

# 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.)

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

2

3           Section 2. [*Legislative Findings.*]

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

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

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

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

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

- 24                                   (i) To emphasize preventive care and wellness;  
25                                   (ii) To empower people with disabilities to manage their own lives;  
26                                   (iii) To provide opportunities for employment for people with disabilities;

27 and

28                                   (iv) To provide and to promote family-centered, community-based,  
29 coordinated care for children with special health care needs.

30 (c) Elders. The broad policy goal for the Medicaid Program For Elders is to  
31 finance and deliver cost-effective individualized care which is integrated, to the greatest extent  
32 possible, with Medicare coverage. Additional specific goals are:

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

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

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

42  
43 Section 3. *[Definitions.]* As used in this Act:

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

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

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

50 (4) "Department" means the [department of health and welfare].

51 (5) "Director" means the [director of the department of health and welfare].

52 (6) "Health risk assessment" means a process of assessing the health status and health  
53 needs of participants.

54 (7) "Medicaid" means the state Medical Assistance Program.

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

58 (9) "Medical home" means a primary care case manager designated by the participant or  
59 the [department] to coordinate the participant's care.

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

63 (11) "Participant" means a person eligible for and enrolled in the state Medical Assistance  
64 Program.

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

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

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

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

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

76  
77 Section 4. *[Powers and Duties of the Director.]*

78 (1) The [director] is hereby encouraged and empowered to obtain federal approval in order  
79 that this state design and implement changes to its Medicaid Program that advance the quality of

80 services to participants while allowing access to needed services and containing excessive costs.  
81 The design of this state's Medicaid Program shall incorporate and promote advance the concepts  
82 outlined in section 2 of this Act.

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

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

89 (4) The [director] shall establish a mechanism to ensure placement of participants into the  
90 appropriate state plan. This mechanism shall include, but not be limited to, a health risk  
91 assessment. This assessment shall comply with federal requirements for Early and Periodic  
92 Screening, Diagnosis and Treatment (EPSDT) services for children, in accordance with section  
93 1905(a)(4)(B) of the Social Security Act.

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

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

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

103 (8) The [director] is given authority to promulgate rules consistent with this Act.  
104

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

107 (1) The state plan for low-income children and working-age adults includes the following  
108 people:

109 (a) Children in families whose family income does not exceed [one hundred  
110 eighty-five percent (185%)] of the federal poverty guideline and who meet age-related and other  
111 eligibility standards in accordance with [department] rule;

112 (b) Pregnant women of any age whose family income does not exceed [one  
113 hundred thirty-three percent (133%)] of the federal poverty guideline and who meet other  
114 eligibility standards in accordance with [department] rule, or who meet the presumptive eligibility  
115 guidelines in accordance with section 1920 of the Social Security Act;

116 (c) Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must  
117 be offered throughout the first year of life so long as the infant remains in the mother's household  
118 and she remains eligible, or would be eligible if she were still pregnant;

119 (d) Adults in families with dependent children as described in section 1931 of the  
120 Social Security Act, who meet the requirements in the state's Assistance to Families With  
121 Dependent Children (AFDC) plan in effect on [July 16, 1996];

122 (e) Families who are provided [six (6) to twelve (12) months] of Medicaid  
123 coverage following loss of eligibility under section 1931 of The Social Security Act due to  
124 earnings, or [four (4) months] of Medicaid coverage following loss of eligibility under section 19  
125 02 (a) (31) of the Social Security Act due to an increase in child or spousal support;

126 (f) Employees of small businesses who meet the definition of "eligible adult" as  
127 described in [insert citation], whose eligibility is limited to the Medical Assistance Program  
128 described in [insert citation]; and

129 (g) All other mandatory groups as defined in Title XIX of the Social Security Act,  
130 if not listed separately in subsection (2) or (3) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

174  
175 Section 6. *[Medical Assistance Program -- Services to be Provided.]*

176 (1) The department may make payments for the following services furnished by providers  
177 to participants who are determined to be eligible on the dates on which the services were  
178 provided. Any service under this section shall be reimbursed only when medically necessary and

179 in accordance with federal law and regulation, state law and [department] rule. Notwithstanding  
180 any other provision of this Act, medical assistance includes the following benefits specific to the  
181 eligibility categories established in [insert citation], as well as a list of benefits to which all  
182 Medicaid participants in this state are entitled, defined in subsection (5) of this section.

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

185 (a) All services described in subsection (5) of this section;

186 (b) Early and periodic screening, diagnosis and treatment services for individuals  
187 under age [twenty-one (21) years], and treatment of conditions found; and

188 (c) Cost-sharing required of participants. Participants in the low-income children  
189 and working-age adult group are subject to the following premium payments, as stated in  
190 [department] rules:

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

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

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

198 (a) All services described in subsection (5) of this section;

199 (b) Early and periodic screening, diagnosis and treatment services for individuals  
200 under age [twenty-one (21)] years, and treatment of conditions found;

201 (c) Case management services as defined in accordance with subsection  
202 1905(a)(19) or section 1915(g) of the Social Security Act; and

203 (d) Mental health services, including:

204 (i) Inpatient psychiatric facility services whether in a hospital, or for people  
205 under age [twenty-two (22)] years in a freestanding psychiatric facility, as permitted by federal  
206 law, in excess of those limits in [department] rules on inpatient psychiatric facility services  
207 provided under subsection (5) of this section;

208 (ii) Outpatient mental health services in excess of those limits in  
209 [department] rules on outpatient mental health services provided under subsection (5) of this  
210 section; and

211 (iii) Psychosocial rehabilitation for reduction of mental disability for  
212 children under the age of [eighteen (18) years] with a Serious Emotional Disturbance (SED) and  
213 for severely and persistently mentally ill adults, aged [eighteen (18) years or older], with severe  
214 and persistent mental illness;

215 (e) Long-term care services, including:

216 (i) Nursing facility services, other than services in an institution for mental  
217 diseases, subject to participant cost-sharing;

218 (ii) Home-based and community-based services, subject to federal  
219 approval, provided to people who require nursing facility level of care who, without home-based  
220 and community-based services, would require institutionalization. These services will include  
221 community supports, including an option for self-determination, which will enable people to have  
222 greater freedom to manage their own care; and

223 (iii) Personal care services in a participant's home, prescribed in  
224 accordance with a plan of treatment and provided by a qualified person under supervision of a  
225 registered nurse;

226 (f) Services for people with developmental disabilities, including:

227 (i) Intermediate care facility services, other than such services in an  
228 institution for mental diseases, for people determined in accordance with section 1902(a)(31) of

229 the Social Security Act to be in need of such care, including such services in a public institution,  
230 or distinct part thereof, for the mentally retarded or people with related conditions;

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

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

241 (g) Home health services, including:

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

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

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

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

248 (i) Specialized medical equipment and supplies; and

249 (j) Medicare cost-sharing, including:

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

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

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

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

258 (4) Specific health benefits for elders include:

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

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

263 (c) Other services that supplement Medicare coverage.

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

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

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

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

273 (iii) Hospital care, including:

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

276 2. Outpatient hospital services; and

277 3. Emergency hospital services;

278 (iv) Laboratory and x-ray services;

279 (v) Prescribed drugs;  
280 (vi) Family planning services and supplies for individuals of child-bearing  
281 age;  
282 (vii) Certified pediatric or family nurse practitioners' services;  
283 (viii) Emergency medical transportation;  
284 (ix) Mental health services, including:  
285 1. Outpatient mental health services that are appropriate, within  
286 limits stated in [department] rules; and  
287 2. Inpatient psychiatric facility services within limits stated in  
288 [department] rules;  
289 (x) Medical supplies, equipment, and appliances suitable for use in the  
290 home; and  
291 (xi) Physical therapy and related services;  
292 (b) Primary care case management;  
293 (c) Dental services, and medical and surgical services furnished by a dentist in  
294 accordance with section 1905(a)(5)(B) of the Social Security Act;  
295 (d) Medical care and any other type of remedial care recognized under state law,  
296 furnished by licensed practitioners within the scope of their practice as defined by state law,  
297 including:  
298 (i) Podiatrists' services;  
299 (ii) Optometrists' services;  
300 (iii) Chiropractors' services; and  
301 (iv) Other practitioners' services, in accordance with [department] rules;  
302 (e) Services for individuals with speech, hearing and language disorders, provided  
303 by or under the supervision of a speech pathologist or audiologist;  
304 (f) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an  
305 optometrist;  
306 (g) Services provided by essential providers, including:  
307 (i) Rural health clinic services and other ambulatory services furnished by a  
308 rural health clinic in accordance with section 1905(l)(1) of the Social Security Act;  
309 (ii) Federally qualified health center (FQHC) services and other ambulatory  
310 services that are covered under the plan and furnished by an FQHC in accordance with section  
311 1905(l)(2) of the Social Security Act;  
312 (iii) Indian health services; and  
313 (iv) District health [departments];  
314 (h) Any other medical care and any other type of remedial care recognized under  
315 state law, specified by the secretary of the federal department of health and human services;  
316 (i) Nonemergency medical transportation; and  
317 (j) Physician, hospital or other services deemed experimental are excluded from  
318 coverage. The [director] may allow coverage of procedures or services deemed investigational if  
319 the procedures or services are as cost-effective as traditional, standard treatments.

320  
321 Section 7. [*Severability.*] [Insert severability clause.]

322  
323 Section 8. [*Repealer.*] [Insert repealer clause.]

324  
325 Section 9. [*Effective Date.*] [Insert effective date.]