249N.2 Definitions.

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

1. *"Accountable care organization"* means a risk-bearing, integrated health care organization characterized by a payment and care delivery model that ties provider reimbursement to quality metrics and reductions in the total cost of care for an attributed population of patients.
2. *"Affordable Care Act"* means the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.
3. *"Covered benefits"* means covered benefits as specified in section 249N.5.
4. *"Department"* means the department of health and human services.
5. *"Director"* means the director of health and human services.
6. *"Eligible individual"* means an individual eligible for medical assistance pursuant to section 249A.3, subsection 1, paragraph *"v"*.
7. *"Essential health benefits"* means essential health benefits as defined in section 1302 of the Affordable Care Act, that include at least the general categories and the items and services covered within the categories of ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
8. *"Federal approval"* means approval by the centers for Medicare and Medicaid services of the United States department of health and human services.
9. *"Federal poverty level"* means the most recently revised poverty income guidelines published by the United States department of health and human services.
10. *"Household income"* means household income as determined using the modified adjusted gross income methodology pursuant to section 2002 of the Affordable Care Act.
11. *"Iowa health and wellness plan"* or *"plan"* means the Iowa health and wellness plan established under this chapter.
12. *"Iowa health and wellness plan provider"* means any provider enrolled in the medical assistance program or any participating accountable care organization.
13. *"Iowa health and wellness plan provider network"* means the health care delivery network approved by the department for Iowa health and wellness plan members.
14. *"Medical assistance program"*, *"Medicaid program"*, or *"Medicaid"* means the program paying all or part of the costs of care and services provided to an individual pursuant to chapter 249A and Tit. XIX of the federal Social Security Act.
15. *"Medical home"* means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access and integrate all medical and nonmedical health-related services across all elements of the health care system and the patient's community as needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the following characteristics:
   a. A personal provider.
   b. A provider-directed team-based medical practice.
   c. Whole-person orientation.
   d. Coordination and integration of care.
   e. Quality and safety.
   f. Enhanced access to health care.
   g. A payment system that appropriately recognizes the added value provided to patients who have a patient-centered medical home.
16. *"Member"* means an eligible individual who is enrolled in the Iowa health and wellness plan.
17. *"Participating accountable care organization"* means an accountable care

organization approved by the department to participate in the Iowa health and wellness plan provider network.

18. *"Personal provider"* means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health-related needs and, working with a team of health care professionals and providers of medical and nonmedical health-related services, provides for and coordinates appropriate care to address the health-related needs identified.

19. *"Preventive care services"* means care that is provided to an individual to promote health, prevent disease, or diagnose disease.

20. *"Primary care provider"* includes but is not limited to any of the following licensed or certified health care professionals who provide primary care:

a. A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.

b. An advanced registered nurse practitioner.

c. A physician assistant.

d. A chiropractor.

21. *"Primary medical provider"* means the personal provider trained to provide first contact and continuous and comprehensive care to a member, chosen by a member or to whom a member is assigned under the Iowa health and wellness plan.

22. *"Value-based reimbursement"* means a payment methodology that links provider reimbursement to improved performance by health care providers by holding health care providers accountable for both the cost and quality of care provided.

2013 Acts, ch 138, §167, 187; 2017 Acts, ch 148, §6, 7; 2023 Acts, ch 19, §826
Referred to in §249A.3
Subsections 4, 5, and 14 amended