LEGISLATURE OF THE STATE OF IDAHO

Sixty-second Legislature First Regular Session - 2013

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 288

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO THE MEDICAL ASSISTANCE PROGRAM; AMENDING SECTION 56-255, IDAHO CODE, TO PROVIDE THAT PREGNANT WOMEN AND ADULTS ON THE ENHANCED BENEFIT PLAN SHALL HAVE ACCESS TO DENTAL SERVICES THAT REFLECT EVIDENCE-BASED PRACTICE AND TO MAKE TECHNICAL CORRECTIONS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 56-255, Idaho Code, be, and the same is hereby amended to read as follows:

56-255. 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 within the appropriations provided by law and in accordance with federal law and regulation, Idaho law and department rule. Notwithstanding any other provision of this chapter, medical assistance includes the following benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined in subsection (5) of this section.

(2) Specific health benefits and limitations for low-income children and working-age adults with no 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; 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 persons 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 section 1905(a)(19) or section 1915(g) of the social security act; and

(d) Mental health services delivered by providers that meet national accreditation standards, including:

(i) Inpatient psychiatric facility services whether in a hospital, or for persons under the age of 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). Individuals age eighteen (18) years to age twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of five (5) hours while adults over the age of twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of four (4) hours;

(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 individuals 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 options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule; 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 persons with developmental disabilities, including:

(i) Intermediate care facility services, other than such services in an institution for mental diseases, for persons 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 persons with intellectual disabilities or persons with related conditions;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require an intermediate care facility for people with intellectual disabilities (ICF/ID) level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule. The department shall respond to requests for budget modifications only when health and

safety issues are identified and meet the criteria as defined in department rule; and

(iii) Developmental disability services for children and adults shall be available based upon need through state plan services or waiver services as described in department rule. The department shall develop a blended rate covering both individual and group developmental therapy services;

(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;

(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; and

(k) Nonemergency medical transportation.

(4) Specific health benefits for persons over twenty-one (21) years of age who have medicare and medicaid coverage 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;

(c) Other services that supplement medicare coverage; and

(d) Nonemergency medical transportation.

(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;
(xi) Physical therapy and speech therapies combined to align with the annual medicare caps; and
(xii) Occupational therapy to align with the annual medicare cap;

(b) Primary care medical homes;

(c) Dental services. Children shall have access to prevention, diagnosis and treatment services as defined in federal law. Adult coverage shall be limited to medically necessary oral surgery and palliative services and associated diagnostic services. Select covered benefits include: exams, radiographs, periodontal, oral and maxillofacial surgery and adjunctive general services as defined in department rule. Pregnant women~~, participants on the aged and disabled waiver and the developmental disability waiver~~ and adults on the enhanced benefit plan shall have access to dental services that reflect evidence-based practice;

(d) Medical care and any other type of remedial care recognized under Idaho law, furnished by licensed practitioners within the scope of their practice as defined by Idaho law, including:
(i) Podiatrists' services based upon chronic care criteria as defined in department rule;
(ii) Optometrists' services based upon chronic care criteria as defined in department rule;
(iii) Chiropractors' services shall be limited to six (6) visits per year; and
(iv) Other practitioners' services, in accordance with department rules;

(e) Services for individuals with speech, hearing and language disorders as defined in department rule;

(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;

(iv) District health departments; and

(v) The family medicine residency of Idaho and the Idaho state university family medicine residency; and

(h) 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.