LEGISLATURE OF THE STATE OF IDAHO

Sixty-second Legislature Second Regular Session - 2014

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 601

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO INDIGENT SICK; AMENDING SECTION 31-3502, IDAHO CODE, TO REVISE THE DEFINITION OF REIMBURSEMENT RATE BY REMOVING A SUNSET PROVISION.

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

SECTION 1. That Section 31-3502, Idaho Code, be, and the same is hereby amended to read as follows:

31-3502. DEFINITIONS. As used in this chapter, the terms defined in this section shall have the following meaning, unless the context clearly indicates another meaning:

(1) "Applicant" means any person who is requesting financial assistance under this chapter.

(2) "Application" means the combined application for state and county medical assistance pursuant to sections 31-3504 and 31-3503E, Idaho Code. In this chapter an application for state and county medical assistance shall also mean an application for financial assistance.

(3) "Board" means the board of the catastrophic health care cost program, as established in section 31-3517, Idaho Code.

(4) "Case management" means coordination of services to help meet a patient's health care needs, usually when the patient has a condition that requires multiple services.

(5) "Catastrophic health care costs" means the cost of necessary medical services received by a recipient that, when paid at the then existing reimbursement rate, exceeds the total sum of eleven thousand dollars ($11,000) in the aggregate in any consecutive twelve (12) month period.

(6) "Clerk" means the clerk of the respective counties or his or her designee.

(7) "Completed application" shall include at a minimum the cover sheet requesting services, applicant information including diagnosis and requests for services and signatures, personal and financial information of the applicant and obligated person or persons, patient rights and responsibilities, releases and all other signatures required in the application.

(8) "County commissioners" means the board of county commissioners in their respective counties.

(9) "County hospital" means any county approved institution or facility for the care of sick persons.

(10) "Department" means the department of health and welfare.

(11) "Dependent" means any person whom a taxpayer claims as a dependent under the income tax laws of the state of Idaho.

(12) "Emergency service" means a service provided for a medical condition in which sudden, serious and unexpected symptoms of illness or injury are sufficiently severe to necessitate or call for immediate medical care, including, but not limited to, severe pain, that the absence of immediate

medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(13) "Hospital" means a facility licensed and regulated pursuant to sections 39-1301 through 39-1314, Idaho Code, or an out-of-state hospital providing necessary medical services for residents of Idaho, wherein a reciprocal agreement exists, in accordance with section 31-3503B, Idaho Code, excluding state institutions.

(14) "Medicaid eligibility review" means the process used by the department to determine whether a person meets the criteria for medicaid coverage.

(15) "Medical claim" means the itemized statements and standard forms used by hospitals and providers to satisfy centers for medicare and medicaid services (CMS) claims submission requirements.

(16) "Medical home" means a model of primary and preventive care delivery in which the patient has a continuous relationship with a personal physician in a physician directed medical practice that is whole person oriented and where care is integrated and coordinated.

(17) "Medically indigent" means any person who is in need of necessary medical services and who, if an adult, together with his or her spouse, or whose parents or guardian if a minor or dependent, does not have income and other resources available to him from whatever source sufficient to pay for necessary medical services. Nothing in this definition shall prevent the board and the county commissioners from requiring the applicant and obligated persons to reimburse the county and the catastrophic health care cost program, where appropriate, for all or a portion of their medical expenses, when investigation of their application pursuant to this chapter, determines their ability to do so.

(18) A. "Necessary medical services" means health care services and supplies that:

(a) Health care providers, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms;

(b) Are in accordance with generally accepted standards of medical practice;

(c) Are clinically appropriate, in terms of type, frequency, extent, site and duration and are considered effective for the covered person's illness, injury or disease;

(d) Are not provided primarily for the convenience of the person, physician or other health care provider; and

(e) Are the most cost-effective service or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury or disease.

B. Necessary medical services shall not include the following:

(a) Bone marrow transplants;

(b) Organ transplants;

(c) Elective, cosmetic and/or experimental procedures;

(d) Services related to, or provided by, residential, skilled nursing, assisted living and/or shelter care facilities;
(e) Normal, uncomplicated pregnancies, excluding caesarean section, and childbirth well-baby care;
(f) Medicare copayments and deductibles;
(g) Services provided by, or available to, an applicant from state, federal and local health programs;
(h) Medicaid copayments and deductibles; and
(i) Drugs, devices or procedures primarily utilized for weight reduction and complications directly related to such drugs, devices or procedures.

(19) "Obligated person" means the person or persons who are legally responsible for an applicant including, but not limited to, parents of minors or dependents.

(20) "Primary and preventive health care" means the provision of professional health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems and the overall management of an individual's health care services.

(21) "Provider" means any person, firm or corporation certified or licensed by the state of Idaho or holding an equivalent license or certification in another state, that provides necessary medical services to a patient requesting a medically indigent status determination or filing an application for financial assistance.

(22) "Recipient" means an individual determined eligible for financial assistance under this chapter.

(23) "Reimbursement rate" means the unadjusted medicaid rate of reimbursement for medical charges allowed pursuant to title XIX of the social security act, as amended, that is in effect at the time service is rendered. ~~Beginning July 1, 2011, and sunsetting July 1, 2014,~~ The "reimbursement rate" shall mean ninety-five percent (95%) of the unadjusted medicaid rate.

(24) "Resident" means a person with a home, house, place of abode, place of habitation, dwelling or place where he or she actually lived for a consecutive period of thirty (30) days or more within the state of Idaho. A resident does not include a person who comes into this state for temporary purposes, including, but not limited to, education, vacation, or seasonal labor. Entry into active military duty shall not change a person's residence for the purposes of this chapter. Those physically present within the following facilities and institutions shall be residents of the county where they were residents prior to entering the facility or institution:
(a) Correctional facilities;
(b) Nursing homes or residential or assisted living facilities;
(c) Other medical facility or institution.

(25) "Resources" means all property, for which an applicant and/or an obligated person may be eligible or in which he or she may have an interest, whether tangible or intangible, real or personal, liquid or nonliquid, or pending, including, but not limited to, all forms of public assistance, crime victims compensation, worker's compensation, veterans benefits, medicaid, medicare, supplemental security income (SSI), third party insurance, other insurance or apply for section 1011 of the medicare modernization act

of 2003, if applicable, and any other property from any source. Resources shall include the ability of an applicant and obligated persons to pay for necessary medical services, excluding any interest charges, over a period of up to five (5) years starting on the date necessary medical services are first provided. For purposes of determining approval for medical indigency only, resources shall not include the value of the homestead on the applicant or obligated person's residence, a burial plot, exemptions for personal property allowed in section 11-605(1) through (3), Idaho Code, and additional exemptions allowed by county resolution.

(26) "Third party applicant" means a person other than an obligated person who completes, signs and files an application on behalf of a patient. A third party applicant who files an application on behalf of a patient pursuant to section 31-3504, Idaho Code, shall, if possible, deliver a copy of the application to the patient within three (3) business days after filing the application.

(27) "Third party insurance" means casualty insurance, disability insurance, health insurance, life insurance, marine and transportation insurance, motor vehicle insurance, property insurance or any other insurance coverage that may pay for a resident's medical bills.

(28) "Utilization management" means the evaluation of medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities. "Utilization management" may include, but is not limited to, preadmission certification, the application of practice guidelines, continued stay review, discharge planning, case management, preauthorization of ambulatory procedures, retrospective review and claims review. "Utilization management" may also include the amount to be paid based on the application of the reimbursement rate to those medical services determined to be necessary medical services.