MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, January 18, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
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 Heider** called the meeting to order at 3:00 p.m.

PRESENTATION: **Chairman Heider** introduced Richard Armstrong, Director of the Idaho Department of Health and Welfare (Department), to present a public health update (see Attachment 1). **Director Armstrong** introduced Dr. Christine Hahn, State Epidemiologist and Public Health Director, and Elke Shaw-Tulloch, Administrator of the Division of Public Health, as co-presenters. **Director Armstrong** informed the Committee public health impacts everyone, from restaurant food safety, to vital statistics records of births, marriages, and deaths. The Division of Public Health coordinates medical services throughout Idaho, maintains a universal vaccination program, and operates a radio communication system to contact any emergency vehicle wherever it might be. Public health measures have added 25 years to life expectancy. In 1900, a woman had a life expectancy of 48 years and 48 years for a man. In 2000, life expectancy has increased to 79 years for a woman and 74 years for a man. The U.S. experienced a slight decline in life expectancy last year for the first time, and this is somewhat concerning. Overall mortality rates have declined primarily because of the control of infectious diseases.

Dr. Hahn stated this year's flu season has already resulted in ten deaths and possibly seven more in the last week and a half. Hospitals, emergency rooms, and long-term care centers report people are presenting with flu symptoms. Idaho flu vaccination rates are among the lowest in the United States. Only 39 percent of Idaho residents receive a flu shot. Challenges arise because of a number of myths about the flu vaccine. For example, some believe the flu vaccine can give someone the flu, but it's not possible because there are no live viruses in the vaccine.

Dr. Hahn explained the flu is different from a cold, and even if the vaccine is not 100 percent effective, a person can be less sick and return to work more quickly. She did her infectious disease training at Duke University and started getting a flu shot then because it decreased the chance of her infecting patients with compromised immune systems. It takes two weeks to develop immunity so it is possible to get the flu even after receiving the vaccine. However, the vaccine helps prevent people from spreading the flu. If everyone around is immunized, it won't spread to the unimmunized. This is called "herd immunity." However, if not enough are immunized, then it will continue to spread in the population.

Dr. Hahn informed the Committee another concern about vaccines is a belief they cause autism. The medical journal article published in 1997 making that correlation was since retracted by the journal. The physician author of the article lost his medical license, and all other coauthors withdrew their names. Other studies have been done and found no correlation. Autism Speaks has issued a statement that vaccines do not cause autism and resources should be expended looking for other causes. In addition, some people believe natural immunity is better than vaccinated immunity. While that is sometimes true, a disease can cause death or other complications, and vaccines help protect children and adults from those complications.

Dr. Hahn provided information about the Idaho Immunization Program which distributes vaccines to doctors and nurses and maintains the registry to track the different immunizations. Parents have a right to exempt children from immunizations for medical, religious, and philosophical reasons. A parent can request a conditional admission to school, allowing the child to attend until immunizations are received. A doctor must complete the Department's exemption form in the case of a medical exemption. Religious and philosophical exemptions can be made by the parent. The form (see Attachment 2) helps school administrators track the exemptions and provide statistical information to the Department. If there is an outbreak, some exempted children may need to be pulled out of school so they don't contract the disease. For example, there are presently 179 unimmunized students out of school in Spokane, Washington due an outbreak of mumps.

Dr. Hahn advised the Committee some counties have very high immunization rates and some have higher exemption rates. The most common vaccine parents request exemption from is varicella (chicken pox). This information is important because outbreaks continue. Idaho has had a case of tetanus and cases of mumps. Sometimes the public is not aware this is happening because information does not always get out in the news due to privacy concerns. The "Disneyland measles outbreak" in California is another example, and Utah had several cases of measles. There was a meningitis outbreak in Oregon and one case in Idaho in the last year. California also had a terrible whooping cough outbreak. As a result, California recently eliminated all immunization exemptions except those for medical reasons. Oregon requires a parent to watch a series of educational videos in order to get an exemption.

Vice Chairman Souza stated she has heard there have been a few cases of polio and tuberculosis in the U.S. and wondered whether Idaho will see an increase in communicable diseases with people now entering the country from war-torn areas where services are not available. **Dr. Hahn** answered the refugee health screen clinic is under the Division's purview, and she personally works at the tuberculosis clinic twice a month. Refugees are intensely screened and rescreened again within 30 days. She finds they want to receive immunizations and medication and has no concerns about them. However, with undocumented immigrants, there are no guarantees, and better systems are needed to monitor that population.

Director Armstrong said Idaho Code § 56-1003 mandates the Department to supervise the promotion and protection of the life, health, and mental health of Idaho citizens. It is important to find a reasonable balance between an individual's freedom and public safety. There is now a shift away from loose exemptions to absolute exclusion of an exemption. He wants to keep a level eye and not swing to the more restrictive side, and he willing to engage with anyone on the best way to strike that balance.

Chairman Heider thanked Director Armstrong for explaining the issues and mentioned some members of the Committee have been approached by constituents about them. **Senator Martin** asked if Idaho is statistically within the "herd rate" for disease. **Dr. Hahn** said the immunization rate for polio is 90 percent but other diseases such as pertussis are not at a herd protective rate. Some of the vaccinations now are right at the protective rate and are in danger of falling below. **Senator Martin** sits on the Immunization Assessment Board and has heard that dosages may be a problem. He asked Dr. Hahn to speak to that issue. **Dr. Hahn** replied she has heard this, too. People are used to the idea that it's important to take the lowest dosage possible to have an effect and the immunization dosages are too high. However, the dosages are based on research, and if the dosages for immunizations are reduced, it is unknown whether they will be strong enough to provide immunity. **Senator Foreman** complimented the Department on its enlightened approach to letting people opt out of immunizations and account for competing interests in a professional and workable way. This approach distinguishes Idaho from other states.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.

DOCKET NO. 16-0309-1601 **Medicaid Basic Plan Benefits. Tiffany Kinzler** introduced herself as the Bureau Chief for Medical Care at the Division of Medicaid. The pending rule docket clarifies requirements for ordering and prescribing home health services and durable medical equipment (DME) and ensures compliance with federal regulations. The rule changes clarify these services can be provided in any setting in which normal life activities take place, other than a hospital, intermediate care facility for the intellectually disabled, or nursing facility. The pending rule aligns IDAPA Medicaid rules with federal regulations. The changes have already been implemented by Medicare. **Ms. Kinzler** explained home health services include nursing and aide services, physical and occupational therapy, speech-language pathology services, and audiology services. Home health services are generally provided in the Medicaid participant's home. Durable medical equipment includes items such as crutches and walkers, manual and electric wheelchairs, ventilators, monitors, pressure mattresses, shower chairs, and nebulizers. This equipment is designed for repeated use by individuals with disabilities, injuries, or illnesses. A simple item such as a walker can make the difference between a participant being bedridden and being able to move freely around the home or community.

Ms. Kinzler informed the Committee for services to be covered by Medicaid using federal matching dollars, the service or item must be: 1.) medically necessary to meet the needs of the participant as provided in IDAPA; 2.) ordered based on a face-to-face assessment completed by the participant's primary care provider; 3.) provided under an individualized plan of care developed by the licensed, qualified professional who established the plan; and 4.) signed by the participant's physician. The pending rule: 1.) expands the types of practitioners allowed to complete and document the face-to-face encounter with the participant; 2.) clarifies who can order home health and DME services and supplies; 3.) clarifies the interval at which the plan of care is reviewed; 4.) updates and clarifies references, requirements, and definitions in response to provider concerns and questions about rule requirements; 5.) allows for coverage of services delivered by telehealth methods when appropriate; and 6.) shifts prior authorization requirements from rule to the provider handbook to ensure a more timely and effective response to changes.

Ms. Kinzler advised the Department has worked closely with the Idaho physician assistant, nurse practitioner, primary care, and medical associations as well as therapy and DME providers to develop the rule. The Department held hearings across the state, received several comments, and revised the rules to meet those concerns to the extent possible under the statutes and federal regulations. The Department has standing meetings with the various associations and provider groups and will continue to work with them to address implementation of the rules. **Ms. Kinzler** requested the Committee approve the docket with an effective date of July 1, 2017.

Vice Chairman Souza asked Ms. Kinzler to review the significant changes to the rule. **Ms. Kinzler** explained Section 004.04 updates an incorporation by reference to add a live link to the CMS/Medicare DME Coverage Manual. This change is very important because the manual is developed and updated quarterly, and it would be very quickly out of date otherwise. The manual describes the services most likely to improve the medical condition of an individual. It is available online, but the entire document is not printed in the rule. The second significant change is on pages 80 and 81 of the pending rule book pertaining to home health services. These sections have been updated to align with federal regulations. Everyone is working hard to make sure people have the choice to live in the least restrictive environment while keeping them safe. Currently, a physician must sign the home health and DME order. Due to a lack of medical providers in some parts of Idaho, the rule would add physician assistants, nurse practitioners, and midwives to the list of practitioners who could conduct the face-to-face encounter. The rule would also allow the encounter to take place via telehealth.

Vice Chairman Souza asked for clarification whether nurse practitioners and physician assistants work under the direction of a physician. **Ms. Kinzler** replied nurse practitioners can work alone without physician oversight in Idaho. In reality, many physician assistants also work that way because Idaho is a shortage area and there are not enough primary care providers.

Senator Martin thanked Ms. Kinzler for including the date of the manual in Section 004.04.

Senator Martin asked whether the telehealth approach is working and how that is accommodated. **Ms. Kinzler** answered the Division of Medicaid has not exactly defined how telehealth works because the various medical boards have defined those rules. Medicaid is willing to reimburse for telehealth services. If a nurse practitioner is providing the face-to-face encounter, the telehealth process would include the participant, the primary care provider, and the physician providing the signature. **Senator Martin** further inquired whether telehealth is working. **Ms. Kinzler** responded the Division of Medicaid does not have any data on the use of telehealth. She would be happy to research and provide information to the Committee. **Vice Chairman Souza** thanked Ms. Kinzler and stated the Committee would appreciate having that information.

Senator Lee asked why the rule changes include two definitions of home health services in two sections and whether there are any implications in how payments would be made by changing the definitions. **Ms. Kinzler** reported the changes in both sections are almost word for word out of the federal regulations. The definitions have changed dramatically because the goal is for a participant to be able to receive care in any place where normal life functions.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket 16-0309-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0309-1602

Medicaid Basic Plan Benefits. Ms. Kinzler explained the purpose of this docket is to align IDAPA rule language and definitions with new federal regulations at 42 CFR 447 which represent the Center for Medicare and Medicaid Services (CMS) adoption of the actual acquisition cost pricing methodology. These rules clarify reimbursements to pharmacies and 340B-covered entities for physician-administered drugs. To determine the Actual Acquisition Cost (AAC) for each drug, the Department conducts an annual state cost survey called a rebase. All Idaho Medicaid pharmacies are required to participant in the cost survey. Each pharmacy must disclose the actual acquisition cost of all drugs. The result of the AAC survey is used to establish the pharmacy reimbursement fee schedule.

Ms. Kinzler informed the Committee there are two types of pharmacies for Idaho Medicaid. Most pharmacies are retail pharmacies. When a retail pharmacy submits a claim to Idaho Medicaid for dispensed prescriptions, Idaho Medicaid is allowed to collect a rebate from the drug manufacturer to offset the retail cost of the pharmaceutical supply. These rebates significantly reduce the actual cost of drugs dispensed to Idaho Medicaid participants. The second type of pharmacy is called a 340B entity. These pharmacies purchase drugs at a discounted rate which is roughly equivalent to the average manufacturer's price minus the Medicaid rebate amount; this results in a significant savings to the 340B entity. Ultimately, this discounted price is passed on to Idaho Medicaid when the 340B covered entity submits claims at no more than their 340B actual acquisition cost. Entities such as hospitals and community clinics can participate in the 340B program which is administered by the Health Resources and Services Administration, also known as "HRSA." The 340B Program is designed to help covered entities stretch scarce Federal dollars as far as possible so they can serve more patients and provide more comprehensive services. The 340B entity can choose to serve Medicaid patients or only non-Medicaid patients with their 340B drug stock. The entity's decision determines how they must enroll with Idaho Medicaid and how they price and bill their drug claims.

Ms. Kinzler stated the rule changes specific to 340B entities clarify: 1.) the provider's enrollment requirements, including the disclosure of their 340B status; 2.) the provider must disclose if Idaho Medicaid participants will be given 340B-acquired drugs; and 3.) claim pricing must not exceed actual acquisition cost plus the pharmacy's professional dispensing fee. Additionally, the proposed rules clarify how physician-administered drugs are priced and reimbursed and ensure Idaho Medicaid IDAPA rules are in alignment with federal regulations. The Department has worked closely with the Idaho Pharmacy, Primary Care, Hospital, and Medical Associations to develop these rules and provided opportunity for input by conducting hearings across the state. They received several comments and revised the rules to meet any concerns to the extent possible under the statutes and federal regulations. The Department meets regularly with each of these associations and the providers they represent and will continue to work with them to address implementation of the rules. The effective date of the docket would be July 1, 2017.

Senator Martin noted the effective dates are the same for both this docket and the previous docket and asked how many people attended the public hearings or called in about the docket. **Ms. Kinzler** replied it was a handful, no more than four people at any of the hearing sites. The Department received written comments from the groups before and after the docket was published. In total, there were eight to ten comments on each docket. **Vice Chairman Souza** inquired whether non-340B pharmacies also have the discretion whether or not to take Medicaid orders in the same manner as 340B pharmacies. **Ms. Kinzler** explained 340B pharmacies specify upon enrollment in HRSA whether or not they will use their drug supply for Medicaid participants. Retail pharmacies have the choice not to serve a Medicaid participant, but don't have to track whether or not the drugs are 340B. **Vice Chairman Souza** asked whether retail pharmacies would take a loss if they buy drugs at a different rate and sell to Medicaid patients. **Ms. Kinzler** replied she did not know how to answer the question. Retail pharmacies bill their actual acquisition cost, the Division pays according to statute, and the payment is based on the actual acquisition cost for the drug in the market. The pharmacies receive a dispensing fee in addition to the cost reimbursement.

Senator Harris referred to the last sentence of Section 665 that states, "Reimbursement is restricted to those drugs supplied from labelers that are participating in the CMS Medicaid Drug Rebate Program." **Senator Harris** inquired whether it is difficult for labelers not participating in the CMS drug rebate program to sign up to participate and whether there are a lot of labelers not participating. **Ms. Kinzler** answered she does not know how many do not participate in the Medicaid drug rebate program, but they have multiple manufacturers in every drug class that participate. It is the same rule as with Medicare. **Ms. Kinzler** offered to get more information for the Committee. **Senator Lee** stated there are a lot of definitions in the DME section and asked whether the 2016 rule changes increased any flexibility for the Division or improved services for rural Medicaid patients. **Senator Lee** said in her district there are some rural areas where Medicaid patients appear to be better served by purchasing through the State DME. **Ms. Kinzler** answered she does not have any specific information but they have also heard stories that services are easier to access since the 2016 rule changes.

MOTION: There being no more questions, **Senator Foreman** moved to approve **Docket No. 16-0309-1602. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0310-1601 **Medicaid Enhanced Plan Benefits. Sheila Pugatch** introduced herself as Bureau Chief for the Bureau of Financial Operations in the Division of Medicaid, Department of Health and Welfare. The pending rule aligns Idaho rules with recently-modified federal law regarding hospice reimbursement. Because Idaho Medicaid must follow the federal law regarding hospice reimbursement, the Division did not go through negotiated rulemaking. There was a public comment period and a public hearing was held on June 13, 2016, but they did not receive any comments on the rules. The effective date of this rule was January 01, 2016.

Ms. Pugatch explained hospice is a service when a participant needs supportive care in the final phase of a terminal illness. It focuses on comfort and quality of life, rather than a cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. This rule implements two different payment rates for routine home care resulting in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for the 61st and higher days of hospice care. These differing payment rates more accurately align per-diem payments to appropriately pay for the cost of providing care based on visit intensity. In addition, the rule implements a service intensity add-on payment for hospice care provided in the last seven days of life of a Medicaid participant if certain criteria are met. This add-on payment is in addition to the per-diem rate for routine home care and encourages increased patient visits by the hospice provider when more resource-intensive patient needs typically occur.

Senator Martin noted the rule references payments made as of January 1, 2016 and asked, if the rule was effective January 1, 2016, why the Committee is seeing the rule now instead of one year ago. **Ms. Pugatch** answered the Department's claims processing system had to be updated, and it took some time to make the changes. The rule promulgation process also was lengthy. **Senator Martin** asked for clarification that the Committee was being asked to approve a rule that has been in effect since January 2016. **Matt Wimmer,** Administrator for the Division of Medicaid, was recognized to respond to the question. **Mr. Wimmer** replied the changes were part of MACRA, the Medicaid Access and CHIP Reauthorization Act, passed late last year. The changes came in fairly late. At the same time, because it was a change to federal statute, they were required to comply quickly. The docket was adopted as a temporary rule with an effective date of January 1st for that reason. **Senator Agenbroad** asked Ms. Pugatch if the retroactive rule would have any financial impact and whether there would be billings going back to that date. **Ms. Pugatch** replied there is a small fiscal impact of approximately $213,000 per year. **Senator Agenbroad** inquired how much of that amount is the result of going back to 2016 as opposed to having an effective date of 2017. **Ms. Pugatch** answered it is an annual fiscal impact so it goes back to January 1, 2016. For the full year, it would be $213,000.

Senator Lee inquired about the impact of the 60-day gap provision on recipients who were home, then went into a hospital and returned home. She noted it could be a significant change in the expected reimbursement, and it might have an effect on decisions made had participants understood this rule. **Senator Lee** asked whether the Division anticipates a number of folks will be affected, particularly with the 2016 effective date. **Ms. Pugatch** responded she does not. The reimbursement rate for the first 60 days in Ada County is $182 and for 61 plus days the rate is $143.09 per day. The average time a Medicaid participant stays in hospice care is about 60 days. **Senator Lee** asked if the reimbursement rates are different by county. **Ms. Pugatch** replied the rates are broken out between Franklin, Kootenai, Nez Perce, Bannock, Bonneville, Butte, Jefferson, Ada, Boise, Canyon, Gem, and Owyhee Counties. There is a different rate for the other counties that are all rural. **Vice Chairman Souza** inquired why there is a difference county to county. **Ms. Pugatch** responded the Division of Medicaid is following Medicare reimbursement methodology, and Medicare has dictated the reimbursement rates are different based on county divisions. **Senator Foreman** asked whether the term "rate for which the participant is qualified" could be changed to "reduced rate." **Ms. Pugatch** answered it may not be a reduced rate; it depends on the county where the participant is being served.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 16-0310-1601. Chairman Heider** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0318-1601

Medicaid Cost Sharing. Elizabeth Kriete introduced herself to the Committee as Bureau Chief for the Bureau of Long Term Care for the Division of Medicaid. **Ms. Kriete** informed the Committee the Department elected to move this rule change forward as temporary, in order to secure an appropriation for the change during the 2016 session. The temporary rule has been in effect since July 1, 2016. **Ms. Kriete** explained a Medicaid waiver is a mechanism that allows states flexibility to administer health insurance for specific populations with specific eligibility criteria, which includes applying different methods for income counting and cost-sharing. Idaho waivers provide long term services and support to maintain individuals with special health needs in their home or community, rather than in an institution, such as a nursing facility. Benefits of Idaho waivers include increasing participants' quality of life, enhancing community integration and decreasing costs to the state.

Ms. Kriete reported advocates for Idaho residents with disabilities, including representatives from DisAbility Rights Idaho, requested the Department review the personal needs allowance amounts used in the financial eligibility calculation for Medicaid waiver participants who are responsible for their own rent or mortgage expenses. The purpose of the personal needs allowance is to ensure that waiver participants living in the community have sufficient funds remaining for basic housing expenses after contributing their share of cost for Medicaid waiver services. The personal needs allowance amount is based on a participant's marital status and legal obligation to pay rent or mortgage and is deducted from their countable income. The federal Supplemental Security Income amount, also known as "SSI", is adjusted annually by the Social Security Administration to account for cost of living increases. The Department has determined that the adjustment has not kept pace with the increase of housing and utility expenses in Idaho. These rules increase the personal needs allowance from 150% of SSI, equivalent to $1,100 per month, to 180% of SSI, or $1,319 per month, for eligible waiver participants who incur a rent or mortgage expense.

Ms. Kriete advised the impact to the state general fund is projected to be a total of $443,377 per year for the approximately 2,700 Medicaid waiver participants who live in their own homes. The funds necessary to cover this increase were appropriated during the 2016 Legislative session and on an ongoing basis starting in Fiscal Year 2017. The Department held a negotiated rulemaking session on July 21, 2015, as well as public hearings on June 10, 2016 in Boise and Lewiston and on June 22, 2016 in Idaho Falls. The Department received a total of 14 comments, all in favor. Despite carrying a fiscal impact, Medicaid waiver participants who reside in their community will be better able to afford living expenses and remain out of high cost institutions, saving taxpayer money and improving quality of life.

Vice Chairman Souza invited questions from the Committee. **Senator Lee** thanked Ms. Kriete for the Department's work to be inclusive with changing the rules. She asked to be reminded of the actual amounts resulting from the changes. **Ms. Kriete** replied the estimated amount of the allowance increase will be about $219 per month. **Senator Lee** inquired when the rates were last increased. **Ms. Kriete** answered the last time the rate was changed was 1999.

TESTIMONY: **Vice Chairman Souza** invited testimony from attendees. **Randall Nilson** introduced himself to the Committee to speak in support of the docket (see Attachment 3). He has been a Medicaid participant since 2007 and worked for the State Tax Commission for 26 years. **Mr. Nilson** explained he has been in a wheelchair since 1991 and continued to work for 20 years. He was under a workers with disabilities program for five to six years and he paid a low premium for his Medicaid services. He must have assistance at home with bathing, eating, and other situations. The highest premium he paid was $153 per month, and he deemed that was fairly reasonable. Subsequently, he retired and in 2013 he had to move onto the Aged & Disabled waiver program where he has to pay a share of the costs. At that time, his share went from $153 a month to $2,258 a month. That is partially because he worked in administration at the Tax Commission and was making $60,000 a year. He has a fairly decent retirement and fairly high Social Security. He has no issues with increasing the personal needs allowance but he doesn't think it's enough. He should not have to pay $2,200 a month of his retirement income for services that he only paid $153 a month for when he was working. He owns a three bedroom home in West Boise and pays mortgage, property taxes, and other expenses. He is not allowed to keep enough of his own retirement money to actually enjoy life. His money is going all to Medicaid whereas a lot of other states have higher allowances.

Mr. Nilson began working with Health and Welfare in 2013 to increase the personal needs allowance. Most states allow a participant to keep more money, either an unlimited amount of income or 300 percent of SSI rate. That would be equivalent to approximately $2,200 per month. If someone owns a house, there are other expenses a renter doesn't have. Medicaid sets a budget for him to live on and all the rest of his money goes to Medicaid for his share of costs, so there's no money to buy a washer. Under Medicaid he can only have $2,000 in his checking account. It's not viable for a person to stay in their house by keeping the allowance so low. AARP did a survey in 2010 showing 25 states had an allowance of $2,200 on up, and Idaho at that time only had $1,100. A lot of states like New Mexico don't make a participant pay anything for share of costs, and Medicare and CMS allow for that. He doesn't mind paying some of his income for Medicaid services, but he worked and paid into the system for 26 years. There has to be some recognition of that, and he should be able to keep a little of his retirement money to enjoy retirement.

Senator Martin asked Mr. Nilson if the rule docket affects him. **Mr. Nilson** said it does not. He filed an ADA reasonable request to get a higher personal needs allowance and his allowance is currently higher than $1,300. He is not the only person in the State of Idaho who could be in that situation. For example, an electrician who becomes injured after 30 or 40 years with a high retirement income might only be allowed to live on a limited amount of money, even though they earned much more. It doesn't seem fair to him. It's not a CMS issue, it's a State of Idaho issue. Health and Welfare is setting the budget for Randy Nilson, saying, "You have to live on this amount of money and we are going to take all the rest." **Senator Martin** thanked Mr. Nilson for making the effort to attend the meeting and testify, and for his service to the State of Idaho. **Vice Chairman Souza** also thanked Mr. Nilson for sharing his experiences with the Committee. Mr. Nilson provided a letter to be included in the record of Committee proceedings.

Alec Pechota introduced himself as a representative of DisAbility Rights Idaho. He informed the Committee the Idaho "Share of Cost" rules were set many years ago. There is no evidence they were based on actual costs. In the intervening years, the cost of housing in most Idaho communities has gone up disproportionately to other essential costs. People with disabilities serious enough to qualify for skilled nursing care can qualify for Medicaid with a household income exceeding the typical income limits. However, they are required to pay most of this income to the State as their share of cost. The share of cost is not a fixed amount or percentage of the cost of care. Instead, a participant is required to pay all income except for a fixed personal needs allowance. In most cases, the only income these people have is from disability payments, Social Security, or veterans or employer benefits.

Mr. Pechota commented the personal needs allowance was originally set for people in nursing homes where room and board are provided. Since the late 1980s, Idaho residents have had the opportunity to receive care at home instead of an institutional setting through Home and Community Based Services waivers, as long as the in-home services cost Medicaid less than the cost of nursing home care. A different personal needs allowance was set for these participants. People receiving the waivers have to pay for their own housing, food, utilities, transportation, etc. The participant can only keep the personal needs allowance and must pay the rest of their income to the State as share of cost. The current personal needs allowance is $1,102 per month or the current SSI benefit level times one point five. This is grossly inadequate for most housing markets in Idaho, especially if the person requires wheelchair accessible housing. It is especially inadequate for people who bought a home before they became disabled and now carry a mortgage. Increasing the personal needs allowance is not an increase in benefits. It only allows a person to keep more of their own money. When the allowance is too low, people try to get by on fewer services than they need, sometimes leading to health problems and institutionalization, or they lose their home and are forced into nursing care. This docket increases the personal needs allowance to about $1,323 per month. It will not be enough for everyone, but it will allow more people to stay in their homes and neighborhoods and get the home-based services they need.

Senator Martin asked Mr. Peculate for clarification that he supports the docket but would like it to be more. **Mr. Pechota** replied Senator Martin's characterization was correct and his testimony was more in the nature of an impact statement. **Vice Chairman Souza** advised Mr. Peculate that having his statement on the record was very helpful. She asked whether he thought it was a step in the right direction but not a big enough step. **Mr. Pechota** answered yes.

MOTION: There being no more testimony or questions, **Senator Foreman** moved to approve **Docket No. 16-0318-1601. Senator Jordan** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:30 p.m.

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Senator Heider
Chair

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Jeanne Jackson-Heim
Secretary