LEGISLATURE OF THE STATE OF IDAHO

Sixty-first Legislature Second Regular Session - 2012

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 609

BY STATE AFFAIRS COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE LAW; AMENDING SECTION 56-255, IDAHO CODE, TO REVISE PROVISIONS RELATING TO DENTAL SERVICES FOR CERTAIN MEDICAID PARTICIPANTS AND TO MAKE A TECHNICAL CORRECTION; AND AMENDING SECTION 56-264, IDAHO CODE, TO REVISE PROVISIONS RELATING TO THE RULEMAKING AUTHORITY OF THE DEPARTMENT OF HEALTH AND WELFARE.

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 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). 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 re-

spond 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 on 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; ~~and~~

(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<u>, participants on the aged and disabled waiver and the developmental disability waiver</u> 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 on chronic care criteria as defined in department rule;

(ii) Optometrists' services based on 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.

SECTION 2. That Section 56-264, Idaho Code, be, and the same is hereby amended to read as follows:

56-264. RULEMAKING AUTHORITY. In addition to the rulemaking authority granted to the department in this chapter and elsewhere in Idaho Code regarding the medicaid program and notwithstanding any other Idaho law to the contrary, the department shall have the authority to promulgate rules regarding:

(1) Medical services to:
(a) Change the primary case management paid to providers to a tiered payment based on the health needs of the populations that are managed. A lower payment is to be made for healthier populations and a higher payment is to be made for individuals with special needs, disabilities or are otherwise at risk. An incentive payment is to be provided to practices that provide extended hours beyond the normal business hours that help reduce unnecessary higher-cost emergency care;
(b) Provide that a healthy connections referral is no longer required for urgent care as an alternative to higher cost but unnecessary emergency services; and
(c) Eliminate payment for collateral contact;
(2) Mental health services to:
(a) Eliminate administrative requirements for a functional and intake assessment and add a comprehensive diagnostic assessment addendum;
(b) Restrict duplicative skill training from being provided by a mental health provider when the individual has chosen to receive skill training from a developmental disability provider. ~~The individual may choose to receive skill training from a mental health provider but can not receive skill building simultaneously from two (2) providers~~ Mental health providers may not provide training for skills included in the individual's developmental disability plan, but may provide services related to the individual's mental illness that require specialized expertise of mental health professionals, such as management of mental health symptoms, teaching coping skills related to mental health diagnosis, assisting with psychiatric medical appointments and educating individuals about their diagnosis and treatment;

(c) Increase the criteria for accessing the partial care benefit and restrict to those individuals who have a diagnosis of serious and persistent mental illness;

(d) Eliminate the requirement for new annual plans; and

(e) Direct the department to develop an effective management tool for psychosocial rehabilitation services;

(3) In-home care services to:

(a) Eliminate personal care service coordination; and

(b) Restrict duplicative nursing services from a home health agency when nursing services are being provided through the aged and disabled waiver;

(4) Vision services to:

(a) Align coverage requirements for contact lenses with commercial insurers and other state medicaid programs; and

(b) Limit coverage for adults based on chronic care criteria;

(5) Audiology services to eliminate audiology benefits for adults;

(6) Developmental disability services to:

(a) Eliminate payment for collateral contact;

(b) Eliminate supportive counseling benefit;

(c) Reduce annual assessment hours from twelve (12) to four (4) hours and exclude psychological and neuropsychological testing services within these limits;

(d) Reduce plan development payment from twelve (12) to six (6) hours and reduce requirements related to adult developmental disabilities plan development;

(e) Restrict duplicative skill training from being provided by a developmental disabilities provider when an individual has chosen to receive skill training from his mental health provider. The individual may receive skill development services from a developmental disability provider only for skills that are not addressed by the mental health service provider's plan and that relate directly to the individual's developmental disability, such as skills related to activities of daily living and functional independence;

(f) Implement changes to certified family homes pursuant to chapter 31, title 39, Idaho Code, to:

(i) Create approval criteria and process for approving new certified family homes;

(ii) Recertify current certified family homes; and

(iii) Develop applicant and licensing fees to cover certifying and recertifying costs;

~~(g) Move individualized adult budgets to a tiered approach as currently used by the department for children's developmental therapy;~~ and

(7) Institutional care services to discharge individuals from institutional settings where such services are no longer necessary.