**Senate File 452 - Reprinted**

SENATE FILE 452
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SSB 1253)

(As Amended and Passed by the Senate March 18, 2015)

## A BILL FOR

An Act relating to Medicaid program transformation and oversight.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **249A.9 Medicaid transformation and oversight commission — findings, goals, and intent.**

1. The general assembly finds that state Medicaid program initiatives have consistently advanced the goals of a health care delivery system that improves population health, enhances the experiences and outcomes of patients, reduces the costs of care, and integrates and coordinates services and supports to address social determinants of health. Existing initiatives, including the healthiest state initiative, the balancing incentive program, the Iowa health and wellness plan created pursuant to chapter 249N, and the state innovation models initiative, all reflect these consistent goals. Each of these programs and initiatives has been formulated to realign the health care delivery system to provide whole-person, patient-centered and family-centered care while moving toward a value and risk-based model of reimbursement.

2. Legislative involvement and oversight is essential to ensure stakeholder input, consumer protection, and quality assurance in the transformation of the Medicaid program. A transition to a managed care system, especially one that affects vulnerable populations so diverse in medical and functional needs and that involves such a wide spectrum of providers and state agencies, requires intentional planning and attention. The state must also provide for appropriate and adequate infrastructure, resources, and funding to ensure accountability to and compliance with state policy, rules, and contract requirements.

3. Given the challenges presented, a Medicaid transformation and oversight commission is created to provide a formal venue for guidance and oversight of and stakeholder engagement in, the design, development, and implementation of Medicaid program transformation.

4. *a.* The commission shall include all of the following members:

(1) The co-chairpersons and ranking members of the

legislative joint appropriations subcommittee on health and human services, or members of the joint appropriations subcommittee designated by the respective co-chairpersons or ranking members.

(2) The chairpersons and ranking members of the human resources committees of the senate and house of representatives, or members of the respective committees designated by the respective chairpersons or ranking members.

(3) The chairpersons and ranking members of the appropriations committees of the senate and house of representatives, or members of the respective committees designated by the respective chairpersons or ranking members.

*b.* The members of the commission shall receive a per diem as provided in section 2.10.

*c.* The commission shall meet at least quarterly, but may meet as often as necessary. The commission may use sources of information deemed appropriate, and the department of human services and other agencies of state government shall provide information to the commission as requested. The legislative services agency shall provide staff support to the commission.

*d.* The commission shall select co-chairpersons, one representing the senate and one representing the house of representatives, annually, from its membership. A majority of the members of the commission shall constitute a quorum.

*e.* The commission may contract for the services of persons who are qualified by education, expertise, or experience to advise, consult with, or otherwise assist the commission in the performance of its duties. The commission may specifically enlist the assistance of entities such as the university of Iowa public policy center to provide ongoing evaluation of the Medicaid program and to make evidence-based recommendations to improve the program.

5. The commission shall do all of the following:

*a.* Provide overall long-term and real-time guidance for the Medicaid program including but not limited to:

(1) Developing a strategic plan to provide a predictable guide for transformation prior to any transition. The strategic plan shall address health care delivery and payment reforms that reflect a holistic, integrated, patient-centered and family-centered, primary care-focused, value-based model and extend beyond a medical model to address the social determinants of health.

(2) Reviewing, recommending, and approving the design, development, and implementation of all initiatives under the Medicaid program, and making additional recommendations for Medicaid program reform.

(3) Monitoring progress in obtaining federal approval of proposals such as those relating to benefit design, service delivery, payment reform, and quality and cost containment measures.

(4) Reviewing other states' models of health care delivery and payment reform and specifically those related to Medicaid managed care to determine best practices and inform future state Medicaid program initiatives.

(5) Ensuring that at each stage of transformation, existing models, provider networks, reimbursement methodologies, and performance and quality metrics are integrated into the subsequent stage to provide consistency and reliability.

(6) Ensuring that the state has a clearly articulated vision for the Medicaid program, which is reflected in contract expectations, oversight, incentives, and penalties under the program.

(7) Assessing state agencies including those involved in the Medicaid program, child welfare, aging and disability services, and public health to articulate clear roles and responsibilities and to promote state program interoperability.

(a) The commission shall review and make recommendations regarding potential integration of various service delivery systems including public health, aging and disability services agencies, and mental health and disability services regions to

more efficiently and effectively address consumer needs.

(b) The commission shall ensure that state agencies provide leadership and have the appropriate organizational structures, adequate resources and funding, and qualified staff with specialized skills, training, and expertise to provide the level of expertise and scrutiny required to administer and oversee the various transformation initiatives, including those related to Medicaid managed care.

(8) Ensuring that state Medicaid managed care initiatives comply with the guidance to states using 1115 demonstrations or 1915(b) waivers for managed long-term services and supports programs published by the centers for Medicare and Medicaid services of the United States department of health and human services on May 20, 2013, including those relating to adequate planning, stakeholder engagement, enhanced provision of home and community-based services, alignment of structures and goals, support for beneficiaries, a person-centered process, a comprehensive, integrated service package, qualified providers, consumer protections, and quality.

(9) Reviewing the performance under and outcomes of contracts including but not limited to those between the state and the Iowa Medicaid enterprise and managed care organizations, to determine compliance.

(10) Ensuring that the various Medicaid populations are managed at all times within funding limitations and contract terms. The commission shall also monitor service delivery and utilization to ensure the responsibility for provision of services to Medicaid consumers is not shifted to non-Medicaid covered services solely to attain savings, and that such responsibility is not shifted to mental health and disability services regions, local public health agencies, aging and disability resource centers, or other entities unless agreement to provide, and provision for adequate compensation for, such services is agreed to in advance.

*b.* Address provider access and workforce adequacy issues.

(1) As the state moves toward integration of long-term services and supports into Medicaid managed care, the commission shall provide for a comprehensive review of long-term services and supports and make recommendations to create a sustainable, person-centered approach that increases health and life outcomes, supports maximum independence, addresses medical and social needs in a coordinated, integrated manner, and provides for sufficient resources including a stable, well-qualified workforce.

(a) The commission shall provide a forum for open and constructive dialogue among stakeholders representing individuals involved in the delivery and financing of long-term services and supports, address the cost and financing of long-term services and supports, the coordination of services among providers, and the availability of and access to a well-qualified workforce, and consider methods to educate consumers and enhance engagement of consumers in the broader conversation regarding long-term services and supports.

(b) The commission shall recommend ways to eliminate Iowa's institutional bias and come into full compliance with the Olmstead decision.

(2) The commission shall review current and projected overall health care workforce availability to determine the most efficient utilization of the roles, functions, responsibilities, activities, and decision-making capacity of health care professionals and make recommendations for improvement. The commission shall encourage the use of alternative modes of health care delivery, as appropriate.

(3) The commission shall ensure the linguistic and cultural competency of providers and other program facilitators.

*c.* Provide for consumer engagement, address consumer choice and satisfaction, and provide for consumer appeal and grievance procedures. The commission shall provide for input from the medical assistance advisory council created in section 249A.4B, the mental health and disabilities services commission

created in section 225C.5, the commission on aging created in section 231.11, the medical home system advisory council created in section 135.159, the bureau of substance abuse of the department of public health, and other appropriate entities to provide advice to the commission.

*d.* Review and make recommendations regarding reimbursement and rate setting to ensure adequate compensation for all providers of services and supports to the Medicaid population, an adequate provider network, and timely access to services for consumers.

*e.* Define the desired outcomes and the metrics by which improvement is determined. The commission shall provide for consistency and uniformity of metrics and required outcomes across payors and providers to the greatest extent possible.

*f.* Ensure that care coordination and case management are provided in a patient-centered and family-centered manner that requires a knowledge of community supports, a reasonable ratio of care coordinators to consumers, standards for frequency of contact with the consumer, and specific and adequate reimbursement.

*g.* Address health information technology and data collection and sharing.

6. The commission shall submit a report of its findings and recommendations to the governor and the general assembly by December 15, annually.

Sec. 2. TRANSITION TO MEDICAID MANAGED CARE —— DIRECTIVES. In order to ensure a seamless transition of Medicaid consumers to Medicaid managed care, all of the following circumstances shall be considered and all of the following conditions shall be met in any design, development, or implementation of Medicaid managed care on or after March 1, 2015:

1. The state shall engage in a thoughtful and deliberative planning process that permits sufficient time to outline a clear vision for the program, solicit and consider stakeholder

input, educate program consumers, assess readiness, and develop safeguards and oversight mechanisms to ensure a smooth transition to and effective ongoing implementation of Medicaid managed care. The movement to Medicaid managed care shall retain an emphasis on choice, consumer-driven care and services, a community-based infrastructure, and promotion of community-based alternatives. The state shall demonstrate that systems and processes are in place between state agencies to support the populations enrolled in Medicaid managed care such as elders, persons with physical, intellectual, and developmental disabilities, persons with chronic diseases, and persons with mental health or substance abuse issues.

2. a. Prior to the transition to Medicaid managed care of any population, and especially to ensure that high-risk populations are provided continuity of care and do not experience gaps in coverage or access to care issues, the state shall perform a readiness assessment to ensure that managed care organizations are in compliance with network adequacy requirements, that necessary consumer and provider outreach and education have been conducted, and that programmatic gaps have been identified prior to the system becoming operational.

b. A managed care contract shall include a provision for continuity and coordination of care for a consumer transitioning to managed care, including maintaining existing provider-consumer relationships and honoring the amount and duration of an individual's authorized services under an existing service plan, based on individual assessment and needs. In the initial transition of a consumer to Medicaid managed care, to ensure the least amount of disruption, managed care organizations shall provide, at a minimum, a one-year transition of care period for all provider types, regardless of network status with an individual managed care organization.

c. The state shall ensure that if an individual is auto-enrolled in a Medicaid managed care plan, there are sufficient staff and safeguards available to ensure continuity

of care for the consumer through the consumer's existing provider.

d. The state shall administratively credential existing Medicaid providers, rather than requiring such providers to complete a new credentialing process, to ensure a seamless transition to the new managed care system and to ensure rapid development of managed care provider networks.

e. The state shall retain external managed care experts to guide patient transition, system implementation, and oversight until the department of human services is able to develop the internal staff capacity to confidently operate independently. Such external experts shall be selected through a request for proposals process and the state shall ensure that such experts are not affiliated with any of the managed care organizations selected in order to provide unbiased and appropriate guidance.

3. a. The state shall establish a specific, enforceable process to ensure managed care organizations grievance and appeals procedures are fully accessible to patients regardless of physical, intellectual, behavioral, or sensory barriers.

b. Managed care contracts shall include consumer protections including a statement of consumer rights and responsibilities, a critical incident management system with safeguards to prevent abuse, neglect, and exploitation, and fair hearing protections including the continuation of services during an appeal.

c. Managed care organization contracts shall include provider appeals and grievance procedures that in part allow a provider to file a grievance independently but on behalf of a member and to appeal claims denials which, if determined to be based on claims for medically necessary services whether or not denied on an administrative basis, shall receive appropriate payment.

4. a. The state shall utilize public forums, public input surveys, stakeholder workgroup sessions, and other effective formal channels for stakeholder engagement in the design,

development, and implementation of Medicaid managed care. The state shall utilize the medical assistance advisory council established pursuant to section 249A.4B to provide a forum for oversight of managed care organizations and to advise the department regarding systemic issues identified by the council.

b. Managed care organizations shall maintain stakeholder panels comprised of an equal number of consumers and providers in place at least thirty days prior to the transition to managed care. Managed care organizations shall provide for separate provider-specific panels to address detailed payment and claims issues and grievance and appeals processes.

5. a. The state shall ensure that a managed care organization develops and maintains a network of qualified providers who meet state licensing, credentialing, and certification requirements, as applicable, which network shall be sufficient to provide adequate access to all services covered and for all populations served under the managed care contract. The state shall ensure that managed care organizations incorporate existing and traditional providers, including but not limited to those that comprise the Iowa collaborative safety net provider network created in section 135.153.

b. Managed care contracts shall specify provider network composition and access requirements including continuity of care provisions and rules for when and how consumers may access out-of-network providers. Managed care plans shall provide reports of compliance with state network composition and access standards and the state shall include financial incentives and disincentives as management tools to support state expectations.

c. The state shall review managed care organization credentialing processes to provide consistency across such organizations and to simplify and streamline the credentialing process.

d. The state shall ensure that management of care for the

population served is consumer-driven, patient-focused and family-focused, and provider-led.

e. The state shall monitor and enforce access standards to ensure that consumers are able to access appropriate care as close to their own homes as possible. The state shall review, at least quarterly, network adequacy compliance and require the dissemination of easily accessible and updated provider directories to ensure consumers have the most accurate information possible regarding the number, location, type, and current capacity of providers contracted with the individual managed care organization. The state shall ensure that noncompliance results in swift corrective action.

f. The state shall require managed care plans to remove administrative barriers to, provide reimbursement for, and utilize emerging technologies such as e-health, mobile technologies, and telehealth in health care delivery in a medically appropriate manner in order to expand access to services and extend the reach of approved provider networks into rural and underserved areas of the state. Reimbursement for telehealth shall be at the same rate as in-person services. Reimbursable activities shall include store and forward consultation, direct-to-consumer virtual care, telehealth visits, home-based monitoring, and telehealth monitoring in long-term care facilities.

g. The state shall require managed care organizations to implement tools and strategies that support community-level system integration between acute care, long-term services and supports, and community-level agencies and organizations to further population health goals.

6. a. (1) The state shall require managed care organizations to align economic incentives, delivery system reform, and performance and outcome metrics with those of the state innovation models initiative and Medicaid accountable care organizations.

(2) The state shall develop a common, uniform set of

process, quality, and consumer satisfaction measures across all Medicaid payors and providers that align with those developed through the state innovation models initiative and shall ensure that such measures are expanded and adjusted to address additional populations and to meet population health objectives. Measures considered may include but are not limited to those related to consumer education, transition to and ongoing implementation of managed care, monitoring and oversight, consumer input and rights, network adequacy and access to care including services that address social determinants of health, the provision of preventive services and supports as well as those that address chronic conditions, continuity of care, long-term services and supports, provider standards, and evaluation and quality measures.

(3) Any quality data collected regarding provider performance shall be shared with providers for review and input prior to dissemination to consumers.

b. Managed care contracts shall include long-term performance goals that reward success in achieving population health goals such as improved community health metrics.

c. The state shall require consistency and uniformity of processes and forms across all managed care organizations including but not limited to the use of uniform cost and quality reporting and uniform prior authorization procedures.

7. The state shall require the provision of independent choice counseling, education, functional assessment, and enrollment and disenrollment from a managed care plan by an entity free of conflicts. The state shall ensure an independent advocate is available to assist consumers in navigating the Medicaid managed care landscape, understanding their rights, responsibilities, choices, and opportunities, and helping to resolve any problems that arise between the consumer and the managed care organization. Unless such an entity declines, as applicable to the population of consumers, the aging and disability resource centers and the long-term

care ombudsman shall provide such independent, conflict-free services in an accessible, ongoing, and consumer-friendly manner, and shall be provided adequate resources and reimbursement for provision of such services.

7A. a. Managed care organization contracts shall specifically and appropriately address the unique needs of children and children's health care delivery.

b. Managed care organizations shall maintain child health panels that include representatives of child health, welfare, policy, and advocacy organizations in the state that address child health and child well-being.

c. Managed care organization contracts that apply to children's health care delivery shall address early intervention and prevention strategies, the provision of a child health delivery infrastructure for children with special health care needs, utilization of current standards and guidelines for children's health care and pediatric-specific screening and assessment tools, the inclusion of pediatric specialty providers in the provider network, and the utilization of health homes for children and youth with special health care needs including intensive care coordination and family support and access to a professional family-to-family support system.

d. Managed care organization contracts that apply to children's health care delivery shall utilize pediatric-specific quality measures, which shall align with existing pediatric-specific measures as determined in consultation with the child health panel.

*e.* Managed care contracts shall provide special incentives for innovative and evidence-based preventive, behavioral, and developmental health care and mental health care for children's programs that improve the life course trajectory of those children.

8. The state shall require the use of uniform, standardized, person-centered, and state-approved instruments to assess

a consumer's physical, psychosocial, and functional needs, including current health status and treatment needs; social, employment, and transportation needs and preferences; personal goals; consumer and caregiver preferences for care; back-up plans for situations in which caregivers are unavailable; and informal networks. The state shall approve a pediatric-specific assessment tool and quality measures. The information collected from these assessments shall be used to identify health risks and social determinants of health that impact health outcomes. Plans and providers shall use this data in care coordination and interventions to improve patient outcomes and to drive program designs that improve the health of the population. Managed care organizations shall share aggregate assessment data for consumers with providers on a routine basis.

9. The state shall establish guidelines for care coordination across managed care organizations to ease administrative burdens on providers and help streamline access to care. Coordinated care shall utilize the team-based care model by connecting a Medicaid consumer to a single primary care provider. The state shall require managed care organizations to coordinate data sharing and analytics across providers to facilitate care coordination. A managed care plan shall provide for identification of the care coordination needs of a consumer including those related to social determinants of health, ensure that appropriate care coordination services are provided, and provide evidence on an ongoing basis to the state that both have occurred.

10. The state shall review and integrate the activities of state agencies, including those agencies with public health, child welfare, aging and disabilities, and ombudsman functions to ensure there is no wrong door for consumers to access the medical and social services and supports necessary for improved outcomes. Managed care organizations shall provide or ensure that consumers are connected with or referred to providers

and services to meet social determinants of health, even if provision of services is outside their provider network. Managed care contracts shall encourage partnerships between managed care organizations and local public health agencies, aging and disability resource centers, child welfare agencies, mental health and disability services regions, and others to address the holistic needs of the consumer and shall provide for adequate reimbursement for such services.

11. a. Managed care plans shall include policies, plans, and procedures to prepare consumers for transitions between care settings to improve the quality of care for all consumers, reduce avoidable rehospitalizations, and allow individuals to live and receive services in the setting of their choice.

b. The state shall require managed care organizations to have in place nursing facility diversion programs. The state shall provide for the use of incentives in managed care contracts for transition of consumers from a nursing facility to home and community-based services.

12. The state shall ensure a sufficient and sustainable state infrastructure for monitoring managed care organizations. There shall be sufficient resources for the state to evaluate contractually required quality reports and financial reports, evaluate the impact or effectiveness of incentive programs, conduct quality-focused audits, provide quality-related technical assistance, validate that managed care organization corrective actions have been implemented, analyze quality findings and develop reports to assess quality trends and to identify areas for improvement, develop, implement, and evaluate performance improvement projects, solicit and analyze consumer feedback, and investigate and follow up on critical incident events.

13. *a.* Managed care contracts shall require that a portion of the savings achieved by a managed care organization be reinvested in innovations and longer-term community investments to address population health, infrastructure, the healthcare

workforce, and improved service delivery and capacity.

*b.* A managed care contract shall impose a medical loss ratio of at least eighty-five percent and shall include well-defined criteria of what qualifies as a medical expense, and reporting requirements and recoupment provisions to ensure compliance.

14. a. The state shall ensure that savings achieved through Medicaid managed care do not come at the expense of further reduction in already inadequate provider rates. The state shall ensure that managed care organizations use reasonable reimbursement standards for all provider types and compensate providers for covered services at not less than current Medicaid fee-for-service levels, as determined in conjunction with actuarially sound rate setting procedures. Such reimbursement shall extend for the entire duration of a managed care organization's contract.

b. The state shall address rate setting and reimbursement of the entire scope of services provided under the Medicaid program to ensure the adequacy of the provider network and to ensure that providers that contribute to the holistic health of the consumer, whether inside or outside of the provider network, are compensated for their services.

c. The state shall ensure that managed care organizations do not arbitrarily deny coverage for medically necessary services solely based on financial reasons.

15. a. In order to provide adequate access to care for vulnerable Iowans, managed care organizations shall extend nonemergency transportation services to all consumers.

b. The state shall ensure that dental coverage, if not integrated into an overall managed care contract, is provided and is part of the overall integrated coverage for physical, behavioral, and long-term services and supports provided to a Medicaid consumer.

c. The state shall ensure that the existing formulary for pharmacy benefits under the Medicaid state plan is honored and continued.

d. Managed care plans shall ensure consumers receive services and supports in the amount, duration, scope, and manner as identified through the applicable person-centered assessment and service planning process.

e. The state shall ensure that for those populations for whom Medicaid home and community-based services waiver services have been historically provided, managed care organizations address with specific plans the expansion, support, reinvestment of savings in, and adequate reimbursement of community-based services and supports.

16. a. The state shall utilize the application of liquidated damages in contracts to be paid from moneys other than those paid by the state to hold managed care organizations accountable regarding such provisions as timely claims processing and claims payment accuracy, compliance with licensure and background check requirements, timely provision of an approved service, continuation of benefits pending appeal, timely development of a plan of care, initiation of long-term services and supports, and completion of care coordination contacts.

b. The state shall review and approve or deny approval for contract amendments on an ongoing basis to provide for continuous improvement in Medicaid managed care.

c. Medicaid managed care organization contracts shall include sanctions for failure to comply with the terms of a contract, including failure relating to performance or deliverables including meeting of performance and outcomes measures. Such sanctions may include but are not limited to assessment of a penalty or assessment of liquidated damages or other monetary remedies.

Sec. 3. EFFECTIVE UPON ENACTMENT. This Act, being deemed of immediate importance, takes effect upon enactment.