MINUTES

# HOUSE HEALTH & WELFARE COMMITTEE

**DATE:** Tuesday, January 31, 2017

**TIME:** 9:00 A.M.

**PLACE:** Room EW20

**MEMBERS:** Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Vander Woude, Redman, Gibbs, Blanksma, Hanks, Kingsley, Zollinger, Chew, Rubel

**ABSENT/ EXCUSED:** None

**GUESTS:** Keith Fletcher, Community Care Advisory Council; Kelli Brassfield, ID Assoc. of Counties; Maggie Mann, SE Idaho Public Health; Carol Moehrle, NC Idaho Public Health; Geri Rackow, Eastern Idaho Public Health; Bill Leake, Board of Trustees PH Dists; Scott Tiffany, Telligen; Steve Scanlin, Central Dist. Health Dept.; Mary Sheridan, IDHW, Public Health; Casey Suter, IDHH, Public Health; Russ Drake, CDHD

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

**MOTION:** **Rep. Rubel** made a motion to approve the minutes of the January 19 and 23, 2017, meetings. **Motion carried by voice vote.**

**RS 25051:** **Rep. Megan Blanksma**, District 23, presented **RS 25051**. This proposed legislation sets in code a standardized distribution formula for state funds allocated to the public health districts. An Office of Performance Evaluation (OPE) report determined the existing formula required a clear or consistent link to program needs and also suggested any new formula be phased in to avoid dramatic changes. The proposed formula in **RS 25051** has both population and poverty components, which are already public health program drivers. After a three-year phase-in, the formula will provide each district with a 67% county match. The remaining balance will be portioned to each district at 75% based on population and 25% based on poverty numbers.

**Rep. Blanksma** declared **Rule 38** as a member of the Central District Health Board.

**MOTION:** **Vice Chairman Packer** made a motion to introduce **RS 25051. Motion carried by voice vote. Reps. Hanks** and **Kingsley** requested they be recorded as voting **NAY**.

**RS 25086:** **Rep. Caroline Nilsson Troy**, District 5, presented **RS 25086**, proposed legislation for the placement of foreign trained physicians, a recruitment option of last resort, using the Conrad J-1 Visa Waiver Program. The inability to recruit an American physician must be demonstrated. Of the thirty waiver slots available, no more than ten can be used for specialist physician recruitments. Non-rural health care organizations can use the J-1 waiver slots if a rural health care organization has not been able to use them within six months. The physicians filling those slots must also be available for the rural areas.

**Casey Suter**, Program Manager, Department of Health and Welfare (DHW), was invited to respond to a committee question. Applications take thirty hours of review prior to sending for a final determination. The monitoring of physicians during the minimum three-year service obligation can include on-site visits, along with the required end-of-obligation report.

**MOTION:** **Rep. Perry** made a motion to introduce **RS 25086. Motion carried by voice vote.**

**Keith Fletcher**, Council Member, Community Care Advisory Council (CCAC), Owner, Assisted Living and Hospice Companies, presented the annual CCAC legislative report. The CCAC participates in the various aspects of Rules and standards pertaining to residential care/assisted living facilities (RALF) and certified family homes (CFH). CCAC members include providers, advocates, family members, clients, and the DHW.

RALF licensed beds have increased to 9,943; however, smaller facilities are closing and larger corporate facilities are moving into the state. The DHW hired and trained temporary surveyors to complete overdue surveys and complaint investigations, reflected in the increased citation numbers.

While the CFHs have slowed their growth, surveys have increased by 7.1% and core deficiencies have declined by 33%. This large group of small providers have developed peer groups and mentors to help each other use the DHW tools and increase regulation compliance. This effort is also expected to improve the high rate of certification fee non-payment.

Issues include outdated Medicaid reimbursement rates. The Medicaid Uniform Assessment Instrument (UAI) being used by RALFs and CFHs results in licensing or certification violations.

Locating appropriate residential placements for individuals who exhibit difficult behaviors is an issue, especially since it is also a facility licensing or certification requirement. Most of these individuals are Medicaid recipients. Providers do not receive adequate funding for the appropriate supervision and services to manage the behaviors.

The DHW has been training small facilities to bill accurately to alleviate the hardship they expressed from the twenty-four hour staff awake Rule change.

Answering questions, **Mr. Fletcher** said the DHW is testing a short-term-stay facility to address the difficult behavior need. Providers have requested a review of the Rules to delineate reoccurring and one-time difficult behavioral needs. The Medicaid in-depth cost study may provide a shock when comparing current needs to the low rates received. Any current rate increase request requires proof of an access or quality problem, which has proven burdensome. Access issues for Medicaid patients are serious because 40% of all Idaho RALFs do not take Medicaid. A two-year spend-down option is available in 25% of the facilities and most have no beds available.

**ADJOURN:** There being no further business to come before the committee, the meeting was adjourned at 9:37 a.m.

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Representative Wood
Chair

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Irene Moore
Secretary