CHAPTER 1141

IOWACARE PROGRAM CHANGES

S.F. 2156

AN ACT relating to the IowaCare program, and providing for repeals.

Be It Enacted by the General Assembly of the State of Iowa:

DIVISION I
IOWACARE PROGRAM UPDATE

Section 1. Section 249J.5, subsections 1, 2, 7, 8, and 9, Code 2009, are amended to read as follows:

1. Except as otherwise provided in this chapter, an individual nineteen through sixty-four years of age shall be eligible solely for the expansion population benefits described in this chapter when provided through the expansion population provider network as described in this chapter, if the individual meets all of the following conditions:

a. The individual is not eligible for coverage under the medical assistance program ~~in effect on or after April 1, 2005~~.

b. The individual has a family income at or below two hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

c. The individual fulfills all other conditions of participation for the expansion population described in this chapter, including requirements relating to personal financial responsibility.

2. Individuals otherwise eligible solely for family planning benefits authorized under the medical assistance family planning services waiver~~, effective January 1, 2005, as described in 2004 Iowa Acts, chapter 1175, section 116, subsection 8,~~ may also be eligible for expansion population benefits provided through the expansion population provider network.

~~7. The department shall contract with the county general assistance directors to perform intake functions for the expansion population, but only at the discretion of the individual county general assistance director.~~

~~8.~~ 7. If the department provides intake services at the location of a provider included in the expansion population provider network, the department shall consider subcontracting with local nonprofit agencies to promote greater understanding between providers, under the medical assistance program and included in the expansion population provider network, and their recipients and members.

~~9.~~ 8. Following initial enrollment, an expansion population member shall reenroll annually by the last day of the month preceding the month in which the expansion population member initially enrolled. The department may provide a process for automatic reenrollment of expansion population members.

Sec. 2. Section 249J.6, subsection 1, unnumbered paragraph 1, Code 2009, is amended to read as follows:

~~Beginning July 1, 2005, the~~ The expansion population shall be eligible for all of the following expansion population services:

Sec. 3. Section 249J.6, subsection 2, Code 2009, is amended to read as follows:

2. *a.* Each expansion population member ~~who enrolls or reenrolls in the expansion population on or after January 31, 2007,~~ shall ~~participate, in conjunction with receiving~~ receive a ~~single~~ comprehensive medical examination ~~and completing a personal health improvement plan, in a health risk assessment coordinated by a health consortium representing providers, consumers, and medical education institutions~~ annually. The ~~criteria for the~~ department may implement a web-based health risk assessment~~, the comprehensive medical examination, and the personal health improvement plan shall be developed and applied in a manner that takes into consideration cultural variations that may exist within the expansion population~~ for expansion population members that may include facilitation, if deemed to be cost-effective to the program. ~~The health risk assessment shall utilize a~~

~~gender-specific approach. In developing the queries unique to women, a clinical advisory team shall be utilized that includes women's health professionals including but not limited to those with specialties in obstetrics and gynecology, endocrinology, mental health, behavioral health, oncology, cardiology, and rheumatology.~~

~~*b.* The health risk assessment shall be a web-based electronic system capable of capturing and integrating basic data to provide an individualized personal health improvement plan for each expansion population member. The health risk assessment shall provide a preliminary diagnosis of current and prospective health conditions and recommendations for improving health conditions with an individualized wellness program. The health risk assessment shall be made available to the expansion population member and the provider specified in paragraph "*c*" who performs the comprehensive medical examination and provides the individualized personal health improvement plan.~~

~~*c.* The single comprehensive medical examination and personal health improvement plan may be provided by an expansion population provider network physician, advanced registered nurse practitioner, or physician assistant or any other physician, advanced registered nurse practitioner, or physician assistant, available to any full benefit recipient including but not limited to such providers available through a free clinic or rural health clinic under a contract with the department to provide these services, through federally qualified health centers that employ a physician, or through any other nonprofit agency qualified or deemed to be qualified by the department to perform these services.~~

~~*d.* Following completion of an initial health risk assessment, comprehensive medical examination, and personal health improvement plan, an expansion population member may complete subsequent assessments, examinations, or plans with the recommendation and approval of a provider specified in paragraph "*c*".~~

~~*e.*~~ *b.* Refusal of an expansion population member to participate in a ~~health risk assessment,~~ comprehensive medical examination~~, or personal health improvement plan~~ or any health risk assessment implemented by the department, shall not be a basis for ineligibility for or disenrollment from the expansion population.

Sec. 4. Section 249J.6, subsection 3, Code 2009, is amended to read as follows:

3. ~~Beginning no later than July 1, 2006, expansion~~ Expansion population members shall be provided ~~all of the following:~~

~~*a.* Access to a pharmacy assistance clearinghouse program to match expansion population members with free or discounted prescription drug programs provided by the pharmaceutical industry.~~

~~*b.* Access~~ access to ~~a medical information hotline~~ an IowaCare nurse helpline, accessible twenty-four hours per day, seven days per week, to assist expansion population members in making appropriate choices about the use of emergency room and other health care services.

Sec. 5. Section 249J.7, subsection 1, Code 2009, is amended to read as follows:

1. Expansion population members shall only be eligible to receive expansion population services through a provider included in the expansion population provider network. Except as otherwise provided in this chapter, the expansion population provider network shall be limited to a publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand~~,~~ and the university of Iowa hospitals and clinics~~, and the state hospitals for persons with mental illness designated pursuant to section 226.1 with the exception of the programs at such state hospitals for persons with mental illness that provide substance abuse treatment, serve gero-psychiatric patients, or treat sexually violent predators~~. [1]

Sec. 6. Section 249J.8, Code 2009, is amended to read as follows:

249J.8 Expansion population members — financial participation.

1. Each expansion population member whose family income exceeds one hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services shall

[1] See chapter 1193, §202 herein

pay a monthly premium not to exceed one-twelfth of five percent of the member's annual family income. Each expansion population member whose family income is equal to or less than one hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services shall not be subject to payment of a monthly premium. All premiums shall be paid on the last day of the month of coverage. The department shall deduct the amount of any monthly premiums paid by an expansion population member for benefits under the healthy and well kids in Iowa program when computing the amount of monthly premiums owed under this subsection. An expansion population member shall ~~pay~~ respond to the monthly premium notices either through timely payment or a request for a hardship exemption during the entire period of the member's enrollment. Regardless of the length of enrollment, the member is subject to payment of the premium for a minimum of four consecutive months. However, an expansion population member who complies with the requirement of payment of the premium for a minimum of four consecutive months during a consecutive twelve-month period of enrollment shall be deemed to have complied with this requirement for the subsequent consecutive twelve-month period of enrollment and shall only be subject to payment of the monthly premium on a month-by-month basis. Timely payment of premiums, including any arrearages accrued from prior enrollment, is a condition of receiving any expansion population services. The payment to and acceptance by an automated case management system or the department of the premium required under this subsection shall not automatically confer initial or continuing program eligibility on an individual. A premium paid to and accepted by the department's premium payment process that is subsequently determined to be untimely or to have been paid on behalf of an individual ineligible for the program shall be refunded to the remitter in accordance with rules adopted by the department. Premiums collected under this subsection shall be deposited in the premiums subaccount of the account for health care transformation created pursuant to section 249J.23. An expansion population member shall also pay the same copayments required of other adult recipients of medical assistance.

2. The department may reduce the required out-of-pocket expenditures for an individual expansion population member based upon the member's increased wellness activities such as smoking cessation or compliance with the personal health improvement plan completed by the member. The department shall also waive the required out-of-pocket expenditures for an individual expansion population member based upon a hardship that would accrue from imposing such required expenditures. Information regarding the premium payment obligation and the hardship exemption, including the process by which a prospective enrollee may apply for the hardship exemption, shall be provided to a prospective enrollee at the time of application. The prospective enrollee shall acknowledge, in writing, receipt and understanding of the information provided.

~~3. The department shall submit to the governor and the general assembly by March 15, 2006, a design for each of the following:~~

~~*a.* An insurance cost subsidy program for expansion population members who have access to employer health insurance plans, provided that the design shall require that no less than fifty percent of the cost of such insurance shall be paid by the employer.~~

~~*b.* A health care account program option for individuals eligible for enrollment in the expansion population. The health care account program option shall be available only to adults who have been enrolled in the expansion population for at least twelve consecutive calendar months. Under the health care account program option, the individual would agree to exchange one year's receipt of benefits under the expansion population, to which the individual would otherwise be entitled, for a credit to obtain any medical assistance program covered service up to a specified amount. The balance in the health care account at the end of the year, if any, would be available for withdrawal by the individual.~~

~~4.~~ 3. The department shall track ~~the impact of the~~ out-of-pocket expenditures ~~on~~ by expansion population ~~enrollment~~ members and shall report the ~~findings~~ data on ~~at least a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.20~~ the department's internet website. The ~~findings~~ report shall include estimates of the number of expansion population members complying and not complying with payment of required out-of-pocket expenditures~~, the number of expansion~~

~~population members not complying with payment of required out-of-pocket expenditures and the reasons for noncompliance, any impact as a result of the out-of-pocket requirements on the provision of services to the populations previously served, the administrative time and cost associated with administering the out-of-pocket requirements, and the benefit to the state resulting from the out-of-pocket expenditures~~. To the extent possible, the department shall track the income level of the member, the health condition of the member, and the family status of the member relative to the out-of-pocket information.

Sec. 7. Section 249J.9, Code 2009, is amended to read as follows:

249J.9 Future ~~expansion population,~~ benefits~~,~~ and provider network growth.

~~1. *Population.* The department shall contract with the division of insurance of the department of commerce or another appropriate entity to track, on an annual basis, the number of uninsured and underinsured Iowans, the cost of private market insurance coverage, and other barriers to access to private insurance for Iowans. Based on these findings and available funds, the department shall make recommendations, annually, to the governor and the general assembly regarding further expansion of the expansion population.~~

~~2.~~ 1. *Benefits.*

a. The department shall not provide services to expansion population members that are in addition to the services originally designated by the department pursuant to section 249J.6, without express authorization provided by the general assembly.

b. The department, upon the recommendation of the clinicians advisory panel established pursuant to section 249J.18, may change the scope and duration of any of the available expansion population services, but this subsection shall not be construed to authorize the department to make expenditures in excess of the amount appropriated for benefits for the expansion population.

~~3.~~ 2. *Expansion population provider network.*

a. The department shall not expand the expansion population provider network unless the department is able to pay for expansion population services provided by such providers at the full benefit recipient rates.

b. The department may limit access to the expansion population provider network by the expansion population to the extent the department deems necessary to meet the financial obligations to each provider under the expansion population provider network. This subsection shall not be construed to authorize the department to make any expenditure in excess of the amount appropriated for benefits for the expansion population.

Sec. 8. Section 249J.10, subsection 2, Code 2009, is amended to read as follows:

2. The department ~~of human services shall~~ may include in its annual budget submission, recommendations relating to a disproportionate share hospital and graduate medical education allocation plan that maximizes the availability of federal funds for payments to hospitals for the care and treatment of indigent patients.

Sec. 9. Section 249J.11, Code 2009, is amended to read as follows:

249J.11 Nursing facility level of care determination for facility-based and community-based services.

The department shall amend the medical assistance state plan to provide for all of the following:

1. That nursing facility level of care services under the medical assistance program shall be available to an individual admitted to a nursing facility ~~on or after July 1, 2005~~, who meets eligibility criteria for the medical assistance program pursuant to section 249A.3, if the individual also meets any of the following criteria:

a. Based upon the minimum data set, the individual requires limited assistance, extensive assistance, or has total dependence on assistance, provided by the physical assistance of one or more persons, with three or more activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems".

b. Based on the minimum data set, the individual requires the establishment of a safe, secure environment due to moderate or severe impairment of cognitive skills for daily decision making.

c. The individual has established a dependency requiring residency in a medical institution for more than one year.

2. That ~~an individual admitted to a nursing facility prior to July 1, 2005, and~~ an individual applying for home and community-based services waiver services at the nursing facility level of care ~~on or after July 1, 2005~~, who meets the eligibility criteria for the medical assistance program pursuant to section 249A.3, shall also meet any of the following criteria:

a. Based on the minimum data set, the individual requires supervision, or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems".

b. Based on the minimum data set, the individual requires the establishment of a safe, secure environment due to modified independence or moderate impairment of cognitive skills for daily decision making.

3. That, ~~beginning July 1, 2005,~~ if nursing facility level of care is determined to be medically necessary for an individual and the individual meets the nursing facility level of care requirements for home and community-based services waiver services under subsection 2, but appropriate home and community-based services are not available to the individual in the individual's community at the time of the determination or the provision of available home and community-based services to meet the skilled care requirements of the individual is not cost-effective, the criteria for admission of the individual to a nursing facility for nursing facility level of care services shall be the criteria in effect on June 30, ~~2005~~ 2010. The department of human services shall establish the standard for determining cost-effectiveness of home and community-based services under this subsection.

4. The department shall develop a process to allow individuals identified under subsection 3 to be served under the home and community-based services waiver at such time as appropriate home and community-based services become available in the individual's community.

Sec. 10. Section 249J.13, Code 2009, is amended to read as follows:

249J.13 Children's mental health waiver services.

The department shall provide medical assistance waiver services to ~~not more than three hundred~~ children who meet the eligibility criteria for the medical assistance program pursuant to section 249A.3, and also meet the criteria specified in section 234.7, subsection 2.

Sec. 11. Section 249J.14, Code 2009, is amended to read as follows:

249J.14 Health promotion partnerships.

~~1. *Services for adults at state mental health institutes.* Beginning July 1, 2005, inpatient and outpatient hospital services at the state hospitals for persons with mental illness designated pursuant to section 226.1 shall be covered services under the medical assistance program.~~

~~2.~~ 1. *Dietary counseling.* ~~By July 1, 2006~~ If a cost-effective strategy with a measurable return on investment or an impact on health care outcomes is identified, the department ~~shall~~ may design and ~~begin implementation of~~ implement a strategy to provide dietary counseling and support to child and adult recipients of medical assistance and to expansion population members to assist these recipients and members in avoiding excessive weight gain or loss and to assist in development of personal weight loss programs for recipients and members determined by the recipient's or member's health care provider to be clinically overweight.

~~3.~~ 2. ~~*Electronic medical records*~~ *Medical assistance health information technology program.* ~~By October 1, 2006, the~~ The department shall develop a ~~practical strategy for expanding utilization of electronic medical recordkeeping by providers under the medical assistance program and the expansion population provider network. The plan shall focus, initially, on medical assistance program recipients and expansion population members whose quality of care would be significantly enhanced by the availability of~~ medical assistance health information technology program for promoting the adoption and meaningful use of electronic medical recordkeeping by providers under the medical assistance program and the Iowa Medicaid enterprise pursuant to the federal American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5. The department shall do all of the following:

a. Design and implement a program for distribution and monitoring of provider incentive payments, including development of a definition of *"meaningful use"* for purposes of promoting the use of electronic medical recordkeeping by providers. The department shall develop this program in collaboration with the department of public health and the electronic health information advisory council and executive committee created pursuant to section 135.156.

b. Develop the medical assistance health information technology plan as required by the centers for Medicare and Medicaid services of the United States department of health and human services. The plan shall provide detailed implementation plans for the medical assistance program for promotion of the adoption and meaningful use of health information technology by medical assistance providers and the Iowa Medicaid enterprise. The plan shall include the integration of health information technology and health information exchange with the medical assistance management information system. The plan shall be developed in collaboration with the department of public health and the electronic health information advisory council and executive committee created pursuant to section 135.156.

~~4.~~ 3. *Provider incentive payment programs.* ~~By January 1, 2007~~ If a cost-effective strategy with a measurable return on investment or an impact on health care outcomes is identified, the department ~~shall~~ may design and implement a provider incentive payment program for providers under the medical assistance program and providers included in the expansion population provider network ~~based upon evaluation of public and private sector models~~.

~~5. *Health assessment for medical assistance recipients with mental retardation or developmental disabilities.* The department shall work with the university of Iowa colleges of medicine, dentistry, nursing, pharmacy, and public health, and the university of Iowa hospitals and clinics to determine whether the physical and dental health of recipients of medical assistance who are persons with mental retardation or developmental disabilities are being regularly and fully addressed and to identify barriers to such care. The department shall report the department's findings to the governor and the general assembly by January 1, 2007.~~

~~6.~~ 4. *Smoking cessation.* The department, in collaboration with ~~Iowa~~ department of public health programs relating to tobacco use prevention and cessation, shall implement a program with the goal of reducing smoking among recipients of medical assistance ~~who are children to less than one percent~~ and among ~~recipients of medical assistance and~~ expansion population members ~~who are adults to less than ten percent, by July 1, 2007~~.

~~7.~~ 5. *Dental home for children.* The department shall enter into an interagency agreement with the department of public health for infrastructure development and oral health coordination services for recipients of medical assistance to increase access to dental care for medical assistance recipients. By December 31, ~~2010~~ 2011, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings, preventive services, diagnostic services, treatment services, and emergency services as defined under the early and periodic screening, diagnostic, and treatment program.

~~8.~~ 6. *Reports.* The department shall issue a report on the department's internet website on a quarterly basis ~~to the medical assistance projections and assessment council established pursuant to section 249J.20 and the medical assistance advisory council created pursuant to section 249A.4B,~~ regarding ~~the~~ any changes or updates to the health promotion partnerships described in this section. To the greatest extent feasible, and if applicable to a data set, the data reported shall include demographic information concerning the population served including but not limited to ~~factors, such as race and~~ economic status, as specified by the department.

Sec. 12. Section 249J.16, Code 2009, is amended to read as follows:

249J.16 Cost and quality performance evaluation.

~~Beginning July 1, 2005, the~~ The department shall ~~contract with an independent consulting firm to~~ do all of the following:

1. ~~Annually~~ Prior to initiating reprocurement of Iowa Medicaid enterprise contracts, evaluate and compare the cost and quality of care provided by the medical assistance

program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state.

2. Annually evaluate the improvements by the medical assistance program and the expansion population in the cost and quality of services provided to Iowans over the cost and quality of care provided in the prior year.

Sec. 13. Section 249J.17, Code 2009, is amended to read as follows:

249J.17 Operations — performance evaluation.

~~Beginning July 1, 2006, the~~ The department shall ~~submit~~ publish on its internet website a report of the ~~results of an evaluation of the~~ performance of each component of the Iowa Medicaid enterprise using the performance standards contained in the contracts with the Iowa Medicaid enterprise partners.

Sec. 14. Section 249J.18, Code 2009, is amended to read as follows:

249J.18 Clinicians advisory panel — clinical management.

1. ~~Beginning July 1, 2005, the~~ The medical director of the Iowa Medicaid enterprise, with the approval of the administrator of the division of medical services of the department, shall assemble and act as chairperson for a clinicians advisory panel to recommend to the department clinically appropriate health care utilization management and coverage decisions for the medical assistance program and the expansion population which are not otherwise addressed by the Iowa medical assistance drug utilization review commission created pursuant to section 249A.24 or the medical assistance pharmaceutical and therapeutics committee established pursuant to section 249A.20A. The meetings shall be conducted in accordance with chapter 21 and shall be open to the public except to the extent necessary to prevent the disclosure of confidential medical information.

~~2. The medical director of the Iowa Medicaid enterprise shall report on a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.20 and the medical assistance advisory council created pursuant to section 249A.4B, any recommendations made by the panel and adopted by rule of the department pursuant to chapter 17A regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.~~

~~3.~~ 2. The medical director of the Iowa Medicaid enterprise shall prepare an annual report summarizing the recommendations made by the panel and adopted by rule of the department regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.

Sec. 15. Section 249J.19, Code 2009, is amended to read as follows:

249J.19 Health care services pricing and reimbursement of providers.

The department ~~shall~~ may annually collect data on third-party payor rates in the state and, as appropriate, the usual and customary charges of health care providers, including the reimbursement rates paid to providers and by third-party payors participating in the medical assistance program and through the expansion population. The department shall consult with the division of insurance of the department of commerce in adopting administrative rules specifying the reporting format and guaranteeing the confidentiality of the information provided by the providers and third-party payors. ~~The~~ If collected, the department shall review the data and make recommendations to the governor and the general assembly regarding pricing changes and reimbursement rates annually by January 1. Any recommended pricing changes or changes in reimbursement rates shall not be implemented without express authorization by the general assembly.

Sec. 16. Section 249J.21, Code 2009, is amended to read as follows:

249J.21 Payments to health care providers ~~based on actual costs.~~

~~Payments, including graduate medical education payments, under the medical assistance program and the expansion population to each public hospital and each public nursing facility shall not exceed the actual medical assistance costs of each such facility reported on the Medicare hospital and hospital health care complex cost report submitted to the centers for Medicare and Medicaid services of the United States department of health and human services.~~ Each public hospital and each public nursing facility shall retain one hundred

percent of the medical assistance payments earned under state reimbursement rules. State reimbursement rules may provide for reimbursement at less than actual cost.

Sec. 17. Section 249J.22, Code 2009, is amended to read as follows:

249J.22 Independent annual audit.

The department shall contract with a certified public accountant to provide an analysis, on an annual basis, to the governor and the general assembly ~~regarding compliance of the~~ verifying that the Iowa medical assistance program ~~with each of the following:~~

~~1. That the state has not instituted any new provider taxes as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.~~

~~2. That public hospitals and public nursing facilities are not paid more than the actual costs of care for medical assistance program and disproportionate share hospital program recipients based upon Medicare program principles of accounting and cost reporting.~~

~~3. That the state~~ is not recycling federal funds provided under ~~Title~~ Tit. XIX of the Social Security Act as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.

Sec. 18. Section 249J.23, subsection 3, Code 2009, is amended to read as follows:

3. Moneys deposited in the account for health care transformation shall be used only as provided in appropriations from the account for the costs associated with certain services provided to the expansion population pursuant to section 249J.6, ~~certain initiatives to be designed pursuant to section 249J.8, the case-mix adjusted reimbursement system for persons with mental retardation or developmental disabilities pursuant to section 249J.12,~~ certain health promotion partnership activities pursuant to section 249J.14, the cost and quality performance evaluation pursuant to section 249J.16, auditing requirements pursuant to section 249J.22, the provision of additional indigent patient care and treatment, and administrative costs associated with this chapter.

Sec. 19. Section 249J.24, Code Supplement 2009, is amended to read as follows:

249J.24 IowaCare account.

1. An IowaCare account is created in the state treasury under the authority of the department of human services. Moneys appropriated from the general fund of the state to the account, moneys received as federal financial participation funds under the expansion population provisions of this chapter and credited to the account, moneys received for disproportionate share hospitals and credited to the account, moneys received for graduate medical education and credited to the account, proceeds distributed from the county treasurer as specified in subsection ~~6~~ 4, and moneys from any other source credited to the account shall be deposited in the account. Moneys deposited in or credited to the account shall be used only as provided in appropriations or distributions from the account for the purposes specified in the appropriation or distribution. Moneys in the account shall be appropriated to the university of Iowa hospitals and clinics~~,~~ and to a publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand~~, and to the state hospitals for persons with mental illness designated pursuant to section 226.1~~ for the purposes provided in the federal law making the funds available or as specified in the state appropriation and shall be distributed as determined by the department.

2. The account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys in the account shall not be considered revenue of the state, but rather shall be funds of the account. The moneys in the account are not subject to section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes of this chapter. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the account shall be credited to the account.

3. The department shall adopt rules pursuant to chapter 17A to administer the account.

~~4. The treasurer of state shall provide a quarterly report of activities and balances of the account to the director.~~

~~5. Notwithstanding section 262.28 or any provision of this chapter to the contrary, payments to be made to participating public hospitals under this section shall be made on a prospective basis in twelve equal monthly installments based upon the amount appropriated or allocated, as applicable to a specific public hospital, in a specific fiscal year. After the close of the fiscal year, the department shall determine the amount of the payments attributable to the state general fund, federal financial participation funds collected for expansion population services, graduate medical education funds, and disproportionate share hospital funds, based on claims data and actual expenditures.~~

~~6.~~ 4. *a.* Notwithstanding any provision to the contrary, for the collection of taxes levied under section 347.7 ~~for which the collection is performed after July 1, 2005~~, the county treasurer of a county with a population over three hundred fifty thousand in which a publicly owned acute care teaching hospital is located shall distribute the proceeds collected pursuant to section 347.7 in a total amount of ~~thirty-four~~ thirty-eight million dollars annually, which would otherwise be distributed to the county hospital, to the treasurer of state for deposit in the IowaCare account under this section as follows:

(1) The first ~~seventeen~~ nineteen million dollars in collections pursuant to section 347.7 between July 1 and December 31 annually shall be distributed to the treasurer of state for deposit in the IowaCare account and collections during this time period in excess of ~~seventeen~~ nineteen million dollars shall be distributed to the acute care teaching hospital identified in this subsection.

(2) The first ~~seventeen~~ nineteen million dollars in collections pursuant to section 347.7 between January 1 and June 30 annually shall be distributed to the treasurer of state for deposit in the IowaCare account and collections during this time period in excess of ~~seventeen~~ nineteen million dollars shall be distributed to the acute care teaching hospital identified in this subsection.

b. The board of trustees of the acute care teaching hospital identified in this subsection and the department shall execute an agreement under chapter 28E ~~by July 1, 2005, and~~ annually by July 1, ~~thereafter,~~ to specify the requirements relative to distribution of the proceeds and the distribution of moneys to the hospital from the IowaCare account. The agreement shall include provisions relating to exceptions to the deadline for submission of clean claims as required pursuant to section 249J.7 and provisions relating to data reporting requirements regarding the expansion population. The agreement may also include a provision allowing such hospital to limit access to such hospital by expansion population members based on residency of the member, if such provision reflects the policy of such hospital regarding indigent patients ~~existing on April 1, 2005,~~ as adopted by its board of hospital trustees.

c. Notwithstanding the specified amount of proceeds to be distributed under this subsection, if the amount allocated that does not require federal matching funds under an appropriation in a subsequent fiscal year to such hospital for medical and surgical treatment of indigent patients, for provision of services to expansion population members, and for medical education, is reduced from the amount allocated that does not require federal matching funds under the appropriation for the fiscal year beginning July 1, ~~2005~~ 2010, the amount of proceeds required to be distributed under this subsection in that subsequent fiscal year shall be reduced in the same amount as the amount allocated that does not require federal matching funds under that appropriation.

~~7. The state board of regents, on behalf of the university of Iowa hospitals and clinics, and the department shall execute an agreement under chapter 28E by July 1, 2005, and annually by July 1, thereafter, to specify the requirements relating to distribution of moneys to the hospital from the IowaCare account. The agreement shall include provisions relating to exceptions to the deadline for submission of clean claims as required pursuant to section 249J.7 and provisions relating to data reporting requirements regarding the expansion population.~~

~~8. The state and any county utilizing the acute care teaching hospital located in a county with a population over three hundred fifty thousand for mental health services prior to July 1, 2005, shall annually enter into an agreement with such hospital to pay a per diem amount that is not less than the per diem amount paid for those mental health services in effect for the fiscal year beginning July 1, 2004, for each individual including each expansion population member accessing mental health services at that hospital on or after July 1, 2005.~~

~~Any payment made under such agreement for an expansion population member pursuant to this chapter shall be considered by the department to be payment by a third-party payor.~~

Sec. 20. Section 249J.25, Code 2009, is amended to read as follows:

249J.25 Limitations.

1. The provisions of this chapter shall not be construed, are not intended as, and shall not imply a grant of entitlement for services to individuals who are eligible for assistance under this chapter or for utilization of services that do not exist or are not otherwise available on July 1, ~~2005~~ 2010. Any state obligation to provide services pursuant to this chapter is limited to the extent of the funds appropriated or distributed for the purposes of this chapter.

2. The provisions of this chapter shall not be construed and are not intended to affect the provision of services to recipients of medical assistance existing on July 1, ~~2005~~ 2010.

Sec. 21. Section 249J.26, Code 2009, is amended to read as follows:

249J.26 Audit — future repeal.

1. The state auditor shall complete an audit of the provisions implemented pursuant to this chapter during the fiscal year beginning July 1, ~~2009~~ 2012, and shall submit the results of the audit to the governor and the general assembly by January 1, ~~2010~~ 2013.

2. This chapter is repealed ~~June 30, 2010~~ October 31, 2013.

Sec. 22. REPEAL. Sections 249J.12 and 249J.15, Code 2009, are repealed.

DIVISION II
CONFORMING PROVISIONS

Sec. 23. Section 135.159, subsection 9, Code Supplement 2009, is amended to read as follows:

9. The department shall coordinate the requirements and activities of the medical home system with the requirements and activities of the dental home for children as described in section 249J.14~~, subsection 7~~, and shall recommend financial incentives for dentists and nondental providers to promote oral health care coordination through preventive dental intervention, early identification of oral disease risk, health care coordination and data tracking, treatment, chronic care management, education and training, parental guidance, and oral health promotions for children.

Sec. 24. Section 218.78, subsection 1, Code 2009, is amended to read as follows:

1. All institutional receipts of the department of human services, including funds received from client participation at the state resource centers under section 222.78 and at the state mental health institutes under section 230.20, shall be deposited in the general fund except for reimbursements for services provided to another institution or state agency, for receipts deposited in the revolving farm fund under section 904.706, for deposits into the medical assistance fund under section 249A.11, ~~for any deposits into the medical assistance fund of any medical assistance payments received through the expansion population program pursuant to chapter 249J,~~ and rentals charged to employees or others for room, apartment, or house and meals, which shall be available to the institutions.

Sec. 25. Section 230.20, subsection 2, paragraph a, Code 2009, is amended to read as follows:

a. The superintendent shall certify to the department the billings to each county for services provided to patients chargeable to the county during the preceding calendar quarter. The county billings shall be based on the average daily patient charge and other service charges computed pursuant to subsection 1, and the number of inpatient days and other service units chargeable to the county. However, a county billing shall be decreased by an amount equal to reimbursement by a third party payor or estimation of such reimbursement from a claim submitted by the superintendent to the third party payor for the preceding calendar quarter. When the actual third party payor reimbursement is greater or less than estimated, the difference shall be reflected in the county billing in the calendar quarter the actual third party payor reimbursement is determined. ~~For the purposes of this paragraph,~~

~~*"third party payor reimbursement"* does not include reimbursement provided under chapter 249J.~~

Sec. 26. Section 230.20, subsections 5 and 6, Code 2009, are amended to read as follows:

5. An individual statement shall be prepared for a patient on or before the fifteenth day of the month following the month in which the patient leaves the mental health institute, and a general statement shall be prepared at least quarterly for each county to which charges are made under this section. Except as otherwise required by sections 125.33 and 125.34 the general statement shall list the name of each patient chargeable to that county who was served by the mental health institute during the preceding month or calendar quarter, the amount due on account of each patient, and the specific dates for which any third party payor reimbursement received by the state is applied to the statement and billing, and the county shall be billed for eighty percent of the stated charge for each patient specified in this subsection. ~~For the purposes of this subsection, *"third party payor reimbursement"* does not include reimbursement provided under chapter 249J.~~ The statement prepared for each county shall be certified by the department and a duplicate statement shall be mailed to the auditor of that county.

6. All or any reasonable portion of the charges incurred for services provided to a patient, to the most recent date for which the charges have been computed, may be paid at any time by the patient or by any other person on the patient's behalf. Any payment made by the patient or other person, and any federal financial assistance received pursuant to Title XVIII or XIX of the federal Social Security Act for services rendered to a patient, shall be credited against the patient's account and, if the charges paid as described in this subsection have previously been billed to a county, reflected in the mental health institute's next general statement to that county. ~~However, any payment made under chapter 249J shall not be reflected in the mental health institute's next general statement to that county.~~

Sec. 27. Section 249A.11, Code 2009, is amended to read as follows:

249A.11 Payment for patient care segregated.

A state resource center or mental health institute, upon receipt of any payment made under this chapter for the care of any patient, shall segregate an amount equal to that portion of the payment which is required by law to be made from nonfederal funds ~~except for any nonfederal funds received through the expansion population program pursuant to chapter 249J which shall be deposited in the IowaCare account created pursuant to section 249J.24~~. The money segregated shall be deposited in the medical assistance fund of the department of human services.

Sec. 28. REPEAL. Chapter 219, Code 2009, is repealed.

Approved April 21, 2010

CHAPTER 1142

CHILD SUPPORT — MISCELLANEOUS CHANGES

S.F. 2158

AN ACT relating to child support recovery including child support provisions for minor parents, medical support, and the review and adjustment process.

Be It Enacted by the General Assembly of the State of Iowa: