MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 10, 2016

TIME: 9:00 A.M.

PLACE: Room EW20

MEMBERS: Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Romrell, Vander Woude, Beyeler, Redman, Troy, Rusche, Chew

ABSENT/ EXCUSED: None

GUESTS: Christine Hahn and Michael Farley, IDHW; Lori Wolff, Russ Barron, and Gary Moore, DHW.

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

MOTION: **Rep. Hixon** made a motion to approve the minutes of January 28, January 29, and February 3, 2016. **Motion carried by voice vote.**

Dick Armstrong, Director, Department of Health & Welfare (DHW) presented the 2017 DHW budget.

Medicaid continues to be the highest costing program. The welfare program budget request is increased to include possible PCAP funds. Trustee and benefits remains 85% of the total $2.78B requested funds.

The workforce had a turnover spike of 15.2%, the highest in ten years. Exit interviews identified pay as a main or contributing factor. An employee engagement survey was conducted. Ratings improved on 46 of 59 survey items, with a decline in two areas. The highest rated response was "my work is important to me personally."

With a state unemployment rate under 5% and a lot of employers seeking skilled employees, the DHW has become a training center. An additional 3% change in employee compensation with the state pickup of employee benefits should help drop the turnover rate.

The state healthcare innovation plan (SHIP) has received an overwhelming response from primary care clinics applying to convert to the patient centered medical home model (PCMH). Fifty-five practices from the seven regional health districts have been selected.

The Medicaid supported living lawsuit requested higher provider reimbursement. In agreement, the district court raised the Medicaid provider rates up 85% in April 2012. When the U.S. Supreme Court, in April 2015, overturned the previous ruling, the Centers for Medicare and Medicaid Services (CMS) wanted an estimated $55M from provider overpayments. Negotiations with CMS approved reinstatement of the 2012 rates at a future date.

Providers were notified that rates would be rolled back beginning January 2016. Responding to provider concerns, Medicaid implemented temporary rates effective February 1, 2016, and is doing a cost analysis for all 63 agencies to establish appropriate rates. This survey and analysis will take about six months. If the temporary rates are 5% greater or lower than those determined from the survey, there will be a reconciliation to February 1, 2016.

Because Medicaid will not have final budget estimates until the rate study is completed and implemented, the originally planned $10M slated to revert to the state is being held. This will assure people with disabilities continue to receive their quality of care until everything is balanced again.

Fiscal year (FY) 2017 budget priorities include the Primary Care Access Program (PCAP), a three-year plan to modernize the child support system, a third community crisis center, addressing psychiatric hospital safety issues, and child and adolescent needs (CANS) assessment tools for schools, correctional institutions, and providers.

PCAP is not insurance or entitlement. Individuals remain eligible by sharing in costs and actively participating in their care plans. The program will help moderate the state and county indigent program impact without replacing them. Start up is scheduled for January 1, 2017, following the multi-day food stamp roll out. Enrollment will be coordinated with the health insurance exchange open enrollment to identify persons eligible for PCAP. The first year budget request is $19.3M. Due to the late start, costs will be for only half of a year. The full year projected costs are $30M, with personnel and operating costs of $1.3M.

Funding for a third community crisis center is requested. The crisis centers have proven to provide a safe, voluntary, effective, and efficient alternative to emergency rooms and jails.

The Northern Idaho Community Crisis Center opened in December, 2015, in Coeur d'Alene and has served 190 patients, discharging 94% with safety plans or referrals. Law enforcement referred 25 patients and hospitals referred 22 patients. The rest were patients brought in by family members or on their own.

The Eastern Idaho Crisis Center opened in December, 2014 and has serviced 2,349 patients. Law enforcement referred 259 patients, saving officers nearly 1,200 hours. Hospitals referred 228 patients. The average level of stay for admissions is 14 hours 39 minutes.

Child support modernization is a means to provide families with economic security, lessening the need for other services. Idaho requires single parents applying for public assistance to open a child support case, if one is not already established. Modernization will take three years to complete the various stages. There is a 66% federal match for the project. The General Funds request is $2.7M for the first year. The total project cost of $24M includes $8.2M in state funds.

Higher patient BH acuity, with demonstrated criminal thinking, requires more one-to-one staffing to protect both patients and staff. These patients are often deemed incompetent to stand trial. The three state prison beds used for extreme cases are always occupied. The DHW budget requests twelve additional safety staff, six to each hospital. A future Idaho forensic facility continues to be discussed.

The CANS instrument is a researched, industry accepted screening tool to identify needs and strengths for children and families. It develops individualized service plans used by schools, juvenile justice, child welfare, and mental health providers. This has been negotiated as part of the Jeff D settlement agreement. The tool is free, but there is a $1.1M one-time set-up cost and $200k annual maintenance cost.

Responding to committee questions, **Lisa Hettinger**, Division Administrator, Medicaid, said she would provide the per member per month cost breakdown to the committee. The pharmaceutical expenditures have increased across the nation as a result of increased generic prices and new extremely expensive speciality drugs.

Answering committee questions, **Director Armstrong** stated the suicide prevention plan establishes an state program office in the DHW public health department, providing a focal point. Existing data already pinpoints which junior and senior high schools are most at risk, so they can begin their programs there.

Unable to qualify for Medicaid, low income adults are dependent upon DHW clinics, crisis centers, charitable services, or nothing at all. With Medicaid coverage they would have all services reimbursable under the current Medicaid benefit structure. The recommended use of the insurance exchange assures the insurance providers have parody between regular medicine and MH care.

Answering committee questions, **Director Armstrong** said the BH Department has isolated funds for limited treatment for non-criminal justice individuals, before they end up in the criminal justice system.

A PCAP impact is expected for both the CAT and indigent funds, including a PCMH assignment for post-discharge care.

The Navigator website, which has existed for seven to eight years, connects persons with resources, without the resource originator's involvement. This program can be used statewide and eventually link with PCAP enrollees.

Equally important to extended clinic hours are open daytime appointment slots for immediate acute care. The clinics will provide primary care support services within their normal scope of practice.

Answering further committee questions, **Director Armstrong** said generic pharmacy generic rebates exist to a limited degree. Brand name pharmaceuticals offer the greatest rebate as a marketing strategy. When faced with expensive pharmaceuticals, consultation with the medical community verifies medical use necessities and any alternative drugs.

Ross Edmunds, DHW, further responded to a committee question. The Children's MH Program reverts funds to the state because the program structure does not maximize funding. An ongoing MH treatment system will save law enforcement costs and connect patients to primary care specialty networks.

Crisis center sustainability requires cost sharing, sliding fee scales, and other avenues to achieve 50% local funding. Patients are referred back to BH clinics for ongoing treatment.

ADJOURN: There being no further business to come before the committee, the meeting was adjourned at 10:38 a.m.

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Representative Wood	Irene Moore
Chair	Secretary