Senate File 2213

S-5045

1 Amend Senate File 2213 as follows:
2 1. By striking everything after the enacting clause
3 and inserting:
4 <Section 1. LEGISLATIVE FINDINGS —— GOALS AND
5 INTENT.
6 1. The general assembly finds all of the following:
7 a. In the majority of states, Medicaid managed care
8 has been introduced on an incremental basis, beginning
9 with the enrollment of low-income children and parents
10 and proceeding in stages to include nonelderly persons
11 with disabilities and older individuals. Iowa, unlike
12 the majority of states, is implementing Medicaid
13 managed care hastily and simultaneously across a broad
14 and diverse population that includes individuals with
15 complex health care and long-term services and supports
16 needs, making these individuals especially vulnerable
17 to receiving inappropriate, inadequate, or substandard
18 services and supports.
19 b. The success or failure of Medicaid managed
20 care in Iowa depends on proper strategic planning and
21 strong oversight, and the incorporation of the core
22 values, principles, and goals of the strategic plan
23 into Medicaid managed care contractual obligations.
24 While Medicaid managed care techniques may create
25 pathways and offer opportunities toward quality
26 improvement and predictability in costs, if cost
27 savings and administrative efficiencies are the
28 primary goals, Medicaid managed care may instead erect
29 new barriers and limit the care and support options
30 available, especially to high-need, vulnerable Medicaid
31 recipients. A well-designed strategic plan and
32 effective oversight ensure that cost savings, improved
33 health outcomes, and efficiencies are not achieved
34 at the expense of diminished program integrity, a
35 reduction in the quality or availability of services,

1 or adverse consequences to the health and well-being of
2 Medicaid recipients.
3 c. Strategic planning should include all of the
4 following:
5 (1) Guidance in establishing and maintaining a
6 robust and appropriate workforce and a provider network
7 capable of addressing all of the diverse, distinct, and
8 wide-ranging treatment and support needs of Medicaid
9 recipients.
10 (2) Developing a sound methodology for establishing
11 and adjusting capitation rates to account for all
12 essential costs involved in treating and supporting the
13 entire spectrum of needs across recipient populations.
14 (3) Addressing the sufficiency of information and
15 data resources to enable review of factors such as
16 utilization, service trends, system performance, and
17 outcomes.
18 (4) Building effective working relationships and
19 developing strategies to support community-level
20 integration that provides cross-system coordination
21 and synchronization among the various service sectors,
22 providers, agencies, and organizations to further
23 holistic well-being and population health goals.
24 d. While the contracts entered into between the
25 state and managed care organizations function as a
26 mechanism for enforcing requirements established by the
27 federal and state governments and allow states to shift
28 the financial risk associated with caring for Medicaid
29 recipients to these contractors, the state ultimately
30 retains responsibility for the Medicaid program and
31 the oversight of the performance of the program's
32 contractors. Administration of the Medicaid program
33 benefits by managed care organizations should not be
34 viewed by state policymakers and state agencies as a
35 means of divesting themselves of their constitutional

1 and statutory responsibilities to ensure that
2 recipients of publicly funded services and supports, as
3 well as taxpayers in general, are effectively served.
4 e. Overseeing the performance of Medicaid managed
5 care contractors requires a different set of skills
6 than those required for administering a fee-for-service
7 program. In the absence of the in-house capacity of
8 the department of human services to perform tasks
9 specific to Medicaid managed care oversight, the state
10 essentially cedes its responsibilities to private
11 contractors and relinquishes its accountability to the
12 public. In order to meet these responsibilities, state
13 policymakers must ensure that the state, including the
14 department of human services as the state Medicaid
15 agency, has the authority and resources, including
16 the adequate number of qualified personnel and the
17 necessary tools, to carry out these responsibilities,
18 provide effective administration, and ensure
19 accountability and compliance.
20 f. State policymakers must also ensure that
21 Medicaid managed care contracts contain, at a minimum,
22 clear, unambiguous performance standards, operating
23 guidelines, data collection, maintenance, retention,
24 and reporting requirements, and outcomes expectations
25 so that contractors and subcontractors are held
26 accountable to clear contract specifications.
27 g. As with all system and program redesign efforts
28 undertaken in the state to date, the assumption
29 of the administration of Medicaid program benefits
30 by managed care organizations must involve ongoing
31 stakeholder input and earn the trust and support of
32 these stakeholders. Medicaid recipients, providers,
33 advocates, and other stakeholders have intimate
34 knowledge of the people and processes involved in
35 ensuring the health and safety of Medicaid recipients,

1 and are able to offer valuable insight into the
2 barriers likely to be encountered as well as propose
3 solutions for overcoming these obstacles. Local
4 communities and providers of services and supports
5 have firsthand experience working with the Medicaid
6 recipients they serve and are able to identify factors
7 that must be considered to make a system successful.
8 Agencies and organizations that have specific expertise
9 and experience with the services and supports needs of
10 Medicaid recipients and their families are uniquely
11 placed to provide needed assistance in developing
12 the measures for and in evaluating the quality of the
13 program.
14 2. It is the intent of the general assembly that
15 the Medicaid program be implemented and administered,
16 including through Medicaid managed care policies
17 and contract provisions, in a manner that safeguards
18 the interests of Medicaid recipients, encourages the
19 participation of Medicaid providers, and protects
20 the interests of all taxpayers, while attaining the
21 goals of Medicaid modernization to improve quality and
22 access, promote accountability for outcomes, and create
23 a more predictable and sustainable Medicaid budget.
24 HEALTH POLICY OVERSIGHT COMMITTEE
25 Sec. 2. Section 2.45, subsection 6, Code 2016, is
26 amended to read as follows:
27 6. The legislative health policy oversight
28 committee, which shall be composed of ten members of
29 the general assembly, consisting of five members from
30 each house, to be appointed by the legislative council.
31 The legislative health policy oversight committee
32 shall ~~receive updates and review data, public input and~~
33 ~~concerns, and make recommendations for improvements to~~
34 ~~and changes in law or rule regarding Medicaid managed~~
35 ~~care~~ meet at least four times annually to evaluate

1 state health policy and provide continuing oversight
2 for publicly funded programs, including but not limited
3 to all facets of the Medicaid and hawk-i programs
4 to, at a minimum, ensure effective and efficient
5 administration of these programs, address stakeholder
6 concerns, monitor program costs and expenditures, and
7 make recommendations relative to the programs.
8 Sec. 3. HEALTH POLICY OVERSIGHT COMMITTEE
9 —— SUBJECT MATTER REVIEW FOR 2016 LEGISLATIVE
10 INTERIM. During the 2016 legislative interim, the
11 health policy oversight committee created in section
12 2.45 shall, as part of the committee's evaluation
13 of state health policy and review of all facets of
14 the Medicaid and hawk-i programs, review and make
15 recommendations regarding, at a minimum, all of the
16 following:
17 1. The resources and duties of the office of
18 long-term care ombudsman relating to the provision of
19 assistance to and advocacy for Medicaid recipients
20 to determine the designation of duties and level of
21 resources necessary to appropriately address the needs
22 of such individuals. The committee shall consider the
23 health consumer ombudsman alliance report submitted to
24 the general assembly in December 2015, as well as input
25 from the office of long-term care ombudsman and other
26 entities in making recommendations.
27 2. The health benefits and health benefit
28 utilization management criteria for the Medicaid
29 and hawk-i programs to determine the sufficiency
30 and appropriateness of the benefits offered and the
31 utilization of these benefits.
32 3. Prior authorization requirements relative
33 to benefits provided under the Medicaid and hawk-i
34 programs, including but not limited to pharmacy
35 benefits.

1 4. Consistency and uniformity in processes,
2 procedures, forms, and other activities across all
3 Medicaid and hawk-i program participating insurers and
4 managed care organizations, including but not limited
5 to cost and quality reporting, credentialing, billing,
6 prior authorization, and critical incident reporting.
7 5. Provider network adequacy including the use of
8 out-of-network and out-of-state providers.
9 6. The role and interplay of other advisory and
10 oversight entities, including but not limited to the
11 medical assistance advisory council and the hawk-i
12 board.
13 REVIEW OF PROGRAM INTEGRITY DUTIES
14 Sec. 4. REVIEW OF PROGRAM INTEGRITY DUTIES ——
15 WORKGROUP —— REPORT.
16 1. The director of human services shall convene
17 a workgroup comprised of members including the
18 commissioner of insurance, the auditor of state, the
19 Medicaid director and bureau chiefs of the managed care
20 organization oversight and supports bureau, the Iowa
21 Medicaid enterprise support bureau, and the medical
22 and long-term services and supports bureau, and a
23 representative of the program integrity unit, or their
24 designees; and representatives of other appropriate
25 state agencies or other entities including but not
26 limited to the office of the attorney general, the
27 office of long-term care ombudsman, and the Medicaid
28 fraud control unit of the investigations division
29 of the department of inspections and appeals. The
30 workgroup shall do all of the following:
31 a. Review the duties of each entity with
32 responsibilities relative to Medicaid program integrity
33 and managed care organizations; review state and
34 federal laws, regulations, requirements, guidance, and
35 policies relating to Medicaid program integrity and

1 managed care organizations; and review the laws of
2 other states relating to Medicaid program integrity
3 and managed care organizations. The workgroup shall
4 determine areas of duplication, fragmentation,
5 and gaps; shall identify possible integration,
6 collaboration and coordination of duties; and shall
7 determine whether existing general state Medicaid
8 program and fee-for-service policies, laws, and
9 rules are sufficient, or if changes or more specific
10 policies, laws, and rules are required to provide
11 for comprehensive and effective administration and
12 oversight of the Medicaid program including under the
13 fee-for-service and managed care methodologies.
14 b. Review historical uses of the Medicaid
15 fraud fund created in section 249A.50 and make
16 recommendations for future uses of the moneys in the
17 fund and any changes in law necessary to adequately
18 address program integrity.
19 c. Review medical loss ratio provisions relative
20 to Medicaid managed care contracts and make
21 recommendations regarding, at a minimum, requirements
22 for the necessary collection, maintenance, retention,
23 reporting, and sharing of data and information by
24 Medicaid managed care organizations for effective
25 determination of compliance, and to identify the
26 costs and activities that should be included in the
27 calculation of administrative costs, medical costs or
28 benefit expenses, health quality improvement costs,
29 and other costs and activities incidental to the
30 determination of a medical loss ratio.
31 d. Review the capacity of state agencies, including
32 the need for specialized training and expertise, to
33 address Medicaid and managed care organization program
34 integrity and provide recommendations for the provision
35 of necessary resources and infrastructure, including

1 annual budget projections.
2 e. Review the incentives and penalties applicable
3 to violations of program integrity requirements to
4 determine their adequacy in combating waste, fraud,
5 abuse, and other violations that divert limited
6 resources that would otherwise be expended to safeguard
7 the health and welfare of Medicaid recipients, and make
8 recommendations for necessary adjustments to improve
9 compliance.
10 f. Make recommendations regarding the quarterly and
11 annual auditing of financial reports required to be
12 performed for each Medicaid managed care organization
13 to ensure that the activities audited provide
14 sufficient information to the division of insurance
15 of the department of commerce and the department
16 of human services to ensure program integrity. The
17 recommendations shall also address the need for
18 additional audits or other reviews of managed care
19 organizations.
20 g. Review and make recommendations to prohibit
21 cost-shifting between state and local and public and
22 private funding sources for services and supports
23 provided to Medicaid recipients whether directly or
24 indirectly through the Medicaid program.
25 2. The department of human services shall submit
26 a report of the workgroup to the governor, the health
27 policy oversight committee created in section 2.45,
28 and the general assembly initially, on or before
29 November 15, 2016, and on or before November 15,
30 on an annual basis thereafter, to provide findings
31 and recommendations for a coordinated approach
32 to comprehensive and effective administration and
33 oversight of the Medicaid program including under the
34 fee-for-service and managed care methodologies.
35 MEDICAID REINVESTMENT FUND

1 Sec. 5. NEW SECTION. **249A.4C Medicaid reinvestment**
2 **fund.**
3 1. A Medicaid reinvestment fund is created in the
4 state treasury under the authority of the department.
5 The department of human services shall collect an
6 initial contribution of five million dollars from each
7 of the managed care organizations contracting with the
8 state during the fiscal year beginning July 1, 2015,
9 for an aggregate amount of fifteen million dollars,
10 and shall deposit such amount in the fund to be used
11 for Medicaid ombudsman activities through the office
12 of long-term care ombudsman. Additionally, moneys
13 from savings realized from the movement of Medicaid
14 recipients from institutional settings to home and
15 community-based services, the portion of the capitation
16 rate withheld from and not returned to Medicaid managed
17 care organizations at the end of each fiscal year, any
18 recouped excess of capitation rates paid to Medicaid
19 managed care organizations, any overpayments recovered
20 under Medicaid managed care contracts, and any other
21 savings realized from Medicaid managed care or from
22 Medicaid program cost-containment efforts, with the
23 exception of the total amount attributable to the
24 projected savings from Medicaid managed care based on
25 the initial capitation rates established for the fiscal
26 year beginning July 1, 2015, shall be credited to the
27 Medicaid reinvestment fund.
28 2. Notwithstanding section 8.33, moneys credited
29 to the fund from any other account or fund shall
30 not revert to the other account or fund. Moneys
31 in the fund shall only be used as provided in
32 appropriations from the fund for the Medicaid program
33 and for health system transformation and integration,
34 including but not limited to providing the necessary
35 infrastructure and resources to protect the interests

1 of Medicaid recipients, maintaining adequate provider
2 participation, and ensuring program integrity. Such
3 uses may include but are not limited to:
4 *a.* Ensuring appropriate reimbursement of Medicaid
5 providers to maintain the type and number of
6 appropriately trained providers necessary to address
7 the needs of Medicaid recipients.
8 *b.* Providing home and community-based services
9 as necessary to rebalance the long-term services and
10 supports infrastructure and to reduce Medicaid home and
11 community-based services waiver waiting lists.
12 *c.* Ensuring that a fully functioning independent
13 Medicaid ombudsman program through the office of
14 long-term care ombudsman is available to provide
15 advocacy services and assistance to eligible and
16 potentially eligible Medicaid recipients.
17 *d.* Ensuring adequate and appropriate capacity of
18 the department of human services as the single state
19 agency designated to administer and supervise the
20 administration of the Medicaid program, to ensure
21 compliance with state and federal law and program
22 integrity requirements.
23 *e.* Addressing workforce issues to ensure a
24 competent, diverse, and sustainable health care
25 workforce and to improve access to health care in
26 underserved areas and among underserved populations,
27 recognizing long-term services and supports as an
28 essential component of the health care system.
29 *f.* Supporting innovation, longer-term community
30 investments, and the activities of local public health
31 agencies, aging and disability resource centers and
32 service agencies, mental health and disability services
33 regions, social services, and child welfare entities
34 and other providers of and advocates for services and
35 supports to encourage health system transformation

1 and integration through a broad range of prevention
2 strategies and population-based approaches to meet the
3 holistic needs of the population as a whole.
4 3. The department shall establish a mechanism to
5 measure and certify the amount of savings resulting
6 from Medicaid managed care and Medicaid program
7 cost-containment activities and shall ensure that such
8 realized savings are credited to the fund and used as
9 provided in appropriations from the fund.
10 MEDICAID OMBUDSMAN
11 Sec. 6. Section 231.44, Code 2016, is amended to
12 read as follows:
13 **231.44 Utilization of resources —— assistance and**
14 **advocacy related to long-term services and supports**
15 **under the Medicaid program.**
16 1. The office of long-term care ombudsman ~~may~~
17 shall utilize its available resources to provide
18 assistance and advocacy services to eligible recipients
19 of long-term services and supports, or individuals
20 seeking long-term services and supports, and the
21 families or legal representatives of such ~~eligible~~
22 ~~recipients, of long-term services and supports provided~~
23 ~~through~~ individuals under the Medicaid program. Such
24 assistance and advocacy shall include but is not
25 limited to all of the following:
26 *a.* Assisting ~~recipients~~ such individuals in
27 understanding the services, coverage, and access
28 provisions and their rights under Medicaid managed
29 care.
30 *b.* Developing procedures for the tracking and
31 reporting of the outcomes of individual requests for
32 assistance, the obtaining of necessary services and
33 supports, and other aspects of the services provided to
34 ~~eligible recipients~~ such individuals.
35 *c.* Providing advice and assistance relating to the

1 preparation and filing of complaints, grievances, and
2 appeals of complaints or grievances, including through
3 processes available under managed care plans and the
4 state appeals process, relating to long-term services
5 and supports under the Medicaid program.
6 *d.* Accessing the results of a review of a level
7 of care assessment or reassessment by a managed care
8 organization in which the managed care organization
9 recommends denial or limited authorization of a
10 service, including the type or level of service, the
11 reduction, suspension, or termination of a previously
12 authorized service, or a change in level of care, upon
13 the request of an affected individual.
14 *e.* Receiving notices of disenrollment or notices
15 that would result in a change in level of care for
16 affected individuals, including involuntary and
17 voluntary discharges or transfers, from the department
18 of human services or a managed care organization.
19 2. A representative of the office of long-term care
20 ombudsman providing assistance and advocacy services
21 authorized under this section for an individual,
22 shall be provided access to the individual, and shall
23 be provided access to the individual's medical and
24 social records as authorized by the individual or the
25 individual's legal representative, as necessary to
26 carry out the duties specified in this section.
27 3. A representative of the office of long-term care
28 ombudsman providing assistance and advocacy services
29 authorized under this section for an individual, shall
30 be provided access to administrative records related to
31 the provision of the long-term services and supports to
32 the individual, as necessary to carry out the duties
33 specified in this section.
34 4. The office of long-term care ombudsman and
35 representatives of the office, when providing

1 assistance and advocacy services under this section,
2 shall be considered a health oversight agency as
3 defined in 45 C.F.R. §164.501 for the purposes of
4 health oversight activities as described in 45 C.F.R.
5 §164.512(d) including access to the health records
6 and other appropriate information of an individual,
7 including from the department of human services or
8 the applicable Medicaid managed care organization,
9 as necessary to fulfill the duties specified under
10 this section. The department of human services,
11 in collaboration with the office of long-term care
12 ombudsman, shall adopt rules to ensure compliance
13 by affected entities with this subsection and to
14 ensure recognition of the office of long-term care
15 ombudsman as a duly authorized and identified agent or
16 representative of the state.
17 5. The department of human services and Medicaid
18 managed care organizations shall inform eligible
19 and potentially eligible Medicaid recipients of the
20 advocacy services and assistance available through the
21 office of long-term care ombudsman and shall provide
22 contact and other information regarding the advocacy
23 services and assistance to eligible and potentially
24 eligible Medicaid recipients as directed by the office
25 of long-term care ombudsman.
26 6. When providing assistance and advocacy services
27 under this section, the office of long-term care
28 ombudsman shall act as an independent agency, and the
29 office of long-term care ombudsman and representatives
30 of the office shall be free of any undue influence that
31 restrains the ability of the office or the office's
32 representatives from providing such services and
33 assistance.
34 7. The office of long-term care ombudsman shall, in
35 addition to other duties prescribed and at a minimum,

1 do all of the following in the furtherance of the
2 provision of advocacy services and assistance under
3 this section:
4 *a.* Represent the interests of eligible and
5 potentially eligible Medicaid recipients before
6 governmental agencies.
7 *b.* Analyze, comment on, and monitor the development
8 and implementation of federal, state, and local laws,
9 regulations, and other governmental policies and
10 actions, and recommend any changes in such laws,
11 regulations, policies, and actions as determined
12 appropriate by the office of long-term care ombudsman.
13 *c.* To maintain transparency and accountability for
14 activities performed under this section, including
15 for the purposes of claiming federal financial
16 participation for activities that are performed to
17 assist with administration of the Medicaid program:
18 (1) Have complete and direct responsibility for the
19 administration, operation, funding, fiscal management,
20 and budget related to such activities, and directly
21 employ, oversee, and supervise all paid and volunteer
22 staff associated with these activities.
23 (2) Establish separation-of-duties requirements,
24 provide limited access to work space and work
25 product for only necessary staff, and limit access to
26 documents and information as necessary to maintain the
27 confidentiality of the protected health information of
28 individuals served under this section.
29 (3) Collect and submit, annually, to the governor,
30 the health policy oversight committee created in
31 section 2.45, and the general assembly, all of the
32 following with regard to those seeking advocacy
33 services or assistance under this section:
34 (a) The number of contacts by contact type and
35 geographic location.

1 (b) The type of assistance requested including the
2 name of the managed care organization involved, if
3 applicable.
4 (c) The time frame between the time of the initial
5 contact and when an initial response was provided.
6 (d) The amount of time from the initial contact to
7 resolution of the problem or concern.
8 (e) The actions taken in response to the request
9 for advocacy or assistance.
10 (f) The outcomes of requests to address problems or
11 concerns.
12 ~~4.~~ 8. For the purposes of this section:
13 *a. "Institutional setting"* includes a long-term care
14 facility, an elder group home, or an assisted living
15 program.
16 *b. "Long-term services and supports"* means the broad
17 range of health, health-related, and personal care
18 assistance services and supports, provided in both
19 institutional settings and home and community-based
20 settings, necessary for older individuals and persons
21 with disabilities who experience limitations in their
22 capacity for self-care due to a physical, cognitive, or
23 mental disability or condition.
24 Sec. 7. NEW SECTION. **231.44A Willful interference**
25 **with duties related to long-term services and supports**
26 **— penalty.**
27 Willful interference with a representative of the
28 office of long-term care ombudsman in the performance
29 of official duties in accordance with section 231.44
30 is a violation of section 231.44, subject to a penalty
31 prescribed by rule. The office of long-term care
32 ombudsman shall adopt rules specifying the amount of a
33 penalty imposed, consistent with the penalties imposed
34 under section 231.42, subsection 8, and specifying
35 procedures for notice and appeal of penalties imposed.

1 Any moneys collected pursuant to this section shall be
2 deposited in the Medicaid reinvestment fund created in
3 section 249A.4C.

4 MEDICAL ASSISTANCE ADVISORY COUNCIL

5 Sec. 8. Section 249A.4B, Code 2016, is amended to
6 read as follows:

7 **249A.4B Medical assistance advisory council.**

8 1. A medical assistance advisory council is
9 created to comply with 42 C.F.R. §431.12 based on
10 section 1902(a)(4) of the federal Social Security Act
11 and to advise the director about health and medical
12 care services under the ~~medical assistance~~ Medicaid
13 program, participate in Medicaid policy development
14 and program administration, and provide guidance on
15 key issues related to the Medicaid program, whether
16 administered under a fee-for-service, managed care, or
17 other methodology, including but not limited to access
18 to care, quality of care, and service delivery.
19 *a.* The council shall have the opportunity for
20 participation in policy development and program
21 administration, including furthering the participation
22 of recipients of the program, and without limiting this
23 general authority shall specifically do all of the
24 following:
25 (1) Formulate, review, evaluate, and recommend
26 policies, rules, agency initiatives, and legislation
27 pertaining to the Medicaid program. The council shall
28 have the opportunity to comment on proposed rules
29 prior to commencement of the rulemaking process and on
30 waivers and state plan amendment applications.
31 (2) Prior to the annual budget development process,
32 engage in setting priorities, including consideration
33 of the scope and utilization management criteria
34 for benefits, beneficiary eligibility, provider and
35 services reimbursement rates, and other budgetary

1 issues.
2 (3) Provide oversight for and review of the
3 administration of the Medicaid program.
4 (4) Ensure that the membership of the council
5 effectively represents all relevant and concerned
6 viewpoints, particularly those of consumers, providers,
7 and the general public; create public understanding;
8 and ensure that the services provided under the
9 Medicaid program meet the needs of the people served.
10 *b.* The council shall meet ~~no more than~~ at least
11 quarterly, and prior to the next subsequent meeting
12 of the executive committee. ~~The director of public~~
13 ~~health~~ The public member acting as a co-chairperson
14 of the executive committee and the professional or
15 business entity member acting as a co-chairperson of
16 the executive committee, shall serve as ~~chairperson~~
17 co-chairpersons of the council.
18 2. The council shall include all of the following
19 voting members:
20 *a.* The president, or the president's
21 representative, of each of the following professional
22 or business entities, or a member of each of the
23 following professional or business entities, selected
24 by the entity:
25 (1) The Iowa medical society.
26 (2) The Iowa osteopathic medical association.
27 (3) The Iowa academy of family physicians.
28 (4) The Iowa chapter of the American academy of
29 pediatrics.
30 (5) The Iowa physical therapy association.
31 (6) The Iowa dental association.
32 (7) The Iowa nurses association.
33 (8) The Iowa pharmacy association.
34 (9) The Iowa podiatric medical society.
35 (10) The Iowa optometric association.

1 (11) The Iowa association of community providers.
2 (12) The Iowa psychological association.
3 (13) The Iowa psychiatric society.
4 (14) The Iowa chapter of the national association
5 of social workers.
6 (15) The coalition for family and children's
7 services in Iowa.
8 (16) The Iowa hospital association.
9 (17) The Iowa association of rural health clinics.
10 (18) The Iowa primary care association.
11 (19) Free clinics of Iowa.
12 (20) The opticians' association of Iowa, inc.
13 (21) The Iowa association of hearing health
14 professionals.
15 (22) The Iowa speech and hearing association.
16 (23) The Iowa health care association.
17 (24) The Iowa association of area agencies on
18 aging.
19 (25) AARP.
20 (26) The Iowa caregivers association.
21 (27) The Iowa coalition of home and community-based
22 services for seniors.
23 (28) The Iowa adult day services association.
24 (29) Leading age Iowa.
25 (30) The Iowa association for home care.
26 (31) The Iowa council of health care centers.
27 (32) The Iowa physician assistant society.
28 (33) The Iowa association of nurse practitioners.
29 (34) The Iowa nurse practitioner society.
30 (35) The Iowa occupational therapy association.
31 (36) The ARC of Iowa, formerly known as the
32 association for retarded citizens of Iowa.
33 (37) The national alliance ~~for the mentally ill~~ on
34 mental illness of Iowa.
35 (38) The Iowa state association of counties.

1 (39) The Iowa developmental disabilities council.
2 (40) The Iowa chiropractic society.
3 (41) The Iowa academy of nutrition and dietetics.
4 (42) The Iowa behavioral health association.
5 (43) The midwest association for medical equipment
6 services or an affiliated Iowa organization.
7 (44) The Iowa public health association.
8 (45) The epilepsy foundation.
9 *b.* Public representatives which may include members
10 of consumer groups, including recipients of medical
11 assistance or their families, consumer organizations,
12 and others, which shall be appointed by the governor
13 in equal ~~in~~ number to the number of representatives of
14 the professional and business entities specifically
15 represented under paragraph *"a"*, ~~appointed by the~~
16 ~~governor~~ for staggered terms of two years each, none
17 of whom shall be members of, or practitioners of, or
18 have a pecuniary interest in any of the professional
19 or business entities specifically represented under
20 paragraph *"a"*, and a majority of whom shall be current
21 or former recipients of medical assistance or members
22 of the families of current or former recipients.
23 3. The council shall include all of the following
24 nonvoting members:
25 ~~*c.*~~ *a.* The director of public health, or the
26 director's designee.
27 ~~*d.*~~ *b.* The director of the department on aging, or
28 the director's designee.
29 *c.* The state long-term care ombudsman, or the
30 ombudsman's designee.
31 *d.* The ombudsman appointed pursuant to section
32 2C.3, or the ombudsman's designee.
33 *e.* The dean of Des Moines university — osteopathic
34 medical center, or the dean's designee.
35 *f.* The dean of the university of Iowa college of

1 medicine, or the dean's designee.
2 *g.* The following members of the general assembly,
3 each for a term of two years as provided in section
4 69.16B:
5 (1) Two members of the house of representatives,
6 one appointed by the speaker of the house of
7 representatives and one appointed by the minority
8 leader of the house of representatives from their
9 respective parties.
10 (2) Two members of the senate, one appointed by the
11 president of the senate after consultation with the
12 majority leader of the senate and one appointed by the
13 minority leader of the senate.
14 ~~3.~~ 4. *a.* An executive committee of the council is
15 created and shall consist of the following members of
16 the council:
17 (1) As voting members:
18 (a) Five of the professional or business entity
19 members designated pursuant to subsection 2, paragraph
20 *"a"*, and selected by the members specified under that
21 paragraph.
22 ~~(2)~~ (b) Five of the public members appointed
23 pursuant to subsection 2, paragraph *"b"*, and selected
24 by the members specified under that paragraph. Of the
25 five public members, at least one member shall be a
26 recipient of medical assistance.
27 ~~(3)~~ (2) As nonvoting members:
28 (a) The director of public health, or the
29 director's designee.
30 (b) The director of the department on aging, or the
31 director's designee.
32 (c) The state long-term care ombudsman, or the
33 ombudsman's designee.
34 (d) The ombudsman appointed pursuant to section
35 2C.3, or the ombudsman's designee.

1 *b.* The executive committee shall meet on a monthly
2 basis. ~~The director of public health~~ A public member
3 of the executive committee selected by the public
4 members appointed pursuant to subsection 2, paragraph
5 *"b"*, and a professional or business entity member of
6 the executive committee selected by the professional
7 or business entity members appointed pursuant to
8 subsection 2, paragraph *"a"*, shall serve as ~~chairperson~~
9 co-chairpersons of the executive committee.
10 *c.* Based upon the deliberations of the council,
11 ~~and~~ the executive committee, and the subcommittees,
12 the executive committee, the council, and the
13 subcommittees, respectively, shall make recommendations
14 to the director, to the health policy oversight
15 committee created in section 2.45, to the general
16 assembly's joint appropriations subcommittee on health
17 and human services, and to the general assembly's
18 standing committees on human resources regarding the
19 budget, policy, and administration of the medical
20 assistance program.
21 5. *a.* The council shall create the following
22 subcommittees, and may create additional subcommittees
23 as necessary to address Medicaid program policies,
24 administration, budget, and other factors and issues:
25 (1) A stakeholder safeguards subcommittee, for
26 which the co-chairpersons shall be a public member
27 of the council appointed pursuant to subsection 2,
28 paragraph *"b"*, and selected by the public members of
29 the council, and a representative of a professional
30 or business entity appointed pursuant to subsection
31 2, paragraph *"a"*, and selected by the professional or
32 business entity representatives of the council. The
33 mission of the stakeholder safeguards subcommittee
34 is to provide for ongoing stakeholder engagement and
35 feedback on issues affecting Medicaid recipients,

1 providers, and other stakeholders, including but not
2 limited to benefits such as transportation, benefit
3 utilization management, the inclusion of out-of-state
4 and out-of-network providers and the use of single-case
5 agreements, and reimbursement of providers and
6 services.
7 (2) The long-term services and supports
8 subcommittee which shall be chaired by the state
9 long-term care ombudsman, or the ombudsman's designee.
10 The mission of the long-term services and supports
11 subcommittee is to be a resource and to provide advice
12 on policy development and program administration
13 relating to Medicaid long-term services and supports
14 including but not limited to developing outcomes and
15 performance measures for Medicaid managed care for the
16 long-term services and supports population; addressing
17 issues related to home and community-based services
18 waivers and waiting lists; and reviewing the system of
19 long-term services and supports to ensure provision of
20 home and community-based services and the rebalancing
21 of the health care infrastructure in accordance with
22 state and federal law including but not limited to the
23 principles established in Olmstead v. L.C., 527 U.S.
24 581 (1999) and the federal Americans with Disabilities
25 Act and in a manner that reflects a sustainable,
26 person-centered approach to improve health and life
27 outcomes, supports maximum independence, addresses
28 medical and social needs in a coordinated, integrated
29 manner, and provides for sufficient resources including
30 a stable, well-qualified workforce. The subcommittee
31 shall also address and make recommendations regarding
32 the need for an ombudsman function for eligible and
33 potentially eligible Medicaid recipients beyond the
34 long-term services and supports population.
35 (3) The transparency, data, and program evaluation

1 subcommittee which shall be chaired by the director of
2 the university of Iowa public policy center, or the
3 director's designee. The mission of the transparency,
4 data, and program evaluation subcommittee is to
5 ensure Medicaid program transparency; ensure the
6 collection, maintenance, retention, reporting, and
7 analysis of sufficient and meaningful data to provide
8 transparency and inform policy development and program
9 effectiveness; support development and administration
10 of a consumer-friendly dashboard; and promote the
11 ongoing evaluation of Medicaid stakeholder satisfaction
12 with the Medicaid program.
13 (4) The program integrity subcommittee which shall
14 be chaired by the Medicaid director, or the director's
15 designee. The mission of the program integrity
16 subcommittee is to ensure that a comprehensive system
17 including specific policies, laws, and rules and
18 adequate resources and measures are in place to
19 effectively administer the program and to maintain
20 compliance with federal and state program integrity
21 requirements.
22 (5) A health workforce subcommittee, co-chaired
23 by the bureau chief of the bureau of oral and health
24 delivery systems of the department of public health,
25 or the bureau chief's designee, and the director of
26 the national alliance on mental illness of Iowa, or
27 the director's designee. The mission of the health
28 workforce subcommittee is to assess the sufficiency
29 and proficiency of the current and projected health
30 workforce; identify barriers to and gaps in health
31 workforce development initiatives and health
32 workforce data to provide foundational, evidence-based
33 information to inform policymaking and resource
34 allocation; evaluate the most efficient application
35 and utilization of roles, functions, responsibilities,

1 activities, and decision-making capacity of health
2 care professionals and other allied and support
3 personnel; and make recommendations for improvement
4 in, and alternative modes of, health care delivery in
5 order to provide a competent, diverse, and sustainable
6 health workforce in the state. The subcommittee shall
7 work in collaboration with the office of statewide
8 clinical education programs of the university of Iowa
9 Carver college of medicine, Des Moines university,
10 Iowa workforce development, and other entities with
11 interest or expertise in the health workforce in
12 carrying out the subcommittee's duties and developing
13 recommendations.
14 *b.* The co-chairpersons of the council shall
15 appoint members to each subcommittee from the general
16 membership of the council. Consideration in appointing
17 subcommittee members shall include the individual's
18 knowledge about, and interest or expertise in, matters
19 that come before the subcommittee.
20 *c.* Subcommittees shall meet at the call of the
21 co-chairpersons or chairperson of the subcommittee,
22 or at the request of a majority of the members of the
23 subcommittee.
24 ~~4.~~ 6. For each council meeting, executive
25 committee meeting, or subcommittee meeting, a quorum
26 shall consist of fifty percent of the membership
27 qualified to vote. Where a quorum is present, a
28 position is carried by a majority of the members
29 qualified to vote.
30 7. For each council meeting, other than those
31 held during the time the general assembly is in
32 session, each legislative member of the council shall
33 be reimbursed for actual travel and other necessary
34 expenses and shall receive a per diem as specified in
35 section 7E.6 for each day in attendance, as shall the

1 members of the council, ~~or~~ the executive committee,
2 or a subcommittee, for each day in attendance at a
3 council, executive committee, or subcommittee meeting,
4 who are recipients or the family members of recipients
5 of medical assistance, regardless of whether the
6 general assembly is in session.
7 ~~5.~~ 8. The department shall provide staff support
8 and independent technical assistance to the council,
9 ~~and~~ the executive committee, and the subcommittees.
10 ~~6.~~ 9. The director shall ~~consider~~ comply with
11 the requirements of this section regarding the
12 duties of the council, and the deliberations and
13 recommendations ~~offered by~~ of the council, ~~and~~ the
14 executive committee, and the subcommittees shall be
15 reflected in the director's preparation of medical
16 assistance budget recommendations to the council
17 on human services pursuant to section 217.3, ~~and~~ in
18 implementation of medical assistance program policies,
19 and in administration of the Medicaid program.
20 10. The council, executive committee, and
21 subcommittees shall jointly submit quarterly reports
22 to the health policy oversight committee created in
23 section 2.45 and shall jointly submit a report to the
24 governor and the general assembly initially by January
25 1, 2017, and annually, therefore, summarizing the
26 outcomes and findings of their respective deliberations
27 and any recommendations including but not limited to
28 those for changes in law or policy.
29 11. The council, executive committee, and
30 subcommittees may enlist the services of persons who
31 are qualified by education, expertise, or experience
32 to advise, consult with, or otherwise assist the
33 council, executive committee, or subcommittees in the
34 performance of their duties. The council, executive
35 committee, or subcommittees may specifically enlist

1 the assistance of entities such as the university of
2 Iowa public policy center to provide ongoing evaluation
3 of the Medicaid program and to make evidence-based
4 recommendations to improve the program. The council,
5 executive committee, and subcommittees shall enlist
6 input from the patient-centered health advisory council
7 created in section 135.159, the mental health and
8 disabilities services commission created in section
9 225C.5, the commission on aging created in section
10 231.11, the bureau of substance abuse of the department
11 of public health, the Iowa developmental disabilities
12 council, and other appropriate state and local entities
13 to provide advice to the council, executive committee,
14 and subcommittees.
15 12. The department, in accordance with 42 C.F.R.
16 §431.12, shall seek federal financial participation for
17 the activities of the council, the executive committee,
18 and the subcommittees.
19 PATIENT-CENTERED HEALTH RESOURCES AND INFRASTRUCTURE
20 Sec. 9. Section 135.159, subsection 2, Code 2016,
21 is amended to read as follows:
22 2. *a.* The department shall establish a
23 patient-centered health advisory council which shall
24 include but is not limited to all of the following
25 members, selected by their respective organizations,
26 and any other members the department determines
27 necessary to assist in the ~~department's duties at~~
28 ~~various stages of~~ development of the medical home
29 system and in the transformation to a patient-centered
30 infrastructure that integrates and coordinates services
31 and supports to address social determinants of health
32 and meet population health goals:
33 (1) The director of human services, or the
34 director's designee.
35 (2) The commissioner of insurance, or the

1 commissioner's designee.
2 (3) A representative of the federation of Iowa
3 insurers.
4 (4) A representative of the Iowa dental
5 association.
6 (5) A representative of the Iowa nurses
7 association.
8 (6) A physician and an osteopathic physician
9 licensed pursuant to chapter 148 who are family
10 physicians and members of the Iowa academy of family
11 physicians.
12 (7) A health care consumer.
13 (8) A representative of the Iowa collaborative
14 safety net provider network established pursuant to
15 section 135.153.
16 (9) A representative of the Iowa developmental
17 disabilities council.
18 (10) A representative of the Iowa chapter of the
19 American academy of pediatrics.
20 (11) A representative of the child and family
21 policy center.
22 (12) A representative of the Iowa pharmacy
23 association.
24 (13) A representative of the Iowa chiropractic
25 society.
26 (14) A representative of the university of Iowa
27 college of public health.
28 (15) A representative of the Iowa public health
29 association.
30 (16) A representative of the area agencies on
31 aging.
32 (17) A representative of the mental health and
33 disability services regions.
34 (18) A representative of early childhood Iowa.
35 *b.* Public members of the patient-centered health

1 advisory council shall receive reimbursement for
2 actual expenses incurred while serving in their
3 official capacity only if they are not eligible for
4 reimbursement by the organization that they represent.
5 *c.* (1) Beginning July 1, 2016, the
6 patient-centered health advisory council shall
7 do all of the following:
8 (a) Review and make recommendations to the
9 department and to the general assembly regarding
10 the building of effective working relationships and
11 strategies to support state-level and community-level
12 integration, to provide cross-system coordination
13 and synchronization, and to more appropriately align
14 health delivery models and service sectors, including
15 but not limited to public health, aging and disability
16 services agencies, mental health and disability
17 services regions, social services, child welfare, and
18 other providers, agencies, organizations, and sectors
19 to address social determinants of health, holistic
20 well-being, and population health goals. Such review
21 and recommendations shall include a review of funding
22 streams and recommendations for blending and braiding
23 funding to support these efforts.
24 (b) Assist in efforts to evaluate the health
25 workforce to inform policymaking and resource
26 allocation.
27 (2) The patient-centered health advisory council
28 shall submit a report to the department, the health
29 policy oversight committee created in section 2.45, and
30 the general assembly, initially, on or before December
31 15, 2016, and on or before December 15, annually,
32 thereafter, including any findings or recommendations
33 resulting from the council's deliberations.
34 HAWK-I PROGRAM
35 Sec. 10. Section 514I.5, subsection 8, paragraph

1 d, Code 2016, is amended by adding the following new
2 subparagraph:
3 NEW SUBPARAGRAPH. (17) Occupational therapy.
4 Sec. 11. Section 514I.5, subsection 8, Code 2016,
5 is amended by adding the following new paragraph:
6 NEW PARAGRAPH. *m.* The definition of medically
7 necessary and the utilization management criteria under
8 the hawk-i program in order to ensure that benefits
9 are uniformly and consistently provided across all
10 participating insurers in the type and manner that
11 reflects and appropriately meets the needs, including
12 but not limited to the habilitative and rehabilitative
13 needs, of the child population including those children
14 with special health care needs.
15 MEDICAID PROGRAM POLICY IMPROVEMENT
16 Sec. 12. DIRECTIVES FOR MEDICAID PROGRAM POLICY
17 IMPROVEMENTS. In order to safeguard the interests
18 of Medicaid recipients, encourage the participation
19 of Medicaid providers, and protect the interests
20 of all taxpayers, the department of human services
21 shall comply with or ensure that the specified entity
22 complies with all of the following and shall amend
23 Medicaid managed care contract provisions as necessary
24 to reflect all of the following:
25 1. CONSUMER PROTECTIONS.
26 a. In accordance with 42 C.F.R. §438.420, a
27 Medicaid managed care organization shall continue a
28 recipient's benefits during an appeal process. If, as
29 allowed when final resolution of an appeal is adverse
30 to the Medicaid recipient, the Medicaid managed care
31 organization chooses to recover the costs of the
32 services furnished to the recipient while an appeal is
33 pending, the Medicaid managed care organization shall
34 provide adequate prior notice of potential recovery
35 of costs to the recipient at the time the appeal is

1 filed, and any costs recovered shall be remitted to
2 the department of human services and deposited in the
3 Medicaid reinvestment fund created in section 249A.4C.
4 b. Ensure that each Medicaid managed care
5 organization provides, at a minimum, all the benefits
6 and services deemed medically necessary that were
7 covered, including to the extent and in the same manner
8 and subject to the same prior authorization criteria,
9 by the state program directly under fee for service
10 prior to January 1, 2016. Benefits covered through
11 Medicaid managed care shall comply with the specific
12 requirements in state law applicable to the respective
13 Medicaid recipient population under fee for service.
14 c. Enhance monitoring of the reduction in or
15 suspension or termination of services provided to
16 Medicaid recipients, including reductions in the
17 provision of home and community-based services waiver
18 services or increases in home and community-based
19 services waiver waiting lists. Medicaid managed care
20 organizations shall provide data to the department
21 as necessary for the department to compile periodic
22 reports on the numbers of individuals transferred from
23 state institutions and long-term care facilities to
24 home and community-based services, and the associated
25 savings. Any savings resulting from the transfers as
26 certified by the department shall be deposited in the
27 Medicaid reinvestment fund created in section 249A.4C.
28 d. (1) Require each Medicaid managed care
29 organization to adhere to reasonableness and service
30 authorization standards that are appropriate for and
31 do not disadvantage those individuals who have ongoing
32 chronic conditions or who require long-term services
33 and supports. Services and supports for individuals
34 with ongoing chronic conditions or who require
35 long-term services and supports shall be authorized in

1 a manner that reflects the recipient's continuing need
2 for such services and supports, and limits shall be
3 consistent with a recipient's current needs assessment
4 and person-centered service plan.
5 (2) In addition to other provisions relating to
6 community-based case management continuity of care
7 requirements, Medicaid managed care contractors shall
8 provide the option to the case manager of a Medicaid
9 recipient who retained the case manager during the
10 six months of transition to Medicaid managed care, if
11 the recipient chooses to continue to retain that case
12 manager beyond the six-month transition period and
13 if the case manager is not otherwise a participating
14 provider of the recipient's managed care organization
15 provider network, to enter into a single case agreement
16 to continue to provide case management services to the
17 Medicaid recipient.
18 e. Ensure that Medicaid recipients are provided
19 care coordination and case management by appropriately
20 trained professionals in a conflict-free manner. Care
21 coordination and case management shall be provided
22 in a patient-centered and family-centered manner
23 that requires a knowledge of community supports, a
24 reasonable ratio of care coordinators and case managers
25 to Medicaid recipients, standards for frequency of
26 contact with the Medicaid recipient, and specific and
27 adequate reimbursement.
28 f. A Medicaid managed care contract shall include
29 a provision for continuity and coordination of care
30 for a consumer transitioning to Medicaid managed care,
31 including maintaining existing provider-recipient
32 relationships and honoring the amount, duration, and
33 scope of a recipient's authorized services based on
34 the recipient's medical history and needs. In the
35 initial transition to Medicaid managed care, to ensure

1 the least amount of disruption, Medicaid managed
2 care organizations shall provide, at a minimum, a
3 one-year transition of care period for all provider
4 types, regardless of network status with an individual
5 Medicaid managed care organization.
6 g. Ensure that a Medicaid managed care organization
7 does not arbitrarily deny coverage for medically
8 necessary services based solely on financial reasons
9 and does not shift the responsibility for provision of
10 services or payment of costs of services to another
11 entity to avoid costs or attain savings.
12 h. Ensure that dental coverage, if not integrated
13 into an overall Medicaid managed care contract, is
14 part of the overall holistic, integrated coverage
15 for physical, behavioral, and long-term services and
16 supports provided to a Medicaid recipient.
17 i. Require each Medicaid managed care organization
18 to verify the offering and actual utilization of
19 services and supports and value-added services,
20 an individual recipient's encounters and the costs
21 associated with each encounter, and requests and
22 associated approvals or denials of services.
23 Verification of actual receipt of services and supports
24 and value-added services shall, at a minimum, consist
25 of comparing receipt of service against both what
26 was authorized in the recipient's benefit or service
27 plan and what was actually reimbursed. Value-added
28 services shall not be reportable as allowable medical
29 or administrative costs or factored into rate setting,
30 and the costs of value-added services shall not be
31 passed on to recipients or providers.
32 j. Provide periodic reports to the governor and
33 the general assembly regarding changes in quality of
34 care and health outcomes for Medicaid recipients under
35 managed care compared to quality of care and health

1 outcomes of the same populations of Medicaid recipients
2 prior to January 1, 2016.
3 k. Require each Medicaid managed care organization
4 to maintain records of complaints, grievances, and
5 appeals, and report the number and types of complaints,
6 grievances, and appeals filed, the resolution of each,
7 and a description of any patterns or trends identified
8 to the department of human services and the health
9 policy oversight committee created in section 2.45,
10 on a monthly basis. The department shall review and
11 compile the data on a quarterly basis and make the
12 compilations available to the public. Following review
13 of reports submitted by the department, a Medicaid
14 managed care organization shall take any corrective
15 action required by the department and shall be subject
16 to any applicable penalties.
17 l. Require Medicaid managed care organizations to
18 survey Medicaid recipients, to collect satisfaction
19 data using a uniform instrument, and to provide a
20 detailed analysis of recipient satisfaction as well as
21 various metrics regarding the volume of and timelines
22 in responding to recipient complaints and grievances as
23 directed by the department of human services.
24 m. Require managed care organizations to allow a
25 recipient to request that the managed care organization
26 enter into a single case agreement with a recipient's
27 out-of-network provider, including a provider outside
28 of the state, to provide for continuity of care when
29 the recipient has an existing relationship with the
30 provider to provide a covered benefit, or to ensure
31 adequate or timely access to a provider of a covered
32 benefit when the managed care organization provider
33 network cannot ensure such adequate or timely access.
34 2. CHILDREN.
35 a. (1) The hawk-i board shall retain all authority

1 specified under chapter 514I relative to the children
2 eligible under section 514I.8 to participate in the
3 hawk-i program, including but not limited to approving
4 any contract entered into pursuant to chapter 514I;
5 approving the benefit package design, reviewing the
6 benefit package design, and making necessary changes
7 to reflect the results of the reviews; and adopting
8 rules for the hawk-i program including those related
9 to qualifying standards for selecting participating
10 insurers for the program and the benefits to be
11 included in a health plan.
12 (2) The hawk-i board shall review benefit plans
13 and utilization review provisions and ensure that
14 benefits provided to children under the hawk-i program,
15 at a minimum, reflect those required by state law as
16 specified in section 514I.5, include both habilitative
17 and rehabilitative services, and are provided as
18 medically necessary relative to the child population
19 served and based on the needs of the program recipient
20 and the program recipient's medical history.
21 (3) The hawk-i board shall work with the department
22 of human services to coordinate coverage and care for
23 the population of children in the state eligible for
24 either Medicaid or hawk-i coverage so that, to the
25 greatest extent possible, the two programs provide for
26 continuity of care as children transition between the
27 two programs or to private health care coverage. To
28 this end, all contracts with participating insurers
29 providing coverage under the hawk-i program and with
30 all managed care organizations providing coverage for
31 children eligible for Medicaid shall do all of the
32 following:
33 (a) Specifically and appropriately address
34 the unique needs of children and children's health
35 delivery.

1 (b) Provide for the maintaining of child health
2 panels that include representatives of child health,
3 welfare, policy, and advocacy organizations in the
4 state that address child health and child well-being.
5 (c) Address early intervention and prevention
6 strategies, the provision of a child health care
7 delivery infrastructure for children with special
8 health care needs, utilization of current standards
9 and guidelines for children's health care and
10 pediatric-specific screening and assessment tools,
11 the inclusion of pediatric specialty providers in
12 the provider network, and the utilization of health
13 homes for children and youth with special health
14 care needs including intensive care coordination
15 and family support and access to a professional
16 family-to-family support system. Such contracts
17 shall utilize pediatric-specific quality measures
18 and assessment tools which shall align with existing
19 pediatric-specific measures as determined in
20 consultation with the child health panel and approved
21 by the hawk-i board.
22 (d) Provide special incentives for innovative
23 and evidence-based preventive, behavioral, and
24 developmental health care and mental health care
25 for children's programs that improve the life course
26 trajectory of these children.
27 (e) Provide that information collected from the
28 pediatric-specific assessments be used to identify
29 health risks and social determinants of health that
30 impact health outcomes. Such data shall be used in
31 care coordination and interventions to improve patient
32 outcomes and to drive program designs that improve the
33 health of the population. Aggregate assessment data
34 shall be shared with affected providers on a routine
35 basis.

1 b. In order to monitor the quality of and access
2 to health care for children receiving coverage under
3 the Medicaid program, each Medicaid managed care
4 organization shall uniformly report, in a template
5 format designated by the department of human services,
6 the number of claims submitted by providers and the
7 percentage of claims approved by the Medicaid managed
8 care organization for the early and periodic screening,
9 diagnostic, and treatment (EPSDT) benefit based
10 on the Iowa EPSDT care for kids health maintenance
11 recommendations, including but not limited to
12 physical exams, immunizations, the seven categories of
13 developmental and behavioral screenings, vision and
14 hearing screenings, and lead testing.
15 3. PROVIDER PARTICIPATION ENHANCEMENT.
16 a. Ensure that savings achieved through Medicaid
17 managed care does not come at the expense of further
18 reductions in provider rates. The department shall
19 ensure that Medicaid managed care organizations use
20 reasonable reimbursement standards for all provider
21 types and compensate providers for covered services at
22 not less than the minimum reimbursement established
23 by state law applicable to fee for service for a
24 respective provider, service, or product for a fiscal
25 year and as determined in conjunction with actuarially
26 sound rate setting procedures. Such reimbursement
27 shall extend for the entire duration of a managed care
28 contract.
29 b. To enhance continuity of care in the provision
30 of pharmacy services, Medicaid managed care
31 organizations shall utilize the same preferred drug
32 list, recommended drug list, prior authorization
33 criteria, and other utilization management strategies
34 that apply to the state program directly under fee for
35 service and shall apply other provisions of applicable

1 state law including those relating to chemically unique
2 mental health prescription drugs. Reimbursement rates
3 established under Medicaid managed care contracts for
4 ingredient cost reimbursement and dispensing fees shall
5 be subject to and shall reflect provisions of state
6 and federal law, including the minimum reimbursements
7 established in state law for fee for service for a
8 fiscal year.
9 c. Address rate setting and reimbursement of the
10 entire scope of services provided under the Medicaid
11 program to ensure the adequacy of the provider network
12 and to ensure that providers that contribute to the
13 holistic health of the Medicaid recipient, whether
14 inside or outside of the provider network, are
15 compensated for their services.
16 d. Managed care contractors shall submit financial
17 documentation to the department of human services
18 demonstrating payment of claims and expenses by
19 provider type.
20 e. Participating Medicaid providers under a managed
21 care contract shall be allowed to submit claims for up
22 to 365 days following discharge of a Medicaid recipient
23 from a hospital or following the date of service.
24 f. (1) A managed care contract entered into on
25 or after July 1, 2015, shall, at a minimum, reflect
26 all of the following provisions and requirements, and
27 shall extend the following payment rates based on the
28 specified payment floor, as applicable to the provider
29 type:
30 (a) In calculating the rates for prospective
31 payment system hospitals, the following base rates
32 shall be used:
33 (i) The inpatient diagnostic related group base
34 rates and certified unit per diem in effect on October
35 1, 2015.

1 (ii) The outpatient ambulatory payment
2 classification base rates in effect on July 1, 2015.
3 (iii) The inpatient psychiatric certified unit per
4 diem in effect on October 1, 2015.
5 (iv) The inpatient physical rehabilitation
6 certified unit per diem in effect on October 1, 2015.
7 (b) In calculating the critical access hospital
8 payment rates, the following base rates shall be used:
9 (i) The inpatient diagnostic related group base
10 rates in effect on July 1, 2015.
11 (ii) The outpatient cost-to-charge ratio in effect
12 on July 1, 2015.
13 (iii) The swing bed per diem in effect on July 1,
14 2015.
15 (c) Critical access hospitals shall receive
16 cost-based reimbursement for one hundred percent of
17 the reasonable costs for the provision of services to
18 Medicaid recipients.
19 (d) Critical access hospitals shall submit annual
20 cost reports and managed care contractors shall submit
21 annual payment reports to the department of human
22 services. The department shall reconcile the critical
23 access hospital's reported costs with the managed care
24 contractor's reported payments. The department shall
25 require the managed care contractor to retroactively
26 reimburse a critical access hospital for underpayments.
27 (e) Community mental health centers shall receive
28 one hundred percent of the reasonable costs for the
29 provision of services to Medicaid recipients.
30 (f) Federally qualified health centers shall
31 receive cost-based reimbursement for one hundred
32 percent of the reasonable costs for the provision of
33 services to Medicaid recipients.
34 (g) The reimbursement rates for substance-related
35 disorder treatment programs licensed under section

1 125.13, shall be no lower than the rates in effect for
2 the fiscal year beginning July 1, 2015.
3 (2) For managed care contract periods subsequent to
4 the initial contract period, base rates for prospective
5 payment system hospitals and critical access hospitals
6 shall be calculated using the base rate for the prior
7 contract period plus 3 percent. Prospective payment
8 system hospital and critical access hospital base rates
9 shall at no time be less than the previous contract
10 period's base rates.
11 (3) A managed care contract shall require
12 out-of-network prospective payment system hospital
13 and critical access hospital payment rates to meet or
14 exceed ninety-nine percent of the rates specified for
15 the respective in-network hospitals in accordance with
16 this paragraph "f".
17 g. If the department of human services collects
18 ownership and control information from Medicaid
19 providers pursuant to 42 C.F.R. §455.104, a managed
20 care organization under contract with the state shall
21 not also require submission of this information from
22 approved enrolled Medicaid providers.
23 h. (1) Ensure that a Medicaid managed care
24 organization develops and maintains a provider network
25 of qualified providers who meet state licensing,
26 credentialing, and certification requirements, as
27 applicable, which network shall be sufficient to
28 provide adequate access to all services covered and for
29 all populations served under the managed care contract.
30 Medicaid managed care organizations shall incorporate
31 existing and traditional providers, including but
32 not limited to those providers that comprise the Iowa
33 collaborative safety net provider network created in
34 section 135.153, into their provider networks.
35 (2) Ensure that respective Medicaid populations

1 are managed at all times within funding limitations
2 and contract terms. The department shall also
3 monitor service delivery and utilization to ensure
4 the responsibility for provision of services to
5 Medicaid recipients is not shifted to non-Medicaid
6 covered services to attain savings, and that such
7 responsibility is not shifted to mental health and
8 disability services regions, local public health
9 agencies, aging and disability resource centers,
10 or other entities unless agreement to provide, and
11 provision for adequate compensation for, such services
12 is agreed to between the affected entities in advance.
13 i. Medicaid managed care organizations shall
14 provide an enrolled Medicaid provider approved by the
15 department of human services the opportunity to be a
16 participating network provider.
17 j. Medicaid managed care organizations shall
18 include provider appeals and grievance procedures
19 that in part allow a provider to file a grievance
20 independently but on behalf of a Medicaid recipient
21 and to appeal claims denials which, if determined to
22 be based on claims for medically necessary services
23 whether or not denied on an administrative basis, shall
24 receive appropriate payment.
25 k. (1) Medicaid managed care organizations
26 shall include as primary care providers any provider
27 designated by the state as a primary care provider,
28 subject to a provider's respective state certification
29 standards, including but not limited to all of the
30 following:
31 (a) A physician who is a family or general
32 practitioner, a pediatrician, an internist, an
33 obstetrician, or a gynecologist.
34 (b) An advanced registered nurse practitioner.
35 (c) A physician assistant.

1 (d) A chiropractor licensed pursuant to chapter
2 151.
3 (2) A Medicaid managed care organization shall not
4 impose more restrictive, additional, or different scope
5 of practice requirements or standards of practice on a
6 primary care provider than those prescribed by state
7 law as a prerequisite for participation in the managed
8 care organization's provider network.
9 4. CAPITATION RATES AND MEDICAL LOSS RATIO.
10 a. Capitation rates shall be developed based on all
11 reasonable, appropriate, and attainable costs. Costs
12 that are not reasonable, appropriate, or attainable,
13 including but not limited to improper payment
14 recoveries, shall not be included in the development
15 of capitated rates.
16 b. Capitation rates for Medicaid recipients falling
17 within different rate cells shall not be expected to
18 cross-subsidize one another and the data used to set
19 capitation rates shall be relevant and timely and tied
20 to the appropriate Medicaid population.
21 c. Any increase in capitation rates for managed
22 care contractors is subject to prior statutory approval
23 and shall not exceed three percent over the existing
24 capitation rate in any one-year period or five percent
25 over the existing capitation rate in any two-year
26 period.
27 d. In addition to withholding two percent of a
28 managed care organization's annual capitation payment
29 as a pay-for-performance enforcement mechanism, the
30 department of human services shall also withhold an
31 additional two percent of a managed care organization's
32 annual capitation payment until the department is able
33 to ensure that the respective managed care organization
34 has complied with all requirements relating to data,
35 information, transparency, evaluation, and oversight

1 specified by law, rule, contract, or other basis.
2 e. The department of human services shall collect
3 an initial contribution of five million dollars from
4 each of the managed care organizations contracting
5 with the state during the fiscal year beginning July
6 1, 2015, for an aggregate amount of fifteen million
7 dollars, and shall deposit such amount in the Medicaid
8 reinvestment fund, as provided in section 249A.4C, as
9 enacted in this Act, to be used for Medicaid ombudsman
10 activities through the office of long-term care
11 ombudsman.
12 f. A managed care contract shall impose a minimum
13 Medicaid loss ratio of at least eighty-eight percent.
14 In calculating the medical loss ratio, medical costs
15 or benefit expenses shall include only those costs
16 directly related to patient medical care and not
17 ancillary expenses, including but not limited to any
18 of the following:
19 (1) Program integrity activities.
20 (2) Utilization review activities.
21 (3) Fraud prevention activities beyond the scope of
22 those activities necessary to recover incurred claims.
23 (4) Provider network development, education, or
24 management activities.
25 (5) Provider credentialing activities.
26 (6) Marketing expenses.
27 (7) Administrative costs associated with recipient
28 incentives.
29 (8) Clinical data collection activities.
30 (9) Claims adjudication expenses.
31 (10) Customer service or health care professional
32 hotline services addressing nonclinical recipient
33 questions.
34 (11) Value-added or cost-containment services,
35 wellness programs, disease management, and case

1 management or care coordination programs.
2 (12) Health quality improvement activities unless
3 specifically approved as a medical cost by state law.
4 Costs of health quality improvement activities included
5 in determining the medical loss ratio shall be only
6 those activities that are independent improvements
7 measurable in individual patients.
8 (13) Insurer claims review activities.
9 (14) Information technology costs unless they
10 directly and credibly improve the quality of health
11 care and do not duplicate, conflict with, or fail to be
12 compatible with similar health information technology
13 efforts of providers.
14 (15) Legal department costs including information
15 technology costs, expenses incurred for review and
16 denial of claims, legal costs related to defending
17 claims, settlements for wrongly denied claims, and
18 costs related to administrative claims handling
19 including salaries of administrative personnel and
20 legal costs.
21 (16) Taxes unrelated to premiums or the provision
22 of medical care. Only state and federal taxes and
23 licensing or regulatory fees relevant to actual
24 premiums collected, not including such taxes and fees
25 as property taxes, taxes on investment income, taxes on
26 investment property, and capital gains taxes, may be
27 included in determining the medical loss ratio.
28 g. (1) Provide enhanced guidance and criteria for
29 defining medical and administrative costs, recoveries,
30 and rebates including pharmacy rebates, and the
31 recording, reporting, and recoupment of such costs,
32 recoveries, and rebates realized.
33 (2) Medicaid managed care organizations shall
34 offset recoveries, rebates, and refunds against
35 medical costs, include only allowable administrative

1 expenses in the determination of administrative costs,
2 report costs related to subcontractors properly, and
3 have complete systems checks and review processes to
4 identify overpayment possibilities.
5 (3) Medicaid managed care contractors shall submit
6 publicly available, comprehensive financial statements
7 to the department of human services to verify that the
8 minimum medical loss ratio is being met and shall be
9 subject to periodic audits.
10 5. DATA AND INFORMATION, EVALUATION, AND OVERSIGHT.
11 a. Develop and administer a clear, detailed policy
12 regarding the collection, storage, integration,
13 analysis, maintenance, retention, reporting, sharing,
14 and submission of data and information from the
15 Medicaid managed care organizations and shall require
16 each Medicaid managed care organization to have in
17 place a data and information system to ensure that
18 accurate and meaningful data is available. At a
19 minimum, the data shall allow the department to
20 effectively measure and monitor Medicaid managed care
21 organization performance, quality, outcomes including
22 recipient health outcomes, service utilization,
23 finances, program integrity, the appropriateness
24 of payments, and overall compliance with contract
25 requirements; perform risk adjustments and determine
26 actuarially sound capitation rates and appropriate
27 provider reimbursements; verify that the minimum
28 medical loss ratio is being met; ensure recipient
29 access to and use of services; create quality measures;
30 and provide for program transparency.
31 b. Medicaid managed care organizations shall
32 directly capture and retain and shall report actual and
33 detailed medical claims costs and administrative cost
34 data to the department as specified by the department.
35 Medicaid managed care organizations shall allow the

1 department to thoroughly and accurately monitor the
2 medical claims costs and administrative costs data
3 Medicaid managed care organizations report to the
4 department.
5 c. Any audit of Medicaid managed care contracts
6 shall ensure compliance including with respect to
7 appropriate medical costs, allowable administrative
8 costs, the medical loss ratio, cost recoveries,
9 rebates, overpayments, and with specific contract
10 performance requirements.
11 d. The external quality review organization
12 contracting with the department shall review the
13 Medicaid managed care program to determine if the
14 state has sufficient infrastructure and controls in
15 place to effectively oversee the Medicaid managed care
16 organizations and the Medicaid program in order to
17 ensure, at a minimum, compliance with Medicaid managed
18 care organization contracts and to prevent fraud,
19 abuse, and overpayments. The results of any external
20 quality review organization review shall be submitted
21 to the governor, the general assembly, and the health
22 policy oversight committee created in section 2.45.
23 e. Publish benchmark indicators based on Medicaid
24 program outcomes from the fiscal year beginning July 1,
25 2015, to be used to compare outcomes of the Medicaid
26 program as administered by the state program prior
27 to July 1, 2015, to those outcomes of the program
28 under Medicaid managed care. The outcomes shall
29 include a comparison of actual costs of the program
30 as administered prior to and after implementation of
31 Medicaid managed care. The data shall also include
32 specific detail regarding the actual expenses incurred
33 by each managed care organization by specific provider
34 line of service.
35 f. Review and approve or deny approval of contract

1 amendments on an ongoing basis to provide for
2 continuous improvement in Medicaid managed care and
3 to incorporate any changes based on changes in law or
4 policy.
5 g. (1) Require managed care contractors to track
6 and report on a monthly basis to the department of
7 human services, at a minimum, all of the following:
8 (a) The number and details relating to prior
9 authorization requests and denials.
10 (b) The ten most common reasons for claims denials.
11 Information reported by a managed care contractor
12 relative to claims shall also include the number
13 of claims denied, appealed, and overturned based on
14 provider type and service type.
15 (c) Utilization of health care services by
16 diagnostic related group and ambulatory payment
17 classification as well as total claims volume.
18 (2) The department shall ensure the validity
19 of all information submitted by a Medicaid managed
20 care organization and shall make the monthly reports
21 available to the public.
22 h. Medicaid managed care organizations shall
23 maintain stakeholder panels comprised of an equal
24 number of Medicaid recipients and providers. Medicaid
25 managed care organizations shall provide for separate
26 provider-specific panels to address detailed payment,
27 claims, process, and other issues as well as grievance
28 and appeals processes.
29 i. Medicaid managed care contracts shall align
30 economic incentives, delivery system reforms, and
31 performance and outcome metrics with those of the state
32 innovation models initiatives and Medicaid accountable
33 care organizations. The department of human services
34 shall develop and utilize a common, uniform set of
35 process, quality, and consumer satisfaction measures

1 across all Medicaid payors and providers that align
2 with those developed through the state innovation
3 models initiative and shall ensure that such measures
4 are expanded and adjusted to address additional
5 populations and to meet population health objectives.
6 Medicaid managed care contracts shall include long-term
7 performance and outcomes goals that reward success in
8 achieving population health goals such as improved
9 community health metrics.
10 j. (1) Require consistency and uniformity of
11 processes, procedures, and forms across all Medicaid
12 managed care organizations to reduce the administrative
13 burden to providers and consumers and to increase
14 efficiencies in the program. Such requirements shall
15 apply to but are not limited to areas of uniform cost
16 and quality reporting, uniform prior authorization
17 requirements and procedures, uniform utilization
18 management criteria, centralized, uniform, and seamless
19 credentialing requirements and procedures, and uniform
20 critical incident reporting.
21 (2) The department of human services shall
22 establish a comprehensive provider credentialing
23 process to be recognized and utilized by all Medicaid
24 managed care organization contractors. The process
25 shall meet the national committee for quality assurance
26 and other appropriate standards. The process shall
27 ensure that credentialing is completed in a timely
28 manner without disruption to provider billing
29 processes.
30 k. Medicaid managed care organizations and any
31 entity with which a managed care organization contracts
32 for the performance of services shall disclose at no
33 cost to the department all discounts, incentives,
34 rebates, fees, free goods, bundling arrangements, and
35 other agreements affecting the net cost of goods or

1 services provided under a managed care contract.
2 Sec. 13. RETROACTIVE APPLICABILITY. The section of
3 this Act relating to directives for Medicaid program
4 policy improvements applies retroactively to July 1,
5 2015.
6 Sec. 14. EFFECTIVE UPON ENACTMENT. This Act, being
7 deemed of immediate importance, takes effect upon
8 enactment.>

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AMANDA RAGAN

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LIZ MATHIS

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JOE BOLKCOM