HB 31 -- Medical Services and Eligibility

Co-Sponsors: Bearden, Reinhart, Portwood, Wright, Jetton, Stevenson, Crowell, Hanaway

This bill makes several changes to the laws relating to Medicaid eligibility and covered services. In its major provisions, the bill:

(1) Provides that if money is not appropriated in a given fiscal year to fund medical services for aged, blind, and disabled individuals whose income is greater than 80% of the federal poverty level, then those individuals are not eligible for medical assistance for that fiscal year;

(2) Allows Medicaid to cover non-prescription drugs;

(3) Allows the Department of Social Services to negotiate with drug manufacturers for supplemental rebates;

(4) Requires restrictions on payments for pharmacy services and prior authorization to be implemented only by rule or regulation;

(5) Provides that if money is not appropriated in a given year for any service authorized for coverage by the Medicaid Program, then the service may not be provided and individuals otherwise eligible to receive the service are no longer deemed eligible;

(6) Adds non-emergency medical transportation to the list of services for which the Division of Medical Services may require the recipient to make a copayment and specifies that the copayment is a credit against payments owed by the state for the service;

(7) Requires that general relief payments and medical assistance for individuals receiving general relief be provided only if appropriations are made for them. If the funds appropriated are insufficient to make the payments, the amount of the payments must be reduced pro rata; and if money is not appropriated, the benefits will not be provided, and individuals otherwise eligible are no longer deemed eligible for benefits during that fiscal year;

(8) Specifies that medical assistance benefits for individuals receiving general relief are subject to appropriations; and

(9) Requires the department to establish by rule certain requirements for participation in the MC+ for Kids Program. These requirements include verifying available income, allowing the department to contact the participant’s employer to verify

the availability or unavailability of employer-sponsored health insurance, and making participants ineligible if they fail to provide three copayments within a one-year period.

The bill contains an emergency clause.