CHAPTER 120

MEDICAL ASSISTANCE PROGRAM — MISCELLANEOUS CHANGES

S.F. 313

AN ACT relating to medical assistance program-related provisions.

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

DIVISION I
MEDICAL ASSISTANCE — GENERAL PROVISIONS

Section 1. Section 8A.504, subsection 1, paragraph c, subparagraph (1), Code 2011, is amended to read as follows:

(1) Any debt, which is assigned to the department of human services, or which is owed to the department of human services for unpaid premiums under section 249A.3, subsection 2, paragraph "*a*", subparagraph (1), or section 249J.8, subsection 1, or which the child support recovery unit is otherwise attempting to collect, or which the foster care recovery unit of the department of human services is attempting to collect on behalf of a child receiving foster care provided by the department of human services.

Sec. 2. Section 217.34, Code 2011, is amended to read as follows:

217.34 Debt setoff.

The investigations division of the department of inspections and appeals and the department of human services shall provide assistance to set off against a person's or provider's income tax refund or rebate any debt which has accrued through written contract, nonpayment of premiums pursuant to section 249A.3, subsection 2, paragraph "*a*", subparagraph (1), or section 249J.8, subsection 1, subrogation, departmental recoupment procedures, or court judgment and which is in the form of a liquidated sum due and owing the department of human services. The department of inspections and appeals, with approval of the department of human services, shall adopt rules under chapter 17A necessary to assist the department of administrative services in the implementation of the setoff under section 8A.504 in regard to money owed to the state for public assistance overpayments or nonpayment of premiums as specified in this section. The department of human services shall adopt rules under chapter 17A necessary to assist the department of administrative services in the implementation of the setoff under section 8A.504, in regard to collections by the child support recovery unit and the foster care recovery unit.

Sec. 3. Section 249A.3, subsection 2, paragraph a, subparagraph (1), Code 2011, is amended to read as follows:

(1) (a) As allowed under 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII), individuals with disabilities, who are less than sixty-five years of age, who are members of families whose income is less than two hundred fifty percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, who have earned income and who are eligible for medical assistance or additional medical assistance under this section if earnings are disregarded. As allowed by 42 U.S.C. § 1396a(r)(2), unearned income shall also be disregarded in determining whether an individual is eligible for assistance under this subparagraph. For the purposes of determining the amount of an individual's resources under this subparagraph and as allowed by 42 U.S.C. § 1396a(r)(2), a maximum of ten thousand dollars of available resources shall be disregarded, and any additional resources held in a retirement account, in a medical savings account, or in any other account approved under rules adopted by the department shall also be disregarded.

(b) Individuals eligible for assistance under this subparagraph, whose individual income exceeds one hundred fifty percent of the official poverty guidelines published by the United States department of health and human services for an individual, shall pay a premium. The amount of the premium shall be based on a sliding fee schedule adopted by rule of the department and shall be based on a percentage of the individual's income. The maximum

premium payable by an individual whose income exceeds one hundred fifty percent of the official poverty guidelines shall be commensurate with the cost of state employees' group health insurance in this state. The payment to and acceptance by an automated case management system or the department of the premium required under this subparagraph 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. Any unpaid premium shall be a debt owed the department.

Sec. 4. Section 249J.6, subsection 2, paragraph b, Code 2011, is amended to read as follows:

b. Refusal of an expansion population member to participate in a comprehensive medical examination or any health risk assessment implemented by the department shall not be a basis for ineligibility for or disenrollment from the expansion population. Refusal of an expansion population member to participate in a comprehensive medical examination or other preventative health service shall not negatively affect the calculation of performance payments for an expansion population network provider medical home.

Sec. 5. Section 249J.6, subsection 3, Code 2011, is amended to read as follows:

3. Expansion population members, including members assigned to an expansion population network provider medical home, shall be provided access to 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. 6. Section 249J.7, subsection 1, paragraph c, Code 2011, is amended to read as follows:

c. (1) Tertiary care shall only be provided to eligible expansion population members residing in any county in the state at the university of Iowa hospitals and clinics.

(2) Secondary care shall be provided by the 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, based on county of residence, only to the extent specified in the phase-in of the regional provider network designated by the department.

Sec. 7. Section 249J.8, subsection 1, Code 2011, is amended to read as follows:

1. *a.* ~~Each~~ The total monthly premium and other cost-sharing for an expansion population member whose family income exceeds one hundred fifty 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 ~~pay a monthly premium~~ not ~~to~~ exceed one-twelfth of five percent of the ~~member's~~ annual family income regardless of the number of expansion population members in the household. The department shall adopt rules to establish a premium schedule in accordance with this subsection that is calculated based on a member's family income for each ten percent increment of the federal poverty level.

b. ~~Each~~ An expansion population member whose family income is equal to or less than one hundred fifty 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.

c. All premiums shall be paid ~~on~~ by the last day of the month of coverage.

d. 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.

e. An expansion population member shall 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.

f. 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.

g. Timely payment of premiums~~, including any arrearages accrued from prior enrollment,~~ is a condition of receiving any expansion population services. An expansion population member who does not provide timely payment within sixty days of the date the premium is due is subject to disenrollment.

h. Any unpaid premiums are a debt owed to the department.

i. 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.

j. 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.

k. 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.

l. An expansion population member shall also pay the same copayments required of other adult recipients of medical assistance.

Sec. 8. Section 249J.14, subsection 5, Code 2011, is amended to read as follows:

5. *Dental home for children.*

a. 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.

b. By ~~December 31, 2011~~ July 1, 2013, 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.

Sec. 9. Section 249J.24A, subsection 1, Code 2011, is amended to read as follows:

1. A nonparticipating provider may be reimbursed for covered expansion population services provided to an expansion population member ~~by a nonparticipating provider if the nonparticipating provider contacts the appropriate participating provider prior to providing covered services to verify consensus regarding one of the following courses of action~~ if any of the following conditions is met:

~~*a.* If the nonparticipating provider and the participating provider agree that the medical status of the expansion population member indicates it is medically possible to postpone provision of services, the nonparticipating provider shall direct the expansion population member to the appropriate participating provider for services.~~

~~*b.*~~ *a.* If the nonparticipating provider ~~and the participating provider agree~~ determines that the medical status of the expansion population member indicates it is not medically ~~possible~~ advisable to postpone provision of services, the nonparticipating provider shall provide medically necessary services.

~~*c.*~~ *b.* If the nonparticipating provider and the participating provider agree that transfer of the expansion population member is not possible due to lack of available inpatient capacity, the nonparticipating provider shall provide medically necessary services.

~~*d.*~~ *c.* If the medical status of the expansion population member indicates a medical emergency and the nonparticipating provider is not able to contact the appropriate participating provider prior to providing medically necessary services, the nonparticipating provider shall document the medical emergency and inform the appropriate participating provider immediately after the member has been stabilized of any covered services provided.

Sec. 10. Section 249J.24A, subsection 2, paragraph a, Code 2011, is amended to read as follows:

a. If the nonparticipating provider meets the requirements specified in subsection 1, the nonparticipating provider shall be reimbursed for covered expansion population services, limited to emergency and other inpatient hospital services provided to the expansion population member up to the point of transfer to another provider, discharge, or transfer to another level of care, through the nonparticipating provider reimbursement fund in accordance with rules adopted by the department of human services. However, any funds received from participating providers, appropriated to participating providers, or deposited in the IowaCare account pursuant to section 249J.24, shall not be transferred or appropriated to the nonparticipating provider reimbursement fund or otherwise used to reimburse nonparticipating providers.

Sec. 11. Section 514I.5, subsection 3, Code 2011, is amended to read as follows:

3. Members appointed by the governor shall serve two-year staggered terms as designated by the governor, and legislative members of the board shall serve two-year terms. The filling of positions reserved for the public representatives, vacancies, membership terms, payment of compensation and expenses, and removal of the members are governed by chapter 69. Members of the board are entitled to receive reimbursement of actual expenses incurred in the discharge of their duties. Public members of the board are also eligible to receive compensation as provided in section 7E.6. A majority of the voting members constitutes a quorum and the affirmative vote of a majority of the voting members is necessary for any substantive action to be taken by the board. The members shall select a chairperson on an annual basis from among the membership of the board.

Sec. 12. REGIONAL PROVIDER NETWORK — ALTERNATIVE PROVIDER — PILOT. The department of human services shall consult with providers of primary care services in regional provider network areas established pursuant to section 249J.7 to determine if the option of establishing an alternative provider location is feasible. The department may implement a pilot program establishing an alternative provider location in an established regional provider network area experiencing capacity issues during the fiscal year beginning July 1, 2011, if the department determines that this option would most appropriately address such capacity issues and provide better access to care for expansion population members in the area. Any such pilot program shall be implemented within funds available under the existing appropriation for the regional provider network and any alternative provider location shall be subject to the requirements applicable to an expansion population provider pursuant to chapter 249J.

Approved July 26, 2011