appear to be malpractice.

ROLL CALL VOTE: Chairman Martin called for a roll call vote. Senators Heider, Lee, Harris, Burtenshaw, Jordan, and Chairman Martin voted aye. Senators Bayer and Nelson voted nay. The motion carried.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:37 p.m.
The Honorable Fred Martin
Chairman, Senate Committee on Health & Welfare
Idaho State Senate
700 W Jefferson St
Boise, ID 83702

Dear Chairman Martin,

My name is Dr. Marc Ackerman and I am the Executive Director of the American Teledentistry Association (ATDA). I write to you in support of House Bill 342. I understand that HB 342 was passed by unanimous vote in the Idaho House of Representatives and I hope that endorsement reflects its public policy value on your deliberations.

During my academic and clinical career, I’ve had the opportunity to publish numerous peer-reviewed articles on orthodontics and I am a proud recipient of the B.F. and Helen E. Dewel Award, which is given annually to the highest-rated clinical research article published that year. I have a deep passion for helping others and making sure that everyone receives the care that they deserve; that’s why I signed on with The American Teledentistry Association’s mission to increase access to dental care through advocacy for and the implementation of innovative teledentistry guidelines and solutions. I believe that the public policy debate surrounding telehealth in Idaho as it applies to House Bill 342 could benefit from the national perspective that our organization can provide as a third party.

The technological innovations happening right now are increasing access to affordable health care for millions of Americans while maintaining quality of care standards. As we continue to fight escalating health care costs, telehealth has the potential to offer significant solutions. However, it will require thoughtful public policy, and to that end, I would like to share with you the ATDA’s guiding principles for good telehealth legislation.

1. **Technology Neutral.** Legislation should allow for current and future innovation and not discriminate from one technology to another.
2. **Maximize Patient Choice and Access.** Legislation should permit maximum patient choice and keep the patient at the center of care.
3. **Rely on Professional Discretion.** Legislation should rely on a provider’s professional discretion as to whether the technology chosen by the patient is appropriate and adequate to diagnose and treat the patient as presented.
4. **Promote Transparency.** Both patient and treating provider should be identified to each other.
5. **Ensure the Standard of Care Through Licensure.** Only licensed providers should be able to evaluate, diagnose, and provide treatment and the standard of care should be the same as for in-person patient encounters.

6. **Remove Artificial Barriers to Care.** Legislation and regulations should not require unnecessary licensure or impose geographic restriction to access to care.

With these guiding principles in mind, the **ATDA stands strongly in support of House Bill 342.**

To explain why this is important, let's look at the data. The American Dental Association’s Health Policy Institute conducts an annual review of the dental health of Idahoans and, unfortunately, the numbers paint a dim picture. A quarter of Idahoans do not smile and feel embarrassed due to the condition of their teeth and mouths. One in five Idahoans experience anxiety for the same reason. Over a third of Idahoans have difficulty biting/chewing and experience pain in their mouths. And, according to the same study, the driving reasons that people are not getting these serious issues resolved is because of the cost of care (66%) or a lack of access to care (29%). These statistics are simply unacceptable.

Thankfully, telehealth offers a market-driven solution to these issues. Technology and innovation have revolutionized the way healthcare services can be delivered to patients, offering more flexible and affordable solutions to healthcare service that, traditionally, has been rigid, expensive, and exclusive. By utilizing the full suite of technology available to providers – as this bill does - costs can be significantly reduced, access to care is expanded to anyone with an internet connection, at the same quality of care or desired outcomes. Thousands of Idahoans who have been priced out or shut out from accessing care will now be able to get the care they want, need, and deserve.

To be clear, the quality of care delivered by telehealth tools is just as good as traditional healthcare methods. This is supported by clinical evidence, peer-reviewed studies, and data collected from providers and patients alike. It is important to note that what the legislation does is to bring Idaho into line with many other states by not discriminating against a particular modality of technology. By relying instead on the licensed providers’ professional discretion as to the efficacy of the technology selected, Idaho can expand access to quality care to patients in the state. The same patient safeguards are in place as for in-person care.

**Accordingly, I urge you to support this legislation.**

If you have any questions regarding my comments, I would be happy to talk at your convenience. Feel free to give me a call at (781) 304-4409.

Sincerely,
Marc Bernard Ackerman, DMD, MBA, FACD

CC: Members of the Senate Committee on Health & Welfare
Good afternoon Mr. Chairman and member of the committee, I am Robert Baratta, national telehealth consultant for Teladoc Health. I am here as a poor substitute for Claudia Tucker, the Vice President for Government Affairs, whom some of you may know. She was called elsewhere and I am filling in today.

By way of introduction, Teladoc Health is the world’s largest telehealth company. We serve patients in 130 countries around the world and in all 50 states here at home, including Idaho. Our general medical platform about which some of you may be familiar provides non-emergent, episodic care remotely to patients through our network of more than 300 staff doctors and more than 3,100 board-certified physicians and behavioral health providers. To date, millions of patients have received effective treatment over that platform. Teladoc Health performed the first virtual visit in Idaho in 2005. Currently, there are over 112,000 lives covered by Teladoc. We have 52 Idaho licensed, board certified physicians who performed over 4,000 virtual visits in 2019. Over 1600 employers in Idaho offer to their employees the Teladoc Health benefit. In 2019 alone saved Idaho and its citizens over $1.9 million dollars in health care costs.

A sampling of our clients include the University of Idaho, US Dairy Systems, City of Pocatello, City of Idaho Falls, City of Rexburg, Jefferson County and its School District, Teach for America, Home Depot, Kroger, Costco, National Rural Electric Coop and many more. It is on behalf of those clients that we are here today requesting this amendment to the Idaho Telehealth Access Act.

Teladoc Health was here back in 2015 and worked with the Legislature on the initial telehealth legislation. The state wanted to move cautiously, and it did. Five years later, we have the opportunity to see what other states are doing regarding the treatment of remote technology, including your neighbors. Every single one allows both interactive audio or video. Nationally, only three other states have such
a statutory requirement (New Hampshire, Delaware and Arkansas).

HB 342 will do one thing; it will remove the requirement for a video first virtual exam as long as the treating provider has access to and reviews the patient's medical history. It will allow for patient choice and facilitate health care provider professional discretion. The Idaho licensed providers will use their professional judgement as to the type of technology needed for each individual interaction. If the patient chooses an audio consultation and the provider believes that he/she needs a visual interaction, then that's what will happen.

I urge you to allow Idahoans to have choice in their health care by using a tool that will increase access to quality care and decrease costs. I urge you to vote YES on HB 342. Thank you for your time and kind consideration.
Support House Bill 342 (Blanksma) to expand Telehealth in Idaho

Idaho is behind the national trend

Idaho is one of only four states in the nation that require an audio-visual connection for an initial telehealth visit. Most states allow for patient choice of technology and physician discretion over whether that technology can be used to meet the standard of care. Telehealth rules in Idaho should maximize access to quality care and choice while protecting patient safety, not arbitrarily restrict it. This audio-visual only requirement is an unnecessary and clinically unsubstantiated barrier to technologies in healthcare that could provide high-quality, affordable care to every corner of the state. Innovation and technology allow for access to quality healthcare using video, interactive audio, high definition photos for dermatology, remote patient monitoring and the use of text and SMS communications for behavioral health interactions. The critical point to ensuring patient safety is to require that the physician have access to and review the patient’s medical record before the virtual visit begins; this removes the fear of pill mills and internet prescribing.

Idaho was once a leader in implementing telehealth but has not kept up with innovation and policies that encourage the use of technology. By having this restrictive requirement, Idaho has been left behind.

Idaho’s neighbors are technology neutral on Telehealth

<table>
<thead>
<tr>
<th>State</th>
<th>Technology Requirement</th>
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<tr>
<td>Washington</td>
<td>Interactive audio and video technology / “enabling” technology / asynchronous store and forward</td>
</tr>
<tr>
<td>Oregon</td>
<td>Electronic communications</td>
</tr>
<tr>
<td>Nevada</td>
<td>Information and audiovisual technology / examined electronically, telephonically or by fiber optics</td>
</tr>
<tr>
<td>Utah</td>
<td>Electronic communication or information technology</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Interactive electronic communication, information technology, or other means</td>
</tr>
<tr>
<td>Montana</td>
<td>Electronic communication or other means</td>
</tr>
</tbody>
</table>
Telehealth’s Idaho Footprint

Telemedicine technologies enable secure electronic communication and exchange of information between a board-certified, state-licensed physician in one location and a patient in another. Telemedicine is a valuable tool to practice medicine, expand access to healthcare, and offer an alternative to visiting a doctor’s office, urgent care center or emergency room.

Teladoc HEALTH

Where Idaho stands

Idaho has the nation’s lowest physician supply ratio in national rankings by the United Health Foundation. 
https://www.americahealthrankings.org/explore/annual/measure/PCP/state/ID

42 of 44 Idaho counties face primary care health provider shortages, Health Resources and Services Administration data shows. 
https://data.hrsa.gov/tools/shortage-area/hpsa-find

Idaho has only 194 physicians per 100,000 population, according to the Association of American Medical Colleges. 

Sampling of Idaho Employers Offering Teladoc Health

Mission Aviation Fellowship
Terteling
University of Idaho
Treasure Valley Coffee
National Rural Electric Coop Assn
American Medical Plan
Albertsons Companies
Norco, Inc.
US Dairy Systems
Arlo G Lott Trucking, Inc.
Cradlepoint, Inc.
Bayer Corporation
Aitlus Federal Plans
City of Pocatello
City of Rexburg
City of Henderson-Standard
Jefferson County
Jefferson County School District
Idaho Falls School District
City of Idaho Falls
Cache County School District
Rolling Hills Charter School
Lillian Valleyle School
Chugach School District
Teach for America
Costco
The Home Depot
T-Mobile
NTCA-The Rural Broadband
State Farm
UPS
KTVB-TV, TEGNA Inc.
Lowe’s
Starbucks
Farmers Insurance
Good afternoon. My name is Dr. Laura Lineberry and I’m here in support of Senate Bill 1295.

I am the owner of Lineberry Orthodontics here in Boise and Mountain Home, and I’ve practiced orthodontics for more than 20 years. I’m actively involved in the American Dental Association, American Association of Orthodontists and the Idaho State Dental Association among other professional groups. I strive to keep up with the rapid changes in orthodontics and technology so my patients can receive the best care possible.

I was the first orthodontist in Idaho to reach “Elite” status for Invisalign and have used their aligning trays on more than 700 patients, when they and I determine together that it is an appropriate treatment.

But in the last few years I’ve noticed a rising trend of patients coming in for treatment after they either had no improvement or end up in a worse situation than when they started “do-it-yourself” dentistry, or “direct-to-consumer” orthodontics treatments. This happens because these are not patients whose problems can be corrected by “do-it-yourself” dentistry, or “direct-to-consumer” orthodontics treatments. Had the prescribing dentist followed the parameters outlined in S1295, it would have been clear that these patients should not have been prescribed these type of aligner services.

I thought I would go through a few of these cases, to help explain why I and many others in my field are deeply concerned about this sort of practice.

Although these patients have granted me permission to discuss their case in general, we have chosen together to not reveal their identities, to protect their privacy.
(I have included images and clinical notes for each case if you’d like to read about these in more depth.)

Patient One
This young woman made it halfway through her direct-to-consumer tooth aligners before she gave up. They didn’t fit, her teeth were moving in the opposite direction she felt they should be, and when she tried to identify and call her treating orthodontist with questions or concerns, the people she spoke with told her that improper fit was normal.

So, the patient came to me and brought her records from the company she worked with. They had poor-quality photos, no X-ray images or any clinical exam notes from an orthodontist or dentist—they were impossible to make a diagnosis from.

I conducted my own exam and found that she had several issues:
1. She demonstrated a lack of overall function, which means over time her teeth will wear and break down causing greater problems.
2. I noted and diagnosed a horizontal-direction overbite, and an open bite where her teeth don’t close properly.
3. Finally, I noticed a clicking in her jaw, which can cause greater problems, ranging from headaches to sleep apnea.

Patient Two
This young man came to my office after completing six months with a direct-to-consumer company. They’d promised him straight teeth and he was not pleased with the end result.
He tried to contact the company to ask questions about his results. Just like the previous patient, the company representative dismissed his concern and wouldn’t tell him who his practicing orthodontist was or help him contact that doctor.

Upon examination, we found that he started with severe crowding that the company misdiagnosed as simple crowding—which is a dramatic difference.

You can treat severe crowding in three ways: pull some teeth, file the teeth, or flare them outward. The first two methods require in-office treatments. Well, the company went ahead with option number three. In so doing, they pushed his teeth to an unhealthy position where it was uncomfortable to even close his mouth because his mouth muscles were stretched into an uncomfortable position.

**Patient Three**
Finally, this patient came to me after finishing a 13-week treatment with an aligner product.

He followed instructions but said it felt like nothing changed. Like the others, he never had x-rays taken. There was no exam performed. The patient never met his doctor.

When I examined him, I found that the aligner treatment left him with a deep overbite, incisors that incline too deeply inward, among other challenges.

His treatment will take at least 44 weeks and will require elastics and attachments that could never be performed in a DIY setting. So much for a “quick, cost-saving method.”

**Conclusion:**
These patients are just three examples of many cases I’ve seen in my office— they were lucky the results weren’t worse.

Patients often come to my practice because they want a pretty smile. But as oral health professionals we are responsible for looking at every part of their mouth to understand how alignment, wear, roots and structure can affect a patient in the long term.

These direct-to-consumer teeth alignment companies aren’t considering anything other than a pretty smile—and they’re not even doing that correctly.

As trained, medical professionals it’s important that our patients know who we are, so they can ask questions and get the best possible care.

When we make decisions, we do that in consultation with our patients. We perform a comprehensive oral exam with x-rays. In my case, it’s in the same room with the patient. This is our community standard of care, and it needs to be followed to ensure patient safety. After all, we are dealing with a patient’s oral health—which is a direct link to their overall health. Idaho citizens deserve more.

This is why I hope you pass Senate Bill 1295 and preserve the transparency, safety and quality care the people of Idaho deserve.

Thank you, Mr. Chairman and members of the committee.
Testimony – Wednesday, Feb. 12
Senate Health & Welfare
S.1295

Good afternoon. My name is Dr. Kathleen Beaudry a Periodontist licensed in the state of Idaho, and I’m here in support of Senate Bill 1295.

As a Periodontist, I focus my practice on bone loss, gum disease, and the placement and treatment of dental implants. On 7/9/19 I saw a patient for a comprehensive periodontal exam. This 62 year old male presented with generalized moderate to severe periodontitis, failed/mobile implant #30, fractured and non-restorable #4, gross decay and non-restorable #3, decay #2, 14, 15 and 31. (review x-rays and speak to issues)

This patient reported having “photos” taken and trays made by a direct to consumer aligner company in or around February of 2019. He confirmed that no oral exam was performed and, to his knowledge, no radiographs were taken. He had no contact with a dentist and was never given the name of the dentist or orthodontist who prescribed his aligner treatment.

The patient has active periodontal disease and decay and is in no way a candidate for orthodontic movement. Moving teeth with active infection, decay, or inflammation can cause bone loss and ultimately tooth loss. These issues can only be seen through a combination of a comprehensive oral exam with periodontal probing, and radiographs.

He reported the onset of pain and mobility around implant #30 while wearing his first tray. He has since stopped wearing the trays as he felt it was causing the discomfort and mobility of implant #30. Implants cannot be orthodontically moved. Attempted movement of an implant will result in bone loss and failure. This reinforces the need for a patient to have access to and contact with the prescribing dentist, and for that dentist to have reviewed a comprehensive oral examination and radiographs.

In my opinion, if a provider had looked in his mouth and read diagnostic radiographs, they would have determined without a doubt that this patient was not a candidate for orthodontic movement. It is a challenge to see the damage that improper use of these prescribed medical devices can cause. Your support for Senate Bill 1295 today will better ensure that patients will be more appropriately evaluated and not sold a device that will do more harm than good for their oral health.

Thank you Mr. Chairman and members of the committee. I will stand for any questions.
Respective Senators of the Health and Welfare Committee:

I am writing you to urge you to vote yest on S1295. I am the dentist leader in one of two programs that have received federal funding to implement teledentistry as a way to expand access to care in Idaho. I am currently beginning to practice teledentistry in Idaho. I have learned a lot in this process. There are many advantages to a teledental system, however there is also abuse potential.

What this bill will do: This will make sure that Idaho citizens who receive teledental services will have a way to get needed treatment, if treatment is needed. It mandates that the dentist providing the teledental services either provides the treatment or that they have an established referral system where the patients are aware of the terms prior to utilizing the patient’s single exam per year insurance benefits.

An example of teledentistry gone wrong without this bill:

Idaho Medicaid patient receives teledental exam, finds out they have a cavity that needs repair, the dentist who did the teledental exam lives in Nebraska. This patient can’t go to Nebraska for care. They then go to another dentist in Idaho who accepts Medicaid, however only one exam per year is allowed with Medicaid so they will have to pay for this new exam. They can’t afford this exam so they just go on knowing they have a cavity. Idaho Medicaid paid the Nebraska dentist, yet this was not a benefit for the patient, nor was it a good use of our limited Medicaid funds. The only ‘winner” in this situation is the Nebraska dentist who was paid for the exam.

The same scenario if this bill were passed: (two possible outcomes):

1. The patient knows in advance that they will have to pay for a subsequent exam because the dentist in Nebraska does not have someone who has agreed to perform the treatment for the patient on a referral basis. The patient decides to go to another dentist where they can have treatment if needed.

2. The dentist in Nebraska has established a referral system with a dentist the patient can see without charging a second exam. The Nebraska dentist refers the patient to the Idaho dentist and the treatment is done. The Idaho dentist doesn’t charge an exam as that was the agreement they had previously worked out.

3. The patient knew that they may have to pay for an exam with an Idaho dentist if treatment was needed. Before their teledental exam, they knew who the Idaho dentist is and they called to see how much the exam would cost if needed. They agree to take on the risk of needing to pay for the exam and are prepared for that. The Nebraska teledental dentist tells them they have a cavity, they were prepared they pay the Idaho dentist for the exam, they pay for the exam then go have their needed treatment.

I am happy to discuss this further with you if you would like. Email is the best way to get a hold of me until Tuesday as I am currently in Chicago for a meeting. My cell is 208-859-8449, texting is the best way to get a hold of me ordinarily.
Respectfully,
Dr. Brooke MO Fukuoka

Your Special Smiles PLLC
Dr. Brooke MO Fukuoka DMD -Owner Dentist

(208) 859-8449

"Our mission is to increase the quality of life for adults with special needs and geriatric patients with mobility issues through caregiver education and increasing access to comprehensive dental care."
February 12, 2020

Senator Fred Martin  
Chairman, Idaho Senate Health and Welfare Committee  
Idaho Capitol Building  
700 West Jefferson Street  
Boise, Idaho

Senator Mary Souza  
Vice Chairman, Idaho Senate Health and Welfare Committee  
Idaho Capitol Building  
700 West Jefferson Street  
Boise, Idaho

VIA E-MAIL: Ms. Margo Miller, shel@senate.idaho.gov

Dear Chairman Martin, Vice Chairman Souza, and Members of the Senate Health and Welfare Committee,

The American Association of Orthodontists (AAO) respectfully requests your support for S 1295, relating to dentists and to provide for teledentistry. The AAO is the world’s oldest and largest dental specialty organization, created in 1900. It represents more than 19,000 orthodontists throughout the United States, Canada, and abroad, and specifically 86 members in Idaho. AAO member orthodontists have successfully completed an accredited orthodontic residency program, after previously graduating from dental school.

As a professional organization, the AAO is dedicated to, among other goals: (a) ethically advancing the art and science of orthodontics and dentofacial orthopedics worldwide; (b) improving the health of the public by promoting quality orthodontic care, the importance of overall oral healthcare, and advocating for the public interest; and (c) educating the public about the benefits of orthodontic treatment and the educational qualifications of orthodontic specialists.
The AAO supports legislation that it believes will best protect patient health and safety, which we believe is accomplished with S 1295. Specific sections of the bill that the AAO supports are set forth below:

- [Section 54-901. Definition—Practice of Dentistry] The practice of dentistry is the doing by one (1) person, for a direct or indirect consideration, of one (1) or more of the following with respect to the teeth, gums, alveolar process, jaws, or adjacent tissues of another person, namely:...

    (4)(a) Providing telehealth services, also referred to as teledentistry, in accordance with chapter 57, title 54, Idaho Code, and in accordance with the community standard of care where the patient is located in Idaho. Prior to providing any teledentistry services, a dentist must provide the patient with his contact information and the contact information for all dental providers who may be working with the patient. Such information shall include but is not limited to name, Idaho license, practice address, and telephone number; ...

The AAO agrees with the purpose of provision because regardless of modality, the AAO believes patients should always be aware of this health provider information as it pertains to their treating dentists or potential dentists.

- [Section 54-924. Other Grounds of Refusal, Revocation or Suspension of Dentists—Probation Agreements.] The Board may refuse to issue or renew a dental license, or may revoke, suspend, place on probation, reprimand or take other disciplinary action with respect to a dental license as the board may deem proper, including administrative penalties not to exceed ten thousand dollars ($10,000) per violation and assessment of the costs of disciplinary proceedings in the event a dentist shall:...

    (15) Authorize or perform, either directly or through the use of telehealth communication technologies, dental procedures to correct the malposition of human teeth without first:

    (a) Conducting an in-person comprehensive oral evaluation and review of the patient’s most recent diagnostic digital or conventional radiograph or other necessary imaging, to ensure that the community standard of care has been met. New radiographs or other equivalent bone imaging may be ordered if deemed appropriate by the treating dentist; ...

The AAO agrees with this provision in the interests of patient health and safety, because the requirement would allow the treating dentist to understand what is going on beneath the gums (impacted teeth, bone loss, etc.), seek to avoid complications, and determine if patients are suitable candidates for orthodontic treatment. The AAO believes there are certain diagnoses and evaluations that can only be performed in-person or are best performed in-person (x-rays, etc.), and the AAO believes that dental treatment, especially the movement of teeth via orthodontic treatment, should not be undertaken without sufficient diagnostic information.
(16) Require directly, or as a member, representative, contracted agent, or employee of or in connection with any company, association, corporation, or partnership, that a patient sign an agreement limiting his right or ability to file a complaint with the Board.

The AAO believes that Idaho patients should have the right to express their opinions on any dental issue to their state dental board, and that right should not be abridged.

The AAO supports increased access to care as long as it is care that is in the best interest of patients' health and safety and complies with Idaho’s dental laws. The AAO believes that S 1295 keeps patient health and safety a priority in Idaho, while still allowing telehealth advancements to continue to grow in a thoughtful way. If you have any questions, please contact the AAO’s Government Affairs Specialist, Gianna Hartwig, at ghartwig@aaortho.org or 314-292-6527.

Thank you for your time and your service to your Idaho constituents.

Sincerely,

[Signature]

Norman Nagel, DDS, MS
Pacific Coast Society of Orthodontists, Trustee
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, February 13, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>PRESENTATION:</td>
<td>Child Protective Services (CPS) Process</td>
<td>Judge Bryan Murray Magistrate Judge, Bannock County</td>
</tr>
<tr>
<td>PRESENTATION:</td>
<td>Department of Health and Welfare, Division of Family and Community Services (FACS), Annual Report</td>
<td>Roxanne Printz, Deputy Administrator, Division of FACS Department of Health and Welfare</td>
</tr>
<tr>
<td>H 317</td>
<td>Relating to Optometrists; Repealing Chapter 15, Title 54, Idaho Code; Amending Title 54, Idaho Code</td>
<td>Kelley Packer, Bureau Chief, Bureau of Occupational Licenses</td>
</tr>
<tr>
<td>PAGE FAREWELL</td>
<td>Farewell and thanks to page, Brenna Bolinder</td>
<td>Chairman Martin</td>
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If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin          Sen Burtenshaw
Vice Chairman Souza     Sen Bayer
Sen Heider               Sen Jordan
Sen Lee                  Sen Nelson
Sen Harris               

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 13, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the Senate Health and Welfare Committee (Committee) at 2:59 p.m.
PASSED THE GAVEL: Chairman Martin passed the gavel to Vice Chair Souza.

PRESENTATION: Child Protective Services (CPS) Process. Judge Bryan Murray, Magistrate Judge, Bannock County, Chair of CPS Committee, explained the process of reuniting children with parents/guardians. See attachment 1. Judge Murray said his duties consist of finding out who a child's guardians are and creating custody orders. Idaho has a mandatory reporting act with the majority of referrals coming from law enforcement. He said 40 percent of children in care are Native Americans. He explained that a termination trial is very serious but many parents do not show up for this hearing. These cases are appealed directly to the Supreme Court. Records are closed and hearings are closed. He explained the Family First Act of 2018.

Senator Lee asked Judge Murray how they could help create a specialty court. Judge Murray said that the Yes Plan and Medicaid expansion will help. In response to Senator Harris, Judge Murray said they experienced an increase in cases due to opioid use. Chairman Martin, Senator Harris and Vice Chair Souza praised Judge Murray for his efforts.
PASSED THE GAVEL: Vice Chair Souza passed the gavel to Chairman Martin.

PRESENTATION: Family and Community Services (FACS), Annual Report.

Chairman Martin asked for unanimous consent to hold the presentation of FACS Annual Report for a later date. There were no objections.

H 317 Relating to Optometrists. Kelly Packer, Executive Director of Occupational Licenses, presented H 317, which seeks to organize the Optometric Physician Act and regulate the profession. The legislation will add an inactive license status, clarify that the sale of reading glasses does not apply to the act, and add exemptions from licensure for federal employees in the scope of their employment and optometrists licensed in other states. She said it would establish the State Board of Optometry (SBO), provide powers to the SBO to grant licenses, endorsements, and to establish disciplinary actions and prohibited acts. This legislation also expands the scope of practice, allowing optometrists to perform certain laser surgical procedures and set exam and experience requirements for such procedures. She explained that after conversations with the Idaho Bureau
of Occupational Licenses (IBOL), they came to a conclusion that optometrists do receive the education to perform certain laser surgical procedures. She said they have no problem mirroring the ophthalmologist minimum number of supervised procedures and planned to do so. The community standard of care will be the standard for optometrists. She made a point that there are over 1.8 million people in Idaho but only 92 ophthalmologists and 603 optometrists. This legislation would help to increase the accessibility of care.

Kris Ellis said she represented the Idaho Optometric Physicians and agreed that there is a problem with access to care. She quoted an ophthalmology laser center located in Eagle, Idaho, Eagle Eye Center, stating that the laser procedures have no systemic side effects and are safe procedures that may be performed in an office space setting. She quoted officials at the Department of Veteran's Affairs (VA) that there were no adverse outcomes performed by VA optometrists. She argued that increased consumer protection and increased competition occur at the same time.

DISCUSSION: In response to Vice Chair Souza, Ms. Ellis said that VA optometrists do not perform outside their legal scope of work. They do not perform the duties this bill would grant optometrists. Senator Nelson queried if the Eagle Eye Center endorsed H 317. Ms. Ellis said she was not aware of their stance.

In response to Chairman Martin, Ms. Packer said they would present the language to the stakeholders during the negotiated rulemaking process in order to facilitate a temporary rule in place by July 1, 2020, to be active at the same time the bill would be in effect, so that the side boards and safety nets are in place. The two main concerns expressed by opponents are that they are unclear whether the five proctored procedures are for each surgical procedure. In rule, they mirrored the ophthalmologist residency. This is what they would present in the negotiated rulemaking. The next concern is supervisor qualifications. They propose a rule that allows optometrists to obtain training from an ophthalmologist and eventually opens up the ability of optometrists to facilitate their own supervision of the training qualifications.

Senator Jordan asked why this was proposed as a commitment to a rule and not as an amendment to the legislation. Ms. Packer said they proposed the rule instead of the amendment in order not to lose momentum this legislative session.

TESTIMONY: Several spoke in support of H 317 and expressed common themes that H 317 saves their patients' time and allows them to return to work faster. They believe the training is sufficient, that it is a dispute over loss in patients, and that it is an opportunity to expand their field. Several spoke against H 317 and expressed common themes that H 317 is inadequate in its training requirements, oversight of procedures, that children are not excluded from the practice, and shared a general fear of malpractice.

Senator Grow, District 14, said he supports this bill, as it increases access to medical care, reduces the cost of that care, and he feels confident that a Board of Optometry will do what they are asked to do from the Governor. He asked that the Committee vote to send this bill to the Senate floor for full consideration.

MOTION: Senator Heider moved that H 317 be held in Committee. Senator Jordan seconded the motion.

SUBSTITUTE MOTION: Senator Bayer moved to send H 317 to the floor without recommendation. Senator Harris seconded the motion.
DISCUSSION: Committee discussion focused on the following concerns: whether H 317 should leave the committee; the unpredictably of the human body and seriousness of operating on the eyes; concern that they are asked to make a decision on procedures that are not listed in H 317; a lack of clear language in the statute which would hinder the rulemaking process; the potential to increase access to care; and, unintended consequences of access.

Senators Bayer and Harris said they were in favor of the substitute motion, feeling that the Senate had enough information to make a decision.

Senators Heider, Jordan, Nelson, Lee, and Vice Chair Souza spoke in opposition to the substitute motion. Their concerns were those listed in the discussion.

ROLL CALL VOTE: Chairman Martin called for a roll call vote on the substitute motion. Senators Harris, Bayer, and Chairman Martin voted aye. Vice Chair Souza, Senators Heider, Lee, Burtenshaw, Jordan, and Nelson voted nay. The motion failed.

ROLL CALL VOTE: Chairman Martin called for a roll call vote on the original motion. Vice Chair Souza, Senators Heider, Lee, Burtenshaw, Jordan, and Nelson voted aye. Senators Harris, Bayer, and Chairman Martin voted nay. The motion carried.

PAGE FAREWELL: Brenna Bolinder, Senate page, said she is grateful to be welcomed by the Senate and that the experience taught her more than her government classes. She stated that she wants to pursue an education in pre-medical and work in the field of psychiatry.

Senator Harris thanked Ms. Bolinder for her work. Vice Chair Souza wished her well and hoped that she would study conflict resolution while in school in light of the recent debate and testimony.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 5:19 p.m.
IDAHO'S CHILD PROTECTION SYSTEM
A Balance of Parents Rights and the Right of Children to be Protected

IDAHO'S PROMISE TO CHILDREN
State Jurisdiction If:
1. Neglected
2. Abused
3. Abandoned
4. Homeless
5. Parents or legal custodian fail to provide a stable home environment
6. Another child in same household or visitation (risk)

Section 16-1603, Idaho Code, 1 TO 5 Defined in Section 16-1602, Idaho Code

PARENTS' RIGHTS
1. "[N]or shall any state deprive any person of life, liberty or property without due process of law."
   United States Constitution, Amendment XIV, Section 1
2. "[P]arents have a right to the companionship, care, custody and management of their children."
3. Due process requires that a parent is entitled to a hearing on his/her fitness before his/her children are taken from him/her.
HOW SHOULD THE STATE RESPOND?

Section 16-602 (Idaho Code)

A. Establishment of a legal framework conducive to the judicial processing, including periodic review of child abuse, abandonment and neglect cases, and the protection of any child whose life, health or welfare is endangered. At all times, the health and safety of the child shall be the primary concern. Each child coming within the purview of this chapter shall receive, preferably in his own home, the care, guidance and control that will promote his welfare and the best interest of the state of Idaho; and if he is removed from the control of one (1) or more of his parents, guardian or other custodian, the state shall secure adequate care for him; provided, however, that the state of Idaho shall, to the fullest extent possible, seek to preserve, protect, enhance and reunite the family relationship.

Directions to the Court

Section 16-603 (Idaho Code)

1) At all times, the health and safety of the child shall be the primary concern.
2) Preserve the privacy and unity of the family wherever possible.
3) Take such actions as are necessary and feasible to prevent the abuse, neglect, abandonment or homelessness of children.
4) Take such actions as may be necessary to provide the child with permanency including concurrent planning.
5) Clarify for the purposes of this act the rights and responsibilities of parents with joint legal or joint physical custody of children at risk, and
6) Maintain sibling bonds by placing siblings in the same home when possible, and support or facilitate sibling visitation when not, unless such contact is not in the best interest of one (1) or more of the children.

IDAHO MANDATORY REPORTING

- Physician
- Hospital staff
- Intern
- Nurse
- School teacher
- Day care
- Social Worker
- Other person having reason to believe

Section 16-1605 Idaho Code
IDAHO DEPARTMENT OF HEALTH AND WELFARE (IDHW) INVESTIGATES

1. Do nothing, unsubstantiated claim
2. Informally work with family and make referrals
3. Create a written plan with the family
4. File a CP petition and wait for adjudicatory hearing
5. File a CP petition and ask court for an order removing the child (child is unsafe)

REMOVAL BY PEACE OFFICER

- DUI (many times with kids in car)
- Substance abuse arrest
- Warrant for arrest (often failure to appear for court)
- Child wandering in the street
- Sex abuse allegation and investigation
- Parent involved in their crimes
- Parent goes on vacation; leaves child unsupervised
- Substitute caretaker quasi, drops off child
- Chronic neglect, officer won't leave child in home
- Child born under the influence, officer declares

TEMPORARY SHELTER CARE

Court Options and Findings

- Petition filed by prosecutor or deputy attorney general, reasonable cause for jurisdiction?
- IDHW made reasonable efforts to avoid shelter care?
- Temporary custody of one parent?
- Contrary to welfare to remain in home?
- Best interests to be in shelter care?
- Would a “protective order” allow a child to return home safely?
ADJUDICATORY HEARING

• 30 days after filing
• Preponderance of the evidence for jurisdiction
• If jurisdiction disposition decided:
  • Legal custody with IDHW
  • Protective supervision by IDHW
  • Court order of conditions to keep child safe
  • Removal and/or no contact orders

PLANNING HEARING

<table>
<thead>
<tr>
<th>PARENT PLAN</th>
<th>CHILD PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reunification</td>
<td>• Health</td>
</tr>
<tr>
<td>• Treatment</td>
<td>• Treatment</td>
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<tr>
<td>• Skills</td>
<td>• Education</td>
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<td>• Lifestyle</td>
<td>• Sibling groups</td>
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<tr>
<td>• Support</td>
<td>• Family connections</td>
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<tr>
<td>• Housing</td>
<td>• Visitation-Home Visits</td>
</tr>
</tbody>
</table>

REVIEW HEARING

<table>
<thead>
<tr>
<th>REVIEW 6 MONTHS</th>
<th>STATUS AS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full review of the case</td>
<td>• Keep case moving</td>
</tr>
<tr>
<td>• Reunification efforts</td>
<td>• Engagement of parent</td>
</tr>
<tr>
<td>• Case closure efforts</td>
<td>• Services needed</td>
</tr>
<tr>
<td>• Plan changes, if needed</td>
<td>• Motivational hearing</td>
</tr>
<tr>
<td>• Wellbeing of child</td>
<td>• Limited issues</td>
</tr>
<tr>
<td>• Permanency progress</td>
<td></td>
</tr>
</tbody>
</table>
PERMANENCY HEARING 12 MO.

PERMANENCY GOAL
- Reunification
- Case closure

CONCURRENT GOAL
- Termination
- Adoption
- Guardianship
- APPLA (Another Parental Permanent Living Arrangement)

TERMINATION
- IDHW has custody and may file at anytime
- IDHW must file when:
  - 15 of last 22 months child is in IDHW custody
  - 30 days after permanency plan of termination
  - 30 days after court rules infant abandoned
  - 30 days after finding of aggravated circumstances
  - Or a finding of compelling reasons termination is not in the best interest of child.

TERMINATION TRIAL
- Title 16 Chapter 20 Idaho code
- Clear and Convincing Evidence
  - Abandoned
  - Neglected or abused
  - Not the biological parent
  - Unable to parent for prolonged time
  - Remaining incarcerated
  - Best interest of child
APPEALS

- Idaho Appellate Rule 11.1
- Direct expedited appeal to the Idaho Supreme Court
- Saves between one and two years for child
- Need for court reporters to create a record on appeal

TIME IS CRITICAL

- To the child
- To the parents
- To the courts
- To IDHW
- To the foster parents

CLOSED RECORD AND HEARINGS

A court shall not disclose any of the contents of a case file of any action brought under the Juvenile Corrections Act or the Child Protective Act, nor other records of such proceedings, except as authorized under Rule 32 of the Idaho Court Administrative Rules and Section 16-1626, Idaho Code (addressing the disclosure of judicial records.)
FAMILY FIRST PREVENTION SERVICES ACT 2018

- The entire community is responsible for the well-being of children and families.
- F&E funding to IDHW for prevention.
- Challenges and opportunities.
- Children should be protected whenever possible within their own homes, communities and cultures.
- Requires interagency collaboration and the engagement of child- and families-serving agencies from the public, private, and faith-based sectors.
AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, February 18, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
<th>PRESENTER</th>
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<tbody>
<tr>
<td>MINUTES APPROVAL:</td>
<td>Minutes of January 23, 2020</td>
<td>Senator Souza</td>
</tr>
<tr>
<td>PAGE WELCOME:</td>
<td></td>
<td>Chairman Martin</td>
</tr>
<tr>
<td>VOTE ON Gubernatorial Appointment:</td>
<td>Kevin C. Boling, Coeur d'Alene, Idaho, has been reappointed to the Department of Environmental Quality Board.</td>
<td></td>
</tr>
<tr>
<td>VOTE ON Gubernatorial Appointment:</td>
<td>Leonard &quot;Nick&quot; Purdy, Picabo, Idaho, has been reappointed to the Department of Environmental Quality Board.</td>
<td></td>
</tr>
<tr>
<td>H 392</td>
<td>Relating to Volunteer Health Care Provider Immunity</td>
<td>Emily McClure</td>
</tr>
<tr>
<td>S 1331</td>
<td>Relating to Chiropractic Practice Act</td>
<td>Caroline Merritt, Idaho Association of Chiropractic Physicians</td>
</tr>
<tr>
<td>RS27719</td>
<td>Unanimous Consent to Print Relating To The Use Of The Prescription Drug Monitoring Program</td>
<td>Senator Lee</td>
</tr>
<tr>
<td>PRESENTATION:</td>
<td>Office of Drug Policy</td>
<td>Melinda Smyser</td>
</tr>
</tbody>
</table>

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin             Sen Burtenshaw
Vice Chairman Souza        Sen Bayer
Sen Heider                 Sen Jordan
Sen Lee                    Sen Nelson
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 18, 2020
TIME: 3:00 P.M.
PLACE: Room WW54

MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson

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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:10 p.m.

MINUTES APPROVAL: Vice Chair Souza moved to approve the Minutes of January 23, 2020. Senator Heider seconded the motion. The motion carried by voice vote.

PAGE WELCOME: Chairman Martin welcomed the Committee's new page, Lila Pulver, and asked her to introduce herself to the Committee and tell about her future plans. Ms. Pulver indicated she attends Boise High School and next year will attend Point Loma Nazarene University in San Diego to study international development. She enjoys baking and involvement in the Young Life youth group.

VOTE ON GUBERNATORIAL APPOINTMENT: Senator Nelson moved to send the Gubernatorial reappointment of Kevin C. Boling to the Board of Environmental Quality to the floor with recommendation that he be confirmed by the Senate. Vice Chair Souza seconded the motion. The motion carried by voice vote. Vice Chair Souza will be the floor sponsor.

VOTE ON GUBERNATORIAL APPOINTMENT: Senator Heider moved to send the Gubernatorial reappointment of Leonard "Nick" Purdy to the Board of Environmental Quality to the floor with recommendation that he be confirmed by the Senate. Senator Jordan seconded the motion. The motion carried by voice vote. Senator Heider will be the floor sponsor.

H 392 Emily McClure, a lawyer and lobbyist representing the Idaho Medical Association, asked for the Committee's support of H 392. She explained that previously, the Legislature enacted Chapter 77, Title 39 of Idaho Code (1998) to limit civil liability for doctors, dentists, optometrists, physician assistants, and nurses who volunteer at free medical clinics. In 2018 this protection was extended to community health screening events. This legislation would extend this protection to other volunteer healthcare professionals and students in training. The liability would still only apply to civil actions, and the patient must be informed of the liability limitation and if the provider is a student in training. This bill would include additional professionals such as podiatrists, chiropractors, pharmacists, physical therapists, oncologists, speech-language pathologists; audiologists; social workers; counsellors; therapists; dieticians; occupational therapists, and respiratory therapists, but only to the extent that they are practicing within the scope of their practice. It would also apply to students in training in these professions, but only if under the direct supervision of a licensed professional and only if the patient is informed he or she is a student in training. This will also help students achieve their hours toward accreditation.
Idaho Code § 39-7703 describes the liability protection and does not extend to healthcare providers for any acts constituting intentional, willful, or grossly negligent conduct or acts of a healthcare provider that are outside the scope of practice authorized by the provider's license, certification, or registration. The volunteer healthcare provider and the patient must sign a waiver.

DISCUSSION: Vice Chair Souza commented on the need for this bill and thanked Ms. McClure for bringing it.

MOTION: Senator Lee moved to send H 392 to the floor with a do pass recommendation. Senator Bayer seconded the motion. The motion carried by voice vote. Senator Lee will be the floor sponsor.

S 1331 Caroline Merritt, representing the Idaho Association of Chiropractic Physicians, presented S 1331, which relates to chiropractic physicians. She introduced Dr. Tim Klena, Boise chiropractor. She said this bill amends Idaho Code § 57-704, which would allow a chiropractor certified in clinical nutrition to issue certain patient specific prescriptions. This bill also makes certain technical corrections and amends Idaho Code § 54-716, which would allow for approved vitamins or minerals to be obtained from a compounding pharmacy for use in the chiropractor's office. A 503(a) compounding pharmacy would be more cost effective than using a 503(b) outsourcing pharmacy. Ms. Merritt explained this bill does not expand the scope of practice or the list of products.

DISCUSSION: In response to Senator Heider's question about the process not having same day availability from order to delivery of the prescription vitamin or mineral compound, Ms. Merritt explained the ongoing nature of the doctor-patient relationship which would allow the doctor to know when the prescription would be needed and reiterated the patient specific use, so it could not be used for any other patient.

Senator Nelson and Ms. Merritt discussed the possibility of the cost being driven up by limiting to an Idaho licensed pharmacy, and the experiences of Idaho chiropractors being restricted without prescriptive authority. There are 35 outsourcing facilities in Idaho, but not all the pharmacies are willing to service chiropractors; in fact, there is only one in eastern Idaho that is willing to service Idaho chiropractors.

Dr. Timothy J. Klena, chiropractor and past president of the Chiropractic Association, stated he had been working on this legislation approximately five years. S 1331 overcomes some of the limitations still facing chiropractors. Chairman Martin asked about the compounds and Dr. Klena explained that only those listed on the formulary are included: the B vitamin family, vitamin C, calcium, and others. The problem is attaining them at a cost effective basis.

In response to a question from Vice Chair Souza, Dr. Klena explained the difference between 503(a) and 503(b) pharmacies and how this bill affects them and chiropractors.

Senator Heider asked about license to compound. Dr. Klena explained the extra training required to use and administer the vitamin-mineral formulas, and only by those chiropractic physicians who have chosen to advance their studies in this area.

MOTION: Vice Chair Souza moved to send S 1331 to the floor with a do pass recommendation. Senator Lee seconded the motion.
DISCUSSION: Senator Heider stated that he intends to vote in favor of the bill, but expressed concerns of misuse. Vice Chair Souza clarified that only chiropractors certified in clinical nutrition may prescribe and administer these formulas and the chiropractic physicians are not compounding them, only the pharmacies selected are compounding.

VOICE VOTE: The motion to send S 1331 to the floor with a do pass recommendation passed by voice vote. Vice Chair Souza will be the floor sponsor.

RS 27719 Senator Lee presented RS 27719 and explained that this RS addresses a long-standing problem in our community. She is a member of the opioid task force and this RS requires prescribers of opioids to use the database pharmacists currently use as a way to look at who is using opioids and what they are using.

MOTION: Chairman Martin asked for unanimous consent to send RS 27719 to the State Affairs Committee for a print hearing. There were no objections.

PRESENTATION: Melinda Smyser, Administrator of the Governor's Office of Drug Policy, reported on statistics of vaping, drug overdose deaths in Idaho, illicit drug use, and states that have legal retail or medical marijuana. She also gave an overview of substance use prevention grant programs and outcomes, the underage drinking prevention media campaign known as "Be the Parents," Millennium Fund Projects, and naloxone distribution. See attachment 1.

DISCUSSION: Senator Lee commended Ms. Smyser on what the task force is working on. It's one of the most functional work groups involving tribes, doctors' offices, facilities, and more. Vice Chair Souza commented on the bag that dissolves opioids and looks forward to seeing the bag handed out with each opioid prescription to encourage proper disposal of unused opioids.

Ms. Smyser closed her presentation adding that acute and chronic pain are included among their projects.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the Committee at 4:04 p.m.

___________________________   _________________________
Senator Martin                  Margo Miller
Chair                           Secretary

___________________________   _________________________
Juanita Budell                  Secretary
Assistant Secretary
PROPOSED PRESENTATION TO SENATE HEALTH AND WELFARE COMMITTEE

The Idaho Office of Drug Policy (ODP) proposes a presentation to the Senate Health and Welfare Committee covering the following topics regarding substance misuse in Idaho and ODP’s role in prevention and education.

STATISTICS
- 1 in 2 Idaho high school students has ever used an electronic vapor product (Idaho YRBS, 2019)
- At least 50% of drug overdose deaths in Idaho in 2018 involved opioids—125 out of 248. (IDHW, Vital Stats)
- Idaho ranks 40th for the number of individuals 12 and older reporting illicit drug use, including marijuana, in the past month. (NSDUH, 2018-2019)
- The top 18 states all have either legal retail or medical marijuana

OVERVIEW OF SUBSTANCE USE PREVENTION GRANT PROGRAMS AND OUTCOMES
- Partnerships for Success (PFS) — $2.3 million annually
  - The goal of the PFS is to prevent underage drinking, marijuana use, and methamphetamine use in communities using evidence-based prevention programs and practices. The PFS funds each Public Health District and up to 21 law enforcement (LE) agencies annually.
- Substance Abuse Block Grant (SABG) — $1.8 million annually
  - The SABG program’s objective is to help plan, implement and evaluate activities that prevent substance use disorders. The SABG funds 49 grantees across Idaho in FY2020.

BE THE PARENTS UNDERAGE DRINKING PREVENTION CAMPAIGN
- Be the Parents approaches parents from a strengths-based perspective and focuses on giving parents tools and strategies to help prevent their children from using alcohol. In FY19, through digital media Be the Parents reached approximately 66,000 individuals and through broadcast an estimated 417,000 individuals.

MILLENNIUM FUND PROJECTS
- FY19 — Adapted a prescription opioid misuse prevention campaign from Utah and implemented it in five hospitals in Idaho. Made campaign materials available statewide and to date have distributed over 30,000 pieces of print collateral to 45 partners.
- FY20 — Opened a youth e-cigarette and vaping education mini-grant and have awarded $65,505.00 inmini-grants to 20 organizations. $36,000 toward a vaping digital campaign launching February 1 – April 30, 2020.

NALOXONE DISTRIBUTION
- Through sub-grants from IDHW, from February 2019-September 2019, 84 agencies were awarded 4,184 doses of naloxone and reported 47 naloxone administrations resulting in 37 known overdose reversals.
OFFICE OF DRUG POLICY
SUBSTANCE MISUSE INITIATIVES

1 in 2 Idaho high school students have ever used an electronic vapor product. (2019, YRBS)

At least 50% of drug overdose deaths in Idaho in 2018 involved opioids (125 out of 248, IDHW, Vital Stats)

Perception of great risk from smoking marijuana once a month significantly decreased 4% among Idahoans 12-17 (NSDUH 2016/2017 to 2017/2018)

Idaho ranks 40th for the number of individuals 12 and older reporting illicit drug use in the past month. (NSDUH, 2018-2019)
ABOUT ODP

We envision a safe and healthy Idaho free from the devastating impact of substance use on youth, families, and communities.

Statute


Mission

The Idaho Office of Drug Policy leads Idaho's substance use and misuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related consequences.

Purpose

To coordinate policy and programs related to drug and substance abuse in Idaho

Awarded to:

- Each of the 7 public health districts to work with their Regional Behavioral Health Boards on the identified priority areas and populations specific to their district.
  - Priority areas
    - Underage drinking
    - Marijuana use
    - Methamphetamine use
  - Priority populations
    - American Indians
    - Hispanics/Latinos
    - Veterans and their families
    - Rural communities
- Local law enforcement agencies
  - 22 currently funded

Partnership for Success Grant (PFS Grant)

$2.3 million annually
Awarded to:
- Prevention providers who deliver substance abuse services directly to youth, families and other at-risk individuals of Idaho, and/or community coalitions seeking funding to employ environmental strategies
  - 54 providers in FY19
  - Prevention programs and activities must be evidence-based,
  - Served 20,071 individuals in FY19 through Direct service programs such as LifeSkills Training, Project Alert, Positive Action and Strengthening Families.

Substance Abuse Block Grant (SABG)

$1.8 million annually

BE THE PARENTS – UNDERAGE DRINKING PREVENTION CAMPAIGN

- Strengths-based prevention campaign aimed at parents of youth 8-20
  - Social Media, Website, Print
  - Broadcast and Digital Ads
  - Print Materials and Activities

- FY19 Reach

- Activities in FY20
  - Family Dinner Night
  - Partnership with Universities
  - “Talk About It. Be About It. Campaign”
FY19 MILLENNIUM FUND PROJECT

Hospital-based Prescription Opioid Misuse Prevention Campaign

- Adaptation of Utah campaign
- Implemented in 5 hospitals in Idaho
  - PHD 1
    - Bonner’s Ferry
    - Sandpoint
  - PHD 6
    - Blackfoot
  - PHD 7
    - Rexburg
    - Driggs
FY20 MILLENNIUM FUND PROJECT

ODP received funding from the Idaho Millennium Fund to implement prevention strategies and education programming that will address the use of e-cigarettes amongst Idaho youth.

- $69,905.30 was awarded to 21 providers throughout the state
- ODP is currently implementing a digital media campaign focused on parent education.
- Panhandle Health District was awarded the grant and brought in Dr. Victor DeNoble, Addiction Scientist who spoke to over 3300 students about tobacco addiction and vaping

$106,000 FOR FY20

“CLEAR THE AIR” ABOUT TEEN VAPING VIDEOS

CLEAR THE AIR
ABOUT TEEN VAPING
Get resources and tips for talking to your child.
betheparents.org/teen-vaping-facts

:15 “What’s in a Vape?”
"CLEAR THE AIR" ABOUT TEEN VAPING VIDEOS

CLEAR THE AIR
ABOUT TEEN VAPING

Get resources and tips for talking to your child.
betheparents.org/teen-vaping-facts

:15 "Is Vaping Addictive?"

Awarded to:
- IDHW Grants:
  - First responders, SUD treatment and recovery support organizations, crisis centers, shelters, hospital emergency departments, corrections, and jails.
    - From February 2019 – September 2019 distributed 2,092 naloxone kits to 84 agencies across Idaho
  - HDTA Grant:
    - Law enforcement in the three HIDTA counties in Idaho (Ada, Canyon, and Bannock)
    - From April 2019 – September 2019 distributed 292 kits to three POs and one Sheriff’s Office.

Outcomes
- For quarterly reports February – September
  - 52 naloxone administrations
    - 42 reversed the overdose
    - 5 failed to reverse the overdose
    - 5 unknown outcomes

Naloxone Mini-Grant Program

Funded by multiple sub-grants through IDHW from SAMHSA and BJA, and HITDA
OTHER PROJECTS

- Opioid Misuse and Overdose Strategic Plan 2017 – 2022 + Workgroup
- Governor’s Opioid and Substance Use Disorder Advisory Group

THANK YOU

MELINDA SMYSER, ADMINISTRATOR
GOVERNOR’S OFFICE OF DRUG POLICY

- 208-880-4434
- Melinda.smyser@odp.idaho.gov
- www.odp.idaho.gov
If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 19, 2020
TIME: 3:00 P.M.
PLACE: Room WW54

MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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.

CONVENEDED: Chairman Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:13 p.m.

HCR 33 Stating Findings And Recognizing Missing And Murdered Indigenous Persons As A Crisis In Idaho.

Chairman Martin announced that HCR 33 was a place holder and was addressed in another committee, so this Committee will not be discussing it today. He said they would see it on the floor of the Senate.

HJM 012 Senator Lee presented HJM 012, Relating to Controlled Substances. She stated that this Joint Memorial sends a message of appreciation to the President of the United States for work on the national level to try to combat the importation of illegal drugs, specifically opioids and fentanyl. Everything that can be done should be done to hold these individuals accountable, especially in China and Mexico, who are creating a scourge in society through the importation of illegal drugs. It holds accountable the manufacturers, the countries, and the banking institutions that provide the funds for this illegal activity. This Joint Memorial encourages the federal government to continue doing all it can to prevent illegal drugs from coming into the U.S. from the international market.

DISCUSSION: Senator Souza commented on the high importance of this resolution and asked what action Senator Lee is looking for. Senator Lee explained that Joint Memorials are affirmations of what the Legislature expects on the federal level, and this is the expectation of the federal government to continue to protect safety within the United States.

Senators Lee, Harris, and Vice Chair Souza discussed the issue of illegal drugs being transported by mail, and technology used to detect that.

MOTION: Senator Burtenshaw moved to send HJM 012 to the floor with a do pass recommendation. Senator Heider seconded the motion. The motion carried by voice vote.

Chairman Martin welcomed Colby Jeppesen in the audience, son of Department of Health and Welfare Director, Dave Jeppesen. Colby is a junior at Eagle High School and is interested in serving in the page program next year.
Chairman Martin asked for a unanimous consent request and apologized to the Committee for the late notice. He stated it was not received in time to add it to the agenda. Chairman Martin asked Senator Harris to explain the RS.

Senator Harris explained that when a hospital has someone in restraints, according to Idaho standards, a nurse has to check the patient every 15 minutes and document the observation. It's a burden of unnecessary time and money to have a nurse constantly at the bedside. This RS relaxes those rules. The Department of Health and Welfare and hospitals use a better approach.

Senator Lee provided additional information for the Committee's understanding. She stated this regulation is unique to Idaho and is more restrictive than the standards set forth by the Centers for Medicare and Medicaid Services (CMS). She explained that this rule has created additional costs for sitters in the rooms of patients, and the reason we have this more restrictive rule in Idaho is because State Hospital North (SHN) is not an accredited institution. This RS does not reduce the requirements, or reduce the serious nature of when patients are in restraints. This rule was set up for SHN, and it increases costs for all the other hospitals. In no way is this RS intended to reduce patient safety. This is a rule that is intended to be fixed in statute, so it can be clarified for all the hospitals.

MOTION: Chairman Martin asked for unanimous consent to send RS 27719 to the State Affairs Committee for printing. There were no objections.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:26 p.m.
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, February 24, 2020

SUBJECT            DESCRIPTION                        PRESENTER

PRESENTATION: U.S. Ecology Legislative Update

H 385               Relating to Nurses, To Establish Provisions Regarding Certified Medication Assistant
                     Kris Ellis, Idaho Health Care Association

S 1348              Relating To Controlled Substances; To Provide for a Review of a Patient's Prescription Drug History Under Certain Circumstances
                     Senator Lee

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin       Sen Burtenshaw
Vice Chairman Souza  Sen Bayer
Sen Heider            Sen Jordan
Sen Lee               Sen Nelson
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 24, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m. He asked for unanimous consent to change the order of the agenda, hearing H 385 first, then S 1348, followed by the presentation. There was no objection from the Committee.

H 385 Kris Ellis, representing the Idaho Health Care Association, presented H 385. This legislation updates and clarifies the requirements to become a certified medication assistant. This is not a new certification, but a revamping of an existing statute that was eliminated this year. Additional training is provided for current certified nurse aides to be certified to administer medications which will help the workforce shortage in long-term care facilities.

DISCUSSION: Senator Bayer inquired about the certification process. Ms. Ellis responded by saying a person needed to first be a certified nurse aide, then obtain additional training to administer medications, and then would become a certified medication assistant.

MOTION: Senator Bayer moved to send H 385 to the floor with a do pass recommendation. Senator Heider seconded the motion. The motion carried by voice vote.

S 1348 Senator Lee stated that S 1348 is a result of recommendations from the Governor’s Opioid and Substance Use Disorder Advisory Group. The prescription drug monitoring program (PDMP) now requires prescribers to check the system prior to writing a prescription for opioids or benzodiazepines, with certain exemptions. Previously, data showed the prescribers only checked the system 32 percent of the time. Regular checks of the PDMP can help curb prescription misuse.

DISCUSSION: Vice Chair Souza said she wanted to thank Senator Lee for her work on this bill. She stated that she had previously been on the opioid task force and this bill has no negative consequences, just strong encouragement to check the system. Senator Nelson inquired if there were barriers in the system and if that was why the prescribers were not using it. Senator Lee replied that if improvement was needed, they have the resources to do it. Senator Jordan asked if the regulatory boards have the ability to look at all their members to see if they are accessing the system, and noted this could become a board issue if abuse was showing up for a particular physician. In response to the question, Senator Lee stated that discipline can be imposed. Senator Bayer wanted to know what contributed to the effective date of October, rather than July. Senator Lee replied that if there were barriers, it would give people more time to comply.
MOTION: Senator Harris moved to send S 1348 to the floor with a do pass recommendation. Senator Jordan seconded the motion. The motion carried by voice vote. Senator Lee will be the floor sponsor.

PRESENTATION: Roy Eiguren, a Boise Attorney representing the US Ecology Corporation, introduced Simon Bell, Executive Vice President and Chief Operating Officer; Andrew Marshall, Executive Vice President of Regulatory Compliance and Safety; and Terry Geis, Vice President of the Western Region Operations. He stated that they will provide a legislative update for the US Ecology Corporation with Mr. Marshall giving an overview, Mr. Geis reporting on the Grand View site, and Mr. Bell sharing the news about the growth of the company that they have achieved this past year. Mr. Eiguren said the reason for the presentation is that the environmental rules that govern the operation of the company are reviewed and approved by this Committee. He noted that representatives from the Department of Environmental Quality (DEQ) are here and can answer any questions that the Committee might have.

Mr. Marshall provided background information on the Company, relayed its mission, and discussed its various facilities. He expanded on hazardous waste and recycling services. See attachment 1.

Mr. Geis provided details of the Grand View facility. He discussed revenue generated for the state, and described the community outreach programs it is involved in.

Mr. Geis said the company has several challenges facing them. They are:

- industry competitiveness;
- declining federal government revenues;
- geographical disadvantages;
- transportation costs; and
- diversified federal government services business.

DISCUSSION: Vice Chair Souza inquired if there were injuries in the explosion that happened in 2018 at the Grand View site. Mr. Geis responded by saying there was one fatality and two employees with significant injuries. There were 21 people working at the site that day and some of them suffered other injuries. Corrective action has been taken and lessons learned to prevent similar incidents in the future. The facilities and operations are coming back online and most structures have been repaired or replaced; however, the business is still impacted. Senator Harris asked if the cause of the explosion was known. Mr. Geis replied that the explosion was caused by a generation of heat through a chemical reaction that was actually categorized as a steam explosion.

Mr. Geis said with regard to the fire at the facility this past December 2019, it occurred on a Saturday afternoon and was discovered by a security guard. The fire started in an area where household hazardous waste had been placed. The fire spread to other combustible materials including aerosol cans, fire extinguishers, batteries, and cleaning products. The fire was extinguished through a combination of clay and water. Mr. Geis said that corrective actions have been taken to prevent potential fires from similar types of waste of happening again.

Mr. Bell stated that with the lessons learned, the company is increasing, improving, and expanding their technical resources.
Mr. Bell then reported on the growth of the company, doubling in size by merging with NRC Group. This merger has turned US Ecology into one of the largest hazardous waste companies in North America. It furthers their vision of becoming a premier provider of comprehensive environmental services. Mr. Bell said the company has balanced its portfolio with both the collection network and the disposal facilities that support the collection network. NRC is one of the largest emergency response companies in North America. There was a derailment at Bonners Ferry with locomotives and rail cars in the river, as well as a fuel spill. Mr. Bell said the teams were excited to go deep into the emergency response business, plus it is just a great thing to do. Senator Harris asked how the locomotives were retrieved from the river and the response was by giant cranes.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:52 p.m.
**Introductions**

**SIMON BELL**
- *Executive Vice President and Chief Operating Officer*
- Simon is responsible for all of the Company's operating assets and services and joined US Ecology in 2001.

**TERRY GEIS**
- *Vice President, Western Region Operations*

**ANDY MARSHALL**
- *Executive Vice President, Regulatory Compliance & Safety*
- Andy is a Professional Engineer with over 20 years of experience assisting companies comply with environmental regulations.
Proudly based in Boise, Idaho
US Ecology is a Growing Idaho Company

- Boise is the headquarters for US Ecology, Inc.
- Globally, US Ecology currently employs about 3,400 team members, an increase from 1,671 in 2019.
- In Idaho alone, we employ 192 team members.
- Our Boise office size has grown rapidly along with the overall growth of the Company.
HISTORY & GROWTH

- Founded in 1952, US Ecology has a six decade history and has grown by adding new sites and continuously expanding its unique and comprehensive mix of services in the environmental services industry.

60 Years of Experience

- Founded as Nuclear Engineering Company
- First hazardous waste services facility opened (Sheffield, IL)
- Changed name to US Ecology, Inc.
- Acquired facilities: Tilbury, ON; Vernon, CA
- Announced Acquisition of NRCG

- 1952: Founded as Nuclear Engineering Company
- 1962: First hazardous waste services facility opened (Sheffield, IL)
- 1965: American Ecology Corp. IPO
- 1968: Grand View, ID facility acquired
- 1970: Thermal recycling services opened
- 1973: Dynecol Acquired
- 1975: Divested Allstate PowerVac
- 1976: Changed name to US Ecology, Inc.
- 1984: Acquired facilities: Tilbury, ON; Vernon, CA
- 1992: Announced Acquisition of NRCG

- 1955: America's first licensed LLRW disposal facility (Beatty, NV)
- 1962: America's second LLRW disposal facility (Richland, WA) opened
- 2001: Upgraded infrastructure at Texas, Nevada and Idaho; Added rail fleet
- 2005: EQ Acquired; US Ecology is nationwide: Field & Industrial Services added
- 2007: ES&H Dallas and Midland Acquired; Emergency & Spill Response Services added
- 2010: Stablex facility acquired
- 2012: EQ Acquired; US Ecology is nationwide: Field & Industrial Services added
- 2014: ES&H Dallas and Midland Acquired; Emergency & Spill Response Services added
- 2015: Divested Allstate PowerVac
- 2016: Divested Allstate PowerVac
- 2018: Acquired facilities: Tilbury, ON; Vernon, CA
- 2019: Announced Acquisition of NRCG
Our Guiding Principles

Ongoing Focus

Perfect Sight

Why We Exist
To provide safe and compliant solutions to protect human health and the environment

Our Vision
To be the premier provider of comprehensive environmental services

Permission to Play
• Safety and Compliance
• Protecting the Environment
• Doing the Right Thing, the Right Way
• Living the Humble, Hungry and Smart Virtues

How We Win!
• Service Excellence
• Being a Trusted Partner
• Innovative Solutions
• Being “One Team”
Our Balanced Strategic Approach

Our Shareholders
Achieve $1 billion revenue and $250 million EBITDA by 2023 through organic and inorganic investment

Our Customers
Position ourselves as:
(a) A top 3 player in each of our core markets
(b) Leader in the "Customer Service Experience"

Our People
Invest in our people to develop a world class work force

Our Processes
Drive Operational Excellence Throughout the Organization through Continuous Improvement

Our Systems
Leverage IT as a strategic advantage, driving efficiency and creating customer stickiness
FULL SERVICE PLATFORM

Our Platform & Strategy

✓ Customer-Centric Approach

✓ National Treatment, Storage and Disposal ("TSDF") Footprint

✓ Broad Set of Environmental Service Solutions

✓ Emphasis on Solving Customer Needs

- Technical Services
  - Emergency Response
  - Total Waste Mgmt.
  - Remed., & Indust. Svcs.
  - Field / On-Site Services
  - Brokering
  - Transportation

Field & Industrial Services

= Services not offered by ECOL

- Beneficial Re-use
- Recycling
- Treatment & Disposal
- Fuels / Solvents
- Incineration

Environmental Services

Unequaled service. Solutions you can trust.
DIVERSE CUSTOMERS WITH MINIMAL CONCENTRATION

- Diverse base of blue chip customers, with 3,500+ commercial and government entities and no customer accounting for >10% of revenue

<table>
<thead>
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<th>Top 10 Customers</th>
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<tr>
<td><strong>Direct</strong></td>
<td>Customer</td>
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<tr>
<td></td>
<td>CDM Constructors</td>
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<tr>
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<td>Veolia</td>
</tr>
<tr>
<td></td>
<td>Amazon</td>
</tr>
<tr>
<td></td>
<td>Univar</td>
</tr>
<tr>
<td></td>
<td>PPG Industries (Barberton OH)</td>
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<tr>
<td></td>
<td>Columbia Pipeline Group</td>
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<td></td>
<td>Stericycle-PSC</td>
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<td></td>
<td>Pacific Gas &amp; Electric</td>
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<td></td>
<td>GM-Global Environmental</td>
</tr>
<tr>
<td></td>
<td>Par Technology</td>
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<tr>
<td><strong>Indirect</strong></td>
<td>Customer</td>
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<tr>
<td></td>
<td>Select FIS Customers</td>
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<td>amazon</td>
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<td>Kroger</td>
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</table>

Unequaled service. Solutions you can trust.
COAST-TO-COAST LANDFILL DISPOSAL INFRASTRUCTURE

- Facilities Positioned throughout North America
  - 5 Haz / Non-Haz Landfills (All Co-Located with Treatment)
  - 1 Radioactive Waste Landfill (Class A, B, C)
- Located near Industrial Centers in the West, Northeast, Midwest and Gulf Regions
- Significant Permitted Capacity & Life – Estimated Life 20+ Years Each
- Broad Range of Permits and Acceptance Criteria
- Infrastructure to Support High Volume Transfer
- Rail and Truck Access
# Long-Lived Facilities with Significant Capacity

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Acres</th>
<th>Permitted Abrace (Cubic Yards)</th>
<th>Non-Permitted Abrace (Cubic Yards)</th>
<th>Estimated Life (Years)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatty, Nevada</td>
<td>480</td>
<td>8,139,634</td>
<td>-</td>
<td>35</td>
<td>Hazardous and non-hazardous industrial, RCRA, TSCA and certain NRC-exempt (NORM) radioactive waste</td>
</tr>
<tr>
<td>Robstown, Texas</td>
<td>873</td>
<td>10,422,212</td>
<td>-</td>
<td>44</td>
<td>Hazardous and non-hazardous industrial, RCRA, PCB remediation and certain NRC-exempt (LARM and NORM/NARM) radioactive waste, Rail transfer station</td>
</tr>
<tr>
<td>Grand View, Idaho</td>
<td>1,411</td>
<td>10,221,577</td>
<td>18,100,000</td>
<td>213</td>
<td>Hazardous and non-hazardous industrial, RCRA, TSCA, and certain NRC-exempt (NORM/NARM, Technologically Enhanced NORM [TENORM]) radioactive waste, Rail transfer station</td>
</tr>
<tr>
<td>Belleville, Michigan</td>
<td>455</td>
<td>11,494,787</td>
<td>-</td>
<td>34</td>
<td>Hazardous and non-hazardous industrial, RCRA, TSCA, and certain NRC-exempt (NORM/NARM, Technologically Enhanced NORM [TENORM]) radioactive waste, Rail transfer station</td>
</tr>
<tr>
<td>Blainville, Québec, Canada</td>
<td>350</td>
<td>5,190,912</td>
<td>-</td>
<td>20</td>
<td>Inorganic hazardous liquid and solid waste and contaminated soils, Direct rail access</td>
</tr>
<tr>
<td>Richland, Washington</td>
<td>100</td>
<td>61,702</td>
<td>-</td>
<td>37</td>
<td>LLRW disposal facility accepts Class A, B, and C commercial LLRW, NORM/NARM and LARM waste</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>45,530,825</td>
<td>18,100,000</td>
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</tbody>
</table>
COMPREHENSIVE OFFERING OF FIELD & INDUSTRIAL SERVICES

Field Services

Small Quantity Generator Services

Retail
End-to-end management of retail hazardous waste programs

LTL / HHW
HHW collection and LTL container management

Lab Pack
Small quantity chemical management services

Other Field Services

Total Waste Management
Outsourced management, tracking and reporting all waste streams for generators

Transportation & Logistics
Transport of waste from point of generation to ultimate disposal

Emergency Response
Services to respond to any spill, natural disaster or accident

Remediation
Management of remedial construction projects from start to finish

Industrial Services

Marine & Terminal Services
Industrial cleaning & maintenance for large petroleum & chemical distribution terminals

Industrial Cleaning & Maintenance
Wet & dry vacuuming, water blasting, paint system cleaning, pollution control, etc.
Large Treatment Network

- Facilities throughout the Northeast, Midwest, West, South and Gulf regions
- Five co-located with disposal facilities
- Ability to manage a wide range of liquid and solid waste streams
- Broad range of de-characterization and de-listing capabilities
- State-of-the-art air handling

15 Treatment Facilities

Located at Landfills
- Idaho
- Michigan
- Nevada
- Quebec
- Texas

Standalone
- Michigan (2)
- Ohio
- Penn.
- Illinois
- Alabama
- Oklahoma
- Florida
- Ontario
- California

Michigan (Detroit)
Treatment / Stabilization and WWT

Ohio, Penn. and Illinois
Liquid and Solid Waste Treatment

Nevada (Beatty)
Treatment / Stabilization
Field Services

Small Quantity Generator Services

**Retail**
End-to-end management of retail hazardous waste programs

**Lab Pack**
Small quantity chemical management services

**LTL / HHW**
Household hazardous waste collection and Less-than-truckload container management

Other Field Services

**Managed Services**
Outsourced management, tracking and reporting all waste streams for generators

**Transportation & Logistics**
Transport of waste from point of generation to ultimate disposal

**Remediation**
Management of remedial construction projects from start to finish
Recycling

- Seven recovery / recycling operations in the Gulf, Midwest, Northeast and Southern Regions
- Market Oriented Solutions:
  - Thermal Desorption – Oil / Catalyst Recovery
  - Solvent Distillation – Airline De-icing, Other Solvents
  - Mobile Distillation – On-site Solvent Recovery for Manufacturing facilities in the South and Midwest
  - Selective Precipitation – Valuable Metals Recovery

Texas (Robstown)
Thermal Recycling

Pennsylvania (York)
Ohio (Canton)
Selective Precipitation Metals Recovery

Resource Recovery
Glycol & NMP Solvent Recycling (MI)
Two Airport Recovery Sites (MN & PA)
US Ecology
Grand View, ID
Overview
US Ecology Idaho: Grand View Facility

- Hazardous, PCB and low-activity (exempt) radioactive disposal
- Employs approximately 50 people in Grand View & Mayfield
- Significant generator of state revenue:
  - Averages $800,000 to $2 million per year in tipping fees
  - ~$750K State income taxes


- Tipping Fees
- Annual Tons Received

Spending in Idaho 2009-2019
Community Involvement and Outreach Extends to Owyhee and Elmore Counties

- OSHA Voluntary Protection Program Participants Association
- Grand View Annual Homecoming Days
- Grand View Volunteer Fire Department and Ambulance Service
- Grand View Food Bank
- Grand View Chamber Of Commerce
- Grand View Lions Club
- Mountain Home Chamber of Commerce
- Mountain Home Highway District
- Mountain Home Parks and Recreation
- Grand View/ Bruneau Little league & Rimrock High School Sports
- Glenns Ferry High School Sports
- Trio Program
Local Initiatives

- **Mountain Home – Household Hazardous Waste Collection and Community Recycling Event**
  - Annual Event
  - Enhance safety of local municipal landfill
  - Contribution-in-kind of approximately $20,000

- **Helping Hands Community Grant Program**
  - Annual Award Distribution
  - Owyhee County Non-Profit Organizations
  - Examples include school programs, senior centers, town libraries and cultural/historical centers
  - Contribution-in-kind of approximately $15,000
  - Disposal of Lions building approximately $12,000
Our Challenges

○ Industry continues to be competitive
○ Competitors have noticed our success
○ Federal Government revenues have been declining (see graph below)
  • Government funding issues
  • Competitors trying to replicate us
○ Idaho is disadvantaged to East coast cleanup projects due to geography

○ Despite investment in rail infrastructure, transportation costs are becoming a deterrent to current business and future growth
○ Exploring ways to diversify our Federal Government services business
  • Expand radiological markets
  • Broaden radiological acceptance criteria
US Ecology Idaho Updates

November 2018 Explosion Incident

- Comprehensive incident investigation was completed, and results shared with agencies
- Negotiated settlement with OSHA completed
- EPA investigation ongoing
- Facilities and operations at Grand View coming back online, most structures have been repaired or replaced
- Advanced corrective action and lessons learned to prevent similar incident in future
- Recruiting and retaining staff as more operations capability returns
- Business is still impacted
US Ecology Idaho Updates

**Landfill Fire Incident – December 2019**

- Fire occurred on Saturday afternoon
- Security guard discovered the fire
- Fire started in an area where Household Hazardous Waste had been placed
- The fire spread to other combustible materials including boxes and containers of household hazardous materials including aerosol cans, fire extinguishers, batteries, and cleaning products
- The fire was extinguished by USE staff through a combination of clay and water
- Active communications with local officials and media
- USEI established significant corrective actions to mitigate the fire potential from similar types of waste
US Ecology Goes Global!

NRC Group Acquired November 1, 2019
Transaction Overview


- On November 1, the transaction closed.

- The transaction has an enterprise value of $966 million.

- On fully-diluted basis, ECOL stockholders own ~70% and NRCG stockholders own ~30% of the combined company.

- The combination brings together two complementary businesses, expands both companies' footprint, enhances capabilities to better serve our customers and results in an improved financial profile and industry leading position.
Overview of NRCG

**Environmental Services**
- Comprehensive service offering including industrial services, emergency response, waste management, site remediation and other services
- High-frequency, non-discretionary, recurring, small-ticket projects
- Serves broad base of industrial, transportation and government customers
- National network of 50 service sites across North America
- Expected to be part of ECOL's Field and Industrial Services segment

**Waste Disposal**
- Three landfills strategically located in the Permian and Eagle Ford Basins providing broad waste disposal capabilities
- Provides highly-regulated, non-discretionary waste disposal services
- Existing services infrastructure in the Permian supports new landfill opening
- Serves energy companies in the Gulf Region, supported by relationships with key operators in the Permian and Eagle Ford Basins
- Expected to be part of ECOL's Environmental Services segment

**Standby Services**
- Only commercial Oil Spill Removal Organization providing federally mandated oil spill compliance and emergency response services nationally
- High-margin, high frequency retainer-based business complemented by potential incremental upside related to large marine-based spill response events
- Maintains prepositioned response equipment and 24/7 operations center to support rapid response capabilities
- Roughly 80% of revenues derived from retainer-based fees and roughly 20% from ER
- Expected to be part of ECOL's Field and Industrial Services segment

**2018 Revenue**

<table>
<thead>
<tr>
<th>Service</th>
<th>Revenue Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standby</td>
<td>21%</td>
</tr>
<tr>
<td>Waste Disposal</td>
<td>42%</td>
</tr>
<tr>
<td>International Field &amp; Industrial Services</td>
<td>32%</td>
</tr>
<tr>
<td>Domestic Field &amp; Industrial Services</td>
<td>63%</td>
</tr>
</tbody>
</table>

**2018 EBITDA**

<table>
<thead>
<tr>
<th>Service</th>
<th>EBITDA Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standby</td>
<td>20%</td>
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<td>Domestic Field &amp; Industrial Services</td>
<td>63%</td>
</tr>
</tbody>
</table>

Source: NRCG company filings and NRCG company estimates
(1) Refers to the segment "International" as reported on NRCG's Form 10-K
(2) Refers to the segment "Domestic Environmental Services" as reported on NRCG's Form 10-K
ECOL + NRCG: A Compelling Combination

- Furthers Vision of Becoming the Premier Provider of Comprehensive Environmental Services
- Expands Leadership in Specialty and Industrial Waste Services with high quality assets and predominantly recurring revenue streams
- Establishes a Leadership Position in Emergency Response, Including a Premier Standby Network
- Provides a National Service Network, including 50 service sites to drive volume to ES assets, accelerating years of organic growth
- Adds Complementary E&P/Specialty Landfill Disposal focused on waste disposal supporting the upstream energy markets in the Permian and Eagle Ford Basins and 13 treatment and recycling facilities
- Synergies of Approximately $20M and Potential for Upside through realization of additional revenue and cross-selling opportunities
- Significantly Enhances Scale – revenue, EBITDA and free cash flow

United States

Québec
Ontario
Mexico

Headquarters

Haz/Rad/E&P Landfills (9)
Treatment & Recycling (36)
Service Centers (70)
Retail Satellites (9)
Equipment Staging (37)
# A Financially Compelling Transaction

<table>
<thead>
<tr>
<th></th>
<th>US Ecology</th>
<th>NRCG</th>
<th>Pro Forma Combined Company (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018A Revenue</td>
<td>$566 million (7)</td>
<td>$389 million (2)</td>
<td>$955 million</td>
</tr>
<tr>
<td>2018A Adj. EBITDA</td>
<td>$125 million (7)</td>
<td>$91 million (2)</td>
<td>$216 million</td>
</tr>
<tr>
<td>2018A % EBITDA Margin</td>
<td>22.0%</td>
<td>23.4%</td>
<td>22.6%</td>
</tr>
</tbody>
</table>

### 2018A Revenue Mix (3)

- **Field & Industrial Services**
  - 29%
  - 71%

- **Environmental Services**
  - 29%
  - 71%

- **Waste Disposal**
  - 21%

- **International Field & Industrial Services (4)**
  - 9%

- **Standby Services**
  - 9%

- **Domestic Field & Industrial Services (5)**
  - 63%

- **Field & Industrial Services**
  - 49%

- **Environmental Services (6)**
  - 51%

---

(1) Excludes synergies.
(2) Pro forma revenue and adjusted EBITDA as reported on NRCG's Form 8-K dated March 18, 2019.
(3) Based on reported FY2018 segment revenues in US Ecology's Form 10-K and NRCG's Form 10-K.
(4) Refers to the segment "International" as reported on NRCG's Form 10-K.
(5) Refers to the segment "Domestic Environmental Services" as reported on NRCG's Form 10-K.
(6) Combination of US Ecology's Environmental Services segment and NRCG's Waste Disposal (i.e., Sprint) segment.
**COMPPELLING ACQUISITION CONSISTENT WITH LONG-TERM INVESTMENT STRATEGY**

<table>
<thead>
<tr>
<th>A Decade of Progress</th>
<th>A Transformative Acquisition</th>
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<tbody>
<tr>
<td>Acquire Valuable Assets to Create a National TSDF Footprint</td>
<td>Expands Leadership in Specialty &amp; Industrial Waste and adds Three E&amp;P Landfills and 13 Treatment &amp; Recycling Facilities</td>
</tr>
<tr>
<td>Expand Permits and Services to Broaden Capabilities</td>
<td>Provides a Highly Complementary New Waste Vertical in E&amp;P Waste Disposal</td>
</tr>
<tr>
<td>Invest in Infrastructure to Diversify Business Model and Increase Flexibility</td>
<td>Substantial National Service Network, which Accelerates Years of Organic Growth</td>
</tr>
</tbody>
</table>
Creating a “Top 3” Player in our Area...

- Pro Forma US Ecology will have ~ $1 billion Revenue
- Positions USE among the Top 3 (WM’s Revenue Unknown)
- Aligned with our vision of being the premier provider of comprehensive environmental services
- Adds high quality fixed facility assets
- Meaningfully expands key service verticals that drive volume into fixed facilities
- Pro forma Revenue and EBITDA achieve our 5-year strategic plan within one year

**Specialty Waste Revenue (Estimated Revenue)**

- Clean Harbors: $3,300
- US Ecology: $1,056 (a)
- Waste Mgmt: $1,000
- Terrapure: $600
- Stericycle: $520
- Veolia: $500
- GFL: $475
- HCCI: $410
- Heritage Env: $400
- Energy Sol.: $400
- Clean Earth: $275
- Waste Cn.: $256
- Tradebe: $150
- Republic: $60
- Ross: $60
- WCS: $50

(a) US Ecology figures are pro forma for the acquisition of NRC Group.
US Ecology and NRC Unite in Idaho

BNSF Railway
Locomotive Derailment
Bonners Ferry Idaho
January 1, 2020

Two locomotives derailed into the Kootenai River near Bonners Ferry, Idaho

A US Ecology/NRC Team responded and conducted remediation.

Crews beginning dismantling and scrapping operations.
Unequaled service. Solutions you can trust.

Thank You
# AMENDED AGENDA #1
## SENATE HEALTH & WELFARE COMMITTEE
### 3:00 P.M.
### Room WW54
### Tuesday, February 25, 2020

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>S 1354</td>
<td>Relating To Hospital Regulations</td>
<td>Senator Harris</td>
</tr>
<tr>
<td>RS27811</td>
<td>Relating To The Medical Consent And Natural Death Act</td>
<td>Senator Martin</td>
</tr>
</tbody>
</table>

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

## COMMITTEE MEMBERS
- Chairman Martin
- Vice Chairman Souza
- Sen Heider
- Sen Lee
- Sen Harris

## COMMITTEE SECRETARY
- Margo Miller
  - Room: WW35
  - Phone: 332-1319
  - Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 25, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:07 p.m.

S 1354 Senator Harris presented S 1354 which relates to hospital regulations. He explained this legislation amends Idaho Code § 39-1307 to state that any IDAPA rules in this chapter that are more restrictive than the federal guidelines shall not apply to hospitals that are certified by Centers for Medicare and Medicaid Services (CMS) through accreditation, survey, or otherwise. The Department of Health and Welfare (DHW) agreed to address the rules after the legislative session and indicated any changes would not go into effect until July 2021.

TESTIMONY: Toni Lawson, Vice President of the Idaho Hospital Association (IHA), stated they are in support of S 1354. IHA represents Idaho's 44 community hospitals around the state. Idaho's hospitals are one of the most regulated facilities in the state with over 70 oversight entities. In most cases, the CMS guidelines are much more stringent and extensive than the state IDAPA rules. In some cases, the state rule has turned out to be more restrictive than the federal government and that causes issues with consistency and compliance. One of problems is the use of restraints. The CMS guidelines and the IDAPA rules are quite problematic over discrepancies, inconsistencies, and guidelines. Ms. Lawson stated that they would like to get as close to one set of guidelines as possible and this legislation would be a big step forward. See attachment 1.

DISCUSSION: Vice Chair Souza said she doesn't remember the IDAPA rule regarding restraints and Ms. Lawson reviewed the rule. Senator Nelson inquired as to what an accreditation survey means and Ms. Lawson said that some hospitals are accredited directly by state surveyors who are representing CMS while other hospitals use the Joint Commission.

Chairman Martin asked if there has been an effort to work with DHW or will there be an effort. Ms. Lawson replied that the DHW has agreed, but it will be after 2021 before the changes are in effect. Senator Lee inquired as to why shouldn't all the IDAPA rules be repealed. Ms. Lawson answered that would not be feasible because some hospitals in Idaho are not CMS accredited and are not under the guidelines, such as State Hospital North (SHN). If all rules were repealed, then those hospitals wouldn't have any guidelines at all to be held accountable to.

Senator Heider said his inquiry concerns the last three lines of the bill and asked who is responsible for determining if the actions are acceptable. Ms. Lawson stated that the Bureau of Facility Standards (BFS) surveyors make that determination. There are multiple entities responsible for following standards.
**Vice Chair Souza** commented about rules in conflict with IDAPA. In closing the discussion, **Ms. Lawson** said DHW sent a letter to both Chairmen of the Senate and House Health and Welfare Committees at the start of the legislative session acknowledging the conflict with state statute.

**TESTIMONY:**  **Jennifer Misajet**, Chief Nursing Officer for Saint Alphonsus Health System said they are in support of **S 1354**. **Ms. Misajet** said they face immense challenges when regulations imposed by the state are inconsistent and even more stringent than CMS standards. They have seen a 25 percent increase in required observation hours from 2018 to July 1, 2019 and that has resulted in the need to hire an additional 60 patient safety attendants to meet the requirements. **Ms. Misajet** said this over-regulation has added costs to the healthcare they provide without necessarily increasing quality. See attachment 2.

**Adrienne Frazier**, a registered nurse with Saint Lukes Intensive Care Unit (ICU) Department, relayed an example of a patient that was not restrained and said the documentation is a burden on the care that is provided. She asked the Committee to please support this bill.

**DISCUSSION:** **Vice Chair Souza** inquired as to why restraints would not be appropriate in ICU. **Ms. Frazier** said the burden of documentation robs her of providing good patient care.

**Senator Harris** concluded the discussion by saying he has served on a critical care access board for 13 years and has seen a huge change in nurses becoming paper-work shufflers, rather than nurses. He asked for the Committee's support on this bill.

**Senator Lee** stated she had a conflict of interest pursuant to Rule 39(H) but intended to vote.

**MOTION:** **Senator Lee** moved to send **S 1354** to the floor with a **do pass** recommendation. **Vice Chair Souza** seconded the motion. The motion carried by **voice vote**. Senator Harris will be the floor sponsor.

**RS 27811** **Chairman Martin** said he is taking **RS 27811** to the House Health and Welfare Committee, as they are a privileged committee. It will not be heard in this Committee at this time.

**ADJOURNED:** There being no further business at this time, **Chairman Martin** adjourned the Committee at 3:44 p.m.

__________________________
Senator Martin
Chair

__________________________
Margo Miller
Secretary

__________________________
Juanita Budell
Assistant Secretary
Good afternoon, Chairman Martin and members of the committee. My name is Toni Lawson. I am a Vice President of the Idaho Hospital Association. We represent Idaho’s 44 community hospitals around the state. I am here today to voice our support for S1354.

- Idaho’s hospitals are arguably one of the most regulated sectors in the state. Idaho’s community hospitals interact with dozens of federal, state, local and affiliated entities each day to meet various, strict, expansive rules, guidance and regulations....from the Idaho Bureau of Facility Standards to CMS....from the DEA to the DOJ....from the AGs office to the US Office of Inspector General. As I reviewed the list of hospital oversight entities, it topped 70.

- We believe this legislation helps decrease some of the confusion and duplication between state IDAPA rules and CMS guidelines. Hospitals are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation in order to receive Medicare and Medicaid payment. All of our community hospitals meet these requirements. So, let me give you an idea of what we currently have in place. I’ve brought a few of the manuals that contain the regulations and interpretive guidelines for hospitals. Don’t worry, I’m not going to go through each one, but I would like to give you a taste of what we already have in place.

  - This is the State Operations Manual that provides survey protocol for regulations and interpretive guidelines for hospitals.
  - These are the manuals used by DNV, a national accrediting entity that a number of Idaho hospitals are now using.
  - There is also a manual for Joint Commission guidelines. Those hospitals that are surveyed by the Joint Commission have that manual, but we don’t at the association. I could have purchased that for $1100 and brought it for you, but I figured you would still get the point.
  - These are the Idaho IDAPA rules.

In the vast majority of cases, the CMS guidelines are more stringent than state IDAPA rules. In theory, those hospitals who meet all of the CMS guidelines should have no problem meeting the state IDAPA rules...except when they don’t. In a few cases, the
state rule has turned out to be more restrictive than the federal government and that causes issues with consistency and compliance. There are some people here to testify today to one such issue and the problems it has caused them when trying to provide care to patients in our hospitals.

This particular example has to do with the use of restraints for non-violent patients. When we're talking about restraints, keep in mind that raising the bed rails can be considered a restraint.

The CMS guideline for the use of restraints indicates that there must be an assessment of the patient to determine why the restraints are needed and how often the status of the patient will be checked. Depending on the patient's situation, you may need constant observation. You might check every 15 minutes...but you cannot go longer than 2 hours without checking on the patient. (Any of you that have been in the hospital know, it is rare that they ever leave you longer than two hours without coming in to do something.)

The IDAPA rule requires that non-violent patients in restraints must be observed every 15 minutes, whether their situation warrants it or not, and that observation must be documented. Patient caregivers will tell you what that change has meant to the way they provide care and the manner in which hospitals have been forced to change their staffing levels.

When the latest IDAPA rule changes went into effect, we quickly started hearing complaints from our hospitals. There were issues with compliance that we had not anticipated. Some are quite problematic and need to be changed. None of the problematic rules are in areas that we don't already have CMS guidelines in place. Last summer, we requested that the department open those rules to make changes. They were unable to grant that request, although they have agreed to take up the rules this summer. Unfortunately, any changes won't go into effect until July of 2021. And this whole process is over discrepancies/inconsistencies in guidelines that already exist.
We would like to get as close to one set of guidelines as possible. We know that isn't completely possible, but this legislation would be a big step forward.

Our hospitals are dedicated to the safety and well-being of the patients they care for. Duplicative, confusing regulation hinders their efforts.

We would ask that you send S1354 to the floor with a "do pass" recommendation. I'm happy to stand for any questions.
Hospital Regulation Legislation: Senate Bill 1354 Testimony

• Good afternoon, Mr. Chairman and members of the Committee.

• My name is Jennifer Misajet and I serve as Chief Nursing Officer for the Saint Alphonsus Health System with 5 hospitals across southwest Idaho and eastern Oregon. It is my pleasure to provide testimony in support of Senate Bill 1354, on behalf of our organization.

• It is always our highest priority to ensure the safety of our patients as we provide care for them on a daily basis. We have many policies, systems, and processes in place to ensure the safest and best care is provided, in compliance with regulations and guidelines set forth by federal and state government agencies and by accrediting organizations such as the Joint Commission.

• However, we face immense challenges when regulations imposed by the state are inconsistent and even more stringent than the regulations imposed by federal regulations under CMS. Since last July when the new state Hospital Facility Standards rules went into effect, we have had to pivot quickly to change processes and allocate significant additional staffing resources to comply with state regulations which are much more burdensome than CMS regulations. (insert stats here about staffing increases & disruption of workflow) Since July 1st, 2019 we have seen a 25% increase in required observation hours from 2018 correlated to the new state requirements that went into effect July 1, 2019. To meet the new regulation and be complaint we have used a total of 1,240 eight-hour shifts covered by non-Patient Safety Attendants colleagues to include Registered Nurses and Certified Nursing Assistants. This has resulted in the need to hire an additional 60 Patient Safety Attendants to meet the former regulatory requirements in addition to the new state requirements.

• At a time when we are challenged by workforce shortages, we are being required to allocate scarce resources to meet these new, duplicative and
unnecessary requirements that place a burden on hospitals and individual staff nurses. This over-regulation has added costs to the healthcare we provide, without necessarily increasing quality.

I sincerely thank you for considering this important legislation to ease the burden of over-regulation on our nurses and our organizations, and I urge your YES vote to send Senate Bill 1354 to the floor with a DO PASS recommendation.

- I would be happy to stand for questions.
AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, February 26, 2020

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<th>SUBJECT</th>
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<tr>
<td><strong>HJM 013</strong></td>
<td>Joint Memorial seeking to remove barriers by the federal government relating to Suboxone (generic, buprenorphine).</td>
<td>Representative Ellis</td>
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**MINUTES APPROVAL:** Minutes of January 27, 2020
Senator Harris

**PRESENTATION:** Idaho Caregiver Alliance - Strategic Plan Update, Accomplishments
Dr. Sarah Toevs, Director, Center for the Study of Aging at Boise State University

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**
Chairman Martin
Vice Chairman Souza
Sen Heider
Sen Lee
Sen Harris

**COMMITTEE SECRETARY**
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 26, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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.

CONVENCED: Chairman Martin called the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

HJM 013 Joint Memorial seeking to remove barriers by the federal government relating to Suboxone (generic, buprenorphine). Representative Ellis, District 15, presented House Joint Memorial 013 which seeks to remove barriers put in place at the federal level relating to Suboxone. He explained it is used to treat opioid addiction.

TESTIMONY: Pamela Meyer, constituent from District 15, explained that she has a family member who suffers from opioid addiction. She said that the stigma of opioid disease keeps desperately ill Idahoans sick and dying. She said her relative who struggles with addiction benefited from Suboxone. She explained that Suboxone is a four to one formulation of buprenorphine with a medication named Narcan that prevents users from getting high. She confronted the concept of addiction diversion, the idea that this is substituting one addiction for another. She said that this legislation will provide more access to medical treatment, and will curb self medication with other drugs of abuse.

In response to questions from Senator Lee, Vice Chair Souza, and Senator Bayer, Ms. Meyer said that her relative chose to quit Suboxone after ten days, against medical advice; and there are pros and cons to short and long term use. She said the chances of relapse are substantially lower when taken for prolonged periods and the chances of death are substantially lower. If Suboxone is taken over the course of a few weeks, experiencing withdrawal is eminent. The medication may be titrated down to muffle withdrawal effects. She said Suboxone was successful with her relative after a ten day period and they had quit Suboxone early to avoid a dependent state.

Senator Lee clarified that the treatment varies on an individual basis and that there is benefit when working with a medical provider.

Ms. Meyer detailed the difficulties of choosing a facility, and that Suboxone may be taken at home.

Representative Ellis explained medication assisted treatment (MAT), a cooperation between a client's physician and psychiatrist to produce a recovery plan. The University of Idaho has a program called Echo Idaho, which provides MAT training throughout the state. He said their goal is to make the medications to treat opioid addiction as available as the opioids. Because of waiver requirements, only 5 percent of Idaho doctors have the ability to prescribe Suboxone.
TESTIMONY: Nicki Chopski, Director of the Idaho Board of Pharmacy, responded to a question from Vice Chair Souza. She explained that the cost varies for Suboxone, ranging from $75 to $300 per month and dependent on insurance and government funded treatment programs. She spoke on behalf of herself, stating that she believed all physicians should have the ability to prescribe Suboxone. She explained the side effects and use with pre-existing conditions.

Representative Ellis said that the memorial was unanimously supported by the Governor’s Opioid and Substance Use Disorder Advisory Group.

MOTION: Senator Jordan moved to send HJM 013 to the floor with a do pass recommendation. Senator Lee seconded the motion. The motion carried by voice vote. Senator Heider will sponsor the bill.

MINUTES APPROVAL: Chairman Martin asked for unanimous consent to approve the minutes at the end of the Committee meeting. There were no objections.

PRESENTATION: Dr. Sarah Toevs, Director of the Center for the Study of Aging, Boise State University (BSU), said she was representing the Idaho Family Caregiver Alliance (IFCA). She said the majority of their funding comes from the federal Administration for Community Living. The Idaho Commission on Aging has actively supported their initiative. She explained that their services are not limited to families taking care of the elderly; they work with caregivers across life spans.

She said everyday they can help keep someone in their home which saves resources and promotes better quality of life. She pointed out that they are fiscally responsible and they hope to prevent unnecessary costs to the state, and that an issue that most caregivers face is a lack of rest and personal time. They have established or supported seven new lifespan respite facilities around Idaho which include at-home care assistance.

In response to Vice Chair Souza, Ms. Toevs expanded on their costs.

Dr. Toevs said they have a strategic plan for 2024, they are here to act as a catalyst for change and to work on behalf of the unpaid family caregivers. She also described the Caregiver Navigator program they are piloting which aims to assist care providers. She asked that the Committee and State help by informing the IFCA on potential partners, when funding opportunities are available, and supporting legislation that helps caregivers throughout Idaho. In response to a question from Vice Chair Souza, Ms. Toevs said they do not have statistics on how many employers are caregiver friendly but through Department of Labor data, they realized there is potential to help businesses retain and support their current work force. She said BSU was engaged in supports that meet the caregiver need.

MINUTES APPROVAL: Senator Harris moved to approve the Minutes of January 27, 2020. Senator Heider seconded the motion. The motion carried by voice vote.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:50 p.m.
AMENDED AGENDA #1  
SENATE HEALTH & WELFARE COMMITTEE  
3:30 P.M.  
Room WW54  
Tuesday, March 03, 2020

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<tr>
<td>H 317</td>
<td>Reconsideration of bill</td>
<td>Chairman Martin</td>
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<td>H 317</td>
<td>Debate by Committee with no public testimony</td>
<td>Senator Harris</td>
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<td>MINUTES</td>
<td>Minutes of February 3, 2020</td>
<td>Senator Heider</td>
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<td>APPROVAL:</td>
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If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS
Chairman Martin
Vice Chairman Souza
Sen Heider
Sen Lee
Sen Harris

COMMITTEE SECRETARY
Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, March 03, 2020
TIME: 3:30 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:32 p.m.

H 317
Reconsideration of Bill. Chairman Martin described the process of reconsidering a bill. He announced that there would be no public testimony because there had been one previously.

DISCUSSION: Vice Chair Souza expressed her apprehension in reconsidering H 317, for the reason that it had been heard and the Committee had already decided. Chairman Martin stated that Senator Harris will be the presenter for the reconsideration of the amended bill.

MOTION: Senator Lee moved to reconsider H 317. Senator Bayer seconded the motion.

SUBSTITUTE MOTION: Vice Chair Souza moved that H 317 be held in Committee. Senator Heider seconded the motion.

DISCUSSION: Vice Chair Souza requested for further analysis and study by the Office of Performance Evaluations (OPE) on some medical issues of H 317. The study would give the Committee better recommendations that could be looked into next legislative session. Senators Heider, Jordan and Nelson spoke in accord with Vice Chair Souza, and stated that more medical science data, clinical studies, and alternative proposals are needed in order to reconsider H 317. Senator Heider rationalized his standpoint that diagnosis is more important than medical surgeries or procedures. He mentioned that public safety is his main concern.

Senators Bayer, Lee and Harris spoke in support of the reconsideration of H 317. Senator Lee emphasized that reconsidering the proposed amendments of the bill would give the Committee an opportunity to weigh in on issues that both parties have not agreed on. Senators Bayer and Harris made remarks on the proposed amendments. They have observed significant changes and some clarity on the bill.

Senator Harris expounded that the amendments on the bill narrow down the procedures that optometrists could perform. The proposed amendments would only authorize optometrists to strictly conduct two types of therapeutic laser procedures, and with direct supervision of an approved ophthalmologist. Senator Bayer commented that optometrists' minimal education on medical surgery and procedures is correlated to the current restrictions and prohibitions on what they are allowed to perform.
Chairman Martin called for a role call vote on the substitute motion. Senators Heider, Burtenshaw, Jordan, Nelson, and Vice Chair Souza voted aye. Senators Lee, Harris, Bayer, and Chairman Martin voted nay. The substitute motion carried.

Senator Heider moved to approve the Minutes of February 3, 2020. Vice Chair Souza seconded the motion. The motion carried by voice vote.

There being no further business at this time, Chairman Martin adjourned the meeting at 3:52 p.m.

__________________________________________  _______________________________________
Senator Fred S. Martin  Margo Miller
Chair  Committee Secretary

__________________________________________  _______________________________________
  Rellie Wisdom  Majority Staff Assistant
**AMENDED AGENDA #1**

**SENATE HEALTH & WELFARE COMMITTEE**

**3:00 P.M.**

Room WW54

**Wednesday, March 04, 2020**

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| MINUTES APPROVAL | Minutes of January 30, 2020 | Senator Burtenshaw |
| | Minutes of February 5, 2020 | Senator Nelson |
| | Minutes of February 6, 2020 | Senator Lee |

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**

Chairman Martin  
Vice Chairman Souza  
Sen Heider  
Sen Lee  
Sen Harris  
Sen Burtenshaw  
Sen Bayer  
Sen Jordan  
Sen Nelson

**COMMITTEE SECRETARY**

Margo Miller  
Room: WW35  
Phone: 332-1319  
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, March 04, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:05 p.m.

DOCKET NO. 16-0000-1900F RULE 16.02.08 Vital Statistics Rules. Elke Shaw-Tulloch, Administrator of the Bureau of Vital Records and Health Statistics, Department of Health and Welfare (DHW), presented the Rule 16.02.08. Ms. Shaw-Tulloch explained that on January 9, the Committee approved the omnibus Docket No. 16-0000-1900F, but withheld the vital statistics Rule 16.02.08. The purpose of the vital statistics rule chapter is to provide guidance for records, forms, and registration requirements for reporting. Ms. Shaw-Tulloch respectfully requested that the Committee approve the rule.

DISCUSSION: Senator Heider asked what the consequences would be if the chapter is not approved. Ms. Shaw-Tulloch replied that if the chapter is not approved, based on the lawsuit that required DHW to change the identity on birth certificates, they will need to continue processing applications, but without standards and proper authority.

Vice Chair Souza inquired if there were no reauthorization, when would that part of rejection go into effect. Dennis Stevenson, Administrative Rules Coordinator, stated that all rules become effective upon adoption or very close to sine die.

TESTIMONY: Lori Burelle, representing the Southwest Chapter of the National Organization for Women (NOW), urged support and approval for this docket. Ms. Burelle said there is a health and safety risk without approval and there is a need to comply with the federal court order. Career public servants will pay the price of disapproval and asked for the passage of the rule.

Kathy Griesmyer, Policy Director, Idaho American Civil Liberties Union (ACLU), said they are in support of Rule 16.02.08. Ms. Griesmyer said that Section 201.06. would provide for the completion of requirements and there are no known complications from allowing this. See attachment 1.

DISCUSSION: Senator Lee inquired about the legal decision regarding Section 201.06.c. Richie Eppink, ACLU of Idaho, responded. The court ordered DHW to prepare a policy to allow a name change. Senator Lee asked if there could be a possible misuse of the name change. James Aydelotte, Bureau Chief, Bureau of Vital Records and Health Statistics in DHW, said there is a one-time opportunity to have a name change without fee, but one must still follow the process for a usual name change. The referenced section addresses the name change must not be marked amended and must not refer to the original birth certificate name or indicator of sex.
Senator Heider asked if the Committee doesn't approve this rule, is there a threat of physical violence and requested an example or firsthand experience. Ms. Griesmyer said transgender individuals have shared stories about being turned away because their driver's license doesn't match how they look. Vice Chair Souza doesn't think a birth certificate is required to get a driver's license and asked if that was true. Ms. Griesmyer replied that there are different requirements for different documents.

TESTIMONY: Moné Miller, representing the Idaho Coalition Against Sexual Violence, asked for approval of this docket. The current process is the best way to address this.

Emily Jackson, a transgender person, thanked DHW and its employees for being highly professional. She stated that she served a six-year obligation with the Idaho Army National Guard during the Vietnam era and was honorably discharged with the rank of Sergeant E-5. Ms. Jackson said she is a civil engineer, parent, grandparent, and great-grandparent. She said she doesn't just identify as a woman, she is a woman. A woman is much more than chromosomes. Ms. Jackson indicated that all of her many identity documents identify her and without humiliation. She thanked the Committee for allowing her to testify in favor of Rule 16.02.08

DISCUSSION: Senator Lee and Mr. Aydelotte discussed the requirement to obtain a court order for a name change, and where in the rule it is referenced. Mr. Aydelotte said the only thing that has changed is how it is documented, and how DHW documents the name change on the certificate. He added that none of the name change process was being invalidated, and the rule didn't address that specifically.

TESTIMONY: Peter C. Renn, Counsel at Lambda Legal, submitted written testimony. See attachment 2.

MOTION: Vice Chair Souza moved to approve Docket No. 16-0000-1900F, Rule 16.02.08, with the exception of Section 06, page 38-39. Senator Bayer seconded the motion.

SUBSTITUTE MOTION: Senator Jordan moved to approve Docket No. 16-0000-1900F, Rule 16.02.08.

DISCUSSION: Senators Jordan, Lee, Nelson, Bayer, Heider, and Chairman Martin discussed several aspects of following, or not following, the court order.

Senator Bayer commented that if the Committee doesn't object to the court order, then it would be seen as accepting it, and the court won't do anything if questions aren't raised.

ROLL CALL VOTE: Chairman Martin called for a roll call vote on the substitute motion. Senators Jordan, Nelson and Chairman Martin voted aye. Senators Heider, Lee, Harris, Burtenshaw, Bayer, and Vice Chair Souza voted nay. The motion failed.

ROLL CALL VOTE: Chairman Martin called for a roll call vote on the original motion. Senators Lee, Harris, Burtenshaw, Bayer, and Vice Chair Souza voted aye. Senators Heider, Jordan, Nelson, and Chairman Martin voted nay. The motion carried.

MINUTES APPROVAL: Senator Burtenshaw moved to approve the Minutes of January 30, 2020. Senator Jordan seconded the motion. The motion carried by voice vote.

Senator Nelson moved to approve the Minutes of February 5, 2020. Senator Lee seconded the Motion. The motion carried by voice vote.

Senator Lee moved to approve the Minutes of February 6, 2020. Senator Burtenshaw seconded the motion. The motion carried by voice vote.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:12 p.m.
Testimony of Kathy Griesmyer  
IDAPA 16.02.08 – Vital Statistics Rule Docket 16-0208-1901  
Before Senate Health & Welfare Committee  
March 4, 2020

The American Civil Liberties Union (ACLU) of Idaho stand before you today in support of the Vital Statistics rule docket 16-0208-1901 regarding amending one’s gender marker on their Idaho birth certificate and asks the members of this committee to fully accept this rule.

In accordance with the court ruling in F.V. v. Barron (2018), the ACLU of Idaho supports Vital Statistics’ rule 201. Completion and Correction of Certificates which now permits adult and minor transgender Idahoans to change the gender marker on their Idaho birth certificate to be consistent with their gender identity through self-attestation. In doing so, it affirms an individuals’ gender expression, provides for consistency among legal identity documents which in turn can reduce harassment and public safety threats for transgender Idahoans.

Since the implementation of this rule on April 6, 2018 there have been over 100 adults and 15 minors who have successfully applied to change their gender marker on their birth certificate, with no documented complications, as was reported at a May 16, 2019 Board of Health and Welfare meeting by James Aydelotte, who spoke in his official capacity as State Registrar and Chief of the Bureau of Vital Records and Health Statistics. Those successful applications, by both adults and minors, confirms that self-reporting one’s gender identity, like many of the other self-reported characteristics that are required on official government documents, does not jeopardize the veracity of state documents. Instead, it confirms that transgender people know themselves best and removes unnecessary and discriminatory burdens that transgender people may face at the hands of government actors.

Idaho is not alone in ensuring legal access to accurate identity documents for transgender people. Under the current Idaho Department of Health & Welfare rule, Idaho joins 30 other states that have current administrative procedures that permit transgender people to change the gender marker on their birth certificate. And we join our Western neighbors of Montana, Nevada, Oregon and Washington in permitting transgender people to complete the birth certificate update via self-attestation which removes unnecessary and discriminatory burdens that transgender people may face at the hands of government actors.

Accurate identity documents is about ensuring basic safety for transgender Idahoans. According to a 2015 National Center on Transgender Equality survey, one-third (32%) of individuals who have shown IDs that did not match their presentation reported negative experiences, such as being harassed, denied services, and/or attacked. And medical and mental health professionals have long recognized the importance of updated identity documents as a part of gender transition. The American Medical Association, the American

For questions or comments, contact Kathy Griesmyer, Policy Director, at 208-344-9750 x1204.
Psychological Association and others support allowing trans people to access ID that reflects their gender without proof of medical intervention or other clinical documentation.

The critical need for securing identity documents that matches one’s gender identity ensures that all transgender Idahoans can maneuver through daily life without fear of discrimination or jeopardizing their physical safety. For these reasons, we strongly urge the committee to accept rule docket 16-0208-1901 and ensure that all transgender Idahoans have equal access to changing the gender marker on their birth certificate. Thank you.
March 4, 2020

Via Email

Idaho State Senate Health & Welfare Committee
Idaho House of Representatives Health & Welfare Committee
P.O. Box 83720
Boise, ID 83720-0081

Re: Statement for the Record on Rules Governing Completion and Correction of Certificates; Vital Statistics Rules 16.02.08

Dear Chairman Wood, Chairman Martin, and Committee Members,

As members of the legal team that represented the Plaintiffs in F.V. v. Barron, 286 F. Supp. 3d 1131 (D. Idaho 2018), we write to submit a statement for record regarding the rules governing the Completion and Correction of Certificates. We write in support of these rules, which were a direct response to, and in compliance with, the U.S. District Court’s March 5, 2018 decision in F.V. ordering the Idaho Department of Health and Welfare (IDHW) to accept applications made by transgender people for the purpose of correcting their gender markers to reflect their gender identity.

These rules are a straightforward means for IDHW to comply with the Court’s order: they replace the previous, unconstitutional policy with a new, constitutionally sound procedure for amendment of birth certificates. In invalidating the previous policy as violating the equal protection clause of the U.S. Constitution, the Court noted the “potential implications of restrictions and restraints IDHW may place on the ability of transgender people to . . . change the sex listed on their birth certificates” and cautioned that “any new rule must not subject one class of people to any more onerous burdens than the burdens placed on others without constitutionally-appropriate justification.” Id. at 1141-1142. The Court also explained that “any constitutionally sound rule must not include the revision history as to sex or name.” Id. at 1135. Finally, the Court chose as its remedy to permanently enjoin the Department from enforcing the prior unconstitutional policy, and to order the Department to “begin accepting applications made by transgender people . . . through a constitutionally-sound approval process.” Id. at 1146.
These rules are a direct response to the Court’s order in *F.V.* They allow a transgender person to apply to have the gender marker on their birth certificate corrected in order to reflect their gender identity, and require that the amended certificate will not include any indication of amendment or revision history. In doing so, the rules comply with the order in *F.V.* without imposing burdens on transgender people in violation of the equal protection clause. *Id.* at 1141.

Indeed, in the nearly two years since these rules first took effect in April of 2018, transgender people with Idaho birth certificates have been able to correct their gender designation without issue. These rules are necessary to alleviate the immense harm and risk to the health and safety of transgender people who are not able to correct the gender designation on their birth certificate. Transgender people are at intense risk for discrimination, including verbal harassment and physical assault, especially when they are perceived or identified as transgender.¹

In particular, transgender people with identity documents that do not match their gender identity are frequently publicly identified as transgender, exposing them to harassment and discrimination.² These numbers are even worse in Idaho—thirty-six percent of transgender Idahoans who showed identity documents that did not match their presentation were verbally harassed, denied benefits or services, asked to leave an establishment, or assaulted.³

Additionally, in the two years since implementation of these rules, nothing has transpired whatsoever to suggest that the rules pose any risk of confusion, fraud, or any other conceivable harm to an identifiable public interest. The status quo, upon which transgender people born in Idaho have already relied for nearly two years, should be maintained. To ensure continued compliance with the Court’s order, and in the interest of protecting the safety and well-being of all transgender people born in Idaho, we urge that these rules remain in place as a

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² Overall, about a third of transgender respondents who have shown IDs with a name or gender that did not match their presentation reported negative experiences, with about a quarter reporting verbal harassment. *Id.* at 89.
constitutionally required remedy to the previous, unconstitutional policy which prevented transgender people from correcting their Idaho birth certificates.

We appreciate the opportunity to provide comment on these important rules and to help ensure the health and safety of all Idahoans, including those who are transgender.

Sincerely,

Peter C. Renn
Counsel

Kara Ingelhart
Staff Attorney

Nora Huppert
Renberg Fellow
# AMENDED AGENDA #1

**SENATE HEALTH & WELFARE COMMITTEE**

3:00 P.M.

Room WW54

Thursday, March 05, 2020

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<tr>
<th>SUBJECT</th>
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<tr>
<td>H 438</td>
<td>Relating To Prevention of Blindness And Diseases In Infants</td>
<td>Representative Giddings</td>
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<tr>
<td>H 549</td>
<td>Relating to Daycare Facilities</td>
<td>Representative Amador</td>
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<tr>
<td>H 531</td>
<td>Relating To Telehealth</td>
<td>Julie Hart, Ideal Option</td>
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</table>

**MINUTES APPROVAL:**

- Minutes of January 23, 2020
- Minutes of February 4, 2020
- Minutes of February 10, 2020

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

**COMMITTEE MEMBERS**

Chairman Martin
Vice Chairman Souza
Sen Heider
Sen Lee
Sen Harris

Sen Burtenshaw
Sen Bayer
Sen Jordan
Sen Nelson

**COMMITTEE SECRETARY**

Margo Miller
Room: WW35
Phone: 332-1319
Email: shel@senate.idaho.gov
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 05, 2020
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
ABSENT/EXCUSED: Senator Heider

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 Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 3:07 p.m.

H 438 Representative Priscilla Giddings introduced H 438, Relating to Prevention of Blindness and Diseases in Infants. She said that there was an increase in home births because of the high costs of medical care. She said their goal is to remove penalties that criminalise parents who birth their children at home and choose not to supply the state with newborn screening data, and to clean up Idaho Code. She explained that some of the language in Idaho Code was adopted in 1921.

DISCUSSION: In response to Vice Chair Souza, Senator Bayer, Senator Lee, and Senator Harris, Representative Giddings said the rules are redundant and stated that cleaning up code is part of the due diligence of state officials. She explained that the changes do not negatively impact the health or safety of newborns, as reporting will not cease. She added that many states are removing this requirement from their laws and that she did get input from the Department of Health and Welfare (DHW); it is their input that guided her to remove the penalties and not merely update the exemptions.

MOTION: Senator Bayer moved to send H 438 to the floor with a do pass recommendation. Vice Chair Souza seconded the motion. The motion carried by voice vote. Senator Bayer will sponsor the bill.

H 549 Representative Amador presented H 549, Relating to Daycare Facilities. He explained that it is an update to the daycare licensing requirements for the State of Idaho. The intention is to make requirements clear for criminal history checks for owners, operators, and employees of daycare facilities, and to remove outdated verbiage and update criminal background checks to comply with other sections. He said H 549 deletes the limited criminal history check because it is no longer offered in Idaho. Another change pertains to infant sleep areas.

DISCUSSION: In response to Chairman Martin, Representative Amador said that the term "babies sleeping alone" refers to cribs without toys, blankets, and pillows. He said children may have specific medical conditions where they cannot sleep on their backs so they focused the language on the parent's ability to choose. Parents may be assured that their childcare facility offers this sleep environment, and it is their choice to utilize it. Senator Bayer sought assurance that childcare facilities would not be penalized for children rolling onto their stomachs while they sleep. Representative Amador said that language was added to protect the parents and the childcare facilities from children rolling onto their stomachs.
In response to questions from the Committee, Shannon Brady, Deputy Administrator for the Division of Welfare, DHW, said H 549 specifically speaks to the licensing status of an individual running a center or home-based care delivery area. She said that H 549 complied at the federal level that daycare owners are subject to licensing and the license application requires a background check. Employees are also subject to background checks.

**TESTIMONY:** Written testimony was provided in a letter from Tom Lovell, President, Professional Fire Fighters of Idaho. See attachment 1.

**MOTION:** Vice Chair Souza moved to send H 549 to the floor with a do pass recommendation. Senator Jordan seconded the motion.

**DISCUSSION:** Senator Bayer stated she won't oppose the motion but reserves the right to change her mind on the Senate floor.

**VOICE VOTE:** The motion carried by voice vote. Senator Lee will carry it to the floor.

**H 531** Relating to Telehealth. Julie Hart, representing Ideal Option, said the Board of Medicine (BOM) requested a definition of medication-assisted treatment (MAT) and that this language comes from the BOM. The new, additional language ensures access to more patients by removing the restriction that the patient must be physically located in a hospital or research clinic. See attachment 2.

**TESTIMONY:** Dr. Richard Mattis, representing Ideal Option, a MAT provider, explained what is regularly monitored by a licensed health care practitioner. He said they routinely do urine samples or buccal swabs on all of their patients and that telemedicine provides a flexible business model. He said he personally treats 25 to 50 patients per day. Relating to pill counts, the best standard of care is to provide enough of their prescription until the patient's next visit. He said that takes away the need for pill counts and that typically a patient is seen every three to four months. See attachment 3.

Anne Lawler, Executive Director, BOM, said that this bill opens the possibility to prescribe medications and therapy by telehealth to any license holder who wishes to perform this type of practice in Idaho. The board wants to ensure this type of therapy is provided in person or by telehealth according to the standard of care. The board requested they meet with the bill sponsor and they proposed language to guarantee that they are seeing the patient in person at regular intervals to perform personal safety checks, pill counts, and drug tests, and to make sure they're getting the support they need. She said they are still unclear how H 531 and the Telehealth Act work with the federal requirements or the Ryan Haight Act, which limits the prescription of controlled substances on the internet or via telehealth.

**DISCUSSION:** Ms. Hart responded to Committee members who inquired about a path to keep language concurrent with the language she proposed while also preventing detraction from the Federal Drug Administration's definition. She said that they would work with Ms. Lawler should the bill go to the amending order.

**MOTION:** Senator Bayer moved to send H 531 to the 14th Order of Business for possible amendment. Vice Chair Souza seconded the motion.

**SUBSTITUTE MOTION:** Senator Jordan moved that H 531 be held in Committee. Senator Lee seconded the motion.

**DISCUSSION:** Senators Jordan and Lee expressed that H 531 would benefit from a few months of analysis.

**ROLL CALL VOTE:** Chairman Martin called for a roll call vote on the substitute motion. Vice Chair Souza and Senators Lee, Harris, Burtenshaw, Jordan, and Nelson voted aye. Senator Bayer and Chairman Martin voted nay. The motion carried.

SENATE HEALTH & WELFARE COMMITTEE
Thursday, March 05, 2020—Minutes—Page 2
MINUTES APPROVAL: Vice Chair Souza moved to approve the Minutes of January 23, 2020. Senator Lee seconded the motion. The motion carried by voice vote.

Senator Jordan moved to approve the Minutes of February 4, 2020. Vice Chair Souza seconded the motion. The motion carried by voice vote.

Senator Bayer moved to approve the Minutes of February 10, 2020. Senator Harris seconded the motion. The motion carried by voice vote.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:23 p.m.

___________________________  ____________________________
Senator Martin  Margo Miller
Chair  Secretary

___________________________  ____________________________
Bryce DeLay  Assistant to the Secretary
March 1, 2020

Representative Amador,

The Professional Firefighters of Idaho are in support of HB549. One of the main points of this change is updating the health standards to include infant safe sleep practices.

Every year over 2,000 children die from SIDS (sudden infant death syndrome) in the US. As Firefighters and EMS workers, we teach the following: The "ABC's of sleep safe".
A-Alone
B-Sleeping on their back
C-In a Crib

By these simple steps, we can hopefully reduce the amount of fatalities from SIDS. Thank you for considering our position on HB549.

Respectfully,

Tom Lovell
Chairman Martin, Senators, my name is Julie Hart, and I'm here today representing Ideal Option.

H531 is straightforward in nature and purpose. If passed, H531 would add the Federal Drug Administration’s definition to Idaho’s telemedicine act.

I will walk you through the changes and the need for these changes. You should have in your packets, a document that helps to illuminate this issue. The document breaks down the federal law mentioned in Idaho Code 54-5707. It might be helpful to have that document side by side the proposed legislation as I walk you through.

- Title 21 of United States Code deals with the federal controlled substance act.
- Section 802 defines terms for the federal law.
- Subsection 54 defines how telemedicine may be used when prescribing controlled substances via telemedicine.
- A – G describes the conditions under which telemedicine can be prescribed.
- Idaho adopted only section A. Section A allows controlled substances prescribed using telemedicine to occur only if the patient is residing in a hospital or research clinic.

Rather than striking (A) from Idaho code, we listened to stakeholders like the members of this committee, the Board of Pharmacy, the Board of Medicine, the Department of Health & Welfare Medicaid Division, multiple Health Insurance Companies, and many addiction treatment providers. The concerns shared by stakeholders are reflected in the language you see before you today.
The Board of Medicine requested language adding the F.D.A. definition of Medication-Assisted Treatment or "M.A.T.", to narrow the scope to this section of code even further.

If passed, the law this bill would say, “no controlled substance can be prescribed using telemedicine in Idaho unless the patient is residing in a hospital or research clinic, or unless the provider prescribes medications approved by the federal food and drug administration for medication-assisted treatment (MAT).”

The change will allow doctors, regardless of proximity to patient, to prescribe Medication-Assisted Therapy. M.A.T. therapy is a best practice in addiction treatment using medication in COMBINATION with behavioral health services providing an individualized approach to the treatment of substance use disorder.

I have one of our doctors here today to help provide technical assistance. Dr. Mattis is an Idaho born, WAMI trained doctor living and working right here in Idaho. Unless the committee has questions for me, that concludes my testimony on H531.
Chairman Wood, Representatives, my name is Dr. Richard Mattis, and I'm here today representing Ideal Option as one of their medical doctors. I have worked with Ideal Option for nearly 6 years now as a Medication Assisted Treatment Provider.

First, I want to thank the chairman and members of this committee for holding this hearing and allowing your constituents the opportunity to have an essential conversation on opioid and drug addiction treatment in Idaho.

I'd also like to thank the members of this committee (and potentially your predecessors) for making the WAMI program possible. I was born and raised in Idaho, and I am one of the many WAMI graduates that have chosen to return to Idaho. Currently, I live in Coeur d' Alene. I am a Board Certified in Family and Addiction Medicine, and I am licensed in Idaho, Montana, and the State of Washington. I have my DATA (Drug Addiction Treatment Act of 2000) waiver at 275. I practiced rural community family medicine for seven years, and currently, I provide urgent care and addiction medicine treatment to Idahoans seeking recovery.

I'm sure this committee knows and understands the struggle to recruit doctors to Idaho as we continue on this path of rapid growth. Unfortunately, our substance use and abuse problems are also rapidly growing, particularly in rural areas of our state. It is difficult at best to recruit general practitioners to rural Idaho, let alone those certified in addiction recovery. The Certification process takes time, and most offices are simply not set up to offer best practices to the local population. Telemedicine offers a technological answer to this problem.

Telemedicine offers rural Idahoans the opportunity to be seen and treated by quality providers. I would contend telemedicine, in many cases, would make for better medical coverage than some rural areas can currently offer, simply on the ability to interact with highly trained, highly experienced professionals, trained in best practices, and up to date on current guidelines. Telemedicine allows frequent contact in a
specialized clinic. In addition, telemedicine has been shown to have HIGHER retention rates than in person visits.

Let me tell you precisely what Ideal Option offers: and why I believe that telemedicine plays such a vital role in my company and treatment in general.

- First of all, we offer Medication Assisted Treatment (MAT).
- Each clinic location has an onsite MA. All patients get vitals checked and preliminary assessments by an MA.
- All patients have a medical history performed and updated. All medications are reconciled and updated.
- Before prescribing any treatment, all patients see and speak with a medical doctor allowing for plenty of doctor-patient interaction. This focused interaction allows each doctor the chance to assess the whole person, asking questions that move beyond the substance abuse problem to find the most accurate diagnosis and uncover factors that may be playing a role in their recovery. This process enables each doctor the opportunity to learn and help patients deal with social issues, housing, anxiety, and mental health issues, need for counseling, and the presence of other contributing medical problems. Our doctors review charts and provide case reviews for each patient. We provide pregnancy testing for individuals who know or suspect they may be pregnant and STI testing for individuals concerned with contracting an STI. We regularly order and review patient lab tests, including CBC, CMP, and Hepatitis Screening, STI screening including HIV and syphilis, and thyroid panel.
- If medical problems are uncovered that are best dealt with in primary care office, we assist with referrals, and have ROI in place to coordinate care. If counselling or social services are needed, we will often have a database of local resources for the patient. In WA, we have live and
telemed substance abuse counsellors available at all times, and we will expand this as allowable and feasible.

• In other states, we offer the ability to be seen quickly with a referral process from local jails and ER’s, and even the ability to screen and treat Hepatitis C.

What I see from our patients

First of all, I think the key to the process is frequent visits. Frequent Brief intervention counseling has been shown to be superior to infrequent visits. And studies show no difference in relapse or retention if visits are done in person or by telehealth. Accountability and close follow up, specifically with motivational interviewing techniques are very successful in lowering our relapse rates well below the national average, and similarly increasing our retention rates. Frequent urine testing is used, not as a punitive measure, but to ensure compliance and help foster a collaborative relationship. And finally, I think continued long term involvement is important. Studies consistently show that rapid taper and total abstinence therapy have very high relapse rates compared to long term MAT, with relapse rates not truly dropping for any modality for at least 6 months, and preferably 1 year of treatment.

Example of how a recent Patient encounter went. Pt was relatively new, a few weeks into treatment. He had done well with motivational interviewing and frequent visits. On the previous visit, Pt had a positive initial urine dip for opiates and denied use. On his next visit, his definitive was reviewed and showed high Hydro levels. I talked at length to the Patient, and he admitted to running out of his meds, having a headache, and taking 3 white pills his mother gave him, which he later identified as hydrocodone. I had already looked at his last 2 notes, where he had mentioned that he was having some cravings and withdrawals and occ wanted to take an extra dose. My treatment—NOT PUNITIVE—thank him for keeping us in the loop with his symptoms, discuss the need to work with us if he has symptoms or a relapse, no matter how minor, increase his dose, discuss dosing techniques, and see him back in 2-3
days...and he is feeling much better without relapses, withdrawals or cravings. All of this was done over the course of less than 2 weeks, and all done by telemedicine in one of the Washington State clinics.

I think the most rewarding part of the job for me is being part of a transformation of patients. Initially the patient abstinence is very tenuous, requiring a large amount of support and feedback, discussion of avoiding triggers, dose adjustments and reassurance. This typically lasts at least 30 days, often with relapses involved. From there I see patients stabilizing but still fighting many battles and needing encouragement. Now we have the chance to talk about stressors that arise, finding a job, more stable housing, and starting or continuing counselling or abstinence groups. This phase can last several months. And finally, after 6 months, and frequently longer than this, patients are stable and the process centers on congratulating them on their families, their jobs and accomplishments, and their ability to help others. I have many patients that I have been seeing for upwards of 2 years without relapse, and they are very productive members of the workforce and community. I am very proud of these accomplishments of my patients, and I remind them of this. Also, many of them have seen ME make the progression from in person to telemed, and we still talk as you and I are talking today. In fact, I have several patients who PREFER to come more frequently, simply for the interaction and accountability.

Finally, I have many patients whom have been seen in other clinics, in person, but with loose rules and infrequent visits, and have continued to relapse until coming to my clinic and being provided some structure and often simply more interaction time with a provider, even though it is by telehealth.

From this discussion, I hope I have helped you see what telemedicine can offer the state of Idaho and its residents to increase access and treatment for this health care crisis we are facing.

Thank you again Chairman Wood and all Representatives for allowing me the opportunity to talk with you this morning, and please feel to ask me any questions you may have.
# Senate Health & Welfare Committee

**February 25, 2020**

**Committee Members**
- **Chairman:** Martin Sen Burtenshaw
- **Vice Chairman:** Souza Sen Bayer
- **Sen Heider:** Sen Jordan
- **Sen Lee:** Sen Nelson
- **Sen Harris:**

**Committee Secretary**
- **Margo Miller**
  - **Room:** WW35
  - **Phone:** 332-1319
  - **Email:** shel@senate.idaho.gov

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<tr>
<td>H 340</td>
<td>Relating To Child Care Licensing</td>
<td>Senator Souza</td>
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<tr>
<td>H 497</td>
<td>Relating To The Yellow Dot Motor Vehicle Medical Information Act</td>
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<td>H 538</td>
<td>Relating to Tobacco Products</td>
<td>Erin Bennett, American Heart Association, Corey Surber, St. Alphonsus</td>
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<td>H 578</td>
<td>Relating To Health</td>
<td>Senator Den Hartog</td>
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**Presentation:** Suicide Prevention

**Minutes Approval:**
- Minutes of February 11, 2020: Senator Jordan
- Minutes of February 18, 2020: Senator Heider
- Minutes of February 19, 2020: Senator Harris
- Minutes of February 25, 2020: Senator Burtenshaw
- Minutes of February 26, 2020: Senator Souza

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.
MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, March 10, 2020
TIME: 2:30 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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.

CONVENE: Chairman Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 2:34 p.m.

MOTION: Chairman Martin asked for unanimous consent to change the order of the agenda, approving the minutes before hearing the bills. There were no objections.

MINUTES APPROVAL: Senator Jordan moved to approve the Minutes of February 11, 2020. Senator Heider seconded the motion. The motion carried by voice vote.

Senator Heider moved to approve the Minutes of February 18, 2020. Vice Chair Souza seconded the motion. The motion carried by voice vote.

Vice Chair Souza moved to approve the Minutes of February 26, 2020. Senator Heider seconded the motion. The motion carried by voice vote.

Senator Burtenshaw moved to approve the Minutes of February 25, 2020. Senator Heider seconded the motion. The motion carried by voice vote.

Senator Harris moved to approve the Minutes of February 19, 2020. Senator Jordan seconded the motion. The motion carried by voice vote.

H 340AA

Vice Chair Souza presented H 340aa relating to child care licensing. She stated there is a serious problem in Idaho regarding teen drug use and teen suicide. Teens under the age of 18 are not legally allowed to seek treatment at a crisis center or an adult rehabilitation center for drug use or for suicide. Access and affordability are huge problems. H 340aa offers exemption for licensure for a private option. Good Samaritan Drug and Alcohol Rehabilitation Program (Good Samaritan) is a private pay agreement between parents and a private treatment program. There is no public money involved. Vice Chair Souza explained past attempts to solve this issue, and her work with Representative Wood to create this bill. Amendments adding safeguards were initially removed, but public concern led them to be included. Good Samaritan is already doing all the things listed in the bill and the amendments. Any complaints will be obtained from law enforcement at the end of the pilot program and presented to the Legislative Child Welfare Oversight Committee for re-evaluation of the pilot program.

Vice Chair Souza read letters from Good Samaritan's community professionals and excerpts from graduates' letters who reported on the success of the program (attachment 1). Good Samaritan has a highly successful track record of 18 years in their adult rehabilitation program. For five of those years, there was an adolescent program with 56 graduates and no complaints. Vice Chair Souza
DISCUSSION: Senator Jordan asked about amendments and assessments. Vice Chair Souza referred Senator Jordan to page 3 of the bill regarding the amendments. With regard to assessments, Representative Remington responded that if there is a major mental health issue or a dual diagnosis, the youth is not accepted into the program. Assessments include the court records and diagnoses youths bring with them if they have come from the court and have been diagnosed, and information from parents or a probation officer.

Chairman Martin requested that Representative Remington explain how his program relates to the bill. Representative Remington, also known as Pastor Tim, representing Good Samaritan, said his program has been in effect for the past 18 years with 3,200 graduates from the adult program. It is faith-based and character-based, and is State certified in various programs. He claimed the bill would save the State millions of dollars and would help more youth. He stated he doesn't license his programs because of affordability, accessibility to families, and because it is a faith-based program.

Senator Jordan and Vice Chair Souza discussed issues surrounding child protection, law enforcement's ability to make unannounced checks, and the involvement of the Legislative Child Welfare Oversight Committee.

Senator Bayer asked about the schools and classwork. Representative Remington answered that the youths get a pass from school and are not enrolled in school, but that they catch up. He said when a teen comes into the program by court order, the teen usually isn't in school due to drug or alcohol use, or incarceration.

Senator Nelson and Representative Remington discussed Good Samaritan's decision not to pursue state licensure.

TESTIMONY: Those testifying in favor of H 340aa included Representative Mendive, representing Legislative District 3; Representative Remington, representing Legislative District 2; and Vice Chair Souza, representing Legislative District 4.

Those testifying in opposition to H 340aa included Michael Sandvig, President of the National Alliance on Mental Illness, Idaho (attachment 2); Sharon Harrigfeld, representing herself; Ruth York, representing the Idaho Federation of Families for Childrens' Mental Health (attachment 3); Pat Martelle, a licensed clinical social worker representing a parent from Hayden, Idaho; Jennifer Griffis, representing herself (attachment 4); Dr. Sheila Sturgeon Freitas, a clinical psychologist; and Amy Jeppesen, a licensed clinical social worker and an advanced chemical dependency counselor.

Written testimony in opposition to H 340aa was provided by the following: Sheila Weaver, a licensed Master of Social Work (attachment 5); Darren Richman, LLC member/CFO, Ascent Behavioral Health Services (attachment 6); Idaho Parents Unlimited, Inc. (attachment 7); and Marilyn Sword, representing Idaho Caregiver Alliance (attachment 8).
DISCUSSION: Senator Nelson and Representative Mendive discussed a letter from the Department of Correction written by a probation and parole officer who was the person assigned to the program, and one who had full access to this program.

In conclusion, Vice Chair Souza read several letters from former clients of the program stating how the Good Samaritan's program helped them. Vice Chair Souza said Idaho is not getting teen substance use under control and this bill provides an alternative, private program for parents to obtain treatment for their children. The parents and the community will have oversight. It will cost the State nothing, and the community wants this and supports the program. Vice Chair Souza asked the Committee to send H 340aa to the 14th Order of Business for possible amendment.

Senator Nelson and Vice Chair Souza discussed sunset language not being in the bill.

Senator Bayer commented that licensing seems to be the main focal point of the testimony the Committee listened to, and believes it is false protection. Two State facilities were mentioned by name as having numerous cases of abuse, yet this program hasn't had any reports of problems with abuse, neglect, or anything else; that is why this program deserves to be tried.

MOTION: Senator Jordan moved that H 340aa be held in Committee. Senator Heider seconded the motion.

DISCUSSION: Senator Jordan applauded the work in Representative Remington’s program, but stated her concerns: whether or not there is a co-presentation of mental health and substance use; the reliance on parents; housing children in light of the Jeff D lawsuit settlement; and the possibility of setting a precedent of unlicensed programs by passage of this bill.

Vice Chair Souza responded that the Jeff D lawsuit does not apply, according to the Attorney General's Office, because it is a private program with no public money, and there would be no connection between youth and adults. In addition, this is a proposed pilot program and that does not set a precedent.

SUBSTITUTE MOTION: Senator Bayer moved to send H 340aa to the 14th Order of Business for possible amendment. Senator Lee seconded the motion.

DISCUSSION: Senator Bayer said she understood there was preparation in the amendments to reinstate all of the protective sideboards that were needed, and the bill should go forward. Senator Lee agreed.

Senator Nelson expressed his opposition to the substitute motion due to the program's unwillingness to obtain state licensure.

ROLL CALL VOTE: Chairman Martin called for a roll call vote on the substitute motion. Vice Chair Souza, Senators Lee, Harris, Burtenshaw, and Bayer voted aye. Senators Heider, Jordan, Nelson, and Chairman Martin voted nay. The motion carried.

MOTION: Due to time constraints, Chairman Martin requested unanimous consent to postpone the hearings for H 497, H 538, and H 578 until the next meeting. There were no objections. He then asked Dr. Hatzenbuehler, who came from out-of-town, to briefly present her report.
PRESENTATION: Dr. Linda Hatzenbuehler said she serves as Chair of the Idaho Council on Suicide Prevention (Council) and introduced Stewart Wilder, President of the Idaho Suicide Prevention Coalition (Coalition). Dr. Hatzenbuehler stated that she has provided the Committee with the Council's 2019 annual report to the Governor and the Legislature (attachment 9 is located in the Legislative Library). She discussed the complexities of preventing a pandemic, such as coronavirus. She stated that, in comparison, preventing death by suicide is more complex than preventing a physical health crisis. Dr. Hatzenbuehler said rather than focusing on Idaho’s troubling statistics, their goal today is to focus on the positive and to discuss activities going on in Idaho to decrease the rising suicide rate. Their goal remains to reduce Idaho's suicide rate by 20 percent by 2025.

Dr. Hatzenbuehler asked Mr. Wilder to report on the activities of the Coalition.

Mr. Wilder explained that the plan embraces many stakeholders, both from public and private entities. They are reviewing the structure, charter, and vision of the Coalition, and the work plans to ensure measurable outcomes. In 2019, the Department of Health and Welfare and Idaho State University completed a state-wide gap analysis. Idaho must engage a system of coordinated care and training to move away from the current judicial and child protection model that is not working for the citizens of our state. Mr. Wilder thanked the Committee and asked for continued support for suicide prevention and mental health initiatives for the future.

DISCUSSION: Chairman Martin asked about the effect of talking about suicide. Mr. Wilder stated that talking about suicide does not have a negative effect.

Chairman Martin said approximately one person per day dies of death by suicide in Idaho. He likened that to a commuter airline crashing in Idaho every month and killing everyone on board. If that happened more than two or three times, the airlines would be grounded and some serious investigation as to the cause of the crashes would be pursued.

Senator Jordan and Dr. Hatzenbuehler discussed the lack of LGBT representation in the Coalition and the need to reach out to that group. In response to a question from Senator Heider, Mr. Wilder discussed suicide rates for older men.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 4:18 p.m.

___________________________  ___________________________
Senator Martin                      Margo Miller
Chair                                Secretary

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, March 10, 2020—Minutes—Page 4
GOOD SAMARITAN DRUG AND ALCOHOL REHABILITATION PROGRAM
Serving the Coeur d’Alene area since 2002.

Cost: $3,000 for a 4 month program

Scholarships from private community donors are provided to about 40% of participants

Capacity: 50 women, 50 men, in separate facilities

Graduates: 3,200 over 18 years

Success Rate: After 5 years out of the program, 78% are still clean and sober.

Paid staff: 32

Staff are State certified in Cognitive Self Change, Moral Reconation Therapy, and Relapse Prevention

Over 90% of grads report they started using drugs and/or alcohol between the ages of 11-15.

ADOLESCENT PROGRAM was open from 2007-2012, with 56 graduates and zero complaints, but was closed, voluntarily, when pressured to license, due to concerns about unaffordable costs and state interference with faith based counseling.
Good Samaritan Rehabilitation Program

Credentialed Classes by the state of Idaho (Required by the State of Idaho)

1. CSC: Cognitive Self Change
2. MRT: Moral Reconciliation Therapy
3. Relapse Prevention

Topics including 30 day packet they have to individually go over:

1. Drug prevention: What about drugs?
2. Alcohol prevention
3. Anger management
4. Anxiety
5. Depression
6. Effects of a runaway
7. Loneliness
8. Rejection
9. Our Higher Power
10. Gods Will
11. The Importance of Family (House management)
12. Marriage
13. Finance (Dave Ramsey training)
14. Friends (living a sober life)
15. How to be a Mom/Dad in today's world
16. Righteous living in an unrighteous world

Total cost of program:

1. Over 50,000 per month (Over 600,000 per year of private money)
2. 3,000 dollars per month for clients
3. 40% of clients are sponsored by community

Quantity of people per year

1. 120-140 people per year

Accountability:

1. State gave us our own Probation officer for our program
2. We DO NOT TAKE SEX OFFENDERS in our facilities.
3. The juvenile and the adult are separated in sleep areas
4. Parents can call and visit on weekends to see family. (no girlfriends or boyfriends, just family only)
To: Idaho Legislature

RE: Inpatient Juvenile Substance Use Treatment Facility

While I do not currently preside over juvenile matters, for five years I presided over a Therapeutic Court in Kootenai County known as Family Support Court. In that Court we treated juveniles who were in the juvenile justice system, who had drug and/or alcohol problem.

I can state without hesitation that a juvenile inpatient drug and alcohol treatment facility would be useful to our area youth, and would be utilized.

My understanding is that the Idaho Legislature may be presented with a bill to help such a program on a pilot two-year basis. I assume that would result in a reduced cost or no cost to the juvenile to attend such a program. If that assumption is correct, I think that would be a wise move as most of the juveniles we had in the Family Support Court were impoverished, and thus could not have afforded the significant cost of inpatient treatment. Good Samaritan charges about $3,000 for their almost year-long program, a bargain compared to other private facilities which can charge $40,000 or more for a 28-day program. Even at $3,000, many families would be hard pressed to come up with that to help their child.

I have known Pastor Tim Remington for about thirty years, and I have been familiar with the Good Samaritan Rehabilitation program for each of the nearly eighteen years I have been a district judge, and can attest to that Good Samaritan Rehabilitation has done a good job rehabilitating adults. In my experience, they have been compliant with the courts and have been good in filing reports with the court. They have separate facilities for men and for women. I consider it to be a safe program.

Very truly yours,

John T. Mitchell
District Judge
February 27, 2020

Idaho State Legislative Services Office
PO Box 83720
Boise, ID 83720-0054

Greetings:

I write in support of a faith based juvenile treatment facility. I have worked in the Criminal Justice arena my entire professional career. Most of my career has been in Kootenai County, the First Judicial District. I am the Chief Public Defender for Kootenai County.

Over the years I have been quite interactive with treatment facilities in our area, including the Good Samaritan. I have particularly gotten to know Pastor Tim Remington. Without reservation I recommend the Good Samaritan. I would welcome the opportunity to recommend a Juvenile program run by Pastor Tim Remington.

There is a need for an alternative to incarceration for young people. I have found that the young people have varying degrees of need, including substance abuse treatment, rules to follow, daily life skills, love and support, and acceptance and belonging. A faith based program, such as the Good Samaritan program, is a necessary component in our community.

I am confident a Juvenile version of the Good Samaritan program is the right fit for our youth and for our community. I am confident because I have supported Good Samaritan for over 15 years; I have worked with clients participating in the program while handling criminal case matters.

Looking at past performance of Good Samaritan is a good indicator of how a Juvenile program would function safely. In the 15 plus years I have worked in conjunction with clients participating in the program I have come to know that the Good Samaritan program is well thought out and encompasses components left being by other programs. Good Samaritan has well trained staff; they are reliable and accountable and hard working. They are responsible to be sure the program is followed and that conditions applying to participants are met.
I have met with many clients prior to participating in Good Samaritan, during participation and post participation. I have heard positive comments from the clients I work with. I have not received a complaint about the program or those that work within the program.

I have worked in the First District for the majority of my career. I have known the reputation of the Good Samaritan to be positive. I have not known Good Samaritan to have a negative or even questionable reputation. In our legal community Good Samaritan is viewed in a positive light and respected among attorneys, probation officers and court personnel.

A Good Samaritan Juvenile program would benefit many at risk youth. I support such a program and greatly hope it becomes a reality. If I can answer any questions, please do not hesitate to call me. I would welcome any opportunity to further discuss how necessary a juvenile program is and why I support Good Samaritan.

Respectfully,

Anne C. Taylor
Chief Public Defender
Kootenai County, Idaho
February 27, 2020

To Whom It May Concern;

I am writing with regards to the Good Samaritan Program in Kootenai County, Idaho. This program, overseen by Pastor Tim Remington has been operating for many, many years in Kootenai County without any significant issues.

This is not to say that the program is 100% successful with all of their clients, but the program equips participants with the skills and resources to combat their addictions and return to society as productive members. I don’t know exactly what the recidivism rate is, but I do know that it is very low. In fact, the local courts often issue orders to my jail requiring us to release inmates only to the Good Samaritan Program so they can get back on the right track, avoid further incarceration and burden on the local tax payer.

Personally, my wife and I have visited and witnessed some of the programming provided by the Good Samaritan Program. We found that did it not only address the substance abuse issues, but taught things such as basic financial literacy and improved self-esteem through the development of skills many would think of as basic, but many substance abusers just don’t have.

I encourage you to really see for yourself the successes of this program and hope that it can be expanded to assist more people in the future.

Sincerely,

Ben Wolfinger, Sheriff
Re: Good Samaritan Rehabilitation

To whom it may concern:

I was asked by Pastor and Representative Tim Remington to write about the Good Samaritan Rehabilitation program’s reliability and accountability. A common request by incarcerated defendants is for the court to release the defendant on no bail or low bail so that the defendant can attend the Good Samaritan inpatient program. One of the things my office relies on is the commitment by Good Samaritan to report to the court and counsel when someone released violates the terms of the release. Good Samaritan has been an honest and reliable participant in that process.

I can say with confidence that if a similar juvenile inpatient program was available through Good Samaritan, you would see the same commitment to reporting requirements imposed by the court.

Please don’t hesitate to contact me with questions.

Yours very truly,

[Signature]

Barry McHugh
Prosecuting Attorney
I have compiled excerpts from several Good Samaritan Graduates' letters. These will give you a feel for the program and its wonderful results.

From Dakota: The Good Samaritan Program had a big impact on my life. The program helped me draw closer to God and understand that drugs ruin lives and families.

One program in the Good Samaritan that really helped me was the Cognitive Self Change class. It broke down my wrong-doing and found the reason behind my action and the consequence.

Spiritually, God showed me that I don't need to bow down to worldly things. I am to worship Him. God's Word filled me with hope, joy and happiness. I am drug free!!!

From Gabriel:

I entered Good Sam Rehabilitation and it changed my life. I was on the road to destruction, using drugs to cope with my feelings and emotions. Good Sam showed me that emotions are natural, and I don't have to deal with them on my own. They taught me to lean on Jesus and allow Him to help me. I learned it's okay to NOT be okay. This program taught me strong moral principles and gave me the discipline to make the right choice under pressure.

The house we stayed in was very nice, space for all of us. It had a weight set in the garage, different exercise machines, as well as a pool table and ping pong table.

While in the program I did not have to worry about anything outside of working on myself. The facilitators handled everything, and we focused on getting right with God. The facilitators were the most important part of the program for me because I was able to talk about my problems with someone who had more life experience. These facilitators make this program special— they are not just working a shift! They CARE and are there to help!
This program not only taught me to lean on Jesus, it also taught me to cook, clean, and do basic skills required in everyday life. I will always be thankful for the impact this program had on my life.

From Maddy:

Before going to Good Samaritan, I was Lost, Rebellious, a Thief, a Liar---a Criminal. I was raised in a home where everyone had an addiction whether it was drugs or alcohol. There was NO one in my life who seemed to care about me.

I started smoking weed when I was young and liked it. Soon it wasn’t enough, and I went further into drugs. It made me feel numb.

I knew it was not good. So, I went to see Pastor Tim and agreed to attend The Good Samaritan program. I attended classes to help with the way I think and the way I respond. These classes were MRT or Moral Reconciliation Therapy and CSC or Cognitive Self Change. All the teachers were so kind and supportive. They were always interested in helping me and I felt safe and loved there.

I learned about being Pure and respecting myself which really translates to respecting God’s Word.

I will never forget how happy I was there. I found purpose and I am grateful for the experience.

My name is Madison:

I came from a broken home where chaos reigned. I rebelled and started using drugs and became sexually active. I became hard and withdrawn.

But my mom knew I was in trouble and took me to Pastor Tim at the Altar. The first two weeks were hard and long. But my shell cracked, and the facilitators got thru to me. I found Jesus and made wonderful new friendships. I learned
so much from practical chores to loving Jesus. With the program I had new hope, a new life---it was a miracle. I am so grateful for The Good Samaritan program.
March 10, 2020

The Honorable Fred S. Martin  
P.O. Box 83720  
Boise, Idaho 83720-0081

RE: HB 340, Child Care, Treatment Facility

Dear Senator Martin,

NAMI Idaho is opposed to HB 340. Allowing an unlicensed facility for the treatment of minors is a giant step backwards. There are enough problems in Idaho with facilities that are licensed. Removing licensing and oversight safeguards put our children at risk. Here are additional comments:

- While the bill says it would exempt other facilities operating before 2020, there are no criteria for being a pilot except the specific listing of the Good Samaritan Rehabilitation Program in Coeur d’Alene.

- A real pilot would have criteria for qualifying and would be evaluated by experts in Substance Use Disorder treatment.

- The “child protection legislative review panel” has no expertise in substance use treatment and no legislative mandate to evaluate Substance Use Disorder treatment. Their only purpose under current statute is to review reports by regional child protection review panels. They have no expertise in “developing a template” for children’s Substance Use Disorder facilities.

- No authentic pilot would allow the project to evaluate their own success. But H340a appears to authorize facilities participating in a pilot, including the Good Samaritan Rehabilitation Program in Coeur d’Alene, to report on its own “success” (without even setting any criteria for success) and will operate without oversight or even reporting until July of 2023.

- There are no protections for either children’s or parents’ rights in an unlicensed facility. The resident, patients, and parental rights specified in Idaho Code 16-2425, 2426, and 2428 do not apply to unlicensed facilities.

- H340a does not require background checks for staff, separation of minors and adults, any clinical training for staff, even building codes and food storage and preparation standards do not apply.

- There are no restrictions on overcrowding or sleeping arrangements.

Please do not support or pass HB 340.

Sincerely,

Michael Sandvig, President  
208 520-4210  
idahonami.president@gmail.com
I am greatly concerned by HB340a. **Most concerning to me is that it is about one center that does not offer the standard of care in adolescent substance abuse treatment.** Senator Souza, Rep. Mendive and Rep. Remmington have all indicated this program will be for adolescents with substance use disorder without co-occurring mental health disorders. Residential treatment is not the recommended treatment modality for adolescents with substance use disorder only. The standard of care for this population is community based services, including intensive day treatment. These options exist in Northern Idaho.

Youth need to maintain their education and Good Samaritan offers an immersion in Bible study only. There is no other educational component planned for their youth program. Education is mandatory for youth in Idaho and it is a parent's responsibility to make sure their children maintain their education. A parent could actually be prosecuted for sending their child to a facility with no educational component for up to 4 months. This bill keeps morphing to try to allow this one center to admit teens and I urge you not to allow this unlicensed program to open its doors to a population that should not be in residential care in the first place, and who should not forfeit their education while in treatment. Schooling is a part of all standard of care day treatment and residential programs. It is not just best-practice. It is considered the only-practice in addressing youth substance youth disorder.

Outpatient and Intensive Outpatient Programs exist in Northern Idaho, and residential clinical programs, for those with diagnoses appropriate for this level of care, can be found within an hour of most Northern Idahoans. It is misleading for lawmakers to say or think that teens in N. Idaho have no options and as a result are in danger on the streets. Parents in Northern Idaho, and in fact in all parts of Idaho, can call our office and receive help in finding options that keep their child safe, and these options are covered by insurance and Medicaid and not financially unavailable to families. We keep parents in the driver's seat in selecting what works best for their situation. If that is a faith-based program we would support that 100% and we would caution them that licensing will protect their rights as guardians and their child's rights to a safe and evidence-based treatment environment. We have no affiliation with any programs and are only driven by our understanding of what parents and youth are experiencing when they have a substance use disorder, or mental, behavioral or emotional health challenges.

Other concerns that indicate this program will not prepare youth for a life of sobriety and success are found in looking at the rules for participation at Good Samaritan as stated on their website:

- **No contact with anyone outside of the program (including immediate family) for a minimum of 2-3 weeks until the program deems it appropriate for them to have contact.** This is a harmful practice for youth in residential care who need to know they are still supported and loved by their family members when a family makes a choice to seek treatment.
- **Women are not allowed to kiss their husbands throughout their adult treatment but men are allowed to kiss their wives while men are in treatment.** This is one of several rules for women which have no compatible rule for men. Teaching young girls that their rights are different than a male's rights goes against the modern culture females live in. Women like Senator Souza and all the good women of the Senate and House hold their current positions because it was made possible for them to have choices outside of the traditional roles for females that this treatment program promotes.
• The potential for abuse of women and girls is increased in male-dominated environment. At Good Samaritan woman and men are being taught that women are supposed to be in service to men and focus their lives in service to their children as well. I don't know any working women or single women who don't focus their lives on their children. Again, please see the website admissions criteria and descriptions of the adult female program, which is twice as long as the male program because women are required to undergo extra training and religious teachings to learn their roles in society before release from the program. If any of this is not found when you look, it will only be because has been taken down or will be taken down as a result of the efforts to push this bill through for this one facility. It was still on the website as of this past weekend.

Let's address the concerns for teenage substance abusers appropriately, safely and with safeguards in place for youth and families. Let's slow down and base decisions like these on the existing substance abuse treatment evidence collected and validated scientifically with non-biased evaluators. Let's ask questions such as:

• Why is Good Samaritan unwilling to consider licensing unlike every other treatment facility in the state?
• Why is Good Samaritan insisting on a residential treatment environment when the standard of care is outpatient which they could easily offer without licensing? If they are unable to attain a good outcome for youth via outpatient treatment, then national data would indicate they are not enrolling the right population - that is youth with only a substance use disorder and no underlying mental health concerns.

Please give yourselves, families and youth time to find the right solution to a problem where the wrong solutions can result in long term harm to youth and their families.

Ruth York

Executive Director
Idaho Federation of Families
for Children’s Mental Health
704 N. 7th St.
Boise, ID 83702
208-433-8845
Dear Senate Health and Welfare Committee,

I am writing to share my concerns about HB 340a. For the past six years I have spent countless volunteer hours working to support various aspects of Idaho’s system of care by providing parent voice and perspective. Currently through my work with Idaho Federation of Families, I spend several hours each week supporting families who are trying to navigate Idaho’s children’s behavioral health systems, including those seeking residential services for substance use treatment. Additionally I have personal experience seeking residential treatment for my own teenage daughter. I have a deep understanding of not only the challenges experienced by families but also the policy and system issues that play a role in these decisions.

The stated purpose of this bill is to address Idaho’s “serious lack of residential substance abuse treatment for teens” by giving “an exemption from licensing” for a single “pilot program”. While I support the need to increase access to substance use treatment for youth, I am highly concerned about the mechanism this bill uses to increase access.

The development of Youth Empowerment Services (YES - the system of care that is a result of the Jeff D. Settlement) has increased access to services for youth across the state. This has happened in three distinct ways: first more of our youth have access to Medicaid (this includes youth needing substance use treatment); secondly we have an increased number of providers offering services (for example Ashwood Recovery, Cottonwood Creek, and Tri-State Behavioral Health are all new substance use providers in the last three months) and we have an increased in the types of services that providers are able to bill for, including more intensive outpatient options which are evidence-based for treating youth with substance use disorder. YES has made a positive difference for families across the state and it will continue to do so as implementation continues to move forward.

Even with this increase in access, there are times youth need to be placed in residential treatment. One of the expectations parents have when making placement decisions is that the facilities will have some sort of oversight and protection. Oversight that will ensure best practices in clinical treatment and protection that will ensure safe and appropriate interactions with staff and peers. This bill creates a situation where that oversight and protection will no longer be a “given” within the state of Idaho.

Here are a few reasons why this is a concern for parents:
* There is no requirement in the bill that facilities inform parents they are unlicensed. Information is not provided to parents about the difference between a licensed and unlicensed facility so that they can make a fully informed choice about placement.

* There is no entity identified in the bill that can practically support a parent with an immediate concern regarding clinical practices or safety issues. Calling law enforcement or involving child protection is not best practice or even effective in these types of treatment situations. It’s a last resort type of intervention.

* There is no due process identified to help parents when concerns about a facility become evident. Parents are left without recourse and protection while placing their child into a treatment situation when they are at their most vulnerable.
Additionally, there are specific concerns with regards to the facility identified in this legislation. Here are just a few of them...
* Youth being taken off psychotropic medications without proper oversight. Local providers have reported that adults in this situation at this particular facility have experienced serious health consequences as a result of this practice.
* Co-mingling of adults and adolescents in treatment and recreational settings.
* The use of this program by judges for youth on probation. Will this program be given as one of several options for youth by the court or will it be mandated (as was stated happens on the adult side)?
* Treatment of adults with pornography and sex addiction at the same facility as teenagers who may be as young as 13.
* Concern about youth of all faiths (or those who claim no faith at all) being able to participate in this program without discrimination or coercion.

Substance use and teen suicide remain challenging issues in Idaho. But they aren’t issues that will be solved by allowing unlicensed facilities to begin providing treatment. I strongly urge you to vote against any bill that allows unlicensed youth treatment facilities in Idaho. Instead I’d like to invite those who want to treat youth to work with parents and system partners to identify any current licensing barriers and move forward in a way that continues to increase access to evidence-based treatment while protecting the rights of parents and youth.

Jen Griffis
Grangeville, ID
jengriffis@gmail.com
Dear Senate Health and Welfare Committee:

Please consider this as my written testimony.

I am a licensed Master of Social Work and native Idahoan in long-term recovery.

My addiction threatened my safety, my freedom, and my life. Getting sober 17 years ago was one of the most challenging experiences I’ve ever had. My recovery was made possible because I had access to evidence-based interventions provided by licensed professionals in a safe environment. Because of the work of highly trained individuals that specialized in substance use treatment, I was given the chance to build a new life, pursue higher education, and become a homeowner in District 17. I ask that you give children the same opportunity that I had to receive the best care they can so they can go on to lead full lives. Without access to competent treatment providers, Idaho children with substance abuse needs will be subjected to needless risk. Idaho children will be incarcerated and die preventable deaths from addiction, and this committee can make an impact in the lives of youth who can’t speak up for themselves.

Today, I am honored to work with vulnerable children and families that are impacted by substance abuse daily. Addiction causes significant distress in a family; Parents seeking treatment options for their children agonize over how to best support them. Substance use disorder treatment is included in all health insurance plans. However, parents would not be able to use this benefit because private insurance will not pay for an unlicensed treatment facility. This means parents will be required to take on substantial debt to pay for treatment. This could result in businesses taking advantage of parents’ financial situation during an already difficult time, something that has occurred in other states related to substance use treatment.

As a professional I have significant concerns about the potential for housing vulnerable children and adults together, particularly when the state is taking on a tremendous liability. Allowing non-licensed “temporary alcohol-drug abuse treatment facilities” for teenagers with essentially zero oversight sets the stage for children to be harmed and you have the power to prevent that. The co-mingling of adults and youth in a treatment setting was the impetus for the Jeff D. lawsuit over 30 years ago. The State should not risk another costly lawsuit as a result of this legislation.

While I sincerely appreciate the efforts of Good Samaritan Rehabilitation’s work with adults, the facility and the authors of this bill have done almost nothing to provide clear standards and accountability for families and children when they need them the most. I ask that you oppose House Bill 340a and protect Idaho children.
Thank you,

Sheila Weaver, LMSW
Senator Martin

I am writing to express concern over HB340a. I have heard many concerns from other parties regarding safety and reporting, however one concern that I have that has not been discussed is the legislature labeling this as a ‘pilot program’. Every pilot program I have ever been involved with has clearly defined parameters, periodic oversight and reporting, and objectives to see if the pilot can be pushed out to treatment providers that would like to provide the service. I am not seeing any of these traits in the HB340a pilot project.

My other concern in labeling this program a pilot project by the State is the false sense of security this may give to parents and children taking part in the pilot program. When the State labels this program as a pilot program most reasonable parents will think there is oversight, strict guidelines, a new best practice program to be evaluated, and a safe environment for their child. This is not what I am seeing with this pilot program. In the treatment world you would never mix adults and adolescents in any way. Evaluations would be completed by licensed professionals trained in ASAM placement criteria. All staff working in this environment would take and pass the State’s background check. These are basic safety precautions. As basic as putting a young child in a car seat. If you do not abide by basic safety practices you are endangering the lives of children and it is not a matter of if an adverse incident will happen but more of when it will happen.

Bottom line is that labeling HB340a as a pilot project in its current form is misleading. Misleading to parents that will assume there is oversight and safety measures in place to protect their child. Misleading to the treatment world that this is a pilot with measurable goals and objectives to be replicated throughout the State if measured outcomes are favorable when there are no specified clearly defined measured outcomes.

Respectfully,
Darren Richman

Darren Richman
LLC Member / CFO
Ascent Behavioral Health Services
366 SW 5th Ave. Suite 100
Meridian, ID 83642

366 SW 5th Avenue Suite 100 • Meridian, Idaho 83642 • Ph# (208)898-9755 • Fax# (208)898-2544
www.ascentbhs.org
Testimony on House Bill 340aa

Idaho Senate Health and Welfare Committee
March 5, 2020

Chairman Martin, Vice Chair Souza, and Members of the Committee,

Thank you for the opportunity to provide written testimony on behalf of Idaho Parents Unlimited (IPUL) on H 340 which pertains to licensing of temporary substance abuse and alcohol treatment facilities for children between the ages of 13 and 17 years, specifically, a single facility as a pilot project.

Idaho Parents Unlimited is a statewide nonprofit organization that serves as both the Parent Training and Information Center and Family to Family Health Information Center for families who have children with disabilities and special health care needs. This includes providing resources, supports, training, and information to families whose children are experiencing substance use and alcohol related disorders.

Our organization agrees that Idaho is in dire need for more facilities and providers that address these problems for children, and we are grateful that options are being considered for how to make more available. However, we disagree completely with allowing any facility to operate with no licensure standards as it increases risk to these children, their families, the State of Idaho, and the providers, themselves as follows:

According to the National Institute on Drug Abuse (https://www.drugabuse.gov/publications/principlesadolescent-substance-use-disorder-treatment-research-based-guide/treatment-settings) best practice for treating youth with a primary diagnosis of substance use disorder (SUD) is not residential treatment. According to NIDA, “Residential treatment is a resource-intensive high level of care, generally for adolescents with severe levels of addiction whose mental health and medical needs and addictive behaviors require a 24-hour structured environment to make recovery possible.”

4619 Emerald, Ste. E., Boise, ID 83706
TEL: 208-342-5884, 800-242-4785
TDD & FAX: 208-342-1408
Furthermore, without licensure, it may lack the resources or expertise to handle a child whose medical and psychiatric needs are co-occurring with a severe alcohol/SUD putting everyone involved at risk even with parental consent.

The evaluation of program effectiveness is not defined, and because (this) these are supposed to be private pay facilities, there are no guarantees that a parent may find themselves with poor outcomes and no financial recourse.

The proposed legislation lacks protections for parents and youth should there be abuse and/or neglect complaints found after an oversight review which would only occur after three years of implementation of the program. In addition to the serious concerns about what may happen to a child where complaints are found (further medical and psychiatric problems if not worse), there also appears to be no ability to close down such a facility and nothing that would prevent someone from re-opening a facility in a new community under a new name since they would not have had a license revoked as no license was required.

Additional concerns include co-mingling of adults and minors with addictions including adults who are being treated for sexual addictions including pornography addiction. Comingling adults and children as young as 13 years old is dangerous and it is likely to create a repeat of the Jeff D. lawsuit that the State spent 35 years to settle and is still in its implementation process today.

To help avoid such risks to all involved and to ensure the best outcomes for youth entering these facilities, IPUL believes that any in-patient/residential treatment facility for children and youth under the age of 18 that provides treatments and interventions should not have an exemption to licensure and there is simply too much risk involved to even consider piloting such a program.

Thank you once again for the opportunity to present this testimony. We welcome any questions or comments. They may be directed to Angela Lindig, Executive Director at 208-342-5884 x102 or angela@ipulidaho.org.
RE: House Bill 340aa

Senator Fred Martin, Chairman
Senate Health and Welfare Committee
Capitol Building
Boise, ID 83720

Dear Chairman Martin and Committee Members:

The Idaho Caregiver Alliance (ICA) is a statewide coalition of over 700 caregivers, organizations, and agencies working together to raise awareness of the impact of unpaid caregiving by families and friends and to advocate for policies and practices that support family caregivers. While our coalition emphasizes supports in the home and community, we recognize that sometimes the services needed require out of home placement. In those instances, it is important to families of individuals across the lifespan to be able to count on services that meet licensure requirements and standards of care. That is why we are concerned about HB 340aa.

The ICA recognizes the need for treatment programs for Idaho’s youth with alcohol dependency and substance abuse diagnoses. We are pleased to see discussions taking place to address those needs. In particular, we applaud the collaboration between the legislature, the administration, and the judiciary to work together on developing a robust behavioral health system of care (SCR126). This work should result in a roadmap for improved and expanded services for youth and adults with mental illness and substance use disorders with a report that we understand is due this fall.

One of the ICA’s partners is the Division of Behavioral Health within the Department of Health and Welfare. This Division has implemented the Youth Empowerment Services (YES) initiative that is engaging parents, providers and systems to improve and enhance services for youth with behavioral disorders. This effort is aligned with the resolution of the Jeff D. lawsuit which required the separation of youth and adults in treatment facilities in Idaho.

These initiatives show promise for providing evidence-based, quality treatment services to youth with emotional disturbance and substance use disorders but they will require legislative support and funding. It is the ICA’s position that rather than implementing programs that do not require licensing and trained staff, that Idaho policymakers focus on how we can move forward with what is already being done to provide licensed, quality programs that are based on clinical best practice. Passing legislation that allows for the creation of unlicensed residential treatment of youth with these disorders is not the solution. In fact, it opens the door to risk for the children and their families and liabilities for the provider and potentially the state.

The original version of HB340 did include some minimal protections: background checks for staff and volunteers, notification of law enforcement, proximity to a medical facility with emergency capabilities, adherence to health and safety standards, a prescription from a medical doctor stating the child’s need for substance abuse treatment, notification of the child’s school counselor that s/he would be entering the facility, and the consent of the parent or guardian. Now, the Good Samaritan Rehabilitation Program
in Coeur d’Alene is being considered a pilot project and these safeguards, minimal as they are, are gone. We are told they are not needed since the program being granted these exemptions does them as a matter of course. But without oversight, how do we know that?

Pilot projects have rigorous parameters including pre-determined data collection and reporting methods, outcomes based on pre and post-tests, and statistical analysis of findings by an independent entity with recommendations for modification. There is no indication of this kind of oversight for this program. In fact, the only monitoring is a report to a child protection legislative review panel, the first report of which is not until 2023. This lack of oversight of the facility poses not only a risk to the child but provides no means for the parent to know what is really going on with their child’s treatment. What is the parent’s recourse if they should learn of mistreatment, abuse, exploitation, or neglect of their child from as far away as Florida, as was cited by the floor sponsor in the House? They can certainly travel to northern Idaho and withdraw the child from the facility, but the damage may already be done.

In 2019, the State of Montana took action to close a loophole in their law that had permitted residential treatment programs of youth with behavior and other disorders to operate unlicensed if they were affiliated with a church. For many years, there were multiple instances of child abuse in some of these programs but no action could be taken by the state because of the religious exemption. That was addressed last year and the state is now overseeing these programs.

In Idaho, parents are also required to provide an education to their child until the age of 16. The child can be educated in a public or private school or home-schooled. But HB340aa allows for a child, under the age of 16, to be pulled from their regular education setting for a 4-month period without requiring the facility to provide an education for the child during that time. Once again, this denies the child access to education and it also jeopardizes the parents as they are the ones who can be found in violation of the law by placing their child in this facility which does not guarantee an educational curriculum.

Family caregivers in Idaho, particularly those of vulnerable youth, need our support. That means they need quality, licensed services. We have the opportunity to build on the YES programs already underway. Please do not allow unlicensed facilities to provide unlicensed services to Idaho’s children. We respectfully request you to hold HB340aa in committee. Thank you for your consideration of our comments.

On behalf of the Idaho Caregiver Alliance,

Marilyn B. Sword, Coordinator

The following members of the Idaho Caregiver Alliance have opted to take no position or cannot take a position on this bill:

- Molina Healthcare
- Representatives from the Department of Health and Welfare, Divisions of Medicaid, Public Health, Long Term Care, Service Integration, and Behavioral Health
- Representative of the Boise VA Medical Center Caregiver Support Program
- Representative of the Idaho Commission on Aging
- Representative of the Department of Insurance SHIBA Program

The following members of the Idaho Caregiver Alliance do not agree with the position stated in this letter:

- Eric Wallentine
## AGENDA

**SENATE HEALTH & WELFARE COMMITTEE**  
**2:00 P.M.**  
Room WW54  
**Wednesday, March 11, 2020**

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<tr>
<th>SUBJECT</th>
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<tbody>
<tr>
<td><strong>H 497</strong></td>
<td>Relating To The Yellow Dot Motor Vehicle Medical Information Act</td>
<td>Senator Harris</td>
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<tr>
<td><strong>H 538</strong></td>
<td>Relating To Tobacco Products</td>
<td>Erin Bennett, American Heart Association; Corey Surber, St. Alphonsus</td>
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<tr>
<td><strong>H 578</strong></td>
<td>Relating To Health</td>
<td>Senator Den Hartog</td>
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**MINUTES APPROVAL:**  
Minutes of February 12, 2020  
Minutes of February 24, 2020  
Senator Bayer  
Senator Nelson

*If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.*

**COMMITTEE MEMBERS**  
Chairman Martin  
Vice Chairman Souza  
Sen Heider  
Sen Lee  
Sen Harris  
Sen Burtenshaw  
Sen Bayer  
Sen Jordan  
Sen Nelson

**COMMITTEE SECRETARY**  
Mago Miller  
Room: WW35  
Phone: 332-1319  
Email: shel@senate.idaho.gov
DATE: Wednesday, March 11, 2020
TIME: 2:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Martin, Vice Chair Souza, Senators Heider, Lee, Harris, Burtenshaw, Bayer, Jordan, and Nelson
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.

CONVENEDED: Chairman Martin called to order the meeting of the Senate Health and Welfare Committee (Committee) at 2:00 p.m.

Chairman Martin asked Committee Page Lila Pulver to go to the podium, before the Committee moved to the business on the agenda, as the Committee wanted to thank her for her help during the second half of this legislative session. Ms. Pulver expressed her thanks for an amazing experience and said she looked forward to some road trips with friends this summer, a graduation trip with her parents, and attendance at Point Loma Nazarene University to study International Development in the fall. Chairman Martin thanked her for her help and wished well in her studies at Point Loma.

H 497AA Senator Harris presented H 497aa, relating to the Yellow Dot Motor Vehicle Medical Information Act. He stated that this bill would help emergency responders identify persons in need of medical help and provide prompt care in the event of an accident. He said the program would be housed in the Department of Health and Welfare, Emergency Medical Services Bureau.

Senator Harris described how the program would work: citizens who choose to participate fill out a medical form with their photo ID which is kept in the glove compartment of their vehicle and a yellow dot sticker is placed in the back window of their car. If they get in an accident and an emergency responder sees the yellow dot on the window, the emergency responder is authorized to look in the glove compartment for the medical information. Senator Harris noted two important points: this holds responders harmless for information they learned from the medical form, and it ensures that law enforcement can't use the yellow dot for a probable cause to stop vehicles. Senator Harris requested approval for H 497aa.

DISCUSSION: Senator Bayer and Senator Harris discussed the reason for the House amendment; it was to prevent law enforcement from using the yellow dot as probable cause to stop a motor vehicle.

In response to Vice Chair Souza, Senator Harris discussed funding, including as outlined in Idaho Code § 39-4704(2) and with federal highway safety funds.

In response to Senator Jordan, Senator Harris explained that if the first responder doesn't see a yellow dot, he continues as if there were none. But if he does see a yellow dot, he will know to look in the glove compartment of the
vehicle for medical information.

**Senator Lee** relayed that she had asked some of her local law enforcement about the helpfulness of the yellow dot in the case of a crash. She related that first responders change the way they approach a vehicle if there is a yellow dot in the window. For example, what might appear to be a drunk driver may turn out to be a diabetic who is having an insulin issue. It gives an awareness to law enforcement that the driver may have a medical condition rather than being noncompliant.

**Senator Nelson** asked about issues with mistaken identity, and **Senator Harris** explained that was the reason for a photo ID on the medical form in the yellow dot medical packet kept in the vehicle.

**MOTION:** **Senator Heider** moved to send H 497aa to the floor with a do pass recommendation. **Senator Lee** seconded the motion. The motion carried by voice vote. Senator Harris will carry the bill on the floor.

**H 538**

**Erin Bennett**, government relations director for the American Heart Association and American Stroke Association in Idaho, presented H 538. She said H 538 seeks to bring parity to tobacco products and electronic smoking devices. She stated that currently, electronic smoking device retailers are not held to the same requirements as tobacco retailers, and there isn't a way to ensure the electronic smoking device retailers are not selling to minors in Idaho. This bill doesn't change the way the current system works, but it includes those electronic smoking devices in the definition and in the permitting process. This bill applies the same standards that are put on current traditional tobacco products, to the electronic smoking devices. **Ms. Bennett** requested the Committee send H 538 to the floor with a do pass recommendation.

**DISCUSSION:** **Vice Chair Souza** and **Ms. Bennett** discussed the problem of not knowing how many vaping shops there were in Idaho and if this bill would help resolve that issue. **Ms. Bennett** explained that H 538 would help the state learn how many vaping shops were in Idaho through the permitting process. **Vice Chair Souza** thanked Ms. Bennett for bringing this bill and commented on the cultural change facing the youth.

**Senator Harris** asked who would regulate the sale of electronic smoking devices and if local ordinances would be affected. **Ms. Bennett** replied that currently, the State, through the Department of Health and Welfare, regulates the permitting process under the Tobacco Project. That would not change, and local ordinances would not be affected.

**Senator Heider** asked about controlling the issue of shipping to minors from internet orders and the types of civil and criminal penalties. **Ms. Bennett** explained third party identification and background checks included for age and identity and federal oversight and guidelines. She said the language is being changed to include electronic smoking devices; the penalties aren’t being changed.

**Senator Burtenshaw** and **Ms. Bennett** discussed the definitions of tobacco and nicotine seeking to ensure both are included in this bill. **Ms. Bennett** stated there's no restriction on how much or how little nicotine, and there are no real labeling requirements on those products, and it varies by brand and different type of device that's being used. She directed the Committee to page 3, line 32, which included the language, "tobacco or nicotine intended for human consumption," in an effort to capture both products.
TESTIMONY: Corey Surber, Director of Advocacy for the Saint Alphonsus Health system, testified in support of H 538 and on behalf of a broad coalition which included the American Heart Association, American Lung Association, United Way, St. Alphonsus, St. Luke's, Idaho Oral Health Alliance, Idaho State Dental Association, Idaho Society for Clinical Oncology, Boise State University, and Tobacco Free Idaho Alliance. She referred to Dr. Bonnie Halpern-Felsher's presentation on vaping (February 4, 2020) and the harmful effects of vaping, including the rewiring and changing of the brain if introduced before age 18. Most adults who use vaping to quit cigarettes actually end up switching, not quitting. Youth statistics show a decline in cigarette smoking but a drastic increase in vaping. She urged support of H 538.

DISCUSSION: Ms. Bennett concluded her remarks saying that online retailers run a background check on the person ordering. This has forced the State permit process. She explained the bill doesn't touch local ordinances and doesn't seek to prevent local ordinances from being enforced. Only three cities in Idaho have smoke-free ordinances, and only Boise has already incorporated electronic smoking devices into that particular ordinance.

TESTIMONY: Pam Eaton, President and CEO of the Idaho Retailers Association (IRA), spoke in support of this bill and parity. She said there was a missing part of the parity issue, and that was the uniformity in laws. She clarified that the IRA would support this law with an amendment to require State regulation to ensure all retailers across Idaho operate under uniform laws. For example, it's important that stores in Meridian will have the same rules as stores in a different community.

DISCUSSION: Senator Jordan asked about finding parity between tobacco sales and vaping laws. Ms. Eaton said the amendment doesn't affect the Clean Air Act or planning and zoning. It does affect the regulations, taxing, permitting, and other basic regulations of how tobacco is sold in the retail market. She stated they were trying to keep laws even across the board.

MOTION: Senator Harris moved to send H 538 to 14th Order of Business for possible amendment. Vice Chair Souza seconded the motion.

SUBSTITUTE MOTION: Senator Nelson moved to send H 538 to the floor with a do pass recommendation. Senator Jordan seconded the motion.

DISCUSSION: Senator Lee would like to revisit this in a year. She said she was appreciative of the intentions but was concerned with parity and consideration of the master tobacco settlement program.

Senator Nelson spoke to his substitute motion and his belief that the language in H 538 is adequate.

Senator Jordan spoke to the substitute motion in agreement with Senator Lee.

ROLL CALL VOTE: Chairman Martin called for a roll call vote on the substitute motion. Senators Heider, Lee, Burtenshaw, Jordan, Nelson, and Chairman Martin voted aye. Senators Harris, Bayer, and Vice Chair Souza voted nay. The motion carried. Senator Lee will sponsor the bill on the floor.
Senator Den Hartog presented H 578, relating to health. This bill is also known as Simon’s Law. She said the bill does not try to solve a problem but tries to prevent a problem from occurring in Idaho. Under existing Idaho law, Idaho physicians, following a hospital futility policy, can place a do-not-resuscitate (DNR) order in a child’s file and withhold lifesaving, life-sustaining treatment, hydration, and nutrition, without informing the child’s parent(s). She explained that this legislation seeks to require parental notification rather than parental consent. A parent would have 48 hours to request transfer to another facility. The family would then have 15 days to complete the transfer. She stated there are a handful of other states that have passed similar legislation and that 17 other states require parental consent of the DNR order, not just notification. Senator Den Hartog concluded that this bill strikes a balance between parental involvement and physician’s best practice.

TESTIMONY: Those testifying in favor of H 578 included: Dr. Tim Johans, a local neurological surgeon specializing in spine and brain surgery; Blaine Conzatti, Director of Family Alliance of Idaho; Christian Welp, representing the Catholic Church in Idaho; Lindsey Zea, reading a letter from Scott Showalter, General Pediatrician, who couldn’t attend today; Jackie Wakefield, legislative assistant for Right to Life, Idaho, on behalf of Carey Willincott; Sandi Enzminger; and Esther Enzminger on behalf of Mrs. Kristen Bolton of Boise.

Those testifying in opposition to H 578 included: Whitney Price, licensed clinical social worker, working with children’s palliative care, reading a letter from Dr. Zach Erickson, palliative care physician; and Bob Aldrich, attorney, who asked the Committee to hold the bill because of the language, "against medical advice," which stops payments by insurance companies.

Senator Den Hartog concluded her presentation citing Idaho Code § 39-4506, which outlines the process for consent but doesn’t see it as creating conflict.

DISCUSSION: Senator Jordan referred to page 2 of the bill, lines 12-16 and asked for the definition of "diligent efforts." Senator Den Hartog responded that a reasonable person standard would probably suffice, but she is not an attorney. Blaine Conzatti, Director of Family Alliance of Idaho, answered the question on "diligent efforts" by explaining that those words are defined by the community standard around them.

MOTION: Senator Bayer moved to send H 578 to the floor with a do pass recommendation. Senator Lee seconded the motion.

DISCUSSION: Senator Jordan stated the bill needed a little more work and that she was concerned about unintended consequences.

Chairman Martin commented that everyone wants the same outcome, and no one takes this difficult decision lightly.


MINUTES APPROVAL: Senator Bayer moved to approve the Minutes of February 12, 2020. Senator Nelson seconded the motion. The motion carried by voice vote.

Senator Nelson moved to approve the Minutes of February 24, 2020. Senator Lee seconded the motion. The motion carried by voice vote.

ADJOURNED: There being no further business at this time, Chairman Martin adjourned the meeting at 3:52 p.m.