MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, March 09, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Lee
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 of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
APPROVAL OF MINUTES:	**Senator Jordan** moved to approve the Minutes of the February 22, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Senator Martin moved to approve the Minutes of the March 1, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Senator Harris moved to approve the Minutes of the March 2, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
HCR 9	**A House Resolution Relating to Rare Diseases. Representative Wintrow** introduced herself to the Committee to present **HCR 9**. **Rep. Wintrow** stated the resolution is written to raise awareness about rare diseases that occur in Idaho, especially in young children, and the lack of pediatricians and pediatric neurologists. She has already received e-mails of interest from people who want to get involved and create networks to help with this issue. **Rep. Wintrow** yielded to Tonya Harvey to present additional information.
	Tonya Harvey introduced herself to the Committee as the mother of a two-year-old son with a rare disorder. Her son was born a happy full-term baby but shortly after his birth, he began showing a variety of symptoms and struggled with breathing and eating. They saw numerous specialists and attended up to four doctor appointments per week, but no one could diagnose the problem. At 11 months, her son became unresponsive at day care and was hospitalized for nearly three weeks. They were referred to Seattle Children's Hospital, and six months ago he was diagnosed with glucose transporter type 1 deficiency syndrome, a rare genetic metabolic disorder involving deficiency of a protein required to carry sugars across the blood frame barrier. The disorder leaves the brain starved of fuel and energy, and there is no cure. The treatment is a special diet that tricks the brain to use fats for fuel instead of sugar.

Ms. Harvey said her goal is to advocate for awareness and change for rare disorders. There is one genetics clinic in all of Idaho and there is a nine month wait list. Her son almost died while awaiting treatment at that clinic. She feels Idaho's programs are overcrowded and underfunded. Her son is on all of the State programs, and they have been waiting months for home nursing. Physicians must be educated on the importance of early recognition of disorders to avoid devastating impacts on brain development. It creates stress on families to travel outside of Idaho, and other states reap the financial benefit for that treatment. Idaho should invest more time, attention, and resources on children's disorders. A communications network is needed for Idaho's specialists to network with specialists in surrounding states to manage patients in Idaho with less travel. Idaho needs pediatricians and family practice doctors who are willing to devote a portion of their practice to rare disorders.

Ms. Harvey commented she is grateful for all her son's doctors, and Seattle Children's Hospital has proven to be a life changer for her son because they preserved his brain development by acting quickly. Not all moms are as aggressive at finding a diagnosis as she is, and she wants to be an advocate to support families affected by rare disorders and complex diseases.

Senator Jordan asked if Ms. Harvey is aware of information about states with more resources dedicated to these rare diseases as a model for what the ideal might look like in Idaho. **Ms. Harvey** replied Seattle Children's Hospital works closely with the University of Washington and has a number of neurologists, while St. Luke's Children's Specialty Unit has the only pediatric gastroenterologist and pediatric pulmonologist in the entire State. Seattle and Salt Lake City are good resources for specialists, but it would be nice to reduce travel out of state for doctor visits.

Senator Souza commented the Legislature has been discussing telehealth. She asked if it would be helpful to use some kind of video conferencing or technology solution with a specialist in Seattle for some of the visits, or must the neurologist perform a hands-on examination. **Ms. Harvey** answered she doesn't know anything about telehealth. She has since learned about Project Echo, and she thinks it would have been instrumental in getting an earlier accurate diagnosis and avoid needless procedures and travel. Project Echo has committees that review cases as a group and uses a Skype-type consultation that is cost effective and more efficient.

Dr. James M. Quinn introduced himself to the Committee to describe Project Echo, an extension of a community health program in New Mexico. A specialist in hepatitis noticed a huge increase in hepatitis C in the area, and the doctor tried to get people to come to Albuquerque to the hospital. There were many rural patients who did not want to travel that far, and there were patients who didn't speak English. The specialist began a program to travel to the rural areas to treat the patients, and those patients got as good treatment as the patients who traveled to Albuquerque.

Dr. Quinn commented medicine should be brought to the people, not the other way around. Traveling to a large city from a rural area is intimidating and expensive, especially when multiple trips are required. Clinics in rural areas and large health centers can be connected by computer technology. The patient can be in a familiar environment and have the same discussion with the doctor as if physically present. **Dr. Quinn** suggested obtaining New Mexico's model as a template. People will go along with this approach if legislators support it and take the information back to their constituents. Patients will save money, time, and their jobs, and the State will save money by not sending Medicaid dollars to neighbor states. This would keep people in their homes.

Rep. Wintrow was recognized to summarize the presentation. The resolution is a good start in raising awareness of the issue. She agrees with the concept of bringing the knowledge to the patients and creating learning communities to support doctors in Idaho.

MOTION: **Senator Jordan** moved that **HCR 9** be sent to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

H 195 **Relating to Chiropractic Practice. Ryan Fitzgerald** introduced himself to the Committee on behalf of the Idaho Association of Chiropractic Physicians (IACP) to present the bill, which addresses the administration of injectable intravenous (IV) nutrients by Idaho chiropractors.

Mr. Fitzgerald said over the last 40 to 50 years, nutritional substances formerly provided to patients by oral and topical means are now administered by injectable and IV methods. Idaho chiropractic physicians (DCs) have provided nutrition via oral and topical means since the inception of chiropractic in Idaho, and many DCs have obtained advance training to provide injectable and IV micronutrients to their patients. Due to federal regulatory changes by the Food and Drug Administration (FDA) in 2008 and 2012, the labeling and regulation of injectable and IV nutrients has changed from a basic natural substance to a prescriptive product which has eliminated the ability of Idaho DCs to provide these treatments.

Mr. Fitzgerald worked with other industry groups and state agencies to develop a balanced approach to allow chiropractic patients to continue accessing these treatments. **H 195** allows a DC who has completed standardized, accredited, post-doctoral education to obtain a clinical nutrition certification by the Idaho State Board of Chiropractic (BOC). The certification would allow the DC to administer IV and injectable nutrients for patients. The bill will establish a specific list of vitamins, minerals, sterile fluids, and emergency substances that can be utilized by chiropractors holding the certification. The bill also provides a set of standards to ensure patient safety, including the requirement for the DC to follow specific safe dosing requirements established by the FDA.

Mr. Fitzgerald stated the bill requires a certified DC to obtain the nutritional substances from a distributor licensed by the Board of Pharmacy to ensure compounding of nutritional substances and the measurements or dosing of those substances will be completed by a licensed pharmacist at a licensed pharmacy outlet. A certified DC would be required to obtain informed consent when providing this type of treatment and must maintain lifesaving certifications and equipment to ensure patient safety in the case of an adverse effect. Finally, the bill directs the BOC to establish continuing education requirements and guidelines for biennial recertification for DCs holding a certification in clinical nutrition.

Mr. Fitzgerald informed the Committee the first few pages of the bill include clean-up language from the Legislative Services Office. Pages 4 through 7 of the bill contain identical language as **H 10** which has already been signed into law by the Governor. Beginning on page 8, the bill includes a new section outlining the stated formulary and safety standards, while page 9 provides the accredited education DCs will be required to obtain. The last page adds chiropractors to the list of health care providers identified by the Board of Pharmacy who can obtain and administer limited substances.

Mr. Fitzgerald commented the bill is a basic and transparent approach to the use of nutritional substances with specific standards and education that all licensees and the regulatory board can understand. There is no fiscal impact to the General Fund, but it does establish a certification fee to cover the cost of reviewing applications by the BOC. This bill has involved three to four years of work and represents the balanced approach requested by legislators.

TESTIMONY: **Dr. Tim Clenha** introduced himself to the Committee to speak in support of **H 195**. **Dr. Clenha** is a DC who has practiced in Boise since 1989. He moved here from California as an athlete to play football and track at Boise State University in 1980. He finished his bachelor's degree in health science in 1985 and his doctorate in chiropractic from the University of Western States in 1989.

Dr. Clenha said his nine years of education prepared him in all basic health sciences, nutritional studies, sports injuries and prevention, general patient care, phlebotomy, and blood lab analysis. He is a diplomate as a board-certified chiropractic orthopedist, which is an additional 400 hours of training covering simple and complex bone and soft tissue injuries utilizing splints, casts, and taping procedures and provided training in treatment using nutritional supplements. He served 13 years as one of the sports DCs for the Idaho Steelheads. He served in nearly all capacities in the IACP, including three years as president. He worked on the task force for **H 195** over the last 18 months to coordinate efforts with University of Western States in Portland on educational standards and with the BOC on statutory language.

Dr. Clenha informed the Committee an Idaho DC is often the initial health care provider, especially in rural areas. Idaho ranks near the bottom of states in regard to physician to citizen ratio, and patients will seek out DCs for conservative treatments not requiring hospitalization. DCs often see acute musculoskeletal pain caused by pathogens such as bacteria and viruses. Often the patients have conditions unresolved by other health care treatments and want safe, non-addictive, and conservative approaches to care, sometimes as a last resort.

Dr. Clenha commented the chiropractic profession, begun in 1895, ranks nationally as the third largest health care provider behind allopathic medicine and dentistry. The average DC has completed a four-year bachelor's degree prior to the 4,500 hours required for the doctorate, including an average of 250 hours in nutritional studies. The majority of over 700 DCs in Idaho practice nutrition in their offices daily. As a profession, DCs balance physical, chemical, and emotional components of life and focus on the significance of a health lifestyle, educating patients on proper daily ergonomics, prescribing preventative and rehabilitative exercises, and counseling on proper nutrition that limits inflammation-causing pain and disease. DCs routinely perform spinal manipulation, utilize various physiotherapies like ultrasound and electric muscle stimulation, and perform x-rays to better evaluate a patient's condition. They take blood work and look for imbalances and deficiencies and then prepare a treatment plan to restore health.

Dr. Clenha stated oral supplementation of vitamins, minerals, essential fatty acids, digestive enzymes, and probiotics are routine treatments in his office. When these measures are followed and the illness persists, there is time for advanced nutritional delivery methods by subcutaneous, IV, and intramuscular (IM) nutrient administration. An unhealthy gut prevents and delays healing, and a very sick individual who presents in a dehydrated and malnourished state needs an expeditious route of nutritional delivery.

Dr. Clenha mentioned in 2007 he completed a 36-hour post-graduate course taught by an adjunct professor of Texas Chiropractic College. The course provided him with skills to perform advanced nutritional delivery methods. His patients signed a consent form and received nutrients such as IM B-12 and specific doses of IV vitamin C, among other micronutrients. The positive outcomes far surpassed his expectations, and he continued to practice in this manner until he received a cease and desist letter from the BOC in July 2016 when he stopped performing this treatment.

Dr. Clenha advised the bill would establish standardized and accredited post doctoral education all DCs must complete, whether they are previously trained or not, in order to provide these additional nutritional methods. As a physician who obtained proper training 10 years ago, he is willing to return to school to ensure he meets all necessary standards established by the BOC. **H 195** would re-establish his ability to use injectable vitamins and minerals, assure appropriate education and training from a federally accredited chiropractic university, and provide necessary oversight and safety standards in treatment of patients. Patients will have access to the health provider of their choice, offering alternatives to patients.

Senator Harris asked how much time the additional training will take to complete. **Dr. Clenha** answered 100 hours.

TESTIMONY: **Suzie Pouliot** introduced herself to the Committee on behalf of the Idaho Medical Association, representing medical doctors and doctors of osteopathy, to speak in opposition to the bill. The IMA opposes **H 195** because of a lack of evidence-based, peer-reviewed studies that demonstrate the results asserted in anecdotal stories from patients who undergo these treatments. Many of the treatments that would be allowed under the bill would likely have to be paid for out of pocket because insurance companies typically do not cover these services.

TESTIMONY: **Dr. Marshall Priest**, a Boise cardiologist for 38 years, introduced himself to speak in opposition to **H 195** because it is outside the scope of practice for chiropractors as defined by the National Board of Chiropractic Examiners in 2015. The only true medical indication for the IV infusion of vitamins and minerals is for intestinal malabsorption, such as Crohn's disease, short gut syndrome, and human immunodeficiency virus. Vitamin and mineral infusions are often packaged as immunity drips, anti-aging drips, and energy drips, none of which have any scientific evidence to support their efficacy.

Dr. Priest explained potassium is one of the elements that would be allowed for infusion, and the normal limits of potassium in the human body are very narrow. Exceeding that narrow limit could potentially trigger a fatal cardiac arrhythmia. Iodine is another element listed for infusion, and iodine in certain people creates a severe allergic reaction called anaphylaxis which creates difficult breathing, airway obstruction, and cardiac collapse requiring resuscitation. **Dr. Priest** expressed concern regarding accountability for adverse outcomes potentially relatable to infusion of these substances and the ability to provide comprehensive resuscitation in patients who have a severe adverse reaction. He asked the Committee to consider the lack of scientific evidence and studies and the potential implications of putting this language into Idaho Code.

Senator Jordan mentioned she understands the absence of studies and inquired whether there are studies showing adverse reactions when the proposed protocols are implemented in the chiropractic community. **Dr. Priest** answered he does not know of any studies either supporting the efficacy or showing adverse outcomes.

Senator Martin asked if Dr. Priest is aware of any patient reactions resulting from these treatments prior to the time they were precluded. **Dr. Priest** replied he is not aware of any.

Mr. Fitzgerald was recognized to summarize the bill presentation and stated this practice has been ongoing in Idaho chiropractic offices for many years. It has been available in Oklahoma since 1986, with over two million injectable nutrient treatments and no adverse effects. The bill ensures safety standards, and the BOC will bring rules to establish specific safety measures to be included in DC offices such as oxygen and epinephrine. Patients are seeking these treatments and they are currently being done in other medical offices, so he challenges the comments regarding the efficacy of the treatments.

Vice Chairman Souza asked for more specifics about the safety equipment and procedures for the chiropractor offices. **Mr. Fitzgerald** responded Alex Adams of the Board of Pharmacy helped draft the bill. DCs will use FDA guidelines that limit dosages to micro amounts. The IMA and Board of Pharmacy will provide guidance on safety procedures, including epinephrine and oxygen as well as lifesaving certifications and equipment. The rules may also provide for automated external defibrillators (AEDs) in offices, and many DCs have AEDs in their clinics now.

MOTION: **Senator Harris** moved to send **H 195** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Anthon** spoke in favor of the motion as the minimal amount of regulation necessary to protect the public health and welfare. He would almost argue the bill goes too far and appreciates the parties have worked together to bring the legislation. His test is to talk to the local doctors in his area, and he trusts their opinion. One of his local doctors is present today and would testify in favor of the bill. This is good legislation and he supports it.

Senator Martin commented he appreciates the work of Senator Hagedorn and others in crafting the bill, and he also supports the legislation.

The motion carried by **voice vote.**

S 1142 **Relating to the Health Care Assistance Program. Senator Hagedorn** introduced himself to the Committee and explained he co-chaired a task force in summer 2016 to address health coverage for the Medicaid "gap" population. He referred to the task force's final report (see Attachment 1) and reviewed the unanimous recommendations in the report.

Senator Hagedorn stated **S 1142** contains all the task force recommendations except for Medicaid expansion and covers eligible participants with regular primary care and care management for chronic conditions. The cost is roughly $10 million which will be insufficient to cover the enter gap population, but many with chronic conditions are obtaining care through emergency rooms and hospitals providing charity care. Those costs are passed on to the insurance companies and subsequently to the insured through premiums.

Senator Hagedorn explained the objective is to get these patients healthy through a managed primary care system. The bill will transfer the current system from a volume-based fee-for-service model to a value-based system of care through clinics utilizing a care coordination and case management model. The program will pay a dollar amount per month per patient to a medical provider to improve and maintain the patient's health. It will be up to the medical provider to take the risk on how many times to see the patient to accomplish that goal, so it will be to the provider's benefit to get the patient healthy as soon as possible.

Senator Hagedorn said he started working last summer with Director Armstrong to put a bill together. The Department of Health and Welfare (Department) already has some programs moving in the same direction. The objective is not to compete with federal requirements for Medicaid but to set up an Idaho system to provide primary care and incentive for providers to provide managed care.

Senator Hagedorn informed the Committee a program participant must fill out an application and have income, household composition, and citizenship verified to ensure eligibility. The Department will set out other eligibility requirements in rule regarding smoking-related illness and other chronic conditions, as the funding will come from the Millennium Fund. Providers must also meet certain criteria to provide health care services, as well as agree to collect and submit usage and clinical data based on the population served so the program can be adjusted to properly meet the needs of patients with chronic conditions. A monthly fee for each participant who receives primary care and limited prescription care coordination services will be paid to the provider, and the provider will charge the participant a fee not to exceed $20.

Senator Hagedorn commented there is a population in need of assistance, and Idaho needs to change the market and bend the health care delivery model cost curve. He asked that the bill be sent to the Fourteenth Order for amendment to clarify the care management and member accountability as well as the clinical and utilization data to be collected and reported.

Vice Chairman Souza asked if this is an ongoing entitlement or a handout. **Senator Hagedorn** answered it is not an entitlement but rather help people with chronic illness get well and lower costs for a population that currently costs Idaho taxpayers a tremendous amount of money. **Vice Chairman Souza** inquired if the proposal is similar to direct primary care. **Senator Hagedorn** replied a direct primary care physician testified to the task force about a direct primary care program. That physician said to keep his doors open, he needs to see between 800 and 1,000 patients per month. A fee-for-service primary care physician testified he needed to see 3,500 patients per month to continue operating. The direct primary care doctor has more time to spend with patients to understand and care for their needs. The public will see the benefit of seeing a doctor regularly.

Vice Chairman Souza commented the typical doctor visit in a regular doctor office is seven to ten minutes, and in the direct primary care setting it tends to be 20 to 40 minutes. This extended time gives the physician a chance to inquire about a patient's life stressers to turn illness visits into wellness visits. She asked if the program will sunset or if it will be an ongoing effort. **Senator Hagedorn** responded the bill sunsets in June 2022 to find out if the program is effective, based on provider and patient feedback. It is likely the program will be amended every year to fine tune it, based on what the federal government does with Medicaid and insurance programs. For the last eight years, the focus has been on insurance, and there has been no focus on the delivery of health care. A fee-for-service doctor must spend 40 percent of his revenue collecting fees and can only see patients seven minutes a day. This program will allow a doctor to spend more time with patients. There will be a shortage of doctors at first, and some things might need to be changed to make it work, but Idaho needs to move in this direction.

Senator Harris referred to Idaho Code § 56-276 and asked the amount of the monthly fee to be paid to the provider. **Senator Hagedorn** answered it is unknown at this time. The estimate is from $700 to $1,000 annually per patient. Some providers will take a chance and agree to see patients for $45 a person, and then evaluate whether there was a return on investment. The first year, any primary care provider is eligible to go under contract with the Department to take a certain number of contracts.

Senator Anthon also referred to Idaho Code § 56-276 and the fee not to exceed $20 paid by the participant, and he asked whether it will be a monthly fee. **Senator Hagedorn** replied it will be a fee per visit. The participant is the patient. The provider will receive a monthly stipend from the Department every month. If the participant needs to see the doctor, there will be some type of fee charged, as determined by the provider. **Senator Anthon** commented the language might need to be tweaked a bit.

Senator Jordan acknowledged Senator Hagedorn's work on this project. She referred to the fiscal note regarding funding of $10 million from the Millennium Fund and commented the Joint Finance and Appropriations Committee (JFAC) took an action the previous day that calls into question whether that sum will be available. **Senator Hagedorn** answered he is aware of the JFAC bill, and that is a policy question to be determined. Spending from the Millennium Fund might have to be reconsidered if **S 1142** passes. **Senator Jordan** inquired if there is funding available today, or if the earliest funding would be in FY 2018. **Senator Hagedorn** answered until the JFAC bill passes both houses, funding is available today in the Millennium Fund.

Chairman Heider said he appreciates all who came to testify. Since time does not permit additional testimony, he asked for a show of hands who is in favor of the bill, and how many are against. (A significant majority of hands raised were opposed to sending the bill to the floor.) (See Attachments 2 and 3 for additional testimony.)

MOTION: **Vice Chairman Souza** moved to send **S 1142** to the floor with a recommendation it be referred to the Fourteenth Order for possible amendment. **Senator Foreman** seconded the motion.

DISCUSSION: **Senator Jordan** declared she will vote against the motion. She is grateful for the effort and conversation on the issue. The federal government proposal announced this week includes continued Medicaid expansion, and she believes that approach is clearly the best for Idaho from a fiscal responsibility standpoint. The $10 million program cost could be used for matching funds at least through FY 2020. She expressed concern that people did not have an opportunity to testify.

The motion carried by **voice vote**. **Senator Jordan** requested she be recorded as voting nay.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:07 p.m.

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Senator Heider
Chair

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Jeanne Jackson-Heim
Secretary