Senate Amendment 5414

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Amend the Senate amendment, H=8439, to House File 2539, as amended, passed, and reprinted by the House, as follows:

#1. By striking page 1, line 3, through page 42, line 14, and inserting the following:

<#___. By striking everything after the enacting clause and inserting the following:

<DIVISION I

HEALTH CARE COVERAGE INTENT

Section 1. DECLARATION OF INTENT.

1. It is the intent of the general assembly to progress toward achievement of the goal that all Iowans have health care coverage with the following priorities:

a. The goal that all children in the state have health care coverage which meets certain standards of quality and affordability with the following priorities:

(1) Covering all children who are declared eligible for the medical assistance program or the hawk=i program pursuant to chapter 514I no later than January 1, 2011.

(2) Building upon the current hawk=i program by creating a hawk=i expansion program to provide coverage to children who meet the hawk=i program's eligibility criteria but whose income is at or below three hundred percent of the federal poverty level, beginning July 1, 2009.

(3) If federal reauthorization of the state children's health insurance program provides sufficient federal allocations to the state and authorization to cover such children as an option under the state children's health insurance program, requiring the department of human services to expand coverage under the state children's health insurance program to cover children with family incomes at or below three hundred percent of the federal poverty level, with appropriate cost sharing established for families with incomes above two hundred percent of the federal poverty level.

b. The goal that the Iowa comprehensive health insurance association, in consultation with the Iowa choice health care coverage advisory council established in section 514E.6, develop a comprehensive plan to first cover all children without health care coverage that utilizes and modifies existing public programs including the medical assistance program, the hawk=i program, and the hawk=i expansion program, and then to provide access to private unsubsidized, affordable, qualified health care coverage for children, adults, and families, who are not otherwise eligible for health care coverage through public programs, that is available for purchase by January 1, 2010.

c. The goal of decreasing health care costs and health care coverage costs by instituting health insurance reforms that assure the availability of private health insurance coverage for Iowans by addressing issues involving guaranteed availability and issuance to applicants, preexisting condition exclusions, portability, and allowable or required pooling and rating classifications.

DIVISION II

HAWK=I AND MEDICAID EXPANSION

Sec. 2. Section 249A.3, subsection 1, paragraph l, Code Supplement 2007, is amended to read as follows:

l. Is an infant whose income is not more than two hundred percent of the federal poverty level, as defined by the most recently revised income guidelines published by the United States department of health and human services. Additionally, effective July 1, 2009, medical assistance shall be provided to an infant whose family income is at or 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, if otherwise eligible.

Sec. 3. Section 249A.3, Code Supplement 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 14. Once initial eligibility for the family medical assistance program=related medical assistance is determined for a child described under subsection 1, paragraphs "b", "f", "g", "j", "k", "l", or "n" or under subsection 2, paragraphs "e", "f", or "h", the department shall provide continuous eligibility for a period of up to twelve months, until the child's next annual review of eligibility under the medical assistance program, if the child would otherwise be determined ineligible due to excess countable income but otherwise remains eligible.

Sec. 4. NEW SECTION. 422.12K INCOME TAX FORM == INDICATION OF DEPENDENT CHILD HEALTH CARE COVERAGE.

1. The director shall draft the income tax form to allow beginning with the tax returns for tax year 2008, a person who files an individual or joint income tax return with the department under section 422.13 to indicate the presence or absence of health care coverage for each dependent child for whom an exemption is claimed.

2. Beginning with the income tax return for tax year 2008, a person who files an individual or joint income tax return with the department under section 422.13, may report on the income tax return, in the form required, the presence or absence of health care coverage for each dependent child for whom an exemption is claimed.

a. If the taxpayer indicates on the income tax return that a dependent child does not have health care coverage, and the income of the taxpayer's tax return does not exceed the highest level of income eligibility standard for the medical assistance program pursuant to chapter 249A or the hawk=i program pursuant to chapter 514I, the department shall send a notice to the taxpayer indicating that the dependent child may be eligible for the medical assistance program or the hawk=i program and providing information about how to enroll in the programs.

b. Notwithstanding any other provision of law to the contrary, a taxpayer shall not be subject to a penalty for not providing the information required under this section.

c. The department shall consult with the department of human services in developing the tax return form and the information to be provided to tax filers under this section.

3. The department, in cooperation with the department of human services, shall adopt rules pursuant to chapter 17A to administer this section, including rules defining "health care coverage" for the purpose of indicating its presence or absence on the tax form.

4. The department, in cooperation with the department of human services, shall report, annually, to the governor and the general assembly all of the following:

a. The number of Iowa families, by income level, claiming the state income tax exemption for dependent children.

b. The number of Iowa families, by income level, claiming the state income tax exemption for dependent children who also indicate the presence or absence of health care coverage for the dependent children.

c. The effect of the reporting requirements and provision of information requirements under this section on the number and percentage of children in the state who are uninsured.

Sec. 5. Section 514I.1, subsection 4, Code 2007, is amended to read as follows:

4. It is the intent of the general assembly that the hawk=i program be an integral part of the continuum of health insurance coverage and that the program be developed and implemented in such a manner as to facilitate movement of families between health insurance providers and to facilitate the transition of families to private sector health insurance

coverage. It is the intent of the general assembly in developing such continuum of health insurance coverage and in facilitating such transition, that beginning July 1, 2009, the department implement the hawk=i expansion program.

Sec. 6. Section 514I.1, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 5. It is the intent of the general assembly that if federal reauthorization of the state children's health insurance program provides sufficient federal allocations to the state and authorization to cover such children as an option under the state children's health insurance program, the department shall expand coverage under the state children's health insurance program to cover children with family incomes at or below three hundred percent of the federal poverty level.

Sec. 7. Section 514I.2, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 7A. "Hawk=i expansion program" or "hawk=i expansion" means the healthy and well kids in Iowa expansion program created in section 514I.12 to provide health insurance to children who meet the hawk=i program eligibility criteria pursuant to section 514I.8, with the exception of the family income criteria, and whose family income is at or 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.

Sec. 8. Section 514I.5, subsection 7, paragraph d, Code Supplement 2007, is amended to read as follows:

d. Develop, with the assistance of the department, an outreach plan, and provide for periodic assessment of the effectiveness of the outreach plan. The plan shall provide outreach to families of children likely to be eligible for assistance under the program, to inform them of the availability of and to assist the families in enrolling children in the program. The outreach efforts may include, but are not limited to, solicitation of cooperation from programs, agencies, and other persons who are likely to have contact with eligible children, including but not limited to those associated with the educational system, and the development of community plans for outreach and marketing. Other state agencies shall assist the department in data collection related to outreach efforts to potentially eligible children and their families.

Sec. 9. Section 514I.5, subsection 7, Code Supplement 2007, is amended by adding the following new paragraph:

NEW PARAGRAPH. l. Develop options and recommendations to allow children eligible for the hawk=i or hawk=i expansion program to participate in qualified employer=sponsored health plans through a premium assistance program. The options and recommendations shall ensure reasonable alignment between the benefits and costs of the hawk=i and hawk=i expansion programs and the employer=sponsored health plans consistent with federal law. The options and recommendations shall be completed by January 1, 2009, and submitted to the governor and the general assembly for consideration as part of the hawk=i and hawk=i expansion programs.

Sec. 10. Section 514I.7, subsection 2, paragraph a, Code 2007, is amended to read as follows:

a. Determine individual eligibility for program enrollment based upon review of completed applications and supporting documentation. The administrative contractor shall not enroll a child who has group health coverage ~~or any child who has dropped coverage in the previous six months, unless the coverage was involuntarily lost or unless the reason for dropping coverage is allowed by rule of the board~~.

Sec. 11. Section 514I.8, subsection 1, Code 2007, is amended to read as follows:

1. Effective July 1, 1998, and notwithstanding any medical assistance program eligibility criteria to the contrary, medical assistance shall be provided to, or on behalf of, an eligible child under the age of

nineteen whose family income does not exceed one hundred thirty=three 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. Additionally, effective July 1, 2000, and notwithstanding any medical assistance program eligibility criteria to the contrary, medical assistance shall be provided to, or on behalf of, an eligible infant whose family income does not exceed 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. Effective July 1, 2009, and notwithstanding any medical assistance program eligibility criteria to the contrary, medical assistance shall be provided to, or on behalf of, an eligible infant whose family income is at or 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.

Sec. 12. Section 514I.10, subsection 2, Code 2007, is amended to read as follows:

2. Cost sharing for eligible children whose family income equals ~~or exceeds~~ one hundred fifty percent but does not exceed two hundred percent of the federal poverty level may include a premium or copayment amount which does not exceed five percent of the annual family income. The amount of any premium or the copayment amount shall be based on family income and size.

Sec. 13. Section 514I.11, subsections 1 and 3, Code 2007, are amended to read as follows:

1. A hawk=i trust fund is created in the state treasury under the authority of the department of human services, in which all appropriations and other revenues of the program and the hawk=i expansion program such as grants, contributions, and participant payments shall be deposited and used for the purposes of the program and the hawk=i expansion program. The moneys in the fund shall not be considered revenue of the state, but rather shall be funds of the program.

3. Moneys in the fund are appropriated to the department and shall be used to offset any program and hawk=i expansion program costs.

Sec. 14. NEW SECTION. 514I.12 HAWK=I EXPANSION PROGRAM.

1. All children less than nineteen years of age who meet the hawk=i program eligibility criteria pursuant to section 514I.8, with the exception of the family income criteria, and whose family income is at or below three hundred percent of the federal poverty level, shall be eligible for the hawk=i expansion program.

2. To the greatest extent possible, the provisions of section 514I.4, relating to the director and department duties and powers, section 514I.5 relating to the hawk=i board, section 514I.6 relating to participating insurers, and section 514I.7 relating to the administrative contractor shall apply to the hawk=i expansion program. The department shall adopt any rules necessary, pursuant to chapter 17A, and shall amend any existing contracts to facilitate the application of such sections to the hawk=i expansion program.

3. The hawk=i board shall establish by rule pursuant to chapter 17A, the cost=sharing amounts, criteria for modification of the cost=sharing amounts, and graduated premiums for children under the hawk=i expansion program.

Sec. 15. MAXIMIZATION OF ENROLLMENT AND RETENTION == MEDICAL ASSISTANCE AND HAWK=I PROGRAMS.

1. The department of human services, in collaboration with the department of education, the department of public health, the division of insurance of the department of commerce, the hawk=i board, consumers who are not recipients of or advocacy groups representing recipients of the medical assistance or hawk-i program, the covering kids and families coalition, and the covering kids now task force, shall

develop a plan to maximize enrollment and retention of eligible children in the hawk=i and medical assistance programs. In developing the plan, the collaborative shall review, at a minimum, all of the following strategies:

a. Streamlined enrollment in the hawk=i and medical assistance programs. The collaborative shall identify information and documentation that may be shared across departments and programs to simplify the determination of eligibility or eligibility factors, and any interagency agreements necessary to share information consistent with state and federal confidentiality and other applicable requirements.

b. Conditional eligibility for the hawk=i and medical assistance programs.

c. Expedited renewal for the hawk=i and medical assistance programs.

2. Following completion of the review the department of human services shall compile the plan which shall address all of the following relative to implementation of the strategies specified in subsection 1:

a. Federal limitations and quantifying of the risk of federal disallowance.

b. Any necessary amendment of state law or rule.

c. Budgetary implications and cost=benefit analyses.

d. Any medical assistance state plan amendments, waivers, or other federal approval necessary.

e. An implementation time frame.

3. The department of human services shall submit the plan to the governor and the general assembly no later than December 1, 2008.

Sec. 16. MEDICAL ASSISTANCE, HAWK=I, AND HAWK=I EXPANSION PROGRAMS == COVERING CHILDREN ==

APPROPRIATION. There is appropriated from the general fund of the state to the department of human services for the designated fiscal years, the following amounts, or so much thereof as is necessary, for the purpose designated:

To cover children as provided in this Act under the medical assistance, hawk=i, and hawk=i expansion programs and outreach under the current structure of the programs:

FY 2008=2009 ..... $ 4,800,000
FY 2009=2010 ..... $ 14,800,000
FY 2010=2011 ..... $ 24,800,000

DIVISION III

IOWA CHOICE HEALTH CARE COVERAGE AND ADVISORY COUNCIL

Sec. 17. Section 514E.1, Code 2007, is amended by adding the following new subsections:

NEW SUBSECTION. 14A. "Iowa choice health care coverage advisory council" or "advisory council" means the advisory council created in section 514E.6.

NEW SUBSECTION. 21. "Qualified health care coverage" means creditable coverage which meets minimum standards of quality and affordability as determined by the association by rule.

Sec. 18. Section 514E.2, subsection 3, unnumbered paragraph 1, Code 2007, is amended to read as follows:

The association shall submit to the commissioner a plan of operation for the association and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation shall include provisions for the development of a comprehensive health care coverage plan as provided in section 514E.5. In developing the comprehensive plan the association shall give deference to the recommendations made by the advisory council as provided in section 514E.6, subsection 1. The association shall approve or disapprove but shall not modify recommendations made by the advisory council. Recommendations that are approved shall be included in the plan of operation submitted to the commissioner. Recommendations that are disapproved shall be submitted to the commissioner with reasons for the disapproval. The plan of operation becomes effective upon approval in writing by the commissioner prior to the date on which the coverage under this chapter must

be made available. After notice and hearing, the commissioner shall approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association, and provides for the sharing of association losses, if any, on an equitable and proportionate basis among the member carriers. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or if at any later time the association fails to submit suitable amendments to the plan, the commissioner shall adopt, pursuant to chapter 17A, rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

Sec. 19. NEW SECTION. 514E.5 IOWA CHOICE HEALTH CARE COVERAGE.

1. The association, in consultation with the Iowa choice health care coverage advisory council, shall develop a comprehensive health care coverage plan to provide health care coverage to all children without such coverage, that utilizes and modifies existing public programs including the medical assistance program, hawk=i program, and hawk=i expansion program, and to provide access to private unsubsidized, affordable, qualified health care coverage to children who are not otherwise eligible for health care coverage through public programs.

2. The comprehensive plan developed by the association and the advisory council, shall also develop and recommend options to provide access to private unsubsidized, affordable, qualified health care coverage to all Iowa children less than nineteen years of age with a family income that is more three hundred percent of the federal poverty level and to adults and families who are not otherwise eligible for health care coverage through public programs.

3. As part of the comprehensive plan developed, the association, in consultation with the advisory council, shall define what constitutes qualified health care coverage for children less than nineteen years of age. For the purposes of this definition and for designing health care coverage options for children, the association, in consultation with the advisory council, shall recommend the benefits to be included in such coverage and shall explore the value of including coverage for the treatment of mental and behavioral disorders. The association and the advisory council shall perform a cost analysis as part of their consideration of benefit options. The association and the advisory council shall also consider whether to include coverage of the following benefits:

a. Inpatient hospital services including medical, surgical, intensive care unit, mental health, and substance abuse services.

b. Nursing care services including skilled nursing facility services.

c. Outpatient hospital services including emergency room, surgery, lab, and x=ray services and other services.

d. Physician services, including surgical and medical, office visits, newborn care, well=baby and well=child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits.

e. Ambulance services.

f. Physical therapy.

g. Speech therapy.

h. Durable medical equipment.

i. Home health care.

j. Hospice services.

k. Prescription drugs.

l. Dental services including preventive services.

m. Medically necessary hearing services.

n. Vision services including corrective lenses.

o. No underwriting requirements and no preexisting

condition exclusions.

p. Chiropractic services.

4. As part of the comprehensive plan developed, the association, in consultation with the advisory council, shall consider and recommend whether health care coverage options that are developed for purchase for children less than nineteen years of age with a family income that is more than three hundred percent of the federal poverty level should require a copayment for services received in an amount determined by the association.

5. As part of the comprehensive plan, the association, in consultation with the advisory council, shall define what constitutes qualified health care coverage for adults and families who are not eligible for a public program. The association, in consultation with the advisory council, shall develop and recommend health care coverage options for purchase by such adults and families that provide a selection of health benefit plans and standardized benefits.

6. As part of the comprehensive plan the association and the advisory council may collaborate with health insurance carriers to do the following, including but not limited to:

a. Design solutions to issues relating to guaranteed issuance of insurance, preexisting condition exclusions, portability, and allowable pooling and rating classifications.

b. Formulate principles that ensure fair and appropriate practices relating to issues involving individual health care policies such as recision and preexisting condition clauses, and that provide for a binding third=party review process to resolve disputes related to such issues.

c. Design affordable, portable health care coverage options for low=income children, adults, and families.

d. Design a proposed premium schedule for health care coverage options that are recommended which include the development of rating factors that are consistent with market conditions.

e. Design protocols to limit the transfer from employer=sponsored or other private health care coverage to state=developed health care coverage plans.

7. The association shall submit the comprehensive plan required by this section to the governor and the general assembly by December 15, 2008. The appropriations to cover children under the medical assistance, hawk=i, and hawk=i expansion programs as provided in this Act and to provide related outreach for fiscal year 2009=2010 and fiscal year 2010=2011 are contingent upon enactment of a comprehensive plan during the 2009 regular session of the Eighty=third General Assembly that provides health care coverage for all children in the state. Enactment of a comprehensive plan shall include a determination of what the prospects are of federal action which may impact the comprehensive plan and the fiscal impact of the comprehensive plan on the state budget.

Sec. 20. NEW SECTION. 514E.6 IOWA CHOICE HEALTH CARE COVERAGE ADVISORY COUNCIL.

1. The Iowa choice health care coverage advisory council is created for the purpose of assisting the association with developing a comprehensive health care coverage plan as provided in section 514E.5. The advisory council shall make recommendations concerning the design and implementation of the comprehensive plan including but not limited to a definition of what constitutes qualified health care coverage, suggestions for the design of health care coverage options, and implementation of a health care coverage reporting requirement.

2. The advisory council consists of the following persons who are voting members unless otherwise provided:

a. The two most recent former governors, or if one or both of them are unable or unwilling to serve, a person or persons appointed by the governor.

b. Seven members appointed by the director of

public health:
(1) A representative of the federation of Iowa insurers.
(2) A health economist who resides in Iowa.
(3) Two consumers, one of whom shall be a representative of a children's advocacy organization and one of whom shall be a member of a minority.
(4) A representative of organized labor.
(5) A representative of an organization of employers.
(6) A representative of the Iowa association of health underwriters.
c. The following members shall be ex officio, nonvoting members of the council:
(1) The commissioner of insurance, or a designee.
(2) The director of human services, or a designee.
(3) The director of public health, or a designee.
(4) Four members of the general assembly, one appointed by the speaker of the house of representatives, one appointed by the minority leader of the house of representatives, one appointed by the majority leader of the senate, and one appointed by the minority leader of the senate.
3. The members of the council appointed by the director of public health shall be appointed for terms of six years beginning and ending as provided in section 69.19. Such a member of the board is eligible for reappointment. The director shall fill a vacancy for the remainder of the unexpired term.
4. The members of the council shall annually elect one voting member as chairperson and one as vice chairperson. Meetings of the council shall be held at the call of the chairperson or at the request of a majority of the council's members.
5. The members of the council shall not receive compensation for the performance of their duties as members but each member shall be paid necessary expenses while engaged in the performance of duties of the council. Any legislative member shall be paid the per diem and expenses specified in section 2.10.
6. The members of the council are subject to and are officials within the meaning of chapter 68B.

DIVISION IV
HEALTH INSURANCE OVERSIGHT

Sec. 21. Section 505.8, Code Supplement 2007, is amended by adding the following new subsection:
NEW SUBSECTION. 5A. The commissioner shall have regulatory authority over health benefit plans and adopt rules under chapter 17A as necessary, to promote the uniformity, cost efficiency, transparency, and fairness of such plans for physicians licensed under chapters 148, 150, and 150A, and hospitals licensed under chapter 135B, for the purpose of maximizing administrative efficiencies and minimizing administrative costs of health care providers and health insurers.
Sec. 22. HEALTH INSURANCE OVERSIGHT == APPROPRIATION. There is appropriated from the general fund of the state to the insurance division of the department of commerce for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:
For identification and regulation of procedures and practices related to health care as provided in section 505.8, subsection 5A:
..... $ 80,000

DIVISION V
IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

DIVISION XXI
IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

Sec. 23. NEW SECTION. 135.154 DEFINITIONS.
As used in this division, unless the context otherwise requires:
1. "Board" means the state board of health created pursuant to section 136.1.
2. "Department" means the department of public health.
3. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer

health care in the ordinary course of business or in the practice of a profession.

4. "Health information technology" means the application of information processing, involving both computer hardware and software, that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication, decision making, quality, safety, and efficiency of clinical practice, and may include but is not limited to:

a. An electronic health record that electronically compiles and maintains health information that may be derived from multiple sources about the health status of an individual and may include a core subset of each care delivery organization's electronic medical record such as a continuity of care record or a continuity of care document, computerized physician order entry, electronic prescribing, or clinical decision support.

b. A personal health record through which an individual and any other person authorized by the individual can maintain and manage the individual's health information.

c. An electronic medical record that is used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery organization, is the legal record of the patient's encounter with the care delivery organization, and is owned by the care delivery organization.

d. A computerized provider order entry function that permits the electronic ordering of diagnostic and treatment services, including prescription drugs.

e. A decision support function to assist physicians and other health care providers in making clinical decisions by providing electronic alerts and reminders to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments.

f. Tools to allow for the collection, analysis, and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction, and other health care=related performance measures.

5. "Interoperability" means the ability of two or more systems or components to exchange information or data in an accurate, effective, secure, and consistent manner and to use the information or data that has been exchanged and includes but is not limited to:

a. The capacity to connect to a network for the purpose of exchanging information or data with other users.

b. The ability of a connected, authenticated user to demonstrate appropriate permissions to participate in the instant transaction over the network.

c. The capacity of a connected, authenticated user to access, transmit, receive, and exchange usable information with other users.

6. "Recognized interoperability standard" means interoperability standards recognized by the office of the national coordinator for health information technology of the United States department of health and human services.

Sec. 24. NEW SECTION. 135.155 IOWA ELECTRONIC HEALTH == PRINCIPLES == GOALS.

1. Health information technology is rapidly evolving so that it can contribute to the goals of improving access to and quality of health care, enhancing efficiency, and reducing costs.

2. To be effective, the health information technology system shall comply with all of the following principles:

a. Be patient=centered and market=driven.

b. Be based on approved standards developed with input from all stakeholders.

c. Protect the privacy of consumers and the security and confidentiality of all health information.

d. Promote interoperability.

e. Ensure the accuracy, completeness, and uniformity of data.

3. Widespread adoption of health information

technology is critical to a successful health information technology system and is best achieved when all of the following occur:

a. The market provides a variety of certified products from which to choose in order to best fit the needs of the user.

b. The system provides incentives for health care professionals to utilize the health information technology and provides rewards for any improvement in quality and efficiency resulting from such utilization.

c. The system provides protocols to address critical problems.

d. The system is financed by all who benefit from the improved quality, efficiency, savings, and other benefits that result from use of health information technology.

Sec. 25. NEW SECTION. 135.156 ELECTRONIC HEALTH INFORMATION == DEPARTMENT DUTIES == ADVISORY COUNCIL == EXECUTIVE COMMITTEE.

1. a. The department shall direct a public and private collaborative effort to promote the adoption and use of health information technology in this state in order to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals with comprehensive, real=time medical information to provide continuity of care and make the best health care decisions. The department shall provide coordination for the development and implementation of an interoperable electronic health records system, telehealth expansion efforts, the health information technology infrastructure, and other health information technology initiatives in this state. The department shall be guided by the principles and goals specified in section 135.155.

b. All health information technology efforts shall endeavor to represent the interests and meet the needs of consumers and the health care sector, protect the privacy of individuals and the confidentiality of individuals' information, promote physician best practices, and make information easily accessible to the appropriate parties. The system developed shall be consumer=driven, flexible, and expandable.

2. a. An electronic health information advisory council is established which shall consist of the representatives of entities involved in the electronic health records system task force established pursuant to section 217.41A, Code 2007, a pharmacist, a licensed practicing physician, a consumer who is a member of the state board of health, a representative of the state's Medicare quality improvement organization, the executive director of the Iowa communications network, a representative of the private telecommunications industry, a representative of the Iowa collaborative safety net provider network created in section 135.153, a nurse informaticist from the university of Iowa, and any other members the department or executive committee of the advisory council determine necessary to assist the department or executive committee at various stages of development of the electronic health information system. Executive branch agencies shall also be included as necessary to assist in the duties of the department and the executive committee. Public members of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent. Any legislative members shall be paid the per diem and expenses specified in section 2.10.

b. An executive committee of the electronic health information advisory council is established. Members of the executive committee of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent. The executive committee shall consist of the following members:

(1) Three members, each of whom is the chief

information officer of one of the three largest private health care systems in the state.

(2) One member who is a representative of the university of Iowa.

(3) One member who is a representative of a rural hospital that is a member of the Iowa hospital association.

(4) One member who is a consumer member of the state board of health.

(5) One member who is a licensed practicing physician.

(6) One member who is a health care provider other than a licensed practicing physician.

(7) A representative of the federation of Iowa insurers.

3. The executive committee, with the technical assistance of the advisory council and the support of the department shall do all of the following:

a. Develop a statewide health information technology plan by July 1, 2009. In developing the plan, the executive committee shall seek the input of providers, payers, and consumers. Standards and policies developed for the plan shall promote and be consistent with national standards developed by the office of the national coordinator for health information technology of the United States department of health and human services and shall address or provide for all of the following:

(1) The effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvement. The executive committee shall recommend requirements for interoperable electronic health records in this state including a recognized interoperability standard.

(2) Education of the public and health care sector about the value of health information technology in improving patient care, and methods to promote increased support and collaboration of state and local public health agencies, health care professionals, and consumers in health information technology initiatives.

(3) Standards for the exchange of health care information.

(4) Policies relating to the protection of privacy of patients and the security and confidentiality of patient information.

(5) Policies relating to information ownership.

(6) Policies relating to governance of the various facets of the health information technology system.

(7) A single patient identifier or alternative mechanism to share secure patient information. If no alternative mechanism is acceptable to the executive committee, all health care professionals shall utilize the mechanism selected by the executive committee by July 1, 2010.

(8) A standard continuity of care record and other issues related to the content of electronic transmissions. All health care professionals shall utilize the standard continuity of care record by July 1, 2010.

(9) Requirements for electronic prescribing.

(10) Economic incentives and support to facilitate participation in an interoperable system by health care professionals.

b. Identify existing and potential health information technology efforts in this state, regionally, and nationally, and integrate existing efforts to avoid incompatibility between efforts and avoid duplication.

c. Coordinate public and private efforts to provide the network backbone infrastructure for the health information technology system. In coordinating these efforts, the executive committee shall do all of the following:

(1) Develop policies to effectuate the logical cost=effective usage of and access to the state=owned network, and support of telecommunication carrier products, where applicable.

(2) Consult with the Iowa communications network, private fiberoptic networks, and any other

communications entity to seek collaboration, avoid duplication, and leverage opportunities in developing a backbone network.

(3) Establish protocols to ensure compliance with any applicable federal standards.

(4) Determine costs for accessing the network at a level that provides sufficient funding for the network.

d. Promote the use of telemedicine.

(1) Examine existing barriers to the use of telemedicine and make recommendations for eliminating these barriers.

(2) Examine the most efficient and effective systems of technology for use and make recommendations based on the findings.

e. Address the workforce needs generated by increased use of health information technology.

f. Recommend rules to be adopted in accordance with chapter 17A to implement all aspects of the statewide health information technology plan and the network.

g. Coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in this state.

h. Seek and apply for any federal or private funding to assist in the implementation and support of the health information technology system and make recommendations for funding mechanisms for the ongoing development and maintenance costs of the health information technology system.

i. Identify state laws and rules that present barriers to the development of the health information technology system and recommend any changes to the governor and the general assembly.

4. Recommendations and other activities resulting from the work of the executive committee shall be presented to the board for action or implementation.

Sec. 26. Section 8D.13, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 20. Access shall be offered to the Iowa hospital association only for the purposes of collection, maintenance, and dissemination of health and financial data for hospitals and for hospital education services. The Iowa hospital association shall be responsible for all costs associated with becoming part of the network, as determined by the commission.

Sec. 27. Section 136.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 11. Perform those duties authorized pursuant to section 135.156.

Sec. 28. Section 217.41A, Code 2007, is repealed.

Sec. 29. IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM == APPROPRIATION. There is appropriated from the general fund of the state to the department of public health for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For administration of the Iowa health information technology system, and for not more than the following full=time equivalent positions:

..... $ 190,600

..... FTEs 2.00

DIVISION VI

LONG=TERM LIVING PLANNING AND PATIENT AUTONOMY IN HEALTH CARE

Sec. 30. NEW SECTION. 231.62 END=OF=LIFE CARE INFORMATION.

1. The department shall consult with the Iowa medical society, the Iowa end=of=life coalition, the Iowa hospice organization, the university of Iowa palliative care program, and other health care professionals whose scope of practice includes end=of=life care to develop educational and patient=centered information on end=of=life care for terminally ill patients and health care professionals.

2. For the purposes of this section, "end=of=life care" means care provided to meet the physical, psychological, social, spiritual, and practical needs of terminally ill patients and their caregivers.

Sec. 31. END=OF=LIFE CARE INFORMATION ==

APPROPRIATION. There is appropriated from the general fund of the state to the department of elder affairs for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For activities associated with the end=of=life care information requirements of this division:

..... $ 10,000

Sec. 32. LONG=TERM LIVING PLANNING TOOLS == PUBLIC EDUCATION CAMPAIGN. The legal services development and substitute decision maker programs of the department of elder affairs, in collaboration with other appropriate agencies and interested parties, shall research existing long=term living planning tools that are designed to increase quality of life and contain health care costs and recommend a public education campaign strategy on long=term living to the general assembly by January 1, 2009.

Sec. 33. LONG=TERM CARE OPTIONS PUBLIC EDUCATION CAMPAIGN. The department of elder affairs, in collaboration with the insurance division of the department of commerce, shall implement a long=term care options public education campaign. The campaign may utilize such tools as the "Own Your Future Planning Kit" administered by the centers for Medicare and Medicaid services, the administration on aging, and the office of the assistant secretary for planning and evaluation of the United States department of health and human services, and other tools developed through the aging and disability resource center program of the administration on aging and the centers for Medicare and Medicaid services designed to promote health and independence as Iowans age, assist older Iowans in making informed choices about the availability of long=term care options, including alternatives to facility=based care, and to streamline access to long=term care.

Sec. 34. LONG=TERM CARE OPTIONS PUBLIC EDUCATION CAMPAIGN == APPROPRIATION. There is appropriated from the general fund of the state to the department of elder affairs for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For activities associated with the long=term care options public education campaign requirements of this division:

..... $ 75,000

Sec. 35. HOME AND COMMUNITY=BASED SERVICES PUBLIC EDUCATION CAMPAIGN. The department of elder affairs shall work with other public and private agencies to identify resources that may be used to continue the work of the aging and disability resource center established by the department through the aging and disability resource center grant program efforts of the administration on aging and the centers for Medicare and Medicaid services of the United States department of health and human services, beyond the federal grant period ending September 30, 2008.

Sec. 36. PATIENT AUTONOMY IN HEALTH CARE DECISIONS PILOT PROJECT.

1. The department of public health shall establish a two=year community coalition for patient treatment wishes across the health care continuum pilot project, beginning July 1, 2008, and ending June 30, 2010, in a county with a population of between fifty thousand and one hundred thousand. The pilot project shall utilize the process based upon the national physicians orders for life sustaining treatment program initiative, including use of a standardized physician order for scope of treatment form. The process shall require validation of the physician order for scope of treatment form by the signature of an individual other than the patient or the patient's legal representative who is not an employee of the patient's physician. The pilot project may include applicability to chronically ill, frail, and elderly or terminally ill individuals in hospitals licensed pursuant to chapter 135B, nursing facilities or residential care facilities licensed pursuant to chapter 135C, or hospice programs as defined in section 135J.1.

2. The department of public health shall convene an advisory council, consisting of representatives of entities with interest in the pilot project, including but not limited to the Iowa hospital association, the Iowa medical society, organizations representing health care facilities, representatives of health care providers, and the Iowa trial lawyers association, to develop recommendations for expanding the pilot project statewide. The advisory council shall report its findings and recommendations, including recommendations for legislation, to the governor and the general assembly by January 1, 2010.

3. The pilot project shall not alter the rights of individuals who do not execute a physician order for scope of treatment.

a. If an individual is a qualified patient as defined in section 144A.2, the individual's declaration executed under chapter 144A shall control health care decision making for the individual in accordance with chapter 144A. A physician order for scope of treatment shall not supersede a declaration executed pursuant to chapter 144A. If an individual has not executed a declaration pursuant to chapter 144A, health care decision making relating to life=sustaining procedures for the individual shall be governed by section 144A.7.

b. If an individual has executed a durable power of attorney for health care pursuant to chapter 144B, the individual's durable power of attorney for health care shall control health care decision making for the individual in accordance with chapter 144B. A physician order for scope of treatment shall not supersede a durable power of attorney for health care executed pursuant to chapter 144B.

c. In the absence of actual notice of the revocation of a physician order for scope of treatment, a physician, health care provider, or any other person who complies with a physician order for scope of treatment shall not be subject to liability, civil or criminal, for actions taken under this section which are in accordance with reasonable medical standards. Any physician, health care provider, or other person against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose the restriction on liability in this paragraph as an absolute defense.

DIVISION VII

HEALTH CARE COVERAGE

Sec. 37. NEW SECTION. 505.31 REIMBURSEMENT ACCOUNTS.

The commissioner of insurance shall assist employers with twenty=five or fewer employees with implementing and administering plans under section 125 of the Internal Revenue Code, including medical expense reimbursement accounts and dependent care accounts. The commissioner shall provide information about the assistance available to small employers on the insurance division's internet site.

Sec. 38. Section 509.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 8. A provision that the insurer will permit continuation of existing coverage for an unmarried child of an insured or enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or attains the age of twenty=five years old, whichever occurs first, or so long as the unmarried child maintains full=time status as a student in an accredited institution of postsecondary education.

Sec. 39. NEW SECTION. 509A.13B CONTINUATION OF DEPENDENT COVERAGE.

If a governing body, a county board of supervisors, or a city council has procured accident or health care coverage for its employees under this chapter such coverage shall permit continuation of existing coverage for an unmarried child of an insured or enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or

attains the age of twenty=five years old, whichever occurs first, or so long as the unmarried child maintains full=time status as a student in an accredited institution of postsecondary education.

Sec. 40. Section 513C.7, subsection 2, paragraph a, Code 2007, is amended to read as follows:

~~a.~~ The individual basic or standard health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition shall not be defined more restrictively than any of the following:

~~(1)~~ a. A condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage.

~~(2)~~ b. A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

~~(3)~~ c. A pregnancy existing on the effective date of coverage.

Sec. 41. Section 513C.7, subsection 2, paragraph b, Code 2007, is amended by striking the paragraph.

Sec. 42. NEW SECTION. 514A.3B ADDITIONAL REQUIREMENTS.

1. An insurer which accepts an individual for coverage under an individual policy or contract of accident and health insurance shall waive any time period applicable to a preexisting condition exclusion or limitation period requirement of the policy or contract with respect to particular services in an individual health benefit plan for the period of time the individual was previously covered by qualifying previous coverage as defined in section 513C.3 that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty=three days prior to the effective date of the new policy or contract. For purposes of this section, periods of coverage under medical assistance provided pursuant to chapter 249A or 514I, or Medicare coverage provided pursuant to Title XVIII of the federal Social Security Act shall not be counted with respect to the sixty=three=day requirement.

2. An insurer issuing an individual policy or contract of accident and health insurance which provides coverage for children of the insured shall permit continuation of existing coverage for an unmarried child of an insured or enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or attains the age of twenty=five years old, whichever occurs first, or so long as the unmarried child maintains full=time status as a student in an accredited institution of postsecondary education.

Sec. 43. APPLICABILITY. This division of this Act applies to policies or contracts of accident and health insurance delivered or issued for delivery or continued or renewed in this state on or after July 1, 2008.

DIVISION VIII
MEDICAL HOME
DIVISION XXII
MEDICAL HOME

Sec. 44. NEW SECTION. 135.157 DEFINITIONS.

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

1. "Board" means the state board of health created pursuant to section 136.1.

2. "Department" means the department of public health.

3. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

4. "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 all medical and nonmedical health=related services 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 characteristics specified in section 135.158.

5. "National committee for quality assurance" means the nationally recognized, independent nonprofit organization that measures the quality and performance of health care and health care plans in the United States; provides accreditation, certification, and recognition programs for health care plans and programs; and is recognized in Iowa as an accrediting organization for commercial and Medicaid=managed care organizations.

6. "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 needs, and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.

7. "Primary care" means health care which emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.

8. "Primary care provider" means any of the following who provide primary care and meet certification standards:

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 licensed pursuant to chapter 151.

Sec. 45. NEW SECTION. 135.158 MEDICAL HOME PURPOSES == CHARACTERISTICS.

1. The purposes of a medical home are the following:

a. To reduce disparities in health care access, delivery, and health care outcomes.

b. To improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage and to provide for the sustainability of the health care system.

c. To provide a tangible method to document if each Iowan has access to health care.

2. A medical home has all of the following characteristics:

a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.

b. A provider=directed medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.

c. Whole person orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end=of=life care.

d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

e. Quality and safety. The following are quality and safety components of the medical home:

(1) Provider=directed medical practices advocate for their patients to support the attainment of optimal, patient=centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.

(2) Evidence=based medicine and clinical decision=support tools guide decision making.

(3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient=centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

g. Payment. The payment system appropriately recognizes the added value provided to patients who have a patient=centered medical home. The payment structure framework of the medical home provides all of the following:

(1) Reflects the value of provider and nonprovider staff and patient=centered care management work that is in addition to the face=to=face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of provider work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee=for=service payments for face=to=face visits. Payments for health care management services that are in addition to the face=to=face visit do not result in a reduction in the payments for face=to=face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider=guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

Sec. 46. NEW SECTION. 135.159 MEDICAL HOME SYSTEM == ADVISORY COUNCIL == DEVELOPMENT AND IMPLEMENTATION.

1. The department shall administer the medical home system. The department shall adopt rules pursuant to chapter 17A necessary to administer the medical home system.

2. a. The department shall establish an advisory council which shall include but is not limited to all of the following members, selected by their respective organizations, and any other members the department determines necessary to assist in the department's duties at various stages of development of the medical home system:

(1) The director of human services, or the director's designee.

(2) The commissioner of insurance, or the commissioner's designee.

(3) A representative of the federation of Iowa insurers.

(4) A representative of the Iowa dental association.

(5) A representative of the Iowa nurses association.

(6) A physician licensed pursuant to chapter 148 and a physician licensed pursuant to chapter 150 who are family physicians and members of the Iowa academy of family physicians.

(7) A health care consumer.

(8) A representative of the Iowa collaborative safety net provider network established pursuant to section 135.153.

(9) A representative of the governor's developmental disabilities council.

(10) A representative of the Iowa chapter of the American academy of pediatrics.

(11) A representative of the child and family policy center.

(12) A representative of the Iowa pharmacy association.

(13) A representative of the Iowa chiropractic society.

(14) A representative of the university of Iowa college of public health.

b. Public members of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent.

3. The department shall develop a plan for implementation of a statewide medical home system. The department, in collaboration with parents, schools, communities, health plans, and providers, shall endeavor to increase healthy outcomes for children and adults by linking the children and adults with a medical home, identifying health improvement goals for children and adults, and linking reimbursement strategies to increasing healthy outcomes for children and adults. The plan shall provide that the medical home system shall do all of the following:

a. Coordinate and provide access to evidence=based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well=child health services.

b. Provide access to appropriate specialty care and inpatient services.

c. Provide quality=driven and cost=effective health care.

d. Provide access to pharmacist=delivered medication reconciliation and medication therapy management services, where appropriate.

e. Promote strong and effective medical management including but not limited to planning treatment strategies, monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of service. The plan shall provide that in sharing information, the priority shall be the protection of the privacy of individuals and the security and confidentiality of the individual's information. Any sharing of information required by the medical home system shall comply and be consistent with all existing state and federal laws and regulations relating to the confidentiality of health care information and shall be subject to written consent of the patient.

f. Emphasize patient and provider accountability.

g. Prioritize local access to the continuum of health care services in the most appropriate setting.

h. Establish a baseline for medical home goals and establish performance measures that indicate a child or adult has an established and effective medical home. For children, these goals and performance measures may include but are not limited to childhood immunizations rates, well=child care utilization

rates, care management for children with chronic illnesses, emergency room utilization, and oral health service utilization.

i. For children, coordinate with and integrate guidelines, data, and information from existing newborn and child health programs and entities, including but not limited to the healthy opportunities to experience, success=healthy families Iowa program, the community empowerment program, the center for congenital and inherited disorders screening and health care programs, standards of care for pediatric health guidelines, the office of multicultural health established in section 135.12, the oral health bureau established in section 135.15, and other similar programs and services.

4. The department shall develop an organizational structure for the medical home system in this state. The organizational structure plan shall integrate existing resources, provide a strategy to coordinate health care services, provide for monitoring and data collection on medical homes, provide for training and education to health care professionals and families, and provide for transition of children to the adult medical care system. The organizational structure may be based on collaborative teams of stakeholders throughout the state such as local public health agencies, the collaborative safety net provider network established in section 135.153, or a combination of statewide organizations. Care coordination may be provided through regional offices or through individual provider practices. The organizational structure may also include the use of telemedicine resources, and may provide for partnering with pediatric and family practice residency programs to improve access to preventive care for children. The organizational structure shall also address the need to organize and provide health care to increase accessibility for patients including using venues more accessible to patients and having hours of operation that are conducive to the population served.

5. The department shall adopt standards and a process to certify medical homes based on the national committee for quality assurance standards. The certification process and standards shall provide mechanisms to monitor performance and to evaluate, promote, and improve the quality of health of and health care delivered to patients through a medical home. The mechanism shall require participating providers to monitor clinical progress and performance in meeting applicable standards and to provide information in a form and manner specified by the department. The evaluation mechanism shall be developed with input from consumers, providers, and payers. At a minimum the evaluation shall determine any increased quality in health care provided and any decrease in cost resulting from the medical home system compared with other health care delivery systems. The standards and process shall also include a mechanism for other ancillary service providers to become affiliated with a certified medical home.

6. The department shall adopt education and training standards for health care professionals participating in the medical home system.

7. The department shall provide for system simplification through the use of universal referral forms, internet=based tools for providers, and a central medical home internet site for providers.

8. The department shall recommend a reimbursement methodology and incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In developing the recommendations for incentives, the department shall consider, at a minimum, providing incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the recommendations for the reimbursement system, the department shall analyze, at a minimum, the feasibility of all of the following:

a. Reimbursement under the medical assistance program to promote wellness and prevention, provide

care coordination, and provide chronic care management.

b. Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations.

c. Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and primary care services.

d. Increased funding for efforts to transform medical practices into certified medical homes, including emphasizing the implementation of the use of electronic health records.

e. Targeted reimbursement to providers linked to health care quality improvement measures established by the department.

f. Reimbursement for specified ancillary support services such as transportation for medical appointments and other such services.

g. Providing reimbursement for medication reconciliation and medication therapy management service, where appropriate.

9. The department shall coordinate the requirements and activities of the medical home system with the requirements and activities of the dental home for children as described in section 249J.14, subsection 7, and shall recommend financial incentives for dentists and nondental providers to promote oral health care coordination through preventive dental intervention, early identification of oral disease risk, health care coordination and data tracking, treatment, chronic care management, education and training, parental guidance, and oral health promotions for children.

10. The department shall integrate the recommendations and policies developed by the prevention and chronic care management advisory council into the medical home system.

11. Implementation phases.

a. Initial implementation shall require participation in the medical home system of children who are recipients of full benefits under the medical assistance program. The department shall work with the department of human services and shall recommend to the general assembly a reimbursement methodology to compensate providers participating under the medical assistance program for participation in the medical home system.

b. The department shall work with the department of human services to expand the medical home system to adults who are recipients of full benefits under the medical assistance program and the expansion population under the IowaCare program. The department shall work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system.

c. The department shall work with the department of administrative services to allow state employees to utilize the medical home system.

d. The department shall work with insurers and self=insured companies, if requested, to make the medical home system available to individuals with private health care coverage.

12. The department shall provide oversight for all certified medical homes. The department shall review the progress of the medical home system and recommend improvements to the system, as necessary.

13. The department shall annually evaluate the medical home system and make recommendations to the governor and the general assembly regarding improvements to and continuation of the system.

14. Recommendations and other activities resulting from the duties authorized for the department under this section shall require approval by the board prior to any subsequent action or implementation.

Sec. 47. Section 136.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 12. Perform those duties authorized pursuant to section 135.159.

Sec. 48. Section 249J.14, subsection 7, Code 2007,

is amended to read as follows:

7. DENTAL HOME FOR CHILDREN. By ~~July 1, 2008~~ 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~~, and~~ preventive ~~care identified in the oral health standards~~ services, diagnostic services, treatment services, and emergency services as defined under the early and periodic screening, diagnostic, and treatment program.

Sec. 49. MEDICAL HOME SYSTEM == APPROPRIATION. There is appropriated from the general fund of the state to the department of public health for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For activities associated with the medical home system requirements of this division and for not more than the following full=time equivalent positions:

..... $ 165,600
..... FTEs 4.00

DIVISION IX
PREVENTION AND CHRONIC CARE MANAGEMENT
DIVISION XXIII
PREVENTION AND CHRONIC CARE MANAGEMENT

Sec. 50. NEW SECTION. 135.160 DEFINITIONS.

For the purpose of this division, unless the context otherwise requires:

1. "Board" means the state board of health created pursuant to section 136.1.

2. "Chronic care" means health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.

3. "Chronic care information system" means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.

4. "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self=care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence=based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

5. "Chronic care plan" means a plan of care between an individual and the individual's principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient's own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.

6. "Chronic care resources" means health care professionals, advocacy groups, health departments, schools of public health and medicine, health plans, and others with expertise in public health, health care delivery, health care financing, and health care research.

7. "Chronic condition" means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.

8. "Department" means the department of public health.

9. "Director" means the director of public health.

10. "Eligible individual" means a resident of this state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance, is a member of the expansion population pursuant to chapter 249J, or is an inmate of a correctional institution in this state.

11. "Health care professional" means health care professional as defined in section 135.157.

12. "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

Sec. 51. NEW SECTION. 135.161 PREVENTION AND CHRONIC CARE MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management. The state initiative consists of the state's plan for developing a chronic care organizational structure for prevention and chronic care management, including coordinating the efforts of health care professionals and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self=care efforts, providing systemic support for the health care professional=patient relationship and options for channeling chronic care resources and support to health care professionals, providing for community development and outreach and education efforts, and coordinating information technology initiatives with the chronic care information system.

2. The director may accept grants and donations and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative or as federal law directs.

3. a. The director shall establish and convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence=based prevention and chronic care management strategies into the public and private health care systems, including the medical home system. Public members of the advisory council shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

b. The advisory council shall elicit input from a variety of health care professionals, health care professional organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.

c. The advisory council shall submit initial recommendations to the director for the state initiative for prevention and chronic care management no later than July 1, 2009. The recommendations shall address all of the following:

(1) The recommended organizational structure for integrating prevention and chronic care management into the private and public health care systems. The organizational structure recommended shall align with the organizational structure established for the medical home system developed pursuant to division XXII. The advisory council shall also review existing prevention and chronic care management strategies used in the health insurance market and in private and public programs and recommend ways to expand the use of such strategies throughout the health insurance market and in the private and public health care systems.

(2) A process for identifying leading health care professionals and existing prevention and chronic care management programs in the state, and coordinating care among these health care professionals and programs.

(3) A prioritization of the chronic conditions for which prevention and chronic care management services should be provided, taking into consideration the prevalence of specific chronic conditions and the

factors that may lead to the development of chronic conditions; the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals; the availability of workable, evidence=based approaches to chronic care for the chronic condition; and public input into the selection process. The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and shall also specify a timeline for inclusion of additional specific chronic conditions in the initiative.

(4) A method to involve health care professionals in identifying eligible patients for prevention and chronic care management services, which includes but is not limited to the use of a health risk assessment.

(5) The methods for increasing communication between health care professionals and patients, including patient education, patient self=management, and patient follow=up plans.

(6) The educational, wellness, and clinical management protocols and tools to be used by health care professionals, including management guideline materials for health care delivery.

(7) The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks such as the best in class estimates utilized in the national healthcare quality report of the agency for health care research and quality of the United States department of health and human services, to provide performance feedback for health care professionals and information on the quality of health care, including patient satisfaction and health status outcomes.

(8) Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of health care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

(9) Methods to involve public and private groups, health care professionals, insurers, third=party administrators, associations, community and consumer groups, and other entities to facilitate and sustain the initiative.

(10) Alignment of any chronic care information system or other information technology needs with other health care information technology initiatives.

(11) Involvement of appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

(12) Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care professionals, health insurers, and the public.

(13) A method to periodically determine the percentage of health care professionals who are participating, the success of the empowerment=of=patients approach, and any results of health outcomes of the patients participating.

(14) A means of collaborating with the health professional licensing boards pursuant to chapter 147 to review prevention and chronic care management education provided to licensees, as appropriate, and recommendations regarding education resources and curricula for integration into existing and new education and training programs.

4. Following submission of initial recommendations to the director for the state initiative for prevention and chronic care management by the advisory council, the director shall submit the state initiative to the board for approval. Subject to approval of the state initiative by the board, the

department shall initially implement the state initiative among the population of eligible individuals. Following initial implementation, the director shall work with the department of human services, insurers, health care professional organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in the state. The advisory council shall continue to review and make recommendations to the director regarding improvements to the initiative. Any recommendations are subject to approval by the board.

Sec. 52. NEW SECTION. 135.162 CLINICIANS ADVISORY PANEL.

1. The director shall convene a clinicians advisory panel to advise and recommend to the department clinically appropriate, evidence=based best practices regarding the implementation of the medical home as defined in section 135.157 and the prevention and chronic care management initiative pursuant to section 135.161. The director shall act as chairperson of the advisory panel.

2. The clinicians advisory panel shall consist of nine members representing licensed medical health care providers selected by their respective professional organizations. Terms of members shall begin and end as provided in section 69.19. Any vacancy shall be filled in the same manner as regular appointments are made for the unexpired portion of the regular term. Members shall serve terms of three years. A member is eligible for reappointment for three successive terms.

3. The clinicians advisory panel shall meet on a quarterly basis to receive updates from the director regarding strategic planning and implementation progress on the medical home and the prevention and chronic care management initiative and shall provide clinical consultation to the department regarding the medical home and the initiative.

Sec. 53. Section 136.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 13. Perform those duties authorized pursuant to section 135.161.

Sec. 54. PREVENTION AND CHRONIC CARE MANAGEMENT == APPROPRIATION. There is appropriated from the general fund of the state to the department of public health for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For activities associated with the prevention and chronic care management requirements of this division:

..... $ 190,500

DIVISION X

FAMILY OPPORTUNITY ACT

Sec. 55. 2007 Iowa Acts, chapter 218, section 126, subsection 1, is amended to read as follows:

1. The provision in this division of this Act relating to eligibility for certain persons with disabilities under the medical assistance program shall ~~only~~ be implemented ~~if the department of human services determines that funding is available in appropriations made in this Act, in combination with federal allocations to the state, for the state children's health insurance program, in excess of the amount needed to cover the current and projected enrollment under the state children's health insurance program~~ beginning January 1, 2009. ~~If such a determination is made, the department of human services shall transfer funding from the appropriations made in this Act for the state children's health insurance program, not otherwise required for that program, to the appropriations made in this Act for medical assistance, as necessary, to implement such provision of this division of this Act.~~

DIVISION XI

MEDICAL ASSISTANCE QUALITY IMPROVEMENT

Sec. 56. NEW SECTION. 249A.36 MEDICAL ASSISTANCE QUALITY IMPROVEMENT COUNCIL.

1. A medical assistance quality improvement council is established. The council shall evaluate the clinical outcomes and satisfaction of consumers

and providers with the medical assistance program. The council shall coordinate efforts with the cost and quality performance evaluation completed pursuant to section 249J.16. The council shall also coordinate its efforts with the efforts of the department of public health regarding health care consumer information under section 135.163.

2. a. The council shall consist of seven voting members appointed by the majority leader of the senate, the minority leader of the senate, the speaker of the house, and the minority leader of the house of representatives. At least one member of the council shall be a consumer and at least one member shall be a medical assistance program provider. An individual who is employed by a private or nonprofit organization that receives one million dollars or more in compensation or reimbursement from the department, annually, is not eligible for appointment to the council. The members shall serve terms of two years beginning and ending as provided in section 69.19, and appointments shall comply with sections 69.16 and 69.16A. Members shall receive reimbursement for actual expenses incurred while serving in their official capacity and may also be eligible to receive compensation as provided in section 7E.6. Vacancies shall be filled by the original appointing authority and in the manner of the original appointment. A person appointed to fill a vacancy shall serve only for the unexpired portion of the term.

b. The members shall select a chairperson, annually, from among the membership. The council shall meet at least quarterly and at the call of the chairperson. A majority of the members of the council constitutes a quorum. Any action taken by the council must be adopted by the affirmative vote of a majority of its voting membership.

c. The department shall provide administrative support and necessary supplies and equipment for the council.

3. The council shall consult with and advise the Iowa Medicaid enterprise in establishing a quality assessment and improvement process.

a. The process shall be consistent with the health plan employer data and information set developed by the national committee for quality assurance and with the consumer assessment of health care providers and systems developed by the agency for health care research and quality of the United States department of health and human services. The council shall also coordinate efforts with the Iowa healthcare collaborative and the state's Medicare quality improvement organization to create consistent quality measures.

b. The process may utilize as a basis the medical assistance and state children's health insurance quality improvement efforts of the centers for Medicare and Medicaid services of the United States department of health and human services.

c. The process shall include assessment and evaluation of both managed care and fee=for=service programs, and shall be applicable to services provided to adults and children.

d. The initial process shall be developed and implemented by December 31, 2008, with the initial report of results to be made available to the public by June 30, 2009. Following the initial report, the council shall submit a report of results to the governor and the general assembly, annually, in January.

DIVISION XII

HEALTH CARE CONSUMER INFORMATION

DIVISION XXIV

HEALTH CARE CONSUMER INFORMATION

Sec. 57. NEW SECTION. 135.163 HEALTH CARE CONSUMER INFORMATION.

The department shall do all of the following to improve consumer education about health cost and quality:

1. Provide for coordination of efforts to promote public reporting of hospital and physician quality measures, including efforts of the Iowa healthcare

collaborative, the state's Medicare quality improvement organization, the Iowa Medicaid enterprise, and the medical assistance quality improvement council established pursuant to section 249A.36.

2. Provide for the coordination of efforts to promote public reporting of health care costs, including efforts of the Iowa hospital association, Iowa medical society, and the Iowa health buyers' alliance.

3. Create a public awareness campaign to educate consumers about enhanced health through lifestyle choices.

4. Promote adoption of health information technology through provider incentives.

5. Evaluate the efficacy of a standard medication therapy management program.

DIVISION XIII

HEALTH AND LONG=TERM CARE ACCESS

Sec. 58. Section 135.63, subsection 2, paragraph l, Code 2007, is amended to read as follows:

l. The replacement or modernization of any institutional health facility if the replacement or modernization does not add new health services or additional bed capacity for existing health services, notwithstanding any provision in this division to the contrary. With reference to a hospital, "replacement" means establishing a new hospital that demonstrates compliance with all of the following criteria through evidence submitted to the department:

(1) Is designated as a critical access hospital pursuant to 42 U.S.C. } 1395i=4.

(2) Serves at least seventy=five percent of the same service area that was served by the prior hospital to be closed and replaced by the new hospital.

(3) Provides at least seventy=five percent of the same services that were provided by the prior hospital to be closed and replaced by the new hospital.

(4) Is staffed by at least seventy=five percent of the same staff, including medical staff, contracted staff, and employees, as constituted the staff of the prior hospital to be closed and replaced by the new hospital.

Sec. 59. NEW SECTION. 135.164 HEALTH AND LONG=TERM CARE ACCESS.

The department shall coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well=qualified, diverse, and sustainable health care workforce in this state. The health care delivery infrastructure and the health care workforce shall address the broad spectrum of health care needs of Iowans throughout their lifespan including long=term care needs. The department shall, at a minimum, do all of the following:

1. Develop a strategic plan for health care delivery infrastructure and health care workforce resources in this state.

2. Provide for the continuous collection of data to provide a basis for health care strategic planning and health care policymaking.

3. Make recommendations regarding the health care delivery infrastructure and the health care workforce that assist in monitoring current needs, predicting future trends, and informing policymaking.

Sec. 60. NEW SECTION. 135.165 STRATEGIC PLAN.

1. The strategic plan for health care delivery infrastructure and health care workforce resources shall describe the existing health care system, describe and provide a rationale for the desired health care system, provide an action plan for implementation, and provide methods to evaluate the system. The plan shall incorporate expenditure control methods and integrate criteria for evidence=based health care. The department shall do all of the following in developing the strategic plan for health care delivery infrastructure and health care workforce resources:

a. Conduct strategic health planning activities related to preparation of the strategic plan.

b. Develop a computerized system for accessing, analyzing, and disseminating data relevant to strategic health planning. The department may enter into data sharing agreements and contractual arrangements necessary to obtain or disseminate relevant data.

c. Conduct research and analysis or arrange for research and analysis projects to be conducted by public or private organizations to further the development of the strategic plan.

d. Establish a technical advisory committee to assist in the development of the strategic plan. The members of the committee may include but are not limited to health economists, representatives of the university of Iowa college of public health, health planners, representatives of health care purchasers, representatives of state and local agencies that regulate entities involved in health care, representatives of health care providers and health care facilities, and consumers.

2. The strategic plan shall include statewide health planning policies and goals related to the availability of health care facilities and services, the quality of care, and the cost of care. The policies and goals shall be based on the following principles:

a. That a strategic health planning process, responsive to changing health and social needs and conditions, is essential to the health, safety, and welfare of Iowans. The process shall be reviewed and updated as necessary to ensure that the strategic plan addresses all of the following:

(1) Promoting and maintaining the health of all Iowans.

(2) Providing accessible health care services through the maintenance of an adequate supply of health facilities and an adequate workforce.

(3) Controlling excessive increases in costs.

(4) Applying specific quality criteria and population health indicators.

(5) Recognizing prevention and wellness as priorities in health care programs to improve quality and reduce costs.

(6) Addressing periodic priority issues including disaster planning, public health threats, and public safety dilemmas.

(7) Coordinating health care delivery and resource development efforts among state agencies including those tasked with facility, services, and professional provider licensure; state and federal reimbursement; health service utilization data systems; and others.

(8) Recognizing long=term care as an integral component of the health care delivery infrastructure and as an essential service provided by the health care workforce.

b. That both consumers and providers throughout the state must be involved in the health planning process, outcomes of which shall be clearly articulated and available for public review and use.

c. That the supply of a health care service has a substantial impact on utilization of the service, independent of the effectiveness, medical necessity, or appropriateness of the particular health care service for a particular individual.

d. That given that health care resources are not unlimited, the impact of any new health care service or facility on overall health expenditures in this state must be considered.

e. That excess capacity of health care services and facilities places an increased economic burden on the public.

f. That the likelihood that a requested new health care facility, service, or equipment will improve health care quality and outcomes must be considered.

g. That development and ongoing maintenance of current and accurate health care information and statistics related to cost and quality of health care and projections of the need for health care facilities and services are necessary to developing an effective health care planning strategy.

h. That the certificate of need program as a

component of the health care planning regulatory process must balance considerations of access to quality care at a reasonable cost for all Iowans, optimal use of existing health care resources, fostering of expenditure control, and elimination of unnecessary duplication of health care facilities and services, while supporting improved health care outcomes.

i. That strategic health care planning must be concerned with the stability of the health care system, encompassing health care financing, quality, and the availability of information and services for all residents.

3. The health care delivery infrastructure and health care workforce resources strategic plan developed by the department shall include all of the following:

a. A health care system assessment and objectives component that does all of the following:

(1) Describes state and regional population demographics, health status indicators, and trends in health status and health care needs.

(2) Identifies key policy objectives for the state health care system related to access to care, health care outcomes, quality, and cost=effectiveness.

b. A health care facilities and services plan that assesses the demand for health care facilities and services to inform state health care planning efforts and direct certificate of need determinations, for those facilities and services subject to certificate of need. The plan shall include all of the following:

(1) An inventory of each geographic region's existing health care facilities and services.

(2) Projections of the need for each category of health care facility and service, including those subject to certificate of need.

(3) Policies to guide the addition of new or expanded health care facilities and services to promote the use of quality, evidence=based, cost=effective health care delivery options, including any recommendations for criteria, standards, and methods relevant to the certificate of need review process.

(4) An assessment of the availability of health care providers, public health resources, transportation infrastructure, and other considerations necessary to support the needed health care facilities and services in each region.

c. A health care data resources plan that identifies data elements necessary to properly conduct planning activities and to review certificate of need applications, including data related to inpatient and outpatient utilization and outcomes information, and financial and utilization information related to charity care, quality, and cost. The plan shall provide all of the following:

(1) An inventory of existing data resources, both public and private, that store and disclose information relevant to the health care planning process, including information necessary to conduct certificate of need activities. The plan shall identify any deficiencies in the inventory of existing data resources and the data necessary to conduct comprehensive health care planning activities. The plan may recommend that the department be authorized to access existing data sources and conduct appropriate analyses of such data or that other agencies expand their data collection activities as statutory authority permits. The plan may identify any computing infrastructure deficiencies that impede the proper storage, transmission, and analysis of health care planning data.

(2) Recommendations for increasing the availability of data related to health care planning to provide greater community involvement in the health care planning process and consistency in data used for certificate of need applications and determinations. The plan shall also integrate the requirements for annual reports by hospitals and health care facilities pursuant to section 135.75, the provisions relating to analyses and studies by the department pursuant to

section 135.76, the data compilation provisions of section 135.78, and the provisions for contracts for assistance with analyses, studies, and data pursuant to section 135.83.

d. An assessment of emerging trends in health care delivery and technology as they relate to access to health care facilities and services, quality of care, and costs of care. The assessment shall recommend any changes to the scope of health care facilities and services covered by the certificate of need program that may be warranted by these emerging trends. In addition, the assessment may recommend any changes to criteria used by the department to review certificate of need applications, as necessary.

e. A rural health care resources plan to assess the availability of health resources in rural areas of the state, assess the unmet needs of these communities, and evaluate how federal and state reimbursement policies can be modified, if necessary, to more efficiently and effectively meet the health care needs of rural communities. The plan shall consider the unique health care needs of rural communities, the adequacy of the rural health care workforce, and transportation needs for accessing appropriate care.

f. A health care workforce resources plan to assure a competent, diverse, and sustainable health care workforce in Iowa and to improve access to health care in underserved areas and among underserved populations. The plan shall include the establishment of an advisory council to inform and advise the department and policymakers regarding issues relevant to the health care workforce in Iowa. The health care workforce resources plan shall recognize long=term care as an essential service provided by the health care workforce.

4. The department shall submit the initial statewide health care delivery infrastructure and resources strategic plan to the governor and the general assembly by January 1, 2010, and shall submit an updated strategic plan to the governor and the general assembly every two years thereafter.

Sec. 61. HEALTH CARE ACCESS == APPROPRIATION. There is appropriated from the general fund of the state to the department of public health for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For activities associated with the health care access requirements of this division, and for not more than the following full=time equivalent positions:

..... $ 172,200
..... FTEs 3.00

DIVISION XIV
PREVENTION AND WELLNESS
INITIATIVES

Sec. 62. Section 135.27, Code 2007, is amended by striking the section and inserting in lieu thereof the following:

135.27 IOWA HEALTHY COMMUNITIES INITIATIVE == GRANT PROGRAM.

1. PROGRAM GOALS. The department shall establish a grant program to energize local communities to transform the existing culture into a culture that promotes healthy lifestyles and leads collectively, community by community, to a healthier state. The grant program shall expand an existing healthy communities initiative to assist local boards of health, in collaboration with existing community resources, to build community capacity in addressing the prevention of chronic disease that results from risk factors including overweight and obesity conditions.

2. DISTRIBUTION OF GRANTS. The department shall distribute the grants on a competitive basis and shall support the grantee communities in planning and developing wellness strategies and establishing methodologies to sustain the strategies. Grant criteria shall be consistent with the existing statewide initiative between the department and the department's partners that promotes increased

opportunities for physical activity and healthy eating for Iowans of all ages, or its successor, and the statewide comprehensive plan developed by the existing statewide initiative to increase physical activity, improve nutrition, and promote healthy behaviors. Grantees shall demonstrate an ability to maximize local, state, and federal resources effectively and efficiently.

3. DEPARTMENTAL SUPPORT. The department shall provide support to grantees including capacity=building strategies, technical assistance, consultation, and ongoing evaluation.

4. ELIGIBILITY. Local boards of health representing a coalition of health care providers and community and private organizations are eligible to submit applications.

Sec. 63. NEW SECTION. 135.27A GOVERNOR'S COUNCIL ON PHYSICAL FITNESS AND NUTRITION.

1. A governor's council on physical fitness and nutrition is established consisting of twelve members appointed by the governor who have expertise in physical activity, physical fitness, nutrition, and promoting healthy behaviors. At least one member shall be a representative of elementary and secondary physical education professionals, at least one member shall be a health care professional, at least one member shall be a registered dietician, at least one member shall be recommended by the department of elder affairs, and at least one member shall be an active nutrition or fitness professional. In addition, at least one member shall be a member of a racial or ethnic minority. The governor shall select a chairperson for the council. Members shall serve terms of three years beginning and ending as provided in section 69.19. Appointments are subject to sections 69.16 and 69.16A. Members are entitled to receive reimbursement for actual expenses incurred while engaged in the performance of official duties. A member of the council may also be eligible to receive compensation as provided in section 7E.6.

2. The council shall assist in developing a strategy for implementation of the statewide comprehensive plan developed by the existing statewide initiative to increase physical activity, improve physical fitness, improve nutrition, and promote healthy behaviors. The strategy shall include specific components relating to specific populations and settings including early childhood, educational, local community, worksite wellness, health care, and older Iowans. The initial draft of the implementation plan shall be submitted to the governor and the general assembly by December 1, 2008.

3. The council shall assist the department in establishing and promoting a best practices internet site. The internet site shall provide examples of wellness best practices for individuals, communities, workplaces, and schools and shall include successful examples of both evidence=based and nonscientific programs as a resource.

4. The council shall provide oversight for the governor's physical fitness challenge. The governor's physical fitness challenge shall be administered by the department and shall provide for the establishment of partnerships with communities or school districts to offer the physical fitness challenge curriculum to elementary and secondary school students. The council shall develop the curriculum, including benchmarks and rewards, for advancing the school wellness policy through the challenge.

Sec. 64. IOWA HEALTHY COMMUNITIES INITIATIVE == APPROPRIATION. There is appropriated from the general fund of the state to the department of public health for the fiscal year beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For Iowa healthy communities initiative grants distributed beginning January 1, 2009, and for not more than the following full=time equivalent positions:

..... $ 900,000
..... FTEs 3.00

Sec. 65. GOVERNOR'S COUNCIL ON PHYSICAL FITNESS AND NUTRITION == APPROPRIATION. There is appropriated from the general fund of the state to the department of public health for the fiscal period beginning July 1, 2008, and ending June 30, 2009, the following amount, or so much thereof as is necessary, for the purpose designated:

For the governor's council on physical fitness:

..... $ 112,100

Sec. 66. SMALL BUSINESS QUALIFIED WELLNESS PROGRAM TAX CREDIT == PLAN. The department of public health, in consultation with the insurance division of the department of commerce and the department of revenue, shall develop a plan to provide a tax credit to small businesses that provide qualified wellness programs to improve the health of their employees. The plan shall include specification of what constitutes a small business for the purposes of the qualified wellness program, the minimum standards for use by a small business in establishing a qualified wellness program, the criteria and a process for certification of a small business qualified wellness program, and the process for claiming a small business qualified wellness program tax credit. The department of public health shall submit the plan including any recommendations for changes in law to implement a small business qualified wellness program tax credit to the governor and the general assembly by December 15, 2008.

DIVISION XV
HEALTH CARE TRANSPARENCY
DIVISION XXVI
HEALTH CARE TRANSPARENCY

Sec. 67. NEW SECTION. 135.166 HEALTH CARE TRANSPARENCY == REPORTING REQUIREMENTS.

1. A hospital licensed pursuant to chapter 135B a physician licensed pursuant to chapter 148, 150, or 150A, and a chiropractor licensed pursuant to chapter 151 shall report quality indicators, annually, to the Iowa healthcare collaborative as defined in section 135.40. The indicators shall be developed by the Iowa healthcare collaborative in accordance with evidence=based practice parameters and appropriate sample size for statistical validation and shall be modeled on national indicators as specified in this section.

2. A manufacturer or supplier of durable medical equipment or medical supplies doing business in the state shall submit a price list to the department of human services, annually, for use in comparing prices for such equipment and supplies with rates paid under the medical assistance program. The price lists submitted shall be made available to the public.

3. Each hospital in the state that is recognized by the Internal Revenue Code as a nonprofit organization or entity shall submit, to the department of public health and to the legislative services agency, annually, a copy of the hospital's internal revenue service form 990, including but not limited to schedule J or any successor schedule that provides compensation information for certain officers, directors, trustees, and key employees, and highest compensated employees within ninety days following the due date for filing the hospital's return for the taxable year.

4. a. The Iowa healthcare collaborative shall publicly report indicators and measures including but not limited to quality, patient safety, pediatric care, patient safety indicators and measures as developed by such nationally recognized entities as the agency for healthcare research and quality of the United States department of health and human services and the centers for Medicare and Medicaid services of the United States department of health and human services and similar national entities.

b. The Iowa healthcare collaborative shall also report health care acquired infection measures and indicators after validity measures have been developed in conjunction with the state epidemiologist and after legal protections for health care providers subject to reporting such data have been established.

Sec. 68. Section 136.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 14. To the greatest extent possible integrate the efforts of the governing entities of the Iowa health information technology system pursuant to division XXI, the medical home pursuant to division XXII, the prevention and chronic care management initiative pursuant to division XXIII, consumer information provisions pursuant to division XXIV, and health and long=term care access pursuant to division XXV.

DIVISION XVI
DIRECT CARE WORKFORCE

Sec. 69. DIRECT CARE WORKER ADVISORY COUNCIL == DUTIES == REPORT.

1. As used in this section, unless the context otherwise requires:

a. "Department" means the department of public health.

b. "Direct care" means environmental or chore services, health monitoring and maintenance, assistance with instrumental activities of daily living, assistance with personal care activities of daily living, personal care support, or specialty skill services.

c. "Direct care worker" means an individual who directly provides or assists a consumer in the care of the consumer by providing direct care in a variety of settings which may or may not require supervision of the direct care worker, depending on the setting and the skills that the direct care workers possess, based on education or certification.

d. "Director" means the director of public health.

2. A direct care worker advisory council shall be appointed by the director and shall include representatives of direct care workers, consumers of direct care services, educators of direct care workers, other health professionals, employers of direct care workers, and appropriate state agencies.

3. Membership, terms of office, quorum, and expenses shall be determined by the director in accordance with the applicable provisions of section 135.11.

4. The direct care worker advisory council shall advise the director regarding regulation and certification of direct care workers, based on the work of the direct care workers task force established pursuant to 2005 Iowa Acts, chapter 88, and shall develop recommendations regarding but not limited to all of the following:

a. Direct care worker classifications based on functions and services provided by direct care workers.

b. Functions for each direct care worker classification.

c. An education and training orientation to be provided by employers.

d. Education and training requirements for each direct care worker classification.

e. The standard curriculum required for each direct care worker classification.

f. Education and training equivalency standards for each direct care worker classification.

g. Guidelines that allow individuals who are members of the direct care workforce prior to the date of required certification to be incorporated into the new regulatory system.

h. Continuing education requirements for each direct care worker classification.

i. Standards for direct care worker educators and trainers.

j. Certification requirements for each direct care worker classification.

k. Protections for the title "certified direct care worker".

l. Standardized requirements for supervision of each direct care worker classification, as applicable, and the roles and responsibilities of supervisory positions.

m. Responsibility for maintenance of credentialing and continuing education and training.

n. Provision of information to income maintenance workers and case managers under the purview of the department of human services about the education and training requirements for direct care workers to provide the care and services to meet consumer needs.

5. The direct care worker advisory council shall report its recommendations to the director by November 30, 2008, including recommendations for any changes in law or rules necessary.

6. Implementation of certification of direct care workers shall begin July 1, 2009.

Sec. 70. DIRECT CARE WORKER COMPENSATION ADVISORY COMMITTEE == REVIEWS.

1. a. The general assembly recognizes that direct care workers play a vital role and make a valuable contribution in providing care to Iowans with a variety of needs in both institutional and home and community=based settings. Recruiting and retaining qualified, highly competent direct care workers is a challenge across all employment settings. High rates of employee vacancies and staff turnover threaten the ability of providers to achieve the core mission of providing safe and high quality support to Iowans.

b. It is the intent of the general assembly to address the long=term care workforce shortage and turnover rates in order to improve the quality of health care delivered in the long=term care continuum by reviewing wages and other compensation paid to direct care workers in the state.

c. It is the intent of the general assembly that the initial review of and recommendations for improving wages and other compensation paid to direct care workers focus on nonlicensed direct care workers in the nursing facility setting. However, following the initial review of wages and other compensation paid to direct care workers in the nursing facility setting, the department of human services shall convene subsequent advisory committees with appropriate representatives of public and private organizations and consumers to review the wages and other compensation paid to and turnover rates of the entire spectrum of direct care workers in the various settings in which they are employed as a means of demonstrating the general assembly's commitment to ensuring a stable and quality direct care workforce in this state.

2. The department of human services shall convene an initial direct care worker compensation advisory committee to develop recommendations for consideration by the general assembly during the 2009 legislative session regarding wages and other compensation paid to direct care workers in nursing facilities. The committee shall consist of the following members, selected by their respective organizations:

a. The director of human services, or the director's designee.

b. The director of public health, or the director's designee.

c. The director of the department of elder affairs, or the director's designee.

d. The director of the department of inspections and appeals, or the director's designee.

e. A representative of the Iowa caregivers association.

f. A representative of the Iowa health care association.

g. A representative of the Iowa association of homes and services for the aging.

h. A representative of the AARP Iowa chapter.

3. The advisory committee shall also include two members of the senate and two members of the house of representatives, with not more than one member from each chamber being from the same political party. The legislative members shall serve in an ex officio, nonvoting capacity. The two senators shall be appointed respectively by the majority leader of the senate and the minority leader of the senate, and the two representatives shall be appointed respectively by the speaker of the house of representatives and the minority leader of the house of representatives.

4. Public members of the committee shall receive

actual expenses incurred while serving in their official capacity and may also be eligible to receive compensation as provided in section 7E.6. Legislative members of the committee are eligible for per diem and reimbursement of actual expenses as provided in section 2.10.

5. The department of human services shall provide administrative support to the committee and the director of human services or the director's designee shall serve as chairperson of the committee.

6. The department shall convene the committee no later than July 1, 2008. Prior to the initial meeting, the department of human services shall provide all members of the committee with a detailed analysis of trends in wages and other compensation paid to direct care workers.

7. The committee shall consider options related but not limited to all of the following:

a. The shortening of the time delay between a nursing facility's submittal of cost reports and receipt of the reimbursement based upon these cost reports.

b. The targeting of appropriations to provide increases in direct care worker compensation.

c. Creation of a nursing facility provider tax.

8. Any option considered by the committee shall be consistent with federal law and regulations.

9. Following its deliberations, the committee shall submit a report of its findings and recommendations regarding improvement in direct care worker wages and other compensation in the nursing facility setting to the governor and the general assembly no later than December 12, 2008.

10. For the purposes of the initial review, "direct care worker" means nonlicensed nursing facility staff who provide hands=on care including but not limited to certified nurse aides and medication aides.

Sec. 71. DIRECT CARE WORKER IN NURSING FACILITIES == TURNOVER REPORT. The department of human services shall modify the nursing facility cost reports utilized for the medical assistance program to capture data by the distinct categories of nonlicensed direct care workers and other employee categories for the purposes of documenting the turnover rates of direct care workers and other employees of nursing facilities. The department shall submit a report on an annual basis to the governor and the general assembly which provides an analysis of direct care worker and other nursing facility employee turnover by individual nursing facility, a comparison of the turnover rate in each individual nursing facility with the state average, and an analysis of any improvement or decline in meeting any accountability goals or other measures related to turnover rates. The annual reports shall also include any data available regarding turnover rate trends, and other information the department deems appropriate. The initial report shall be submitted no later than December 1, 2008, and subsequent reports shall be submitted no later than December 1, annually, thereafter.

Sec. 72. EFFECTIVE DATE. This division of this Act, being deemed of immediate importance, takes effect upon enactment.>

#2. Title page, line 3, by striking the words <end=of=life care decision making> and inserting the following: <long=term living planning and patient autonomy in health care>.

#3. Title page, by striking line 8 and inserting the following: <transparency, health care consumer information, health care access, the direct care workforce, making appropriations, and including effective date and applicability provisions.>

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