CHAPTER 249J

IOWACARE

Chapter to be repealed June 30, 2010; see §249J.26
Tuition assistance for individuals serving
individuals with disabilities pilot program;
2008 Acts, ch 1187, §45, 130

249J.1 Title.

This chapter shall be known and may be cited as the *"IowaCare Act"*.

2005 Acts, ch 167, §1, 66

249J.2 Federal financial participation — contingent implementation.

This chapter shall be implemented only to the extent that federal matching funds are available for nonfederal expenditures under this chapter. The department shall not expend funds under this chapter, including but not limited to expenditures for reimbursement of providers and program administration, if appropriated nonfederal funds are not matched by federal financial participation.

2005 Acts, ch 167, §2, 66

249J.3 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Clean claim"* means a claim submitted by a provider included in the expansion population provider network that may be adjudicated as paid or denied.
2. *"Department"* means the department of human services.
3. *"Director"* means the director of human services.
4. *"Expansion population"* means the individuals who are eligible solely for benefits under the medical assistance program waiver as provided in this chapter.
5. *"Full benefit dually eligible Medicare Part D beneficiary"* means a person who is eligible for coverage for Medicare Part D drugs and is simultaneously eligible for full medical assistance benefits pursuant to chapter 249A, under any category of eligibility.
6. *"Full benefit recipient"* means an adult who is eligible for full medical assistance benefits pursuant to chapter 249A under any category of eligibility.
7. *"Iowa Medicaid enterprise"* means the centralized medical assistance program

infrastructure, based on a business enterprise model, and designed to foster collaboration among all program stakeholders by focusing on quality, integrity, and consistency.

8. *"Medical assistance"* or *"Medicaid"* means payment of all or part of the costs of care and services provided to an individual pursuant to chapter 249A and Title XIX of the federal Social Security Act.

9. *"Medicare Part D"* means the Medicare Part D program established pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173.

10. *"Minimum data set"* means the minimum data set established by the centers for Medicare and Medicaid services of the United States department of health and human services for nursing home resident assessment and care screening.

11. *"Nursing facility"* means a nursing facility as defined in section 135C.1.

12. *"Public hospital"* means a hospital licensed pursuant to chapter 135B and governed pursuant to chapter 145A, 226, 347, 347A, or 392.

2005 Acts, ch 167, §3, 66
Referred to in §21.5, 97B.52A, 249K.2, 476B.1

249J.4 Purpose.

It is the purpose of this chapter to propose a variety of initiatives to increase the efficiency, quality, and effectiveness of the health care system; to increase access to appropriate health care; to provide incentives to consumers to engage in responsible health care utilization and personal health care management; to reward providers based on quality of care and improved service delivery; and to encourage the utilization of information technology, to the greatest extent possible, to reduce fragmentation and increase coordination of care and quality outcomes.

2005 Acts, ch 167, §4, 66

249J.5 Expansion population eligibility.

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

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

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

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

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

3. Individuals with family incomes below three hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services shall also be eligible for obstetrical and newborn care under the expansion population if deductions for the medical expenses of all family members would reduce the family income to two hundred percent of the federal poverty level or below. Such individuals shall be eligible for the same benefits as those provided to individuals eligible under section 135.152. Eligible individuals may choose to receive the appropriate level of care at any licensed hospital or health care facility, with the exception of individuals in need of such care residing in the counties of Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, and Washington, who shall be provided care at the university of Iowa hospitals and clinics.

4. Enrollment for the expansion population may be limited, closed, or reduced and the scope and duration of expansion population services provided may be limited, reduced, or

terminated if the department determines that federal medical assistance program matching funds or appropriated state funds will not be available to pay for existing or additional enrollment.

5. Eligibility for the expansion population shall not include individuals who have access to group health insurance, unless the reason for not accessing group health insurance is allowed by rule of the department.

6. Each expansion population member shall provide to the department all insurance information required by the health insurance premium payment program.

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

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

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

2005 Acts, ch 167, §5, 66; 2006 Acts, ch 1184, §112, 127

249J.6 Expansion population benefits.

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

a. Inpatient hospital procedures described in the diagnostic related group codes or other applicable inpatient hospital reimbursement methods designated by the department.

b. Outpatient hospital services described in the ambulatory patient groupings or non-inpatient services designated by the department.

c. Physician and advanced registered nurse practitioner services described in the current procedural terminology codes specified by the department.

d. Dental services described in the dental codes specified by the department.

e. Limited pharmacy benefits provided by an expansion population provider network hospital pharmacy and solely related to an appropriately billed expansion population service.

f. Transportation to and from an expansion population provider network provider only if the provider offers such transportation services or the transportation is provided by a volunteer.

2. *a.* Each expansion population member who enrolls or reenrolls in the expansion population on or after January 31, 2007, shall participate, in conjunction with receiving a single comprehensive medical examination and completing a personal health improvement plan, in a health risk assessment coordinated by a health consortium representing providers, consumers, and medical education institutions. The criteria for the health risk assessment, the comprehensive medical examination, and the personal health improvement plan shall be developed and applied in a manner that takes into consideration cultural variations that may exist within the expansion population. The health risk assessment shall utilize a gender-specific approach. In developing the queries unique to women, a clinical advisory team shall be utilized that includes women's health professionals including but not limited to those with specialties in obstetrics and gynecology, endocrinology, mental health, behavioral health, oncology, cardiology, and rheumatology.

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

in paragraph "*c*" who performs the comprehensive medical examination and provides the individualized personal health improvement plan.

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

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

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

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

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

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

4. Membership in the expansion population shall not preclude an expansion population member from eligibility for services not covered under the expansion population for which the expansion population member is otherwise entitled under state or federal law.

5. Members of the expansion population shall not be considered full benefit dually eligible Medicare Part D beneficiaries for the purposes of calculating the state's payment under Medicare Part D, until such time as the expansion population is eligible for all of the same benefits as full benefit recipients under the medical assistance program.

2005 Acts, ch 167, §6, 66; 2006 Acts, ch 1184, §113, 114, 128
Referred to in §249J.9, 249J.23
2006 amendments to subsection 2 are retroactively applicable to March 1, 2006; 2006 Acts, ch 1184, §128

249J.7 Expansion population provider network.

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

2. Expansion population services provided to expansion population members by providers included in the expansion population provider network shall be payable at the full benefit recipient rates.

3. Providers included in the expansion population provider network shall submit clean claims within twenty days of the date of provision of an expansion population service to an expansion population member.

4. Unless otherwise prohibited by law, a provider under the expansion population provider network may deny care to an individual who refuses to apply for coverage under the expansion population.

5. Notwithstanding the provision of section 347.16, subsection 2, requiring the provision

of free care and treatment to the persons described in that subsection, the publicly owned acute care teaching hospital described in subsection 1 may require any sick or injured person seeking care or treatment at that hospital to be subject to financial participation, including but not limited to copayments or premiums, and may deny nonemergent care or treatment to any person who refuses to be subject to such financial participation.

2005 Acts, ch 167, §7, 66
Referred to in §249J.24, 249J.24A

249J.8 Expansion population members — financial participation.

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

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

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

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

b. A health care account program option for individuals eligible for enrollment in the expansion population. The health care account program option shall be available only to

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

4. The department shall track the impact of the out-of-pocket expenditures on expansion population enrollment and shall report the findings on at least a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.20. The findings shall include estimates of the number of expansion population members complying with payment of required out-of-pocket expenditures, the number of expansion population members not complying with payment of required out-of-pocket expenditures and the reasons for noncompliance, any impact as a result of the out-of-pocket requirements on the provision of services to the populations previously served, the administrative time and cost associated with administering the out-of-pocket requirements, and the benefit to the state resulting from the out-of-pocket expenditures. To the extent possible, the department shall track the income level of the member, the health condition of the member, and the family status of the member relative to the out-of-pocket information.

2005 Acts, ch 167, §8, 66; 2005 Acts, ch 175, §117; 2006 Acts, ch 1184, §115, 127; 2007 Acts, ch 218, §104, 112; 2008 Acts, ch 1014, §3

Referred to in §249J.23

Healthy and well kids in Iowa program, see chapter 514I

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

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

2. *Benefits.*

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

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

3. *Expansion population provider network.*

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

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

2005 Acts, ch 167, §9, 66

249J.10 Maximization of funding for indigent patients.

1. Unencumbered certified local matching funds may be used to cover the state share of the cost of services for the expansion population.

2. The department of human services shall include in its annual budget submission, recommendations relating to a disproportionate share hospital and graduate medical

education allocation plan that maximizes the availability of federal funds for payments to hospitals for the care and treatment of indigent patients.

3. If state and federal law and regulations so provide and if federal disproportionate share hospital funds and graduate medical education funds are available under Title XIX of the federal Social Security Act, federal disproportionate share hospital funds and graduate medical education funds shall be distributed as specified by the department.

2005 Acts, ch 167, §10, 66

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

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

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

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

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

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

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

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

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

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

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

2005 Acts, ch 167, §11, 66

Federal approval of state planning amendments related to nursing home level of care pending at time of codification of this section; section contingent upon federal approval; 2005 Acts, ch 167, §66

249J.12 Services for persons with mental retardation or developmental disabilities.

1. The department, in cooperation with the Iowa state association of counties, the Iowa

association of community providers, the governor's developmental disabilities council, and other interested parties, shall develop a plan for a case-mix adjusted reimbursement system under the medical assistance program for both institution-based and community-based services for persons with mental retardation or developmental disabilities for submission to the general assembly by January 1, 2007. The department shall not implement the case-mix adjusted reimbursement system plan without express authorization by the general assembly.

2. The department, in consultation with the Iowa state association of counties, the Iowa association of community providers, the governor's developmental disabilities council, and other interested parties, shall develop a plan for submission to the governor and the general assembly no later than July 1, 2007, to enhance alternatives for community-based care for individuals who would otherwise require care in an intermediate care facility for persons with mental retardation. The plan shall not be implemented without express authorization by the general assembly.

2005 Acts, ch 167, §12, 66
Referred to in §249J.23

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

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

2005 Acts, ch 167, §13, 66

249J.14 Health promotion partnerships.

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

2. *Dietary counseling.* By July 1, 2006, the department shall design and begin implementation of a strategy to provide dietary counseling and support to child and adult recipients of medical assistance and to expansion population members to assist these recipients and members in avoiding excessive weight gain or loss and to assist in development of personal weight loss programs for recipients and members determined by the recipient's or member's health care provider to be clinically overweight.

3. *Electronic medical records.* By October 1, 2006, the department shall develop a practical strategy for expanding utilization of electronic medical recordkeeping by providers under the medical assistance program and the expansion population provider network. The plan shall focus, initially, on medical assistance program recipients and expansion population members whose quality of care would be significantly enhanced by the availability of electronic medical recordkeeping.

4. *Provider incentive payment programs.* By January 1, 2007, the department shall design and implement a provider incentive payment program for providers under the medical assistance program and providers included in the expansion population provider network based upon evaluation of public and private sector models.

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

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

7. *Dental home for children.* By December 31, 2010, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings, preventive services, diagnostic services, treatment services, and emergency services as defined under the early and periodic screening, diagnostic, and treatment program.

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

2005 Acts, ch 167, §15, 66; 2006 Acts, ch 1030, §29; 2008 Acts, ch 1188, §48
Referred to in §135.159, 249J.23

249J.15 Task force on indigent care.

1. The department shall convene a task force on indigent care to identify any growth in uncompensated care due to the implementation of this chapter and to identify any local funds that are being used to pay for uncompensated care that could be maximized through a match with federal funds.

2. Any public, governmental or nongovernmental, private, for-profit, or not-for-profit health services provider or payor, whether or not enrolled in the medical assistance program, and any organization of such providers or payors, may become a member of the task force. Membership on the task force shall require that an entity agree to provide accurate, written information and data relating to each of the following items for the fiscal year of the entity ending on or before June 30, 2005, and for each fiscal year thereafter during which the entity is a member:

a. The definition of indigent care used by the member for purposes of reporting the data described in this subsection.

b. The actual cost of indigent care as determined under Medicare principles of accounting or any accounting standard used by the member to report the member's financial status to its governing body, owner, members, creditors, or the public.

c. The usual and customary charge that would otherwise be applied by the member to the indigent care provided.

d. The number of individuals and the age, sex, and county of residence of the individuals receiving indigent care reported by the member and a description of the care provided.

e. To the extent practical, the health status of the individuals receiving the indigent care reported by the member.

f. The funding source of payment for the indigent care including revenue from property tax or other tax revenue, local funding, and other sources.

g. The extent to which any part of the cost of indigent care reported by the member was paid for by the individual on a sliding fee scale or other basis, by an insurer, or by another third-party payor.

h. The means by which the member covered any of the costs of indigent care not covered by those sources described in paragraph "*g*".

3. The department shall convene the task force for a minimum of eight meetings during the fiscal year beginning July 1, 2005, and during each fiscal year thereafter. For the fiscal year beginning July 1, 2005, the department shall convene at least six of the required meetings prior to March 1, 2006. The meetings shall be held in geographically balanced venues throughout the state that are representative of distinct rural, urban, and suburban areas.

4. The department shall provide the medical assistance projections and assessment council created pursuant to section 249J.20 with all of the following, at intervals established by the council:

a. A list of the members of the task force.

b. A copy of each member's written submissions of data and information to the task force.

c. A copy of the data submitted by each member.
d. Any observations or recommendations of the task force regarding the data.
e. Any observations and recommendations of the department regarding the data.

5. The task force shall transmit an initial, preliminary report of its efforts and findings to the governor and the general assembly by March 1, 2006. The task force shall submit an annual report to the governor and the general assembly by December 31 of each year.

6. The department shall, to the extent practical, assist task force members in assembling and reporting the data required of members, by programming the department's systems to accept, but not pay, claims reported on standard medical assistance claims forms for the indigent care provided by the members.

7. All meetings of the task force shall comply with chapter 21.

8. Information and data provided by a member to the task force shall be protected to the extent required under the federal Health Insurance Portability and Accountability Act of 1996.

9. The department shall inform the members of the task force that costs associated with the work of the task force and with the required activities of members may not be eligible for federal matching funds.

2005 Acts, ch 167, §16, 66

249J.16 Cost and quality performance evaluation.

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

1. Annually evaluate and compare the cost and quality of care provided by the medical assistance program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state.

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

2005 Acts, ch 167, §17, 66
Referred to in §249A.36, 249J.23

249J.17 Operations — performance evaluation.

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

2005 Acts, ch 167, §18, 66

249J.18 Clinicians advisory panel — clinical management.

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

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

3. The medical director of the Iowa Medicaid enterprise shall prepare an annual report summarizing the recommendations made by the panel and adopted by rule of the department

regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.

2005 Acts, ch 167, §19, 66; 2006 Acts, ch 1030, §30

Referred to in §249J.9

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

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

2005 Acts, ch 167, §20, 66

249J.20 Medical assistance projections and assessment council.

1. A medical assistance projections and assessment council is created consisting of the following members:

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

b. The chairpersons and ranking members of the human resources committees of the senate and the house of representatives, or a member of the committee designated by the chairperson or ranking member.

c. The chairpersons and ranking members of the appropriations committees of the senate and the house of representatives, or a member of the committee designated by the chairperson or ranking member.

2. The members of the council shall serve terms as provided in section 69.16B.

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

4. The council shall select a chairperson, annually, from its membership. A majority of the members of the council shall constitute a quorum.

5. The council shall do all of the following:

a. Make cost projections for the medical assistance program and the expansion population.

b. Review reports on all initiatives under this chapter, including those provisions in the design, development, and implementation phases, and make additional recommendations for medical assistance program and expansion population reform on an annual basis.

c. Review annual audited financial statements relating to the expansion population submitted by the providers included in the expansion population provider network.

d. Review reports on the success of the Iowa Medicaid enterprise based upon the contractual performance measures for each Iowa Medicaid enterprise partner.

e. Assure that the expansion population is managed at all times within funding limitations. In assuring such compliance, the council shall assume that supplemental funding will not be available for coverage of services provided to the expansion population.

6. The department of human services, the department of management, and the legislative services agency shall utilize a joint process to arrive at an annual consensus projection for medical assistance program and expansion population expenditures for submission to the

council. By December 15 of each fiscal year, the council shall review the consensus projection of expenditures for the fiscal year beginning the following July 1.

2005 Acts, ch 167, §21, 66; 2006 Acts, ch 1184, §116, 127; 2008 Acts, ch 1156, §37, 58; 2008 Acts, ch 1187, §125

Referred to in §249J.8, 249J.14, 249J.15, 249J.18

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

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

2005 Acts, ch 167, §22, 66

249J.22 Independent annual audit.

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

1. That the state has not instituted any new provider taxes as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.
2. That public hospitals and public nursing facilities are not paid more than the actual costs of care for medical assistance program and disproportionate share hospital program recipients based upon Medicare program principles of accounting and cost reporting.
3. That the state is not recycling federal funds provided under Title XIX of the Social Security Act as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.

2005 Acts, ch 167, §23, 66

Referred to in §249J.23

249J.23 Account for health care transformation.

1. An account for health care transformation is created in the state treasury under the authority of the department. Moneys received from sources including but not limited to appropriations from the general fund of the state, grants, and contributions shall be deposited in the account. The account shall include a separate premiums subaccount. Revenue generated through payment of premiums by expansion population members as required pursuant to section 249J.8 shall be deposited in the separate premiums subaccount within the account.
2. Moneys in the account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys deposited in the account are not subject to section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes specified in this section. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the account shall be credited to the account.
3. Moneys deposited in the account for health care transformation shall be used only as provided in appropriations from the account for the costs associated with certain services provided to the expansion population pursuant to section 249J.6, certain initiatives to be designed pursuant to section 249J.8, the case-mix adjusted reimbursement system for persons with mental retardation or developmental disabilities pursuant to section 249J.12, certain health promotion partnership activities pursuant to section 249J.14, the cost and quality performance evaluation pursuant to section 249J.16, auditing requirements pursuant

to section 249J.22, the provision of additional indigent patient care and treatment, and administrative costs associated with this chapter.

2005 Acts, ch 167, §24, 66; 2006 Acts, ch 1169, §1, 7

Referred to in §249J.8

For provisions relating to the transfer, appropriation, and deposit of funds and the amounts of payment adjustments for medical assistance retroactive to May 2, 2003, and May 17, 2004, see 2006 Acts, ch 1169, §2 – 7

249J.24 IowaCare account.

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

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

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

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

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

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

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

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

b. The board of trustees of the acute care teaching hospital identified in this subsection

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

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

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

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

2005 Acts, ch 167, §25, 66; 2006 Acts, ch 1184, §117, 127; 2009 Acts, ch 110, §3
Referred to in §249A.11, 249J.24A

249J.24A Nonparticipating provider reimbursement for covered services — reimbursement fund.

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

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

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

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

d. If the medical status of the expansion population member indicates a medical emergency and the nonparticipating provider is not able to contact the appropriate

participating provider prior to providing medically necessary services, the nonparticipating provider shall document the medical emergency and inform the appropriate participating provider immediately after the member has been stabilized of any covered services provided.

2. *a.* If the nonparticipating provider meets the requirements specified in subsection 1, the nonparticipating provider shall be reimbursed for covered expansion population services provided to the expansion population member through the nonparticipating provider reimbursement fund in accordance with rules adopted by the department of human services. However, any funds received from participating providers, appropriated to participating providers, or deposited in the IowaCare account pursuant to section 249J.24, shall not be transferred or appropriated to the nonparticipating provider reimbursement fund or otherwise used to reimburse nonparticipating providers.

b. Reimbursement of nonparticipating providers under this section shall be based on the reimbursement rates and policies applicable to the nonparticipating provider under the full benefit medical assistance program, subject to the availability of funds in the nonparticipating provider reimbursement fund and subject to the appropriation of moneys in the fund to the department.

c. The department shall reimburse the nonparticipating provider only if the recipient of the services is an expansion population member with active eligibility status at the time the services are provided.

3. *a.* A nonparticipating provider reimbursement fund is created in the state treasury under the authority of the department. Moneys designated for deposit in the fund that are received from sources including but not limited to appropriations from the general fund of the state, grants, and contributions, shall be deposited in the fund. However, any funds received from participating providers, appropriated to participating providers, or deposited in the IowaCare account pursuant to section 249J.24 shall not be transferred or appropriated to the nonparticipating provider reimbursement fund or otherwise used to reimburse nonparticipating providers.

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

c. Moneys deposited in the fund shall be used only to reimburse nonparticipating providers who provide covered services to expansion population members if no other third party is liable for reimbursement and as specified in subsection 1.

d. The department shall attempt to maximize receipt of federal matching funds under the medical assistance program for covered services provided under this section if such attempt does not directly or indirectly limit the federal funds available to participating providers.

4. For the purposes of this section, "*nonparticipating provider*" means a hospital licensed pursuant to chapter 135B that is not a member of the expansion population provider network as specified in section 249J.7.

2009 Acts, ch 182, §127

Beginning July 1, 2010, medical assistance program waivers relating to continuation of IowaCare program to include provisions relating to reimbursement of nonparticipating providers; 2009 Acts, ch 182, §128

249J.25 Limitations.

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

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

2005 Acts, ch 167, §26, 66

249J.26 Audit — future repeal.

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

2. This chapter is repealed June 30, 2010.

2005 Acts, ch 167, §27, 66