Senate File 452 - Introduced

SENATE FILE 452
BY COMMITTEE ON HUMAN
RESOURCES

(SUCCESSOR TO SSB 1253)

A BILL FOR

1 An Act relating to Medicaid program transformation and
2 oversight.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. NEW SECTION. **249A.9 Medicaid transformation and**
2 **oversight commission —— findings, goals, and intent.**
3 1. The general assembly finds that state Medicaid program
4 initiatives have consistently advanced the goals of a health
5 care delivery system that improves population health, enhances
6 the experiences and outcomes of patients, reduces the costs of
7 care, and integrates and coordinates services and supports to
8 address social determinants of health. Existing initiatives,
9 including the healthiest state initiative, the balancing
10 incentive program, the Iowa health and wellness plan created
11 pursuant to chapter 249N, and the state innovation models
12 initiative, all reflect these consistent goals. Each of
13 these programs and initiatives has been formulated to realign
14 the health care delivery system to provide whole-person,
15 patient-centered and family-centered care while moving toward a
16 value and risk-based model of reimbursement.
17 2. Legislative involvement and oversight is essential to
18 ensure stakeholder input, consumer protection, and quality
19 assurance in the transformation of the Medicaid program. A
20 transition to a managed care system, especially one that
21 affects vulnerable populations so diverse in medical and
22 functional needs and that involves such a wide spectrum of
23 providers and state agencies, requires intentional planning
24 and attention. The state must also provide for appropriate
25 and adequate infrastructure, resources, and funding to ensure
26 accountability to and compliance with state policy, rules, and
27 contract requirements.
28 3. Given the challenges presented, a Medicaid
29 transformation and oversight commission is created to provide
30 a formal venue for guidance and oversight of and stakeholder
31 engagement in, the design, development, and implementation of
32 Medicaid program transformation.
33 4. *a.* The commission shall include all of the following
34 members:
35 (1) The co-chairpersons and ranking members of the

1 legislative joint appropriations subcommittee on health
2 and human services, or members of the joint appropriations
3 subcommittee designated by the respective co-chairpersons or
4 ranking members.
5 (2) The chairpersons and ranking members of the
6 human resources committees of the senate and house of
7 representatives, or members of the respective committees
8 designated by the respective chairpersons or ranking members.
9 (3) The chairpersons and ranking members of the
10 appropriations committees of the senate and house of
11 representatives, or members of the respective committees
12 designated by the respective chairpersons or ranking members.
13 *b.* The members of the commission shall receive a per diem as
14 provided in section 2.10.
15 *c.* The commission shall meet at least quarterly, but may
16 meet as often as necessary. The commission may use sources of
17 information deemed appropriate, and the department of human
18 services and other agencies of state government shall provide
19 information to the commission as requested. The legislative
20 services agency shall provide staff support to the commission.
21 *d.* The commission shall select a chairperson, annually, from
22 its membership. A majority of the members of the commission
23 shall constitute a quorum.
24 *e.* The commission may contract for the services of persons
25 who are qualified by education, expertise, or experience to
26 advise, consult with, or otherwise assist the commission in the
27 performance of its duties. The commission may specifically
28 enlist the assistance of entities such as the university of
29 Iowa public policy center to provide ongoing evaluation of the
30 Medicaid program and to make evidence-based recommendations to
31 improve the program.
32 5. The commission shall do all of the following:
33 *a.* Provide overall long-term and real-time guidance for the
34 Medicaid program including but not limited to:
35 (1) Developing a strategic plan to provide a predictable

1 guide for transformation prior to any transition. The
2 strategic plan shall address health care delivery and payment
3 reforms that reflect a holistic, integrated, patient-centered
4 and family-centered, primary care-focused, value-based model
5 and extend beyond a medical model to address the social
6 determinants of health.
7 (2) Reviewing, recommending, and approving the design,
8 development, and implementation of all initiatives under the
9 Medicaid program, and making additional recommendations for
10 Medicaid program reform.
11 (3) Monitoring progress in obtaining federal approval of
12 proposals such as those relating to benefit design, service
13 delivery, payment reform, and quality and cost containment
14 measures.
15 (4) Reviewing other states' models of health care delivery
16 and payment reform and specifically those related to Medicaid
17 managed care to determine best practices and inform future
18 state Medicaid program initiatives.
19 (5) Ensuring that at each stage of transformation, existing
20 models, provider networks, reimbursement methodologies,
21 and performance and quality metrics are integrated into the
22 subsequent stage to provide consistency and reliability.
23 (6) Ensuring that the state has a clearly articulated
24 vision for the Medicaid program, which is reflected in contract
25 expectations, oversight, incentives, and penalties under the
26 program.
27 (7) Assessing state agencies including those involved
28 in the Medicaid program, child welfare, aging and disability
29 services, and public health to articulate clear roles and
30 responsibilities and to promote state program interoperability.
31 (a) The commission shall review and make recommendations
32 regarding potential integration of various service delivery
33 systems including public health, aging and disability services
34 agencies, and mental health and disability services regions to
35 more efficiently and effectively address consumer needs.

1 (b) The commission shall ensure that state agencies provide
2 leadership and have the appropriate organizational structures,
3 adequate resources and funding, and qualified staff with
4 specialized skills, training, and expertise to provide the
5 level of expertise and scrutiny required to administer and
6 oversee the various transformation initiatives, including those
7 related to Medicaid managed care.
8 (8) Ensuring that state Medicaid managed care initiatives
9 comply with the guidance to states using 1115 demonstrations
10 or 1915(b) waivers for managed long-term services and supports
11 programs published by the centers for Medicare and Medicaid
12 services of the United States department of health and human
13 services on May 20, 2013, including those relating to adequate
14 planning, stakeholder engagement, enhanced provision of home
15 and community-based services, alignment of structures and
16 goals, support for beneficiaries, a person-centered process, a
17 comprehensive, integrated service package, qualified providers,
18 consumer protections, and quality.
19 (9) Reviewing the performance under and outcomes of
20 contracts including but not limited to those between the
21 state and the Iowa Medicaid enterprise and managed care
22 organizations, to determine compliance.
23 (10) Ensuring that the various Medicaid populations are
24 managed at all times within funding limitations and contract
25 terms. The commission shall also monitor service delivery
26 and utilization to ensure the responsibility for provision of
27 services to Medicaid consumers is not shifted to non-Medicaid
28 covered services solely to attain savings, and that such
29 responsibility is not shifted to mental health and disability
30 services regions, local public health agencies, aging and
31 disability resource centers, or other entities unless agreement
32 to provide, and provision for adequate compensation for, such
33 services is agreed to in advance.
34 *b.* Address provider access and workforce adequacy issues.
35 (1) As the state moves toward integration of long-term

1 services and supports into Medicaid managed care, the
2 commission shall provide for a comprehensive review of
3 long-term services and supports and make recommendations to
4 create a sustainable, person-centered approach that increases
5 health and life outcomes, supports maximum independence,
6 addresses medical and social needs in a coordinated, integrated
7 manner, and provides for sufficient resources including a
8 stable, well-qualified workforce.
9 (a) The commission shall provide a forum for open and
10 constructive dialogue among stakeholders representing
11 individuals involved in the delivery and financing of long-term
12 services and supports, address the cost and financing of
13 long-term services and supports, the coordination of services
14 among providers, and the availability of and access to a
15 well-qualified workforce, and consider methods to educate
16 consumers and enhance engagement of consumers in the broader
17 conversation regarding long-term services and supports.
18 (b) The commission shall recommend ways to eliminate Iowa's
19 institutional bias and come into full compliance with the
20 Olmstead decision.
21 (2) The commission shall review current and projected
22 overall health care workforce availability to determine
23 the most efficient utilization of the roles, functions,
24 responsibilities, activities, and decision-making capacity
25 of health care professionals and make recommendations for
26 improvement. The commission shall encourage the use of
27 alternative modes of health care delivery, as appropriate.
28 (3) The commission shall ensure the linguistic and cultural
29 competency of providers and other program facilitators.
30 *c.* Provide for consumer engagement, address consumer
31 choice and satisfaction, and provide for consumer appeal and
32 grievance procedures. The commission shall provide for input
33 from the medical assistance advisory council created in section
34 249A.4B, the mental health and disabilities services commission
35 created in section 225C.5, the commission on aging created

1 in section 231.11, the medical home system advisory council
2 created in section 135.159, the bureau of substance abuse of
3 the department of public health, and other appropriate entities
4 to provide advice to the commission.
5 *d.* Review and make recommendations regarding reimbursement
6 and rate setting to ensure adequate compensation for all
7 providers of services and supports to the Medicaid population,
8 an adequate provider network, and timely access to services for
9 consumers.
10 *e.* Define the desired outcomes and the metrics by which
11 improvement is determined. The commission shall provide for
12 consistency and uniformity of metrics and required outcomes
13 across payors and providers to the greatest extent possible.
14 *f.* Ensure that care coordination and case management are
15 provided in a patient-centered and family-centered manner that
16 requires a knowledge of community supports, a reasonable ratio
17 of care coordinators to consumers, standards for frequency
18 of contact with the consumer, and specific and adequate
19 reimbursement.
20 *g.* Address health information technology and data collection
21 and sharing.
22 6. The commission shall submit a report of its findings
23 and recommendations to the governor and the general assembly
24 by January 15, annually.
25 Sec. 2. TRANSITION TO MEDICAID MANAGED CARE ——
26 DIRECTIVES. In order to ensure a seamless transition of
27 Medicaid consumers to Medicaid managed care, all of the
28 following circumstances shall be considered and all of the
29 following conditions shall be met in any design, development,
30 or implementation of Medicaid managed care on or after March
31 1, 2015:
32 1. The state shall engage in a thoughtful and deliberative
33 planning process that permits sufficient time to outline a
34 clear vision for the program, solicit and consider stakeholder
35 input, educate program consumers, assess readiness, and

1 develop safeguards and oversight mechanisms to ensure a
2 smooth transition to and effective ongoing implementation of
3 Medicaid managed care. The movement to Medicaid managed care
4 shall retain an emphasis on choice, consumer-driven care and
5 services, a community-based infrastructure, and promotion of
6 community-based alternatives. The state shall demonstrate
7 that systems and processes are in place between state agencies
8 to support the populations enrolled in Medicaid managed care
9 such as elders, persons with physical, intellectual, and
10 developmental disabilities, persons with chronic diseases, and
11 persons with mental health or substance abuse issues.
12 2. a. Prior to the transition to Medicaid managed care
13 of any population, and especially to ensure that high-risk
14 populations are provided continuity of care and do not
15 experience gaps in coverage or access to care issues, the state
16 shall perform a readiness assessment to ensure that managed
17 care organizations are in compliance with network adequacy
18 requirements, that necessary consumer and provider outreach and
19 education has been conducted, and that programmatic gaps have
20 been identified prior to the system becoming operational.
21 b. A managed care contract shall include a provision
22 for continuity and coordination of care for a consumer
23 transitioning to managed care, including maintaining existing
24 provider-consumer relationships and honoring the amount and
25 duration of an individual's authorized services under an
26 existing service plan, based on individual assessment and
27 needs. In the initial transition of a consumer to Medicaid
28 managed care, to ensure the least amount of disruption, managed
29 care organizations shall provide, at a minimum, a one-year
30 transition of care period for all provider types, regardless of
31 network status with an individual managed care organization.
32 c. The state shall ensure that if an individual is
33 auto-enrolled in a Medicaid managed care plan, there are
34 sufficient staff and safeguards available to ensure continuity
35 of care for the consumer through the consumer's existing

1 provider.
2 d. The state shall administratively credential existing
3 Medicaid providers, rather than requiring such providers to
4 complete a new credentialing process, to ensure a seamless
5 transition to the new managed care system and to ensure rapid
6 development of managed care provider networks.
7 e. The state shall retain external managed care experts to
8 guide patient transition, system implementation, and oversight
9 until the department of human services is able to develop the
10 internal staff capacity to confidently operate independently.
11 Such external experts shall be selected through a request for
12 proposals process and the state shall ensure that such experts
13 are not affiliated with any of the managed care organizations
14 selected in order to provide unbiased and appropriate guidance.
15 3. a. The state shall establish a specific, enforceable
16 process to ensure managed care organizations grievance and
17 appeals procedures are fully accessible to patients regardless
18 of physical, intellectual, behavioral, or sensory barriers.
19 b. Managed care contracts shall include consumer
20 protections including a statement of consumer rights and
21 responsibilities, a critical incident management system with
22 safeguards to prevent abuse, neglect, and exploitation, and
23 fair hearing protections including the continuation of services
24 during an appeal.
25 c. Managed care organization contracts shall include
26 provider appeals and grievance procedures that in part allow a
27 provider to file a grievance independently but on behalf of a
28 member and to appeal claims denials which, if determined to be
29 based on claims for medically necessary services whether or not
30 denied on an administrative basis, shall receive appropriate
31 payment.
32 4. a. The state shall utilize public forums, public input
33 surveys, stakeholder workgroup sessions, and other effective
34 formal channels for stakeholder engagement in the design,
35 development, and implementation of Medicaid managed care. The

1 state shall utilize the medical assistance advisory council
2 established pursuant to section 249A.4B to provide a forum
3 for oversight of managed care organizations and to advise the
4 department regarding systemic issues identified by the council.
5 b. Managed care organizations shall maintain stakeholder
6 panels comprised of an equal number of consumers and providers
7 in place at least thirty days prior to the transition to
8 managed care. Managed care organizations shall provide for
9 separate provider-specific panels to address detailed payment
10 and claims issues and grievance and appeals processes.
11 5. a. The state shall ensure that a managed care
12 organization develops and maintains a network of qualified
13 providers who meet state licensing, credentialing, and
14 certification requirements, as applicable, which network shall
15 be sufficient to provide adequate access to all services
16 covered under the managed care contract. The state shall
17 ensure that managed care organizations incorporate existing and
18 traditional providers, including but not limited to those that
19 comprise the Iowa collaborative safety net provider network
20 created in section 135.153.
21 b. Managed care contracts shall specify provider network
22 composition and access requirements including continuity of
23 care provisions and rules for when and how consumers may
24 access out-of-network providers. Managed care plans shall
25 provide reports of compliance with state network composition
26 and access standards and the state shall include financial
27 incentives and disincentives as management tools to support
28 state expectations.
29 c. The state shall review managed care organization
30 credentialing processes to provide consistency across such
31 organizations and to simplify and streamline the credentialing
32 process.
33 d. The state shall ensure that management of care for the
34 population served is consumer-driven, patient-focused and
35 family-focused, and provider-led.

1 e. The state shall monitor and enforce access standards
2 to ensure that consumers are able to access appropriate care
3 as close to their own homes as possible. The state shall
4 review, at least quarterly, network adequacy compliance and
5 require the dissemination of easily accessible and updated
6 provider directories to ensure consumers have the most accurate
7 information possible regarding the number, location, type, and
8 current capacity of providers contracted with the individual
9 managed care organization. The state shall ensure that
10 noncompliance results in swift corrective action.
11 f. The state shall require managed care plans to remove
12 administrative barriers to, provide reimbursement for,
13 and utilize emerging technologies such as e-health, mobile
14 technologies, and telehealth in health care delivery in a
15 medically appropriate manner in order to expand access to
16 services and extend the reach of approved provider networks
17 into rural and underserved areas of the state. Reimbursement
18 for telehealth shall be at the same rate as in-person services.
19 Reimbursable activities shall include store and forward
20 consultation, direct-to-consumer virtual care, telehealth
21 visits, home-based monitoring, and telehealth monitoring in
22 long-term care facilities.
23 g. The state shall require managed care organizations to
24 implement tools and strategies that support community-level
25 system integration between acute care, long-term services and
26 supports, and community-level agencies and organizations to
27 further population health goals.
28 6. a. (1) The state shall require managed care
29 organizations to align economic incentives, delivery system
30 reform, and performance and outcome metrics with those of the
31 state innovation models initiative and Medicaid accountable
32 care organizations.
33 (2) The state shall develop a common, uniform set of
34 process, quality, and consumer satisfaction measures across
35 all Medicaid payors and providers that align with those

1 developed through the state innovation models initiative and
2 shall ensure that such measures are expanded and adjusted to
3 address additional populations and to meet population health
4 objectives. Measures considered may include but are not
5 limited to those related to consumer education, transition
6 to and ongoing implementation of managed care, monitoring
7 and oversight, consumer input and rights, network adequacy
8 and access to care including services that address social
9 determinants of health, the provision of preventive services
10 and supports as well as those that address chronic conditions,
11 continuity of care, long-term services and supports, provider
12 standards, and evaluation and quality measures.
13 (3) Any quality data collected regarding provider
14 performance shall be shared with providers for review and input
15 prior to dissemination to consumers.
16 b. Managed care contracts shall include long-term
17 performance goals that reward success in achieving population
18 health goals such as improved community health metrics.
19 c. The state shall require consistency and uniformity
20 of processes and forms across all managed care organizations
21 including but not limited to the use of uniform cost and
22 quality reporting and uniform prior authorization procedures.
23 7. The state shall require the provision of independent
24 choice counseling, education, functional assessment, and
25 enrollment and disenrollment from a managed care plan by
26 an entity free of conflicts. The state shall ensure an
27 independent advocate is available to assist consumers in
28 navigating the Medicaid managed care landscape, understanding
29 their rights, responsibilities, choices, and opportunities,
30 and helping to resolve any problems that arise between the
31 consumer and the managed care organization. Unless such an
32 entity declines, as applicable to the population of consumers,
33 the aging and disability resource centers and the long-term
34 care ombudsman shall provide such independent, conflict-free
35 services in an accessible, ongoing, and consumer-friendly

1 manner, and shall be provided adequate resources and
2 reimbursement for provision of such services.
3 7A. a. Managed care organization contracts shall
4 specifically and appropriately address the unique needs of
5 children and children's health care delivery.
6 b. Managed care organizations shall maintain child health
7 panels that include representatives of child health, welfare,
8 policy, and advocacy organizations in the state that address
9 child health and child well-being.
10 c. Managed care organization contracts that apply
11 to children's health care delivery shall address early
12 intervention and prevention strategies, the provision of a
13 child health delivery infrastructure for children with special
14 health care needs, utilization of current standards and
15 guidelines for children's health care and pediatric-specific
16 screening and assessment tools, the inclusion of pediatric
17 specialty providers in the provider network, and the
18 utilization of health homes for children and youth with special
19 health care needs including intense care coordination and
20 family support and access to a professional family-to-family
21 support system.
22 d. Managed care organization contracts that apply
23 to children's health care delivery shall utilize
24 pediatric-specific quality measures, which shall align
25 with existing pediatric-specific measures as determined in
26 consultation with the child health panel.
27 8. The state shall require the use of a uniform,
28 standardized, person-centered, and state-approved instruments
29 to assess a consumer's physical, psychosocial, and functional
30 needs, including current health status and treatment needs;
31 social, employment, and transportation needs and preferences;
32 personal goals; consumer and caregiver preferences for
33 care; back-up plans for situations in which caregivers are
34 unavailable; and informal networks. The state shall approve a
35 pediatric-specific assessment tool and quality measures. The

1 information collected from these assessments shall be used to
2 identify health risks and social determinants of health that
3 impact health outcomes. Plans and providers shall use this
4 data in care coordination and interventions to improve patient
5 outcomes and to drive program designs that improve the health
6 of the population. Managed care organizations shall share
7 aggregate assessment data for consumers with providers on a
8 routine basis.
9 9. The state shall establish guidelines for care
10 coordination across managed care organizations to ease
11 administrative burdens on providers and help streamline
12 access to care. Coordinated care shall utilize the team-based
13 care model by connecting a Medicaid consumer to a single
14 primary care provider. The state shall require managed care
15 organizations to coordinate data sharing and analytics across
16 providers to facilitate care coordination. A managed care plan
17 shall provide for identification of the care coordination needs
18 of a consumer including those related to social determinants of
19 health, ensure that appropriate care coordination services are
20 provided, and provide evidence on an ongoing basis to the state
21 that both have occurred.
22 10. The state shall review and integrate the activities of
23 state agencies, including those agencies with public health,
24 child welfare, aging and disabilities, and ombudsman functions
25 to ensure there is no wrong door for consumers to access the
26 medical and social services and supports necessary for improved
27 outcomes. Managed care organizations shall provide or ensure
28 that consumers are connected with or referred to providers
29 and services to meet social determinants of health, even if
30 provision of services is outside their provider network.
31 Managed care contracts shall encourage partnerships between
32 managed care organizations and local public health agencies,
33 aging and disability resource centers, child welfare agencies,
34 mental health and disability services regions, and others to
35 address the holistic needs of the consumer and shall provide

1 for adequate reimbursement for such services.
2 11. a. Managed care plans shall include policies, plans,
3 and procedures to prepare consumers for transitions between
4 care settings to improve the quality of care for all consumers,
5 reduce avoidable rehospitalizations, and allow individuals to
6 live and receive services in the setting of their choice.
7 b. The state shall require managed care organizations
8 to have in place nursing facility diversion programs. The
9 state shall provide for the use of incentives in managed care
10 contracts for transition of consumers from a nursing facility
11 to home and community-based services.
12 12. The state shall ensure a sufficient and sustainable
13 state infrastructure for monitoring managed care organizations.
14 There shall be sufficient resources for the state to evaluate
15 contractually required quality reports and financial reports,
16 evaluate the impact or effectiveness of incentive programs,
17 conduct quality-focused audits, provide quality-related
18 technical assistance, validate that managed care organization
19 corrective actions have been implemented, analyze quality
20 findings and develop reports to assess quality trends and
21 to identify areas for improvement, develop, implement, and
22 evaluate performance improvement projects, solicit and analyze
23 consumer feedback, and investigate and follow up on critical
24 incident events.
25 13. Managed care contracts shall require that a portion
26 of the savings achieved by a managed care organization be
27 reinvested in innovations and longer-term community investments
28 to address population health, infrastructure, the healthcare
29 workforce, and improved service delivery and capacity.
30 14. a. The state shall ensure that savings achieved
31 through Medicaid managed care does not come at the expense
32 of further reduction in already inadequate provider rates.
33 The state shall ensure that managed care organizations use
34 reasonable reimbursement standards for all provider types and
35 compensate providers for covered services at not less than

1 current Medicaid fee-for-service levels, as determined in
2 conjunction with actuarially sound rate setting procedures.
3 Such reimbursement shall extend for the entire duration of a
4 managed care organization's contract.
5 b. The state shall address rate setting and reimbursement
6 of the entire scope of services provided under the Medicaid
7 program to ensure the adequacy of the provider network and to
8 ensure that providers that contribute to the holistic health
9 of the consumer, whether inside or outside of the provider
10 network, are compensated for their services.
11 c. The state shall ensure that managed care organizations do
12 not arbitrarily deny coverage for medically necessary services
13 solely based on financial reasons.
14 15. a. In order to provide adequate access to care for
15 vulnerable Iowans, managed care organizations shall extend
16 nonemergency transportation services to all consumers.
17 b. The state shall ensure that dental coverage, if not
18 integrated into an overall managed care contract, is provided
19 and is part of the overall integrated coverage for physical,
20 behavioral, and long-term services and supports provided to a
21 Medicaid consumer.
22 c. The state shall ensure that the existing formulary for
23 pharmacy benefits under the Medicaid state plan is honored and
24 continued.
25 d. Managed care plans shall ensure consumers receive
26 services and supports in the amount, duration, scope, and
27 manner as identified through the applicable person-centered
28 assessment and service planning process.
29 e. The state shall ensure that for those populations
30 for whom Medicaid home and community-based services waiver
31 services have been historically provided, managed care
32 organizations address with specific plans the expansion,
33 support, reinvestment of savings in, and adequate reimbursement
34 of community-based services and supports.
35 16. a. The state shall utilize the application of

1 liquidated damages in contracts to be paid from moneys other
2 than those paid by the state to hold managed care organizations
3 accountable regarding such provisions as timely claims
4 processing and claims payment accuracy, compliance with
5 licensure and background check requirements, timely provision
6 of an approved service, continuation of benefits pending
7 appeal, timely development of a plan of care, initiation
8 of long-term services and supports, and completion of care
9 coordination contacts.
10 b. The state shall review and approve or deny approval
11 for contract amendments on an ongoing basis to provide for
12 continuous improvement in Medicaid managed care.
13 c. Medicaid managed care organization contracts shall
14 include sanctions for failure to comply with the terms of
15 a contract, including failure relating to performance or
16 deliverables including meeting of performance and outcomes
17 measures. Such sanctions may include but are not limited to
18 assessment of a penalty or assessment of liquidated damages or
19 other monetary remedies.
20 Sec. 3. EFFECTIVE UPON ENACTMENT. This Act, being deemed of
21 immediate importance, takes effect upon enactment.

22 EXPLANATION

23 The inclusion of this explanation does not constitute agreement with
24 the explanation's substance by the members of the general assembly.

25 This bill relates to Medicaid program transformation.
26 The bill establishes the Medicaid transformation and
27 oversight commission, to provide for legislative involvement
28 and oversight and ensure stakeholder input, consumer
29 protection, and quality assurance in the transformation of the
30 Medicaid program. The membership of the commission consists
31 of the co-chairpersons and ranking members of the legislative
32 joint appropriations subcommittee on health and human services,
33 or a member of the joint appropriations subcommittee designated
34 by the respective co-chairperson or ranking member; the
35 chairpersons and ranking members of the human resources

1 committees of the senate and house of representatives, or a
2 member of the respective committee designated by the respective
3 chairperson or ranking member; and the chairpersons and
4 ranking members of the appropriations committees of the senate
5 and house of representatives, or a member of the respective
6 committee designated by the respective chairperson or ranking
7 member. The bill provides that the members are to receive
8 a per diem, and that the commission shall meet at least
9 quarterly, but may meet as necessary. The commission may use
10 sources of information deemed appropriate, and the department
11 of human services and other agencies of state government are
12 required to provide information to the commission as requested.
13 The legislative services agency will provide staff support to
14 the commission. The commission is to select a chairperson,
15 annually, from its membership and a majority of the members
16 of the commission constitute a quorum. The bill authorizes
17 the commission to contract for the services of persons who are
18 qualified by education, expertise, or experience to advise,
19 consult with, or otherwise assist the commission in the
20 performance of its duties, and provides that the commission
21 may specifically enlist the assistance of entities such as the
22 university of Iowa public policy center to provide ongoing
23 evaluation of the Medicaid program and to make evidence-based
24 recommendations to improve the program.
25 The bill specifies the duties of the commission including:
26 to provide overall long-term and real-time guidance for the
27 Medicaid program, addressing provider access and workforce
28 adequacy, providing for consumer engagement, addressing
29 consumer choice and satisfaction, and providing for consumer
30 appeal and grievance procedures; reviewing and making
31 recommendations regarding reimbursement and rate setting to
32 ensure adequate compensation for all providers of services
33 and supports to the Medicaid population, an adequate provider
34 network, and timely access to services for consumers; defining
35 the desired outcomes and the metrics by which improvement is

1 determined; ensuring that care coordination and case management
2 are provided in a patient-centered manner; and addressing
3 health information technology and data collection and sharing.
4 The commission is required to submit a report of findings and
5 recommendations to the governor and the general assembly by
6 January 15, annually.
7 The bill also specifies directives for the transition to
8 Medicaid managed care. The directives relate to overall
9 policy and planning, transition of Medicaid members to
10 managed care, appeals and grievance procedures, consumer
11 protections, stakeholder input, provider networks and access,
12 uniform processes, conflict-free consumer choice, education,
13 enrollment and disenrollment, care coordination, state agency
14 readiness and infrastructure, the use of savings by managed
15 care organizations, health care delivery alternatives,
16 required benefits, metrics and outcomes, and penalties for
17 noncompliance.