CHAPTER 158

HEALTH CARE SERVICES AND FINANCING — MEDICAID PROGRAM — NURSING FACILITY OWNERSHIP AND CAPACITY — PROHIBITED PASS-THROUGH PAYMENTS AND ASSESSMENTS

H.F. 685

AN ACT relating to health care services and financing, including nursing facility licensing and financing and the Medicaid program including third-party recovery and taxation of Medicaid managed care organization premiums.

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

DIVISION I
MEDICAID PROGRAM THIRD-PARTY RECOVERY

Section 1. Section 249A.37, Code 2023, is amended by striking the section and inserting in lieu thereof the following:

249A.37 Duties of third parties.

1. For the purposes of this section, *"Medicaid payor"*, *"recipient"*, *"third party"*, and *"third-party benefits"* mean the same as defined in section 249A.54.

2. The third-party obligations specified under this section are a condition of doing business in the state. A third party that fails to comply with these obligations shall not be eligible to do business in the state.

3. A third party that is a carrier, as defined in section 514C.13, shall enter into a health insurance data match program with the department for the sole purpose of comparing the names of the carrier's insureds with the names of recipients as required by section 505.25.

4. A third party shall do all of the following:

a. Cooperate with the Medicaid payor in identifying recipients for whom third-party benefits are available including but not limited to providing information to determine the period of potential third-party coverage, the nature of the coverage, and the name, address, and identifying number of the coverage. In cooperating with the Medicaid payor, the third party shall provide information upon the request of the Medicaid payor in a manner prescribed by the Medicaid payor or as agreed upon by the department and the third party.

b. (1) Accept the Medicaid payor's rights of recovery and assignment to the Medicaid payor as a subrogee, assignee, or lienholder under section 249A.54 for payments which the Medicaid payor has made under the Medicaid state plan or under a waiver of such state plan.

(2) In the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under Tit. XIX of the federal Social Security Act, accept authorization provided by the Medicaid payor that the health care item or service is covered under the Medicaid state plan or waiver of such state plan for such individual, as if such authorization were the prior authorization made by the third party for such item or service.

c. If, on or before three years from the date a health care item or service was provided, the Medicaid payor submits an inquiry regarding a claim for payment that was submitted to the third party, respond to that inquiry not later than sixty days after receiving the inquiry.

d. Respond to any Medicaid payor's request for payment of a claim described in paragraph *"c"* not later than ninety business days after receipt of written proof of the claim, either by paying the claim or issuing a written denial to the Medicaid payor.

e. Not deny any claim submitted by a Medicaid payor solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point-of-sale that is the basis of the claim; or in the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of

the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act, solely on the basis of a failure to obtain prior authorization for the health care item or service for which the claim is submitted if all of the following conditions are met:

(1) The claim is submitted to the third party by the Medicaid payor no later than three years after the date on which the health care item or service was furnished.

(2) Any action by the Medicaid payor to enforce its rights under section 249A.54 with respect to such claim is commenced not later than six years after the Medicaid payor submits the claim for payment.

5. Notwithstanding any provision of law to the contrary, the time limitations, requirements, and allowances specified in this section shall apply to third-party obligations under this section.

6. The department may adopt rules pursuant to chapter 17A as necessary to administer this section. Rules governing the exchange of information under this section shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and regulations promulgated in accordance with that Act and published in 45 C.F.R. pts. 160 – 164.

Sec. 2. Section 249A.54, Code 2023, is amended by striking the section and inserting in lieu thereof the following:

249A.54 Responsibility for payment on behalf of Medicaid-eligible persons — liability of other parties.

1. It is the intent of the general assembly that a Medicaid payor be the payor of last resort for medical services furnished to recipients. All other sources of payment for medical services are primary relative to medical assistance provided by the Medicaid payor. If benefits of a third party are discovered or become available after medical assistance has been provided by the Medicaid payor, it is the intent of the general assembly that the Medicaid payor be repaid in full and prior to any other person, program, or entity. The Medicaid payor shall be repaid in full from and to the extent of any third-party benefits, regardless of whether a recipient is made whole or other creditors are paid.

2. For the purposes of this section:

a. "Collateral" means all of the following:

(1) Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's agent, related to any covered injury or illness, or medical services that necessitated that the Medicaid payor provide medical assistance to the recipient.

(2) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(3) Proceeds.

b. "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which the Medicaid payor is, or may be, obligated to provide, or has provided, medical assistance.

c. "Medicaid payor" means the department or any person, entity, or organization that is legally responsible by contract, statute, or agreement to pay claims for medical assistance including but not limited to managed care organizations and other entities that contract with the state to provide medical assistance under chapter 249A.

d. "Medical service" means medical or medically related institutional or noninstitutional care, or a medical or medically related institutional or noninstitutional good, item, or service covered by Medicaid.

e. "Payment" as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. *"To pay"* means to make payment.

f. "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds from the collateral and includes insurance payable because of loss or damage to the collateral or proceeds. *"Cash proceeds"* include money, checks, and deposit accounts and similar proceeds. All other proceeds are *"noncash proceeds"*.

g. "Recipient" means a person who has applied for medical assistance or who has received medical assistance.

h. "Recipient's agent" includes a recipient's legal guardian, legal representative, or any other person acting on behalf of the recipient.

i. "Third party" means an individual, entity, or program, excluding Medicaid, that is or may be liable to pay all or a part of the expenditures for medical assistance provided by a Medicaid payor to the recipient. A third party includes but is not limited to all of the following:

(1) A third-party administrator.

(2) A pharmacy benefits manager.

(3) A health insurer.

(4) A self-insured plan.

(5) A group health plan, as defined in section 607(1) of the federal Employee Retirement Income Security Act of 1974.

(6) A service benefit plan.

(7) A managed care organization.

(8) Liability insurance including self-insurance.

(9) No-fault insurance.

(10) Workers' compensation laws or plans.

(11) Other parties that by law, contract, or agreement are legally responsible for payment of a claim for medical services.

j. "Third-party benefits" mean any benefits that are or may be available to a recipient from a third party and that provide or pay for medical services. *"Third-party benefits"* may be created by law, contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, recipient, or otherwise. *"Third-party benefits"* include but are not limited to all of the following:

(1) Benefits from collateral or proceeds.

(2) Health insurance benefits.

(3) Health maintenance organization benefits.

(4) Benefits from preferred provider arrangements and prepaid health clinics.

(5) Benefits from liability insurance, uninsured and underinsured motorist insurance, or personal injury protection coverage.

(6) Medical benefits under workers' compensation.

(7) Benefits from any obligation under law or equity to provide medical support.

3. Third-party benefits for medical services shall be primary to medical assistance provided by the Medicaid payor.

4. *a.* A Medicaid payor has all of the rights, privileges, and responsibilities identified under this section. Each Medicaid payor is a Medicaid payor to the extent of the medical assistance provided by that Medicaid payor. Therefore, Medicaid payors may exercise their Medicaid payor's rights under this section concurrently.

b. Notwithstanding the provisions of this subsection to the contrary, if the department determines that a Medicaid payor has not taken reasonable steps within a reasonable time to recover third-party benefits, the department may exercise all of the rights of the Medicaid payor under this section to the exclusion of the Medicaid payor. If the department determines the department will exercise such rights, the department shall give notice to third parties and to the Medicaid payor.

5. A Medicaid payor may assign the Medicaid payor's rights under this section, including but not limited to an assignment to another Medicaid payor, a provider, or a contractor.

6. After the Medicaid payor has provided medical assistance under the Medicaid program, the Medicaid payor shall seek reimbursement for third-party benefits to the extent of the Medicaid payor's legal liability and for the full amount of the third-party benefits, but not in excess of the amount of medical assistance provided by the Medicaid payor.

7. On or before the thirtieth day following discovery by a recipient of potential third-party benefits, a recipient or the recipient's agent, as applicable, shall inform the Medicaid payor of any rights the recipient has to third-party benefits and of the name and address of any person that is or may be liable to provide third-party benefits.

8. When the Medicaid payor provides or becomes liable for medical assistance, the Medicaid payor has the following rights which shall be construed together to provide the greatest recovery of third-party benefits:

a. The Medicaid payor is automatically subrogated to any rights that a recipient or a recipient's agent or legally liable relative has to any third-party benefit for the full amount of medical assistance provided by the Medicaid payor. Recovery pursuant to these subrogation rights shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but shall provide full recovery to the Medicaid payor from any and all third-party benefits. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat, reduce, or prorate recovery by the Medicaid payor as to the Medicaid payor's subrogation rights granted under this paragraph.

b. By applying for, accepting, or accepting the benefit of medical assistance, a recipient or a recipient's agent or legally liable relative automatically assigns to the Medicaid payor any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

(1) The assignment granted under this paragraph is absolute and vests legal and equitable title to any such right in the Medicaid payor, but not in excess of the amount of medical assistance provided by the Medicaid payor.

(2) The Medicaid payor is a bona fide assignee for value in the assigned right, title, or interest and takes vested legal and equitable title free and clear of latent equities in a third party. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat or reduce recovery by the Medicaid payor as to the assignment granted under this paragraph.

c. The Medicaid payor is entitled to and has an automatic lien upon the collateral for the full amount of medical assistance provided by the Medicaid payor to or on behalf of the recipient for medical services furnished as a result of any covered injury or illness for which a third party is or may be liable.

(1) The lien attaches automatically when a recipient first receives medical services for which the Medicaid payor may be obligated to provide medical assistance.

(2) The filing of the notice of lien with the clerk of the district court in the county in which the recipient's eligibility is established pursuant to this section shall be notice of the lien to all persons. Notice is effective as of the date of filing of the notice of lien.

(3) If the Medicaid payor has actual knowledge that the recipient is represented by an attorney, the Medicaid payor shall provide the attorney with a copy of the notice of lien. However, this provision of a copy of the notice of lien to the recipient's attorney does not abrogate the attachment, perfection, and notice satisfaction requirements specified under subparagraphs (1) and (2).

(4) Only one claim of lien need be filed to provide notice and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by the Medicaid payor for any specific covered injury or illness. The Medicaid payor may, in the Medicaid payor's discretion, file additional, amended, or substitute notices of lien at any time after the initial filing until the Medicaid payor has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

(5) A release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall not be effective as against a lien created under this paragraph, unless the Medicaid payor joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the Medicaid payor is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the Medicaid payor may recover from the person accepting the release or satisfaction

or the person making the settlement the full amount of medical assistance provided by the Medicaid payor.

(6) The lack of a properly filed claim of lien shall not affect the Medicaid payor's assignment or subrogation rights provided in this subsection nor affect the existence of the lien, but shall only affect the effective date of notice.

(7) The lien created by this paragraph is a first lien and superior to the liens and charges of any provider of a recipient's medical services. If the lien is recorded, the lien shall exist for a period of seven years after the date of recording. If the lien is not recorded, the lien shall exist for a period of seven years after the date of attachment. If recorded, the lien may be extended for one additional period of seven years by rerecording the claim of lien within the ninety-day period preceding the expiration of the lien.

9. Except as otherwise provided in this section, the Medicaid payor shall recover the full amount of all medical assistance provided by the Medicaid payor on behalf of the recipient to the full extent of third-party benefits. The Medicaid payor may collect recovered benefits directly from any of the following:

a. A third party.

b. The recipient.

c. The provider of a recipient's medical services if third-party benefits have been recovered by the provider. Notwithstanding any provision of this section to the contrary, a provider shall not be required to refund or pay to the Medicaid payor any amount in excess of the actual third-party benefits received by the provider from a third party for medical services provided to the recipient.

d. Any person who has received the third-party benefits.

10. *a.* A recipient and the recipient's agent shall cooperate in the Medicaid payor's recovery of the recipient's third-party benefits and in establishing paternity and support of a recipient child born out of wedlock. Such cooperation shall include but is not limited to all of the following:

(1) Appearing at an office designated by the Medicaid payor to provide relevant information or evidence.

(2) Appearing as a witness at a court proceeding or other legal or administrative proceeding.

(3) Providing information or attesting to lack of information under penalty of perjury.

(4) Paying to the Medicaid payor any third-party benefit received.

(5) Taking any additional steps to assist in establishing paternity or securing third-party benefits, or both.

b. Notwithstanding paragraph *"a"*, the Medicaid payor has the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

c. The department may deny or terminate eligibility for any recipient who refuses to cooperate as required under this subsection unless the department has waived cooperation as provided under this subsection.

11. On or before the thirtieth day following the initiation of a formal or informal recovery, other than by filing a lawsuit, a recipient's attorney shall provide written notice of the activity or action to the Medicaid payor.

12. A recipient is deemed to have authorized the Medicaid payor to obtain and release medical information and other records with respect to the recipient's medical services for the sole purpose of obtaining reimbursement for medical assistance provided by the Medicaid payor.

13. *a.* To enforce the Medicaid payor's rights under this section, the Medicaid payor may, as a matter of right, institute, intervene in, or join in any legal or administrative proceeding in the Medicaid payor's own name, and in any or a combination of any, of the following capacities:

(1) Individually.

(2) As a subrogee of the recipient.

(3) As an assignee of the recipient.

(4) As a lienholder of the collateral.

b. An action by the Medicaid payor to recover damages in an action in tort under this subsection, which action is derivative of the rights of the recipient, shall not constitute a waiver of sovereign immunity.

c. A Medicaid payor, other than the department, shall obtain the written consent of the department before the Medicaid payor files a derivative legal action on behalf of a recipient.

d. When a Medicaid payor brings a derivative legal action on behalf of a recipient, the Medicaid payor shall provide written notice no later than thirty days after filing the action to the recipient, the recipient's agent, and, if the Medicaid payor has actual knowledge that the recipient is represented by an attorney, to the attorney of the recipient, as applicable.

e. If the recipient or a recipient's agent brings an action against a third party, on or before the thirtieth day following the filing of the action, the recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice to the Medicaid payor of the action, including the name of the court in which the action is brought, the case number of the action, and a copy of the pleadings. The recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice of intent to dismiss the action at least twenty-one days before the voluntary dismissal of an action against a third party. Notice to the Medicaid payor shall be sent as specified by rule.

14. On or before the thirtieth day before the recipient finalizes a judgment, award, settlement, or any other recovery where the Medicaid payor has the right to recovery, the recipient, the recipient's agent, or the attorney of the recipient or recipient's agent, as applicable, shall give the Medicaid payor notice of the judgment, award, settlement, or recovery. The judgment, award, settlement, or recovery shall not be finalized unless such notice is provided and the Medicaid payor has had a reasonable opportunity to recover under the Medicaid payor's rights to subrogation, assignment, and lien. If the Medicaid payor is not given notice, the recipient, the recipient's agent, and the recipient's or recipient's agent's attorney are jointly and severally liable to reimburse the Medicaid payor for the recovery received to the extent of medical assistance paid by the Medicaid payor. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

15. *a.* Except as otherwise provided in this section, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the Medicaid payor's claim for reimbursement of the amount of medical assistance provided and any lien pursuant to the claim.

b. Insurance and other third-party benefits shall not contain any term or provision which purports to limit or exclude payment or the provision of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance, and any such term or provision shall be void as against public policy.

16. In an action in tort against a third party in which the recipient is a party and which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

a. After deduction of reasonable attorney fees, reasonably necessary legal expenses, and filing fees, there is a rebuttable presumption that all Medicaid payors shall collectively receive two-thirds of the remaining amount recovered or the total amount of medical assistance provided by the Medicaid payors, whichever is less. A party may rebut this presumption in accordance with subsection 17.

b. The remaining recovered amount shall be paid to the recipient.

c. If the recovered amount available for the repayment of medical assistance is insufficient to satisfy the competing claims of the Medicaid payors, each Medicaid payor shall be entitled to the Medicaid payor's respective pro rata share of the recovered amount that is available.

17. *a.* A recipient or a recipient's agent who has notice or who has actual knowledge of the Medicaid payor's rights to third-party benefits under this section and who receives any third-party benefit or proceeds for a covered injury or illness shall on or before the sixtieth day after receipt of the proceeds pay the Medicaid payor the full amount of the third-party benefits, but not more than the total medical assistance provided by the Medicaid payor, or

shall place the full amount of the third-party benefits in an interest-bearing trust account for the benefit of the Medicaid payor pending a determination of the Medicaid payor's rights to the benefits under this subsection.

b. If federal law limits the Medicaid payor to reimbursement from the recovered damages for medical expenses, a recipient may contest the amount designated as recovered damages for medical expenses payable to the Medicaid payor pursuant to the formula specified in subsection 16. In order to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as medical expenses, including future medical expenses, is less than the amount calculated by the Medicaid payor pursuant to the formula specified in subsection 16. Alternatively, to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that Medicaid provided a lesser amount of medical assistance than that asserted by the Medicaid payor. A settlement agreement that designates the amount of recovered damages for medical expenses is not clear and convincing evidence and is not sufficient to establish the recipient's burden of proof, unless the Medicaid payor is a party to the settlement agreement.

c. If the recipient or the recipient's agent filed a legal action to recover against the third party, the court in which such action was filed shall resolve any dispute concerning the amount owed to the Medicaid payor, and shall retain jurisdiction of the case to resolve the amount of the lien after the dismissal of the action.

d. If the recipient or the recipient's agent did not file a legal action, to resolve any dispute concerning the amount owed to the Medicaid payor, the recipient or the recipient's agent shall file a petition for declaratory judgment as permitted under **rule of civil procedure 1.1101** on or before the one hundred twenty-first day after the date of payment of funds to the Medicaid payor or the date of placing the full amount of the third-party benefits in a trust account. Venue for all declaratory actions under this subsection shall lie in Polk county.

e. If a Medicaid payor and the recipient or the recipient's agent disagree as to whether a medical claim is related to a covered injury or illness, the Medicaid payor and the recipient or the recipient's agent shall attempt to work cooperatively to resolve the disagreement before seeking resolution by the court.

f. Each party shall pay the party's own attorney fees and costs for any legal action conducted under this subsection.

18. Notwithstanding any other provision of law to the contrary, when medical assistance is provided for a minor, any statute of limitation or repose applicable to an action or claim of a legally responsible relative for the minor's medical expenses is extended in favor of the legally responsible relative so that the legally responsible relative shall have one year from and after the attainment of the minor's majority within which to file a complaint, make a claim, or commence an action.

19. In recovering any payments in accordance with this section, the Medicaid payor may make appropriate settlements.

20. If a recipient or a recipient's agent submits via notice a request that the Medicaid payor provide an itemization of medical assistance paid for any covered injury or illness, the Medicaid payor shall provide the itemization on or before the sixty-fifth day following the day on which the Medicaid payor received the request. Failure to provide the itemization within the specified time shall not bar a Medicaid payor's recovery, unless the itemization response is delinquent for more than one hundred twenty days without justifiable cause. A Medicaid payor shall not be under any obligation to provide a final itemization until a reasonable period of time after the processing of payment in relation to the recipient's receipt of final medical services. A Medicaid payor shall not be under any obligation to respond to more than one itemization request in any one-hundred-twenty-day period. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

21. The department may adopt rules to administer this section and applicable federal requirements.

DIVISION II
MEDICAID MANAGED CARE ORGANIZATION TAXATION OF PREMIUMS

Sec. 3. NEW SECTION. **249A.13 Medicaid managed care organization premiums fund.**

1. A Medicaid managed care organization premiums fund is created in the state treasury under the authority of the department of health and human services. Moneys collected by the director of the department of revenue as taxes on premiums pursuant to section 432.1A shall be deposited in the fund.

2. Moneys in the fund are appropriated to the department of health and human services for the purposes of the medical assistance program.

3. Notwithstanding section 8.33, moneys in the fund that remain unencumbered or unobligated at the close of a fiscal year shall not revert but shall remain available for expenditure for the purposes designated. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys in the fund shall be credited to the fund.

Sec. 4. NEW SECTION. **432.1A Health maintenance organization — medical assistance program — premium tax.**

1. Pursuant to section 514B.31, subsection 3, a health maintenance organization contracting with the department of health and human services to administer the medical assistance program under chapter 249A, shall pay as taxes to the director of the department of revenue for deposit in the Medicaid managed care organization premiums fund created in section 249A.13, an amount equal to two and one-half percent of the premiums received and taxable under subsection 514B.31, subsection 3.

2. Except as provided in subsection 3, the premium tax shall be paid on or before March 1 of the year following the calendar year for which the tax is due. The commissioner of insurance may suspend or revoke the license of a health maintenance organization subject to the premium tax in subsection 1 that fails to pay the premium tax on or before the due date.

3. *a.* Each health maintenance organization transacting business in this state that is subject to the tax in subsection 1 shall remit on or before June 1, on a prepayment basis, an amount equal to one-half of the health maintenance organization's premium tax liability for the preceding calendar year.

b. In addition to the prepayment amount in paragraph *"a"*, each health maintenance organization subject to the tax in subsection 1 shall remit on or before August 15, on a prepayment basis, an additional one-half of the health maintenance organization's premium tax liability for the preceding calendar year.

c. The sums prepaid by a health maintenance organization under paragraphs *"a"* and *"b"* shall be allowed as credits against the health maintenance organization's premium tax liability for the calendar year during which the payments are made. If a prepayment made under this subsection exceeds the health maintenance organization's annual premium tax liability, the excess shall be allowed as a credit against the health maintenance organization's subsequent prepayment or tax liabilities under this section. The commissioner of insurance shall authorize the department of revenue to make a cash refund to a health maintenance organization, in lieu of a credit against subsequent prepayment or tax liabilities under this section, if the health maintenance organization demonstrates the inability to recoup the funds paid via a credit. The commissioner of insurance shall adopt rules establishing a health maintenance organization's eligibility for a cash refund, and the process for the department of revenue to make a cash refund to an eligible health maintenance organization from the Medicaid managed care organization premiums fund created in section 249A.13. The commissioner of insurance may suspend or revoke the license of a health maintenance organization that fails to make a prepayment on or before the due date under this subsection.

d. Sections 432.10 and 432.14 are applicable to premium taxes due under this section.

Sec. 5. Section 514B.31, Code 2023, is amended by striking the section and inserting in lieu thereof the following:

514B.31 Taxation.

1. For the first five years of the existence of a health maintenance organization and the health maintenance organization's successors and assigns, the following shall not be considered premiums received and taxable under section 432.1:

a. Payments received by the health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter.

b. Payments made by the health maintenance organization to providers for health care services, to insurers, or to corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter.

2. After the first five years of the existence of a health maintenance organization and the health maintenance organization's successors and assigns, the following shall be considered premiums received and taxable under section 432.1:

a. Payments received by the health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter.

b. Payments made by the health maintenance organization to providers for health care services, to insurers, or to corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter.

3. Notwithstanding subsections 1 and 2, beginning January 1, 2024, and for each subsequent calendar year, the following shall be considered premiums received and taxable under section 432.1A for a health maintenance organization contracting with the department of health and human services to administer the medical assistance program under chapter 249A:

a. Payments received by the health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter.

b. Payments made by the health maintenance organization to providers for health care services, to insurers, or to corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter.

4. Payments made to a health maintenance organization by the United States secretary of health and human services under a contract issued under section 1833 or 1876 of the federal Social Security Act, or under section 4015 of the federal Omnibus Budget Reconciliation Act of 1987, shall not be considered premiums received and shall not be taxable under section 432.1 or 432.1A. Payments made to a health maintenance organization contracting with the department of health and human services to administer the medical assistance program under chapter 249A shall not be taxable under section 432.1.

DIVISION III
NURSING FACILITY AND HOSPITAL CAPACITY AND FINANCING

Sec. 6. NEW SECTION. **135C.7A Nursing facility license application for change of ownership — required information.**

1. In addition to the requirements of section 135C.7, the change of ownership of a previously licensed nursing facility shall be subject to approval by the department through application for a license. An applicant for a nursing facility license under this section shall submit all of the following information to the department with the license application:

a. Information about the applicant's organizational and ownership structures. The applicant shall provide information regarding all related parties with a five percent or greater controlling interest in the applicant organization, including the related party's relationship to the applicant organization. The information provided shall be updated at least thirty days prior to issuance of the license if any changes in the information occur.

b. Information regarding any related party transactions and associated reimbursement structures.

c. Information related to the applicant's financial suitability to operate a nursing facility as verified by the applicant, which shall include but is not limited to all of the following:

(1) Financial projections for operational expenses and revenues, including realistic occupancy and reimbursement rates and the disclosure of any related party transactions, projected for the first three years of operation.

(2) Projected initial cash and liquid assets relative to the acquisition or start-up of the applicant's organization.

(3) If the applicant is a component of a corporate chain organization, no less than three years of historical financial and operating information.

d. Information related to the applicant's regulatory history with any other state or licensing jurisdiction as verified by the applicant, which shall include but is not limited to all of the following:

(1) Information related to any complaint, allegation, or investigation concerning the applicant in any other state or licensing jurisdiction.

(2) Affirmation that the applicant has not voluntarily surrendered a license while under investigation in any other state or licensing jurisdiction.

(3) Supporting documentation regarding the resolution of any disciplinary action or complaint, allegation, or investigation against the applicant in any other state or licensing jurisdiction.

(4) Affirmation that no other nursing facility owned or operated by the applicant has been subject to operation by a court-appointed receiver or temporary manager.

2. Information required under subsection 1 shall not be limited to information relating to nursing facility operations but shall also include information relative to any other health care operations under the control and management of the applicant or related parties which may include but is not limited to assisted living programs, hospice services, home health agencies, or other long-term care related health services.

3. The department may request that an applicant provide additional or supplemental information with the application which may include verification of cash or liquid resources to maintain nursing facility operations for a period of not less than two months.

4. The department may require an applicant to create an escrow account sufficient to sustain financial operations of the applicant's nursing facility for a period of not less than two months upon consideration of the timing of projected deposits and disbursements during the nursing facility's initial operating period.

a. The escrow account shall be sufficiently funded by the applicant prior to the issuance of the nursing facility license under this section.

b. The department, in consultation with the applicant, may reduce or return the amounts held in escrow two years from the date of initial commencement of operation of the nursing facility.

c. The escrow requirement shall be terminated no later than five years from the date of initial commencement of operation of the nursing facility.

d. The department may utilize funds held in escrow if the applicant's nursing facility is subject to operation under receivership pursuant to section 135C.30.

5. The department shall verify the accuracy and completeness of the information provided under this section.

6. The information or documents provided to the department under this section detailing the applicant's financial condition or the terms of the applicant's contractual business relationships shall be confidential and not considered a public record under chapter 22.

7. For the purposes of this section:

a. "*Applicant*" means a person required to obtain a nursing facility license under this section due to change of ownership of a previously licensed nursing facility.

b. "*Related party*" means a related party or organization described by rule of the department of health and human services relating to nursing facility financial and statistical reporting and determination of payment rates pursuant to 441 IAC 81.6(11)(1).

Sec. 7. NEW SECTION. **135C.35A Moratorium — new construction or increase in bed capacity — nursing facilities.**

1. Beginning July 1, 2023, and ending no later than June 30, 2026, the department shall impose for an initial period of twelve months a temporary moratorium on submission of applications for new construction of a nursing facility or a permanent change in bed capacity

of a nursing facility that increases the bed capacity of the nursing facility. The department, in consultation with the department of health and human services, may extend the moratorium in six-month increments following the conclusion of the initial twelve-month period, but for no longer than a total of thirty-six months.

2. The department, in consultation with the department of health and human services, may waive the moratorium as specified in this section if any of the following applies:

a. The departments jointly determine there is a specialized need for the nursing facility beds requested.

b. The average occupancy of all licensed nursing facility beds located within the county and contiguous counties of the location of the proposed increase in nursing facility bed capacity exceeded eighty-five percent during the three most recent calendar quarters as published by the centers for Medicare and Medicaid services of the United States department of health and human services at the time of the filing of the application.

3. The department shall publish any request for a waiver of the moratorium as well as an explanation for the decision to either grant or deny the waiver request.

4. For the purposes of this section, "*occupancy*" means the average number of residents of the nursing facility during the applicable time period divided by the licensed bed capacity of the nursing facility.

Sec. 8. NEW SECTION. **135C.35B Availability of nursing facility bed data.**

No later than January 1, 2024, the department of health and human services shall develop a publicly available dashboard detailing the number of nursing facility beds available in the state, the overall quality rating of the available nursing facility beds as specified by the centers for Medicare and Medicaid services of the United States department of health and human services star ratings, any increase in the number of available nursing facility beds in each county during the state fiscal year, any decrease in the number of available nursing facility beds in each county during the state fiscal year, and an explanation of the causes of such increase or decrease in available nursing facility beds.

Sec. 9. NEW SECTION. **249A.28 Hospital directed payment — prohibition of pass-through on non-Medicaid payors.**

A hospital participating in the hospital directed payment program pursuant to 42 C.F.R. §438.6 shall not knowingly pass on the directed payment increase for health care services provided to non-Medicaid payors, including as a fee or rate increase. If a hospital violates this section, the hospital shall not receive the directed payment but shall instead only be reimbursed the hospital base reimbursement rate for health care services provided under the medical assistance program for one year from the date the violation is discovered.

Sec. 10. Section 249L.3, Code 2023, is amended by adding the following new subsection:

NEW SUBSECTION. 6A. A nursing facility shall not knowingly pass on the quality assurance assessment to non-Medicaid payors, including as a rate increase or service charge. If a nursing facility violates this section, the department shall not reimburse the nursing facility the quality assurance assessment due the nursing facility under the medical assistance program, but shall instead only reimburse the nursing facility at the nursing facility base reimbursement rate under the medical assistance program for one year from the date the violation is discovered.

Sec. 11. NURSING FACILITY BED NEED FORMULA — STUDY AND RECOMMENDATIONS. The department of health and human services shall convene a workgroup including representatives of nursing facilities, managed care organizations, the department of inspections, appeals, and licensing, and other appropriate stakeholders to review the existing nursing facility bed need formula. The department of health and human services shall submit a report of the recommendations of the workgroup for improvement to the nursing facility bed need formula, including recommendations related to the process for establishing a projection of future nursing facility bed use taking into consideration

the state's changing demographics and the need to ensure an adequate number of nursing facility beds, to the governor and the general assembly by December 2, 2024.

Approved June 1, 2023