Medicaid Simplification

This Act authorizes the director of the state department of health and welfare to restructure the state Medicaid program in order to achieve improved health outcomes for Medicaid participants and slow the rate of growth in Medicaid costs. The legislation simplifies current eligibility categories by establishing three new population groups, based on participants' health needs. The bill authorizes the director to develop a State Plan for Medical Assistance for each of the three groups. This legislation further describes the benefits for each of the three groups, in addition to a global benefit list for all Medicaid participants in the state.

Submitted as:
Idaho
HB 776
Status: Enacted into law in 2006.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act is entitled “The Medicaid Simplification Act.”

Section 2. [Legislative Findings.]
(1) The [legislature] finds that the current federal Medicaid law and regulations have not kept pace with modern health care management practices, create obstacles to quality care and impose unnecessary costs on the delivery of effective and efficient health care. The [legislature] believes that this state must strive to balance efforts to contain Medicaid costs, improve program quality and improve access to services. The legislature further believes this state can achieve improved health outcomes for Medicaid participants by simplifying eligibility and developing health benefits for Medicaid participants according to their health needs, including appropriate preventive and wellness services.

(2) The [legislature] supports development, at a minimum, of the following health-need categories:

(a) Low-Income Children and Working-Age Adults. The broad policy goal for the Medicaid program for low-income children and working-age adults is to achieve and maintain wellness by emphasizing prevention and by proactively managing health. Additional specific goals are:

(i) To emphasize preventive care and wellness;
(ii) To increase participant ability to make good health choices; and
(iii) To strengthen the employer-based health insurance system.

(b) Persons with Disabilities or Special Health Needs. The broad policy goal for the Medicaid Program for Persons with Disabilities or Special Health Needs is to finance and deliver cost-effective individualized care. Specific program goals are:

(i) To emphasize preventive care and wellness;
(ii) To empower people with disabilities to manage their own lives;
(iii) To provide opportunities for employment for people with disabilities; and
(iv) To provide and to promote family-centered, community-based, coordinated care for children with special health care needs.
(c) Elders. The broad policy goal for the Medicaid Program For Elders is to finance and deliver cost-effective individualized care which is integrated, to the greatest extent possible, with Medicare coverage. Additional specific goals are:

(i) To emphasize preventive care and wellness;
(ii) To improve coordination between Medicaid and Medicare coverage;
(iii) To increase nonpublic financing options for long-term care; and
(iv) To ensure participants’ dignity and quality of life.

(3) To the extent practicable, the [department] shall achieve savings and efficiencies through use of modern care management practices, in areas such as network management, cost-sharing, benefit design and premium assistance.

(4) The [department’s] duty to implement these changes in accordance with the intent of the [legislature] is contingent upon federal approval.

Section 3. [Definitions.] As used in this Act:

(1) “Benefit design” means selection of services, providers and beneficiary cost-sharing to create the scope of coverage for participants.

(2) “Community supports” means services that promote the ability of people with disabilities to be self-sufficient and live independently in their own communities.

(3) “Cost-sharing” means participant payment for a portion of Medicaid service costs such as deductibles, coinsurance or copayment amounts.

(4) “Department” means the [department of health and welfare].

(5) “Director” means the [director of the department of health and welfare].

(6) “Health risk assessment” means a process of assessing the health status and health needs of participants.

(7) “Medicaid” means the state Medical Assistance Program.

(8) “Medical assistance” means payments for part or all of the cost of services funded by Titles XIX or XXI of the Federal Social Security Act as amended, as may be designated by [department] rule.

(9) “Medical home” means a primary care case manager designated by the participant or the [department] to coordinate the participant’s care.

(10) “Network management” means establishment and management of contracts between the [department] and limited groups of providers or suppliers of medical and other services to participants.

(11) “Participant” means a person eligible for and enrolled in the state Medical Assistance Program.

(12) “Premium assistance” means use of Medicaid funds to pay part or all of the costs of enrolling eligible individuals into private insurance coverage.

(13) “Primary care case manager” means a primary care physician who contracts with Medicaid to coordinate the care of certain participants.

(14) “Provider” means any individual, partnership, association, corporation or organization, public or private, which provides residential or assisted living services, certified family home services, nursing facility services or services offered pursuant to medical assistance.

(15) “Self-determination” means Medicaid services that allow people with disabilities to exercise choice and control over the services and supports they receive.

(16) “State plan” means the contract between the state and federal government under 42 U.S.C. section 1396a(a).

Section 4. [Powers and Duties of the Director.]

(1) The [director] is hereby encouraged and empowered to obtain federal approval in order that this state design and implement changes to its Medicaid Program that advance the quality of
services to participants while allowing access to needed services and containing excessive costs.
The design of this state’s Medicaid Program shall incorporate and promote advance the concepts
outlined in section 2 of this Act.

(2) The [director] may create health-need categories other than those stated in [insert
citation], subject to legislative approval, and may develop a Medicaid state plan for each
category.

(3) Each state plan shall include explicit policy goals for the covered population identified
in the plan, as well as specific benefit packages, delivery system components and performance
measures in accordance with [insert citation].

(4) The [director] shall establish a mechanism to ensure placement of participants into the
appropriate state plan. This mechanism shall include, but not be limited to, a health risk
assessment. This assessment shall comply with federal requirements for Early and Periodic
Screening, Diagnosis and Treatment (EPSDT) services for children, in accordance with section

(5) The [director] may require, subject to federal approval, participants to designate a
medical home. Applicants for medical assistance shall receive information about primary care
services, and, if required to so designate, shall select a primary care provider as part of
the eligibility determination process.

(6) The [director] may, subject to federal approval, enter into contracts for medical and
other services when such contracts are beneficial to participant health outcomes as well as
economically prudent for the Medicaid program.

(7) The [director] may obtain agreements from Medicare, school districts and other
entities to provide medical care if it is practical and cost-effective.

(8) The [director] is given authority to promulgate rules consistent with this Act.

Section 5. [Eligibility for Medical Assistance.] The [department] shall make payments for
medical assistance to, or on behalf of, the following people eligible for medical assistance.

(1) The state plan for low-income children and working-age adults includes the following
people:
   (a) Children in families whose family income does not exceed [one hundred
     eighty-five percent (185%)] of the federal poverty guideline and who meet age-related and other
     eligibility standards in accordance with [department] rule;
   (b) Pregnant women of any age whose family income does not exceed [one
     hundred thirty-three percent (133%)] of the federal poverty guideline and who meet other
     eligibility standards in accordance with [department] rule, or who meet the presumptive eligibility
     guidelines in accordance with section 1920 of the Social Security Act;
   (c) Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must
     be offered throughout the first year of life so long as the infant remains in the mother's household
     and she remains eligible, or would be eligible if she were still pregnant;
   (d) Adults in families with dependent children as described in section 1931 of the
     Social Security Act, who meet the requirements in the state's Assistance to Families With
     Dependent Children (AFDC) plan in effect on [July 16, 1996];
   (e) Families who are provided [six (6) to twelve (12) months] of Medicaid
     coverage following loss of eligibility under section 1931 of The Social Security Act due to
     earnings, or [four (4) months] of Medicaid coverage following loss of eligibility under section 19
     02 (a) (31) of the Social Security Act due to an increase in child or spousal support;
   (f) Employees of small businesses who meet the definition of “eligible adult” as
described in [insert citation], whose eligibility is limited to the Medical Assistance Program
described in [insert citation]; and
(g) All other mandatory groups as defined in Title XIX of the Social Security Act, if not listed separately in subsection (2) or (3) of this section.

(2) The state Plan for Persons with Disabilities or Special Health Needs includes the following:

(a) People under age [sixty-five (65) years] eligible in accordance with Title XVI of the Social Security Act, as well as people eligible for Aid To The Aged, Blind And Disabled (AABD) under Titles I, X and XIV of the Social Security Act;

(b) People under age [sixty-five (65) years] who are in need of the services of a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, a state mental hospital, or home based and community-based care, whose income does not exceed [three hundred percent (300%)] of the Social Security Income (SSI) Standard and who meet the asset standards and other eligibility standards in accordance with federal law and regulation, state law and [department] rule;

(c) Certain disabled children described in 42 CFR 435.225 who meet resource limits for Aid to The Aged, Blind And Disabled (AABD) and income limits for Social Security Income (SSI) and other eligibility standards in accordance with [department] rules;

(d) People under age [sixty-five (65) years] who are eligible for services under both Titles XVIII and XIX of the Social Security Act;

(e) Children who are eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care or adoption subsidies, and children for whom the state has assumed temporary or permanent responsibility and who do not qualify for Title IV-E assistance but are in foster care, shelter or emergency shelter care, or subsidized adoption, and who meet eligibility standards in accordance with [department] rule;

(f) Eligible women under [age sixty-five (65) years] with incomes at or below [two hundred percent (200%)] of the federal poverty level, for cancer treatment pursuant to the Federal Breast and Cervical Cancer Prevention and Treatment Act of 2000;

(g) Low-income children and working-age adults under age [sixty-five (65)] years who qualify under subsection (1) of this section and who require the services for persons with disabilities or special health needs; and

(h) People over [sixty-five (65)] years who choose to enroll in this state plan.

(3) The State Plan For Elders includes the following people:

(a) People aged [sixty-five (65) years or older] eligible in accordance with Title XVI of the Social Security Act, as well as people eligible for Aid To The Aged, Blind And Disabled (AABD) under Titles I, X and XIV of the Social Security Act;

(b) People aged sixty-five (65) years or older who are in need of the services of a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, a state mental hospital, or home-based and community-based care, whose income does not exceed [three hundred percent (300%)] of the Social Security Income (SSI) standard and who meet the asset standards and other eligibility standards in accordance with federal and state law and [department] rule;

(c) People aged [sixty-five (65) years or older] who are eligible for services under both titles XVIII and XIX of the Social Security Act who have enrolled in the Medicare program; and

(d) People under age [sixty-five (65) years] who are eligible for services under both Titles XVIII and XIX of the Social Security Act and who elect to enroll in this state plan.

Section 6. [Medical Assistance Program -- Services to be Provided.]

(1) The department may make payments for the following services furnished by providers to participants who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be reimbursed only when medically necessary and
in accordance with federal law and regulation, state law and [department] rule. Notwithstanding
any other provision of this Act, medical assistance includes the following benefits specific to the
eligibility categories established in [insert citation], as well as a list of benefits to which all
Medicaid participants in this state are entitled, defined in subsection (5) of this section.

(2) Specific health benefits and limitations for low-income children and working-age
adults include:

(a) All services described in subsection (5) of this section;
(b) Early and periodic screening, diagnosis and treatment services for individuals
under age [twenty-one (21)] years, and treatment of conditions found; and
(c) Cost-sharing required of participants. Participants in the low-income children
and working-age adult group are subject to the following premium payments, as stated in
[department] rules:

(i) Participants with family incomes equal to or less than [one hundred thirty-three percent (133%)]
of the federal poverty guideline are not required to pay premiums; and

(ii) Participants with family incomes above [one hundred thirty-three percent (133%)]
of the federal poverty guideline will be required to pay premiums in accordance
with [department] rule.

(3) Specific health benefits for people with disabilities or special health needs include:

(a) All services described in subsection (5) of this section;
(b) Early and periodic screening, diagnosis and treatment services for individuals
under age [twenty-one (21)] years, and treatment of conditions found;
(c) Case management services as defined in accordance with subsection
1905(a)(19) or section 1915(g) of the Social Security Act; and
(d) Mental health services, including:

(i) Inpatient psychiatric facility services whether in a hospital, or for people
under age [twenty-two (22)] years in a freestanding psychiatric facility, as permitted by federal
law, in excess of those limits in [department] rules on inpatient psychiatric facility services
provided under subsection (5) of this section;
(ii) Outpatient mental health services in excess of those limits in
[department] rules on outpatient mental health services provided under subsection (5) of this
section; and
(iii) Psychosocial rehabilitation for reduction of mental disability for
children under the age of [eighteen (18) years] with a Serious Emotional Disturbance (SED) and
for severely and persistently mentally ill adults, aged [eighteen (18) years or older], with severe
and persistent mental illness;
(e) Long-term care services, including:

(i) Nursing facility services, other than services in an institution for mental
diseases, subject to participant cost-sharing;
(ii) Home-based and community-based services, subject to federal
approval, provided to people who require nursing facility level of care who, without home-based
and community-based services, would require institutionalization. These services will include
community supports, including an option for self-determination, which will enable people to have
greater freedom to manage their own care; and
(iii) Personal care services in a participant’s home, prescribed in
accordance with a plan of treatment and provided by a qualified person under supervision of a
registered nurse;
(f) Services for people with developmental disabilities, including:

(i) Intermediate care facility services, other than such services in an
institution for mental diseases, for people determined in accordance with section 1902(a)(31) of
the Social Security Act to be in need of such care, including such services in a public institution, or distinct part thereof, for the mentally retarded or people with related conditions;

(ii) Home-based and community-based services, subject to federal approval, provided to Individuals Who Require an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including an option for self-determination, which will enable individuals to have greater freedom to manage their own care; and

(iii) Developmental services. The [department] shall pay for rehabilitative services, including medical or remedial services provided by a facility that has entered into a provider agreement with the department and is certified as a developmental disabilities agency by the [department];

(g) Home health services, including:

(i) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area;

(ii) Home health aide services provided by a home health agency; and

(iii) Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility;

(h) Hospice care in accordance with section 1905(o) of the Social Security Act;

(i) Specialized medical equipment and supplies; and

(j) Medicare cost-sharing, including:

(i) Medicare cost-sharing for qualified Medicare beneficiaries described in section 1905(p) of the Social Security Act;

(ii) Medicare part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Social Security Act;

(iii) Medicare part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Social Security Act; and

(iv) Medicare part B premiums for qualifying individuals described in section 1902(a)(10)(E)(iv) and subject to section 1933 of the Social Security Act.

(4) Specific health benefits for elders include:

(a) All services described in subsection (5) of this section, other than if provided under the federal Medicare program;

(b) All services described in subsection (3) of this section, other than if provided under the federal Medicare program; and

(c) Other services that supplement Medicare coverage.

(5) Benefits for all Medicaid participants, unless specifically limited in subsection (2), (3) or (4) of this section include the following:

(a) Health care coverage including, but not limited to, basic inpatient and outpatient medical services, and including:

(i) Physicians’ services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere;

(ii) Services provided by a physician or other licensed practitioner to prevent disease, disability and other health conditions or their progressions, to prolong life, or to promote physical or mental health; and

(iii) Hospital care, including:

1. Inpatient hospital services other than those services provided in an institution for mental diseases;

2. Outpatient hospital services; and

3. Emergency hospital services;

(iv) Laboratory and x-ray services;
(v) Prescribed drugs;
(vi) Family planning services and supplies for individuals of child-bearing age;
(vii) Certified pediatric or family nurse practitioners’ services;
(viii) Emergency medical transportation;
(ix) Mental health services, including:
   1. Outpatient mental health services that are appropriate, within limits stated in [department] rules; and
   2. Inpatient psychiatric facility services within limits stated in [department] rules;
(x) Medical supplies, equipment, and appliances suitable for use in the home; and
   (xi) Physical therapy and related services;
(b) Primary care case management;
(c) Dental services, and medical and surgical services furnished by a dentist in accordance with section 1905(a)(5)(B) of the Social Security Act;
(d) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law, including:
   (i) Podiatrists' services;
   (ii) Optometrists' services;
   (iii) Chiropractors' services; and
   (iv) Other practitioners' services, in accordance with [department] rules;
(e) Services for individuals with speech, hearing and language disorders, provided by or under the supervision of a speech pathologist or audiologist;
(f) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;
(g) Services provided by essential providers, including:
   (i) Rural health clinic services and other ambulatory services furnished by a rural health clinic in accordance with section 1905(l)(1) of the Social Security Act;
   (ii) Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 1905(l)(2) of the Social Security Act;
   (iii) Indian health services; and
   (iv) District health [departments];
(h) Any other medical care and any other type of remedial care recognized under state law, specified by the secretary of the federal department of health and human services;
(i) Nonemergency medical transportation; and
(j) Physician, hospital or other services deemed experimental are excluded from coverage. The [director] may allow coverage of procedures or services deemed investigational if the procedures or services are as cost-effective as traditional, standard treatments.

Section 7. [Severability.] [Insert severability clause.]

Section 8. [Repealer.] [Insert repealer clause.]

Section 9. [Effective Date.] [Insert effective date.]