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.]