

**EIGHTY-SIXTH GENERAL ASSEMBLY
2016 REGULAR SESSION
DAILY
HOUSE CLIP SHEET**

MARCH 24, 2016

HOUSE FILE 2437

H-8140

1 Amend the amendment, H-8133, to House File 2437 as
2 follows:

3 1. Page 1, after line 1 by inserting:

4 <____. By striking page 1, line 3, through page 3,
5 line 22, and inserting:

6 <Sec. _____. Section 321.1, Code 2016, is amended by
7 adding the following new subsection:

8 NEW SUBSECTION. 06A. "Autocycle" means a
9 three-wheeled motor vehicle originally designed with
10 two front wheels and one rear wheel, a steering wheel
11 rather than handlebars, no more than two permanent
12 seats that do not require the operator or a passenger
13 to straddle or sit astride the vehicle, and foot
14 pedals that control the brakes, acceleration, and
15 clutch, where applicable. A motor vehicle meeting the
16 definition of "autocycle" is an autocycle even if the
17 vehicle bears a vehicle identification number, or is
18 accompanied by a manufacturer's certificate of origin,
19 that identifies the vehicle as a motorcycle.

20 Sec. _____. Section 321.1, subsection 40, paragraph
21 a, Code 2016, is amended to read as follows:

22 a. "Motorcycle" means every motor vehicle having a
23 saddle or seat for the use of the rider and designed to
24 travel on not more than three wheels in contact with
25 the ground including a motor scooter but excluding a
26 tractor, an autocycle, and a motorized bicycle.

27 Sec. _____. Section 321.34, subsection 1, Code 2016,
28 is amended to read as follows:

29 1. Plates issued. The county treasurer upon
30 receiving application, accompanied by proper fee, for
31 registration of a vehicle shall issue to the owner one
32 registration plate for a motorcycle, motorized bicycle,
33 autocycle, truck tractor, trailer, or semitrailer and
34 two registration plates for every other motor vehicle.
35 The registration plates, including special registration

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1 plates, shall be assigned to the owner of a vehicle.
2 When the owner of a registered vehicle transfers or
3 assigns ownership of the vehicle to another person, the
4 owner shall remove the registration plates from the
5 vehicle. The owner shall forward the plates to the
6 county treasurer where the vehicle is registered or the
7 owner may have the plates assigned to another vehicle
8 within thirty days after transfer, upon payment of the
9 fees required by law. The owner shall immediately
10 affix registration plates retained by the owner
11 to another vehicle owned or acquired by the owner,
12 providing the owner complies with section 321.46.
13 The department shall adopt rules providing for the
14 assignment of registration plates to the transferee of
15 a vehicle for which a credit is allowed under section
16 321.46, subsection 6.

17 Sec. _____. Section 321.34, subsection 5, paragraph
18 a, Code 2016, is amended to read as follows:

19 a. Upon application and the payment of a fee of
20 twenty-five dollars, the director may issue to the
21 owner of a motor vehicle registered in this state or
22 a trailer or travel trailer registered in this state,
23 personalized registration plates marked with up to
24 seven initials, letters, or combination of numerals and
25 letters requested by the owner. However, personalized
26 registration plates for autocycles, motorcycles, and
27 motorized bicycles shall be marked with no more than
28 six initials, letters, or combinations of numerals and
29 letters. Upon receipt of the personalized registration
30 plates, the applicant shall surrender the regular
31 registration plates to the county treasurer. The fee
32 for issuance of the personalized registration plates
33 shall be in addition to the regular annual registration
34 fee.

35 Sec. _____. Section 321.34, subsection 8, paragraph

1 a, Code 2016, is amended to read as follows:

2 a. The owner of a motor vehicle subject to
3 registration under section 321.109, subsection
4 1, autocycle, motorcycle, trailer, or motor truck
5 who has been awarded the medal of honor may, upon
6 written application to the department, order special
7 registration plates which shall be red, white, and blue
8 in color and shall bear an emblem of the medal of honor
9 and an identifying number. Each applicant applying for
10 special registration plates under this subsection may
11 order only one set of registration plates under this
12 subsection. The application is subject to approval
13 by the department and the special registration plates
14 shall be issued at no charge to the applicant in
15 exchange for the registration plates previously issued
16 to the person. A person who is issued special plates
17 under this subsection is exempt from payment of any
18 annual registration fee for the motor vehicle bearing
19 the special plates. The department shall validate
20 the special plates in the same manner as regular
21 registration plates are validated under this section.
22 The department shall not issue special registration
23 plates until service organizations in the state have
24 furnished the department either the special dies or the
25 cost of the special dies necessary for the manufacture
26 of the special registration plate.

27 Sec. _____. Section 321.34, subsection 8A, paragraph
28 a, Code 2016, is amended to read as follows:

29 a. The owner of a motor vehicle subject to
30 registration under section 321.109, subsection 1,
31 autocycle, motorcycle, trailer, or motor truck who was
32 a prisoner of war during a time of military conflict
33 may, upon written application to the department, order
34 only one set of special registration plates with an
35 ex-prisoner of war processed emblem. The emblem shall

1 be designed by the department in cooperation with the
2 adjutant general and shall signify that the owner was
3 a prisoner of war as described in this subsection. The
4 application is subject to approval by the department,
5 in consultation with the adjutant general. The special
6 plates shall be issued at no charge and are subject to
7 an annual registration fee of fifteen dollars. The
8 county treasurer shall validate the special plates in
9 the same manner as regular registration plates are
10 validated under this section.

11 Sec. _____. Section 321.34, subsection 11, paragraph
12 a, Code 2016, is amended to read as follows:

13 a. Upon application and payment of the proper fees,
14 the director may issue natural resources plates to the
15 owner of a motor vehicle subject to registration under
16 section 321.109, subsection 1, autocycle, motor truck,
17 motor home, multipurpose vehicle, motorcycle, trailer,
18 or travel trailer.

19 Sec. _____. Section 321.34, subsection 11A, paragraph
20 a, Code 2016, is amended to read as follows:

21 a. Upon application and payment of the proper fees,
22 the director may issue "love our kids" plates to the
23 owner of a motor vehicle subject to registration under
24 section 321.109, subsection 1, autocycle, motor truck,
25 motor home, multipurpose vehicle, motorcycle, trailer,
26 or travel trailer.

27 Sec. _____. Section 321.34, subsection 11B, paragraph
28 a, Code 2016, is amended to read as follows:

29 a. Upon application and payment of the proper fees,
30 the director may issue "motorcycle rider education"
31 plates to the owner of a motor vehicle subject to
32 registration under section 321.109, subsection 1,
33 autocycle, motor truck, motor home, multipurpose
34 vehicle, motorcycle, trailer, or travel trailer.

35 Sec. _____. Section 321.34, subsection 12, paragraphs

1 a and d, Code 2016, are amended to read as follows:

2 a. The owner of a motor vehicle subject to
3 registration pursuant to section 321.109, subsection
4 1, autocycle, motor truck, motor home, multipurpose
5 vehicle, motorcycle, trailer, or travel trailer may,
6 upon written application to the department, order
7 special registration plates with a distinguishing
8 processed emblem as authorized by this section or as
9 approved by the department. The fee for the issuance
10 of special registration plates is twenty-five dollars
11 for each vehicle, unless otherwise provided by this
12 section, which fee is in addition to the regular annual
13 registration fee. The county treasurer shall validate
14 special registration plates with a distinguishing
15 processed emblem in the same manner as regular
16 registration plates, upon payment of five dollars in
17 addition to the regular annual registration fee.

18 d. A special registration plate issued for a
19 motorcycle, autocycle, or motorized bicycle under this
20 section shall be designated in the manner provided for
21 personalized registration plates under subsection 5,
22 paragraph "a".

23 Sec. _____. Section 321.34, subsection 15, paragraph
24 a, Code 2016, is amended to read as follows:

25 a. The owner of a motor vehicle subject to
26 registration under section 321.109, subsection 1,
27 autocycle, motorcycle, trailer, or motor truck who has
28 been awarded the legion of merit shall be issued one
29 set of special registration plates with a legion of
30 merit processed emblem, upon written application to
31 the department and presentation of satisfactory proof
32 of the award of the legion of merit as established by
33 the Congress of the United States. The emblem shall
34 be designed by the department in cooperation with the
35 adjutant general and shall signify that the owner

1 was awarded the legion of merit. The application is
2 subject to approval by the department, in consultation
3 with the adjutant general. The special plates shall
4 be issued at no charge and are subject to an annual
5 registration fee of fifteen dollars. The county
6 treasurer shall validate the special plates in the same
7 manner as regular registration plates are validated
8 under this section.

9 Sec. _____. Section 321.37, subsections 1 and 2, Code
10 2016, are amended to read as follows:

11 1. Registration plates issued for a motor vehicle
12 other than ~~a~~ an autocycle, motorcycle, motorized
13 bicycle, or ~~a~~ truck tractor shall be attached to
14 the motor vehicle, one in the front and the other in
15 the rear. The registration plate issued for ~~a~~ an
16 autocycle, motorcycle, or other vehicle required to be
17 registered hereunder shall be attached to the rear of
18 the vehicle. The registration plate issued for a truck
19 tractor shall be attached to the front of the truck
20 tractor. The special plate issued to a dealer shall be
21 attached on the rear of the vehicle when operated on
22 the highways of this state.

23 2. Registration plates issued for a motor vehicle
24 which is model year 1948 or older, and reconstructed
25 or specially constructed vehicles built to resemble
26 a model year 1948 vehicle or older, other than a
27 truck registered for more than five tons, autocycle,
28 motorcycle, or truck tractor, may display one
29 registration plate on the rear of the vehicle if the
30 other registration plate issued to the vehicle is
31 carried in the vehicle at all times when the vehicle is
32 operated on a public highway.

33 Sec. _____. Section 321.69, subsection 9, Code 2016,
34 is amended to read as follows:

35 9. Except for subsections 10 and 11, this section

1 does not apply to motor trucks and truck tractors with
2 a gross vehicle weight rating of sixteen thousand
3 pounds or more, vehicles more than seven model years
4 old, autocycles, motorcycles, motorized bicycles, and
5 special mobile equipment. This section does apply to
6 motor homes. The requirement in subsection 1 that
7 the new certificate of title and registration receipt
8 shall state on the face whether a prior owner had
9 disclosed that the vehicle was damaged to the extent
10 that it was a wrecked or salvage vehicle as defined
11 in section 321.52, subsection 4, paragraph "d", does
12 not apply to a vehicle with a certificate of title
13 bearing a designation that the vehicle was previously
14 titled on a salvage certificate of title pursuant to
15 section 321.52, subsection 4, paragraph "b", or to a
16 vehicle with a certificate of title bearing a "REBUILT"
17 or "SALVAGE" designation pursuant to section 321.24,
18 subsection 4 or 5. Except for subsections 10 and 11,
19 this section does not apply to new motor vehicles
20 with a true mileage, as defined in section 321.71, of
21 one thousand miles or less, unless such vehicle has
22 incurred damage as described in subsection 2.

23 Sec. _____. Section 321.105A, subsection 2, paragraph
24 c, subparagraph (6), Code 2016, is amended to read as
25 follows:

26 (6) Vehicles, excluding autocycles, motorcycles,
27 and motorized bicycles, subject to registration in
28 any state when purchased for rental or registered and
29 titled by a motor vehicle dealer licensed pursuant to
30 chapter 322 for rental use, and held for rental for a
31 period of one hundred twenty days or more and actually
32 rented for periods of sixty days or less by a person
33 regularly engaged in the business of renting vehicles,
34 including but not limited to motor vehicle dealers
35 licensed pursuant to chapter 322 who rent automobiles

1 to users, if the rental of the vehicles is subject to
2 taxation under section 423.2 or chapter 423C.

3 Sec. _____. Section 321.109, subsection 1, paragraph
4 a, Code 2016, is amended to read as follows:

5 a. The annual fee for all motor vehicles including
6 vehicles designated by manufacturers as station
7 wagons, 1993 and subsequent model year multipurpose
8 vehicles, and 2010 and subsequent model year motor
9 trucks with an unladen weight of ten thousand pounds
10 or less, except motor trucks registered under section
11 321.122, business-trade trucks, special trucks, motor
12 homes, motorsports recreational vehicles, ambulances,
13 hearses, autocycles, motorcycles, motorized bicycles,
14 and 1992 and older model year multipurpose vehicles,
15 shall be equal to one percent of the value as fixed by
16 the department plus forty cents for each one hundred
17 pounds or fraction thereof of weight of vehicle,
18 as fixed by the department. The weight of a motor
19 vehicle, fixed by the department for registration
20 purposes, shall include the weight of a battery,
21 heater, bumpers, spare tire, and wheel. Provided,
22 however, that for any new vehicle purchased in this
23 state by a nonresident for removal to the nonresident's
24 state of residence the purchaser may make application
25 to the county treasurer in the county of purchase for
26 a transit plate for which a fee of ten dollars shall
27 be paid. And provided, however, that for any used
28 vehicle held by a registered dealer and not currently
29 registered in this state, or for any vehicle held
30 by an individual and currently registered in this
31 state, when purchased in this state by a nonresident
32 for removal to the nonresident's state of residence,
33 the purchaser may make application to the county
34 treasurer in the county of purchase for a transit
35 plate for which a fee of three dollars shall be paid.

1 The county treasurer shall issue a nontransferable
2 certificate of registration for which no refund shall
3 be allowed; and the transit plates shall be void thirty
4 days after issuance. Such purchaser may apply for a
5 certificate of title by surrendering the manufacturer's
6 or importer's certificate or certificate of title,
7 duly assigned as provided in this chapter. In this
8 event, the treasurer in the county of purchase shall,
9 when satisfied with the genuineness and regularity of
10 the application, and upon payment of a fee of twenty
11 dollars, issue a certificate of title in the name and
12 address of the nonresident purchaser delivering the
13 title to the owner. If there is a security interest
14 noted on the title, the county treasurer shall mail to
15 the secured party an acknowledgment of the notation
16 of the security interest. The county treasurer shall
17 not release a security interest that has been noted on
18 a title issued to a nonresident purchaser as provided
19 in this paragraph. The application requirements of
20 section 321.20 apply to a title issued as provided
21 in this subsection, except that a natural person
22 who applies for a certificate of title shall provide
23 either the person's social security number, passport
24 number, or driver's license number, whether the license
25 was issued by this state, another state, or another
26 country. The provisions of this subsection relating to
27 multipurpose vehicles are effective for all 1993 and
28 subsequent model years. The annual registration fee
29 for multipurpose vehicles that are 1992 model years and
30 older shall be in accordance with section 321.124.

31 Sec. _____. Section 321.117, Code 2016, is amended to
32 read as follows:

33 321.117 Motorcycle, autocycle, ambulance, and hearse
34 fees.

35 For all motorcycles and autocycles the annual

1 registration fee shall be twenty dollars. For all
2 motorized bicycles the annual registration fee shall
3 be seven dollars. When the motorcycle or autocycle is
4 more than five model years old, the annual registration
5 fee shall be ten dollars. The annual registration fee
6 for ambulances and hearses shall be fifty dollars.
7 Passenger car plates shall be issued for ambulances and
8 hearses.

9 Sec. _____. Section 321.166, subsections 1, 3, and 4,
10 Code 2016, are amended to read as follows:

11 1. a. Registration plates shall be of metal and
12 of a size not to exceed six inches by twelve inches,
13 except that the size of plates issued for use on
14 autocycles, motorized bicycles, motorcycles, motorcycle
15 trailers, and trailers with an empty weight of two
16 thousand pounds or less shall be established by the
17 department.

18 b. Trailers with empty weights of two thousand
19 pounds or less may, upon request, be licensed with
20 regular-sized license plates.

21 3. The registration plate number shall be displayed
22 in characters which shall not exceed a height of four
23 inches nor a stroke width exceeding five-eighths of an
24 inch. Special plates issued to dealers shall display
25 the alphabetical character "D", which shall be of the
26 same size as the characters in the registration plate.
27 The registration plate number issued for autocycles,
28 motorized bicycles, motorcycles, trailers with an empty
29 weight of two thousand pounds or less, and motorcycle
30 trailers shall be a size prescribed by the department.

31 4. The registration plate number, except on
32 autocycles, motorized bicycles, motorcycles, motorcycle
33 trailers, and trailers with an empty weight of two
34 thousand pounds or less, shall be of sufficient size to
35 be readable from a distance of one hundred feet during

1 daylight.

2 Sec. _____. Section 322.2, Code 2016, is amended by
3 adding the following new subsection:

4 NEW SUBSECTION. 1A. "Autocycle" means as defined
5 in section 321.1.

6 Sec. _____. Section 322.5, subsection 6, paragraph a,
7 unnumbered paragraph 1, Code 2016, is amended to read
8 as follows:

9 Upon application for and receipt of a temporary
10 permit issued by the department under this subsection,
11 a motor vehicle dealer authorized to sell used
12 motorcycles or autocycles may display, offer for sale,
13 and negotiate sales of used motorcycles or autocycles
14 at a motorcycle rally located in this state that meets
15 all of the following conditions:

16 Sec. _____. Section 322.5, subsection 6, paragraph
17 b, subparagraph (1), Code 2016, is amended to read as
18 follows:

19 (1) The person presents the department with a
20 current motor vehicle dealer license valid for the sale
21 of used motorcycles or autocycles at retail in the
22 person's state of residence.

23 Sec. _____. Section 322.5, subsection 6, paragraph d,
24 Code 2016, is amended to read as follows:

25 d. A sale of a motorcycle or autocycle at a
26 motorcycle rally shall not be completed and an
27 agreement for the sale of a motorcycle or autocycle
28 shall not be signed at a motorcycle rally. All
29 such sales shall be consummated at the motor vehicle
30 dealer's principal place of business.

31 Sec. _____. Section 322.36, Code 2016, is amended to
32 read as follows:

33 322.36 Motorcycle and autocycle dealer business
34 hours.

35 A person in the business of selling motorcycles

1 or autocycles under chapter 322D is not required
2 to maintain regular business hours at the dealer's
3 principal place of business or other place of business.

4 Sec. _____. Section 322D.1, subsection 2, Code 2016,
5 is amended to read as follows:

6 2. "Attachment" means a machine or part of a
7 machine designed to be used on and in conjunction with
8 a farm implement, motorcycle, autocycle, all-terrain
9 vehicle, or snowmobile.

10 Sec. _____. Section 322D.1, Code 2016, is amended by
11 adding the following new subsection:

12 NEW SUBSECTION. 2A. "Autocycle" means as defined
13 in section 321.1.

14 Sec. _____. Section 322D.1, subsection 4, paragraphs
15 b and e, Code 2016, are amended to read as follows:

16 b. The franchisee is granted the right to offer
17 and sell farm implements, motorcycles, autocycles,
18 all-terrain vehicles, snowmobiles, or related parts
19 or attachments manufactured or distributed by the
20 franchiser.

21 e. The operation of the franchisee's business
22 is substantially reliant on the franchiser for the
23 continued supply of farm implements, motorcycles,
24 autocycles, all-terrain vehicles, snowmobiles, or
25 related parts or attachments.

26 Sec. _____. Section 322D.1, subsections 5, 6, and 7,
27 Code 2016, are amended to read as follows:

28 5. "Franchisee" means a person who receives farm
29 implements, motorcycles, autocycles, all-terrain
30 vehicles, snowmobiles, or related parts or attachments
31 from the franchiser under a franchise and who offers
32 and sells the farm implements, motorcycles, autocycles,
33 all-terrain vehicles, snowmobiles, or related parts or
34 attachments to the general public.

35 6. "Franchiser" means a person who manufactures,

1 wholesales, or distributes farm implements,
2 motorcycles, autocycles, all-terrain vehicles,
3 snowmobiles, or related parts or attachments, and who
4 enters into a franchise.

5 7. "Motorcycle" means a motor vehicle as defined
6 in section 321.1 other than an all-terrain vehicle,
7 which has a saddle or seat for the use of a rider and
8 that is designed to travel on not more than two wheels
9 in contact with the ground, but excluding a motorized
10 bicycle or autocycle as defined in section 321.1.

11 Sec. _____. Section 322D.2, Code 2016, is amended to
12 read as follows:

13 322D.2 Franchisee's rights to payment.

14 1. A franchisee who enters into a written
15 franchise with a franchiser to maintain a stock of
16 farm implements, motorcycles, autocycles, all-terrain
17 vehicles, snowmobiles, or related parts or attachments
18 has the following rights to payment, at the option of
19 the franchisee, if the franchise is terminated:

20 a. One hundred percent of the net cost of new,
21 unused, complete farm implements, motorcycles,
22 autocycles, all-terrain vehicles, snowmobiles, or
23 related attachments, which were purchased from the
24 franchiser. In addition, the franchisee shall have
25 a right of payment for transportation charges on the
26 farm implements, motorcycles, autocycles, all-terrain
27 vehicles, or snowmobiles, which have been paid by the
28 franchisee.

29 b. Eighty-five percent of the net prices of any
30 repair parts, including superseded parts, which
31 were purchased from the franchiser and held by the
32 franchisee on the date that the franchise terminated.

33 c. Five percent of the net prices of parts resold
34 under paragraph "b" for handling, packing, and loading
35 of the parts. However, this payment shall not be due

1 to the franchisee if the franchiser elects to perform
2 the handling, packing, and loading.

3 2. Upon receipt of the payments due under
4 subsection 1, the franchiser is entitled to possession
5 of and title to the farm implements, motorcycles,
6 autocycles, all-terrain vehicles, snowmobiles, or
7 related parts or attachments.

8 3. The cost of farm implements, motorcycles,
9 autocycles, all-terrain vehicles, snowmobiles, or
10 related attachments and the price of repair parts shall
11 be determined by reference to the franchiser's price
12 list or catalog in effect at the time of the franchise
13 termination.

14 Sec. _____. Section 322D.3, subsections 7 and 9, Code
15 2016, are amended to read as follows:

16 7. A farm implement, motorcycle, autocycle,
17 all-terrain vehicle, or snowmobile which is not in new,
18 unused, undamaged, or complete condition.

19 9. A farm implement, motorcycle, autocycle,
20 all-terrain vehicle, or snowmobile which was purchased
21 twenty-four months or more prior to the termination of
22 the franchise.

23 Sec. _____. Section 322D.8, Code 2016, is amended to
24 read as follows:

25 322D.8 Application ---- motorcycle or autocycle
26 franchise agreements.

27 The rights under section 322D.2, subsection 1,
28 apply to motorcycle or autocycle franchise agreements
29 in effect on July 1, 1985, which have no expiration
30 date and are continuing agreements, and to those
31 entered into or renewed after July 1, 1985, but only to
32 motorcycles, autocycles, and motorcycle or autocycle
33 attachments and parts purchased after July 1, 1985.

34 Sec. _____. Section 322G.2, subsection 13, Code 2016,
35 is amended to read as follows:

1 13. "Motor vehicle" means a self-propelled vehicle
2 purchased or leased in this state, except as provided
3 in section 322G.15, and primarily designed for the
4 transportation of persons or property over public
5 streets and highways, but does not include mopeds,
6 motorcycles, autocycles, motor homes, or vehicles over
7 fifteen thousand pounds gross vehicle weight rating.>>

8 2. By renumbering as necessary.

By B. MOORE of Jackson

HOUSE FILE 2438

H-8143

1 Amend House File 2438 as follows:
2 1. Page 10, after line 24 by inserting:
3 <k. For each eligible business issued a renewable
4 chemical production tax credit during each calendar
5 year:
6 (1) The identity of the eligible business.
7 (2) The amount of the tax credit.
8 (3) The manner in which the eligible business first
9 qualified as an eligible business under section 15.317,
10 subsection 4, whether by organizing, expanding, or
11 locating in the state.
12 1. The total amount of all renewable chemical
13 production tax credits claimed during each calendar
14 year, and the portion of the claims issued as refunds.>
15 2. Page 10, line 29, by striking <business> and
16 inserting <business, except as provided in subsection
17 2, paragraph "k">
18 3. Page 10, line 35, by striking <Sections> and
19 inserting <Section>

By HANUSA of Pottawattamie

H-8143 FILED MARCH 23, 2016

SENATE FILE 453

H-8141

1 Amend the amendment, H-8086, to Senate File 453, as
2 passed by the Senate, as follows:

3 1. Page 2, after line 9 by inserting:

4 <c. The board shall not issue a special or
5 limited-use pharmacy license to a proposed telepharmacy
6 site if a licensed pharmacy that dispenses prescription
7 drugs to outpatients is located within ten miles of
8 the proposed telepharmacy site unless the proposed
9 telepharmacy site is located on property owned,
10 operated, or leased by the state or unless the proposed
11 telepharmacy site is located within a hospital campus
12 and is limited to inpatient dispensing. The mileage
13 requirement does not apply to a telepharmacy site that
14 has been approved by the board and is operating as a
15 telepharmacy prior to July 1, 2016.

16 d. An applicant seeking a special or limited-use
17 pharmacy licensed for a proposed telepharmacy site that
18 does not meet the mileage requirement established in
19 paragraph "c" and is not statutorily exempt from the
20 mileage requirement may apply to the board for a waiver
21 of the mileage requirement. A waiver request shall
22 only be granted if the applicant can demonstrate to the
23 board that the proposed telepharmacy site is located
24 in an area where there is limited access to pharmacy
25 services and can establish the existence of compelling
26 circumstances that justify waiving the mileage
27 requirement. The board's decision to grant or deny a
28 waiver request shall be a proposed decision subject to
29 mandatory review by the director of the department of
30 public health. The director shall review a proposed
31 decision and shall have the power to approve, modify,
32 or veto a proposed decision. The director's decision
33 on a waiver request shall be considered final agency
34 action subject to judicial review under chapter 17A.>

35 2. Page 2, line 10, by striking <c.> and inserting <e.>

By BEST of Carroll

H-8141 FILED MARCH 23, 2016

SENATE FILE 2109

H-8144

1 Amend Senate File 2109, as passed by the Senate, as
2 follows:

3 1. Page 1, line 2, after <SERVICES> by inserting
4 <---- MEDICAID PROGRAM ENHANCEMENT>

5 2. Page 1, after line 2 by inserting:

6 <Section 1. LEGISLATIVE FINDINGS ---- GOALS AND
7 INTENT.

8 1. The general assembly finds all of the following:

9 a. In the majority of states, Medicaid managed care
10 has been introduced on an incremental basis, beginning
11 with the enrollment of low-income children and parents
12 and proceeding in stages to include nonelderly persons
13 with disabilities and older individuals. Iowa, unlike
14 the majority of states, is implementing Medicaid
15 managed care simultaneously across a broad and diverse
16 population that includes individuals with complex
17 health care and long-term services and supports needs,
18 making these individuals especially vulnerable to
19 receiving inappropriate, inadequate, or substandard
20 services and supports.

21 b. The success or failure of Medicaid managed
22 care in Iowa depends on proper strategic planning and
23 strong oversight, and the incorporation of the core
24 values, principles, and goals of the strategic plan
25 into Medicaid managed care contractual obligations.
26 While Medicaid managed care techniques may create
27 pathways and offer opportunities toward quality
28 improvement and predictability in costs, if cost
29 savings and administrative efficiencies are the
30 primary goals, Medicaid managed care may instead erect
31 new barriers and limit the care and support options
32 available, especially to high-need, vulnerable Medicaid
33 recipients. A well-designed strategic plan and
34 effective oversight ensure that cost savings, improved
35 health outcomes, and efficiencies are not achieved

H-8144

1 at the expense of diminished program integrity, a
2 reduction in the quality or availability of services,
3 or adverse consequences to the health and well-being of
4 Medicaid recipients.

5 c. Strategic planning should include all of the
6 following:

7 (1) Guidance in establishing and maintaining a
8 robust and appropriate workforce and a provider network
9 capable of addressing all of the diverse, distinct, and
10 wide-ranging treatment and support needs of Medicaid
11 recipients.

12 (2) Developing a sound methodology for establishing
13 and adjusting capitation rates to account for all
14 essential costs involved in treating and supporting the
15 entire spectrum of needs across recipient populations.

16 (3) Addressing the sufficiency of information and
17 data resources to enable review of factors such as
18 utilization, service trends, system performance, and
19 outcomes.

20 (4) Building effective working relationships and
21 developing strategies to support community-level
22 integration that provides cross-system coordination
23 and synchronization among the various service sectors,
24 providers, agencies, and organizations to further
25 holistic well-being and population health goals.

26 d. While the contracts entered into between the
27 state and managed care organizations function as a
28 mechanism for enforcing requirements established by the
29 federal and state governments and allow states to shift
30 the financial risk associated with caring for Medicaid
31 recipients to these contractors, the state ultimately
32 retains responsibility for the Medicaid program and
33 the oversight of the performance of the program's
34 contractors. Administration of the Medicaid program
35 benefits by managed care organizations should not be

1 viewed by state policymakers and state agencies as a
2 means of divesting themselves of their constitutional
3 and statutory responsibilities to ensure that
4 recipients of publicly funded services and supports, as
5 well as taxpayers in general, are effectively served.

6 e. Overseeing the performance of Medicaid managed
7 care contractors requires a different set of skills
8 than those required for administering a fee-for-service
9 program. In the absence of the in-house capacity of
10 the department of human services to perform tasks
11 specific to Medicaid managed care oversight, the state
12 essentially cedes its responsibilities to private
13 contractors and relinquishes its accountability to the
14 public. In order to meet these responsibilities, state
15 policymakers must ensure that the state, including the
16 department of human services as the state Medicaid
17 agency, has the authority and resources, including
18 the adequate number of qualified personnel and the
19 necessary tools, to carry out these responsibilities,
20 provide effective administration, and ensure
21 accountability and compliance.

22 f. State policymakers must also ensure that
23 Medicaid managed care contracts contain, at a minimum,
24 clear, unambiguous performance standards, operating
25 guidelines, data collection, maintenance, retention,
26 and reporting requirements, and outcomes expectations
27 so that contractors and subcontractors are held
28 accountable to clear contract specifications.

29 g. As with all system and program redesign efforts
30 undertaken in the state to date, the assumption
31 of the administration of Medicaid program benefits
32 by managed care organizations must involve ongoing
33 stakeholder input and earn the trust and support of
34 these stakeholders. Medicaid recipients, providers,
35 advocates, and other stakeholders have intimate

1 knowledge of the people and processes involved in
2 ensuring the health and safety of Medicaid recipients,
3 and are able to offer valuable insight into the
4 barriers likely to be encountered as well as propose
5 solutions for overcoming these obstacles. Local
6 communities and providers of services and supports
7 have firsthand experience working with the Medicaid
8 recipients they serve and are able to identify factors
9 that must be considered to make a system successful.
10 Agencies and organizations that have specific expertise
11 and experience with the services and supports needs of
12 Medicaid recipients and their families are uniquely
13 placed to provide needed assistance in developing
14 the measures for and in evaluating the quality of the
15 program.

16 2. It is the intent of the general assembly that
17 the Medicaid program be implemented and administered,
18 including through Medicaid managed care policies
19 and contract provisions, in a manner that safeguards
20 the interests of Medicaid recipients, encourages the
21 participation of Medicaid providers, and protects
22 the interests of all taxpayers, while attaining the
23 goals of Medicaid modernization to improve quality and
24 access, promote accountability for outcomes, and create
25 a more predictable and sustainable Medicaid budget.

26 HEALTH POLICY OVERSIGHT COMMITTEE

27 Sec. _____. Section 2.45, subsection 6, Code 2016, is
28 amended to read as follows:

29 6. The legislative health policy oversight
30 committee, which shall be composed of ten members of
31 the general assembly, consisting of five members from
32 each house, to be appointed by the legislative council.
33 The legislative health policy oversight committee
34 shall ~~receive updates and review data, public input and~~
35 ~~concerns, and make recommendations for improvements to~~

~~1 and changes in law or rule regarding Medicaid managed
2 care meet at least four times annually to evaluate
3 state health policy and provide continuing oversight
4 for publicly funded programs, including but not limited
5 to all facets of the Medicaid and hawk-i programs
6 to, at a minimum, ensure effective and efficient
7 administration of these programs, address stakeholder
8 concerns, monitor program costs and expenditures, and
9 make recommendations relative to the programs.~~

10 Sec. ____ . HEALTH POLICY OVERSIGHT COMMITTEE

11 ---- SUBJECT MATTER REVIEW FOR 2016 LEGISLATIVE

12 INTERIM. During the 2016 legislative interim, the
13 health policy oversight committee created in section
14 2.45 shall, as part of the committee's evaluation
15 of state health policy and review of all facets of
16 the Medicaid and hawk-i programs, review and make
17 recommendations regarding, at a minimum, all of the
18 following:

19 1. The resources and duties of the office of
20 long-term care ombudsman relating to the provision of
21 assistance to and advocacy for Medicaid recipients
22 to determine the designation of duties and level of
23 resources necessary to appropriately address the needs
24 of such individuals. The committee shall consider the
25 health consumer ombudsman alliance report submitted to
26 the general assembly in December 2015, as well as input
27 from the office of long-term care ombudsman and other
28 entities in making recommendations.

29 2. The health benefits and health benefit
30 utilization management criteria for the Medicaid
31 and hawk-i programs to determine the sufficiency
32 and appropriateness of the benefits offered and the
33 utilization of these benefits.

34 3. Prior authorization requirements relative
35 to benefits provided under the Medicaid and hawk-i

1 programs, including but not limited to pharmacy
2 benefits.

3 4. Consistency and uniformity in processes,
4 procedures, forms, and other activities across all
5 Medicaid and hawk-i program participating insurers and
6 managed care organizations, including but not limited
7 to cost and quality reporting, credentialing, billing,
8 prior authorization, and critical incident reporting.

9 5. Provider network adequacy including the use of
10 out-of-network and out-of-state providers.

11 6. The role and interplay of other advisory and
12 oversight entities, including but not limited to the
13 medical assistance advisory council and the hawk-i
14 board.

15 REVIEW OF PROGRAM INTEGRITY DUTIES

16 Sec. ____ REVIEW OF PROGRAM INTEGRITY DUTIES ----
17 WORKGROUP ---- REPORT.

18 1. The director of human services shall convene
19 a workgroup comprised of members including the
20 commissioner of insurance, the auditor of state, the
21 Medicaid director and bureau chiefs of the managed care
22 organization oversight and supports bureau, the Iowa
23 Medicaid enterprise support bureau, and the medical
24 and long-term services and supports bureau, and a
25 representative of the program integrity unit, or their
26 designees; and representatives of other appropriate
27 state agencies or other entities including but not
28 limited to the office of the attorney general, the
29 office of long-term care ombudsman, and the Medicaid
30 fraud control unit of the investigations division
31 of the department of inspections and appeals. The
32 workgroup shall do all of the following:

33 a. Review the duties of each entity with
34 responsibilities relative to Medicaid program integrity
35 and managed care organizations; review state and

1 federal laws, regulations, requirements, guidance, and
2 policies relating to Medicaid program integrity and
3 managed care organizations; and review the laws of
4 other states relating to Medicaid program integrity
5 and managed care organizations. The workgroup shall
6 determine areas of duplication, fragmentation,
7 and gaps; shall identify possible integration,
8 collaboration and coordination of duties; and shall
9 determine whether existing general state Medicaid
10 program and fee-for-service policies, laws, and
11 rules are sufficient, or if changes or more specific
12 policies, laws, and rules are required to provide
13 for comprehensive and effective administration and
14 oversight of the Medicaid program including under the
15 fee-for-service and managed care methodologies.

16 b. Review historical uses of the Medicaid
17 fraud fund created in section 249A.50 and make
18 recommendations for future uses of the moneys in the
19 fund and any changes in law necessary to adequately
20 address program integrity.

21 c. Review medical loss ratio provisions relative
22 to Medicaid managed care contracts and make
23 recommendations regarding, at a minimum, requirements
24 for the necessary collection, maintenance, retention,
25 reporting, and sharing of data and information by
26 Medicaid managed care organizations for effective
27 determination of compliance, and to identify the
28 costs and activities that should be included in the
29 calculation of administrative costs, medical costs or
30 benefit expenses, health quality improvement costs,
31 and other costs and activities incidental to the
32 determination of a medical loss ratio.

33 d. Review the capacity of state agencies, including
34 the need for specialized training and expertise, to
35 address Medicaid and managed care organization program

1 integrity and provide recommendations for the provision
2 of necessary resources and infrastructure, including
3 annual budget projections.

4 e. Review the incentives and penalties applicable
5 to violations of program integrity requirements to
6 determine their adequacy in combating waste, fraud,
7 abuse, and other violations that divert limited
8 resources that would otherwise be expended to safeguard
9 the health and welfare of Medicaid recipients, and make
10 recommendations for necessary adjustments to improve
11 compliance.

12 f. Make recommendations regarding the quarterly and
13 annual auditing of financial reports required to be
14 performed for each Medicaid managed care organization
15 to ensure that the activities audited provide
16 sufficient information to the division of insurance
17 of the department of commerce and the department
18 of human services to ensure program integrity. The
19 recommendations shall also address the need for
20 additional audits or other reviews of managed care
21 organizations.

22 g. Review and make recommendations to prohibit
23 cost-shifting between state and local and public and
24 private funding sources for services and supports
25 provided to Medicaid recipients whether directly or
26 indirectly through the Medicaid program.

27 2. The department of human services shall submit
28 a report of the workgroup to the governor, the health
29 policy oversight committee created in section 2.45,
30 and the general assembly initially, on or before
31 November 15, 2016, and on or before November 15,
32 on an annual basis thereafter, to provide findings
33 and recommendations for a coordinated approach
34 to comprehensive and effective administration and
35 oversight of the Medicaid program including under the

1 fee-for-service and managed care methodologies.

2 MEDICAID REINVESTMENT FUND

3 MEDICAID OMBUDSMAN

4 Sec. _____. Section 231.44, Code 2016, is amended to
5 read as follows:

6 231.44 Utilization of resources ---- assistance and
7 advocacy related to long-term services and supports
8 under the Medicaid program.

9 1. The office of long-term care ombudsman ~~may~~
10 shall utilize its available resources to provide
11 assistance and advocacy services to eligible recipients
12 of long-term services and supports, or individuals
13 seeking long-term services and supports, and the
14 families or legal representatives of such eligible
15 recipients, of long-term services and supports provided
16 through individuals under the Medicaid program. Such
17 assistance and advocacy shall include but is not
18 limited to all of the following:

19 a. Assisting recipients such individuals in
20 understanding the services, coverage, and access
21 provisions and their rights under Medicaid managed
22 care.

23 b. Developing procedures for the tracking and
24 reporting of the outcomes of individual requests for
25 assistance, the obtaining of necessary services and
26 supports, and other aspects of the services provided to
27 eligible recipients such individuals.

28 c. Providing advice and assistance relating to the
29 preparation and filing of complaints, grievances, and
30 appeals of complaints or grievances, including through
31 processes available under managed care plans and the
32 state appeals process, relating to long-term services
33 and supports under the Medicaid program.

34 d. Accessing the results of a review of a level
35 of care assessment or reassessment by a managed care

1 organization in which the managed care organization
2 recommends denial or limited authorization of a
3 service, including the type or level of service, the
4 reduction, suspension, or termination of a previously
5 authorized service, or a change in level of care, upon
6 the request of an affected individual.

7 e. Receiving notices of disenrollment or notices
8 that would result in a change in level of care for
9 affected individuals, including involuntary and
10 voluntary discharges or transfers, from the department
11 of human services or a managed care organization.

12 2. A representative of the office of long-term care
13 ombudsman providing assistance and advocacy services
14 authorized under this section for an individual,
15 shall be provided access to the individual, and shall
16 be provided access to the individual's medical and
17 social records as authorized by the individual or the
18 individual's legal representative, as necessary to
19 carry out the duties specified in this section.

20 3. A representative of the office of long-term care
21 ombudsman providing assistance and advocacy services
22 authorized under this section for an individual, shall
23 be provided access to administrative records related to
24 the provision of the long-term services and supports to
25 the individual, as necessary to carry out the duties
26 specified in this section.

27 4. The office of long-term care ombudsman and
28 representatives of the office, when providing
29 assistance and advocacy services under this section,
30 shall be considered a health oversight agency as
31 defined in 45 C.F.R. {164.501 for the purposes of
32 health oversight activities as described in 45 C.F.R.
33 {164.512(d) including access to the health records
34 and other appropriate information of an individual,
35 including from the department of human services or

1 the applicable Medicaid managed care organization,
2 as necessary to fulfill the duties specified under
3 this section. The department of human services,
4 in collaboration with the office of long-term care
5 ombudsman, shall adopt rules to ensure compliance
6 by affected entities with this subsection and to
7 ensure recognition of the office of long-term care
8 ombudsman as a duly authorized and identified agent or
9 representative of the state.

10 5. The department of human services and Medicaid
11 managed care organizations shall inform eligible
12 and potentially eligible Medicaid recipients of the
13 advocacy services and assistance available through the
14 office of long-term care ombudsman and shall provide
15 contact and other information regarding the advocacy
16 services and assistance to eligible and potentially
17 eligible Medicaid recipients as directed by the office
18 of long-term care ombudsman.

19 6. When providing assistance and advocacy services
20 under this section, the office of long-term care
21 ombudsman shall act as an independent agency, and the
22 office of long-term care ombudsman and representatives
23 of the office shall be free of any undue influence that
24 restrains the ability of the office or the office's
25 representatives from providing such services and
26 assistance.

27 7. The office of long-term care ombudsman shall, in
28 addition to other duties prescribed and at a minimum,
29 do all of the following in the furtherance of the
30 provision of advocacy services and assistance under
31 this section:

32 a. Represent the interests of eligible and
33 potentially eligible Medicaid recipients before
34 governmental agencies.

35 b. Analyze, comment on, and monitor the development

1 and implementation of federal, state, and local laws,
2 regulations, and other governmental policies and
3 actions, and recommend any changes in such laws,
4 regulations, policies, and actions as determined
5 appropriate by the office of long-term care ombudsman.

6 c. To maintain transparency and accountability for
7 activities performed under this section, including
8 for the purposes of claiming federal financial
9 participation for activities that are performed to
10 assist with administration of the Medicaid program:

11 (1) Have complete and direct responsibility for the
12 administration, operation, funding, fiscal management,
13 and budget related to such activities, and directly
14 employ, oversee, and supervise all paid and volunteer
15 staff associated with these activities.

16 (2) Establish separation-of-duties requirements,
17 provide limited access to work space and work
18 product for only necessary staff, and limit access to
19 documents and information as necessary to maintain the
20 confidentiality of the protected health information of
21 individuals served under this section.

22 (3) Collect and submit, annually, to the governor,
23 the health policy oversight committee created in
24 section 2.45, and the general assembly, all of the
25 following with regard to those seeking advocacy
26 services or assistance under this section:

27 (a) The number of contacts by contact type and
28 geographic location.

29 (b) The type of assistance requested including the
30 name of the managed care organization involved, if
31 applicable.

32 (c) The time frame between the time of the initial
33 contact and when an initial response was provided.

34 (d) The amount of time from the initial contact to
35 resolution of the problem or concern.

1 (e) The actions taken in response to the request
2 for advocacy or assistance.

3 (f) The outcomes of requests to address problems or
4 concerns.

5 ~~4.~~ 8. For the purposes of this section:

6 a. "Institutional setting" includes a long-term care
7 facility, an elder group home, or an assisted living
8 program.

9 b. "Long-term services and supports" means the broad
10 range of health, health-related, and personal care
11 assistance services and supports, provided in both
12 institutional settings and home and community-based
13 settings, necessary for older individuals and persons
14 with disabilities who experience limitations in their
15 capacity for self-care due to a physical, cognitive, or
16 mental disability or condition.

17 Sec. ____ NEW SECTION. 231.44A Willful
18 interference with duties related to long-term services
19 and supports ---- penalty.

20 Willful interference with a representative of the
21 office of long-term care ombudsman in the performance
22 of official duties in accordance with section 231.44
23 is a violation of section 231.44, subject to a penalty
24 prescribed by rule. The office of long-term care
25 ombudsman shall adopt rules specifying the amount of a
26 penalty imposed, consistent with the penalties imposed
27 under section 231.42, subsection 8, and specifying
28 procedures for notice and appeal of penalties imposed.
29 Any moneys collected pursuant to this section shall be
30 deposited in the Medicaid reinvestment fund created in
31 section 249A.4C.

32 MEDICAL ASSISTANCE ADVISORY COUNCIL

33 Sec. ____ Section 249A.4B, Code 2016, is amended to
34 read as follows:

35 249A.4B Medical assistance advisory council.

1 1. A medical assistance advisory council is
2 created to comply with 42 C.F.R. {431.12 based on
3 section 1902(a)(4) of the federal Social Security Act
4 and to advise the director about health and medical
5 care services under the ~~medical assistance~~ Medicaid
6 program, participate in Medicaid policy development
7 and program administration, and provide guidance on
8 key issues related to the Medicaid program, whether
9 administered under a fee-for-service, managed care, or
10 other methodology, including but not limited to access
11 to care, quality of care, and service delivery.

12 a. The council shall have the opportunity for
13 participation in policy development and program
14 administration, including furthering the participation
15 of recipients of the program, and without limiting this
16 general authority shall specifically do all of the
17 following:

18 (1) Formulate, review, evaluate, and recommend
19 policies, rules, agency initiatives, and legislation
20 pertaining to the Medicaid program. The council shall
21 have the opportunity to comment on proposed rules
22 prior to commencement of the rulemaking process and on
23 waivers and state plan amendment applications.

24 (2) Prior to the annual budget development process,
25 engage in setting priorities, including consideration
26 of the scope and utilization management criteria
27 for benefits, beneficiary eligibility, provider and
28 services reimbursement rates, and other budgetary
29 issues.

30 (3) Provide oversight for and review of the
31 administration of the Medicaid program.

32 (4) Ensure that the membership of the council
33 effectively represents all relevant and concerned
34 viewpoints, particularly those of consumers, providers,
35 and the general public; create public understanding;

1 and ensure that the services provided under the
2 Medicaid program meet the needs of the people served.

3 b. The council shall meet ~~no more than~~ at least
4 quarterly, and prior to the next subsequent meeting
5 of the executive committee. ~~The director of public~~
6 ~~health~~ The public member acting as a co-chairperson
7 of the executive committee and the professional or
8 business entity member acting as a co-chairperson of
9 the executive committee, shall serve as ~~chairperson~~
10 co-chairpersons of the council.

11 2. The council shall include all of the following
12 voting members:

13 a. The president, or the president's
14 representative, of each of the following professional
15 or business entities, or a member of each of the
16 following professional or business entities, selected
17 by the entity:

- 18 (1) The Iowa medical society.
- 19 (2) The Iowa osteopathic medical association.
- 20 (3) The Iowa academy of family physicians.
- 21 (4) The Iowa chapter of the American academy of
22 pediatrics.
- 23 (5) The Iowa physical therapy association.
- 24 (6) The Iowa dental association.
- 25 (7) The Iowa nurses association.
- 26 (8) The Iowa pharmacy association.
- 27 (9) The Iowa podiatric medical society.
- 28 (10) The Iowa optometric association.
- 29 (11) The Iowa association of community providers.
- 30 (12) The Iowa psychological association.
- 31 (13) The Iowa psychiatric society.
- 32 (14) The Iowa chapter of the national association
33 of social workers.
- 34 (15) The coalition for family and children's
35 services in Iowa.

- 1 (16) The Iowa hospital association.
- 2 (17) The Iowa association of rural health clinics.
- 3 (18) The Iowa primary care association.
- 4 (19) Free clinics of Iowa.
- 5 (20) The opticians' association of Iowa, inc.
- 6 (21) The Iowa association of hearing health
- 7 professionals.
- 8 (22) The Iowa speech and hearing association.
- 9 (23) The Iowa health care association.
- 10 (24) The Iowa association of area agencies on
- 11 aging.
- 12 (25) AARP.
- 13 (26) The Iowa caregivers association.
- 14 (27) The Iowa coalition of home and community-based
- 15 services for seniors.
- 16 (28) The Iowa adult day services association.
- 17 (29) Leading age Iowa.
- 18 (30) The Iowa association for home care.
- 19 (31) The Iowa council of health care centers.
- 20 (32) The Iowa physician assistant society.
- 21 (33) The Iowa association of nurse practitioners.
- 22 (34) The Iowa nurse practitioner society.
- 23 (35) The Iowa occupational therapy association.
- 24 (36) The ARC of Iowa, formerly known as the
- 25 association for retarded citizens of Iowa.
- 26 (37) The national alliance for the mentally ill on
- 27 mental illness of Iowa.
- 28 (38) The Iowa state association of counties.
- 29 (39) The Iowa developmental disabilities council.
- 30 (40) The Iowa chiropractic society.
- 31 (41) The Iowa academy of nutrition and dietetics.
- 32 (42) The Iowa behavioral health association.
- 33 (43) The midwest association for medical equipment
- 34 services or an affiliated Iowa organization.
- 35 (44) The Iowa public health association.

1 (45) The epilepsy foundation.

2 b. Public representatives which may include members
3 of consumer groups, including recipients of medical
4 assistance or their families, consumer organizations,
5 and others, which shall be appointed by the governor
6 in equal ~~in~~ number to the number of representatives of
7 the professional and business entities specifically
8 represented under paragraph "a", ~~appointed by the~~
9 governor for staggered terms of two years each, none
10 of whom shall be members of, or practitioners of, or
11 have a pecuniary interest in any of the professional
12 or business entities specifically represented under
13 paragraph "a", and a majority of whom shall be current
14 or former recipients of medical assistance or members
15 of the families of current or former recipients.

16 3. The council shall include all of the following
17 nonvoting members:

18 ~~e.~~ a. The director of public health, or the
19 director's designee.

20 ~~d.~~ b. The director of the department on aging, or
21 the director's designee.

22 c. The state long-term care ombudsman, or the
23 ombudsman's designee.

24 d. The ombudsman appointed pursuant to section
25 2C.3, or the ombudsman's designee.

26 e. The dean of Des Moines university ---- osteopathic
27 medical center, or the dean's designee.

28 f. The dean of the university of Iowa college of
29 medicine, or the dean's designee.

30 g. The following members of the general assembly,
31 each for a term of two years as provided in section
32 69.16B:

33 (1) Two members of the house of representatives,
34 one appointed by the speaker of the house of
35 representatives and one appointed by the minority

1 leader of the house of representatives from their
2 respective parties.

3 (2) Two members of the senate, one appointed by the
4 president of the senate after consultation with the
5 majority leader of the senate and one appointed by the
6 minority leader of the senate.

7 ~~3.~~ 4. a. An executive committee of the council is
8 created and shall consist of the following members of
9 the council:

10 (1) As voting members:

11 (a) Five of the professional or business entity
12 members designated pursuant to subsection 2, paragraph
13 "a", and selected by the members specified under that
14 paragraph.

15 ~~(2)~~ (b) Five of the public members appointed
16 pursuant to subsection 2, paragraph "b", and selected
17 by the members specified under that paragraph. Of the
18 five public members, at least one member shall be a
19 recipient of medical assistance.

20 ~~(3)~~ (2) As nonvoting members:

21 (a) The director of public health, or the
22 director's designee.

23 (b) The director of the department on aging, or the
24 director's designee.

25 (c) The state long-term care ombudsman, or the
26 ombudsman's designee.

27 (d) The ombudsman appointed pursuant to section
28 2C.3, or the ombudsman's designee.

29 b. The executive committee shall meet on a monthly
30 basis. ~~The director of public health~~ A public member
31 of the executive committee selected by the public
32 members appointed pursuant to subsection 2, paragraph
33 "b", and a professional or business entity member of
34 the executive committee selected by the professional
35 or business entity members appointed pursuant to

1 subsection 2, paragraph "a", shall serve as chairperson
2 co-chairpersons of the executive committee.

3 c. Based upon the deliberations of the council,
4 and the executive committee, and the subcommittees,
5 the executive committee, the council, and the
6 subcommittees, respectively, shall make recommendations
7 to the director, to the health policy oversight
8 committee created in section 2.45, to the general
9 assembly's joint appropriations subcommittee on health
10 and human services, and to the general assembly's
11 standing committees on human resources regarding the
12 budget, policy, and administration of the medical
13 assistance program.

14 5. a. The council shall create the following
15 subcommittees, and may create additional subcommittees
16 as necessary to address Medicaid program policies,
17 administration, budget, and other factors and issues:

18 (1) A stakeholder safeguards subcommittee, for
19 which the co-chairpersons shall be a public member
20 of the council appointed pursuant to subsection 2,
21 paragraph "b", and selected by the public members of
22 the council, and a representative of a professional
23 or business entity appointed pursuant to subsection
24 2, paragraph "a", and selected by the professional or
25 business entity representatives of the council. The
26 mission of the stakeholder safeguards subcommittee
27 is to provide for ongoing stakeholder engagement and
28 feedback on issues affecting Medicaid recipients,
29 providers, and other stakeholders, including but not
30 limited to benefits such as transportation, benefit
31 utilization management, the inclusion of out-of-state
32 and out-of-network providers and the use of single-case
33 agreements, and reimbursement of providers and
34 services.

35 (2) The long-term services and supports

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

28 (3) The transparency, data, and program evaluation
29 subcommittee which shall be chaired by the director of
30 the university of Iowa public policy center, or the
31 director's designee. The mission of the transparency,
32 data, and program evaluation subcommittee is to
33 ensure Medicaid program transparency; ensure the
34 collection, maintenance, retention, reporting, and
35 analysis of sufficient and meaningful data to provide

1 transparency and inform policy development and program
2 effectiveness; support development and administration
3 of a consumer-friendly dashboard; and promote the
4 ongoing evaluation of Medicaid stakeholder satisfaction
5 with the Medicaid program.

6 (4) The program integrity subcommittee which shall
7 be chaired by the Medicaid director, or the director's
8 designee. The mission of the program integrity
9 subcommittee is to ensure that a comprehensive system
10 including specific policies, laws, and rules and
11 adequate resources and measures are in place to
12 effectively administer the program and to maintain
13 compliance with federal and state program integrity
14 requirements.

15 (5) A health workforce subcommittee, co-chaired
16 by the bureau chief of the bureau of oral and health
17 delivery systems of the department of public health,
18 or the bureau chief's designee, and the director of
19 the national alliance on mental illness of Iowa, or
20 the director's designee. The mission of the health
21 workforce subcommittee is to assess the sufficiency
22 and proficiency of the current and projected health
23 workforce; identify barriers to and gaps in health
24 workforce development initiatives and health
25 workforce data to provide foundational, evidence-based
26 information to inform policymaking and resource
27 allocation; evaluate the most efficient application
28 and utilization of roles, functions, responsibilities,
29 activities, and decision-making capacity of health
30 care professionals and other allied and support
31 personnel; and make recommendations for improvement
32 in, and alternative modes of, health care delivery in
33 order to provide a competent, diverse, and sustainable
34 health workforce in the state. The subcommittee shall
35 work in collaboration with the office of statewide

1 clinical education programs of the university of Iowa
2 Carver college of medicine, Des Moines university,
3 Iowa workforce development, and other entities with
4 interest or expertise in the health workforce in
5 carrying out the subcommittee's duties and developing
6 recommendations.

7 b. The co-chairpersons of the council shall
8 appoint members to each subcommittee from the general
9 membership of the council. Consideration in appointing
10 subcommittee members shall include the individual's
11 knowledge about, and interest or expertise in, matters
12 that come before the subcommittee.

13 c. Subcommittees shall meet at the call of the
14 co-chairpersons or chairperson of the subcommittee,
15 or at the request of a majority of the members of the
16 subcommittee.

17 ~~4.~~ 6. For each council meeting, executive
18 committee meeting, or subcommittee meeting, a quorum
19 shall consist of fifty percent of the membership
20 qualified to vote. Where a quorum is present, a
21 position is carried by a majority of the members
22 qualified to vote.

23 7. For each council meeting, other than those
24 held during the time the general assembly is in
25 session, each legislative member of the council shall
26 be reimbursed for actual travel and other necessary
27 expenses and shall receive a per diem as specified in
28 section 7E.6 for each day in attendance, as shall the
29 members of the council, ~~or~~ the executive committee,
30 or a subcommittee, for each day in attendance at a
31 council, executive committee, or subcommittee meeting,
32 who are recipients or the family members of recipients
33 of medical assistance, regardless of whether the
34 general assembly is in session.

35 ~~5.~~ 8. The department shall provide staff support

1 and independent technical assistance to the council,
2 ~~and~~ the executive committee, and the subcommittees.
3 ~~6.~~ 9. The director shall ~~consider~~ comply with
4 the requirements of this section regarding the
5 duties of the council, and the deliberations and
6 recommendations ~~offered by~~ of the council, and the
7 executive committee, and the subcommittees shall be
8 reflected in the director's preparation of medical
9 assistance budget recommendations to the council
10 on human services pursuant to section 217.3, and in
11 implementation of medical assistance program policies,
12 and in administration of the Medicaid program.

13 10. The council, executive committee, and
14 subcommittees shall jointly submit quarterly reports
15 to the health policy oversight committee created in
16 section 2.45 and shall jointly submit a report to the
17 governor and the general assembly initially by January
18 1, 2017, and annually, therefore, summarizing the
19 outcomes and findings of their respective deliberations
20 and any recommendations including but not limited to
21 those for changes in law or policy.

22 11. The council, executive committee, and
23 subcommittees may enlist the services of persons who
24 are qualified by education, expertise, or experience
25 to advise, consult with, or otherwise assist the
26 council, executive committee, or subcommittees in the
27 performance of their duties. The council, executive
28 committee, or subcommittees may specifically enlist
29 the assistance of entities such as the university of
30 Iowa public policy center to provide ongoing evaluation
31 of the Medicaid program and to make evidence-based
32 recommendations to improve the program. The council,
33 executive committee, and subcommittees shall enlist
34 input from the patient-centered health advisory council
35 created in section 135.159, the mental health and

1 disabilities services commission created in section
2 225C.5, the commission on aging created in section
3 231.11, the bureau of substance abuse of the department
4 of public health, the Iowa developmental disabilities
5 council, and other appropriate state and local entities
6 to provide advice to the council, executive committee,
7 and subcommittees.

8 12. The department, in accordance with 42 C.F.R.
9 {431.12, shall seek federal financial participation for
10 the activities of the council, the executive committee,
11 and the subcommittees.

12 PATIENT-CENTERED HEALTH RESOURCES AND INFRASTRUCTURE

13 Sec. _____. Section 135.159, subsection 2, Code 2016,
14 is amended to read as follows:

15 2. a. The department shall establish a
16 patient-centered health advisory council which shall
17 include but is not limited to all of the following
18 members, selected by their respective organizations,
19 and any other members the department determines
20 necessary to assist in the ~~department's duties at~~
21 ~~various stages of~~ development of the medical home
22 system and in the transformation to a patient-centered
23 infrastructure that integrates and coordinates services
24 and supports to address social determinants of health
25 and meet population health goals:

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

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

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

32 (4) A representative of the Iowa dental
33 association.

34 (5) A representative of the Iowa nurses
35 association.

1 (6) A physician and an osteopathic physician
2 licensed pursuant to chapter 148 who are family
3 physicians and members of the Iowa academy of family
4 physicians.

5 (7) A health care consumer.

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

9 (9) A representative of the Iowa developmental
10 disabilities council.

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

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

15 (12) A representative of the Iowa pharmacy
16 association.

17 (13) A representative of the Iowa chiropractic
18 society.

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

21 (15) A representative of the Iowa public health
22 association.

23 (16) A representative of the area agencies on
24 aging.

25 (17) A representative of the mental health and
26 disability services regions.

27 (18) A representative of early childhood Iowa.

28 b. Public members of the patient-centered health
29 advisory council shall receive reimbursement for
30 actual expenses incurred while serving in their
31 official capacity only if they are not eligible for
32 reimbursement by the organization that they represent.

33 c. (1) Beginning July 1, 2016, the
34 patient-centered health advisory council shall
35 do all of the following:

1 (a) Review and make recommendations to the
2 department and to the general assembly regarding
3 the building of effective working relationships and
4 strategies to support state-level and community-level
5 integration, to provide cross-system coordination
6 and synchronization, and to more appropriately align
7 health delivery models and service sectors, including
8 but not limited to public health, aging and disability
9 services agencies, mental health and disability
10 services regions, social services, child welfare, and
11 other providers, agencies, organizations, and sectors
12 to address social determinants of health, holistic
13 well-being, and population health goals. Such review
14 and recommendations shall include a review of funding
15 streams and recommendations for blending and braiding
16 funding to support these efforts.

17 (b) Assist in efforts to evaluate the health
18 workforce to inform policymaking and resource
19 allocation.

20 (2) The patient-centered health advisory council
21 shall submit a report to the department, the health
22 policy oversight committee created in section 2.45, and
23 the general assembly, initially, on or before December
24 15, 2016, and on or before December 15, annually,
25 thereafter, including any findings or recommendations
26 resulting from the council's deliberations.

27 HAWK-I PROGRAM

28 Sec. _____. Section 514I.5, subsection 8, paragraph
29 d, Code 2016, is amended by adding the following new
30 subparagraph:

31 NEW SUBPARAGRAPH. (17) Occupational therapy.

32 Sec. _____. Section 514I.5, subsection 8, Code 2016,
33 is amended by adding the following new paragraph:

34 NEW PARAGRAPH. m. The definition of medically
35 necessary and the utilization management criteria under

1 the hawk-i program in order to ensure that benefits
2 are uniformly and consistently provided across all
3 participating insurers in the type and manner that
4 reflects and appropriately meets the needs, including
5 but not limited to the habilitative and rehabilitative
6 needs, of the child population including those children
7 with special health care needs.

8 MEDICAID PROGRAM POLICY IMPROVEMENT

9 Sec. ____ DIRECTIVES FOR MEDICAID PROGRAM POLICY
10 IMPROVEMENTS. In order to safeguard the interests
11 of Medicaid recipients, encourage the participation
12 of Medicaid providers, and protect the interests
13 of all taxpayers, the department of human services
14 shall comply with or ensure that the specified entity
15 complies with all of the following and shall amend
16 Medicaid managed care contract provisions as necessary
17 to reflect all of the following:

18 1. CONSUMER PROTECTIONS.

19 a. In accordance with 42 C.F.R. {438.420, a
20 Medicaid managed care organization shall continue a
21 recipient's benefits during an appeal process. If, as
22 allowed when final resolution of an appeal is adverse
23 to the Medicaid recipient, the Medicaid managed care
24 organization chooses to recover the costs of the
25 services furnished to the recipient while an appeal is
26 pending, the Medicaid managed care organization shall
27 provide adequate prior notice of potential recovery
28 of costs to the recipient at the time the appeal is
29 filed, and any costs recovered shall be remitted to
30 the department of human services and deposited in the
31 Medicaid reinvestment fund created in section 249A.4C.

32 b. Ensure that each Medicaid managed care
33 organization provides, at a minimum, all the benefits
34 and services deemed medically necessary that were
35 covered, including to the extent and in the same manner

1 and subject to the same prior authorization criteria,
2 by the state program directly under fee for service
3 prior to January 1, 2016. Benefits covered through
4 Medicaid managed care shall comply with the specific
5 requirements in state law applicable to the respective
6 Medicaid recipient population under fee for service.

7 c. Enhance monitoring of the reduction in or
8 suspension or termination of services provided to
9 Medicaid recipients, including reductions in the
10 provision of home and community-based services waiver
11 services or increases in home and community-based
12 services waiver waiting lists. Medicaid managed care
13 organizations shall provide data to the department
14 as necessary for the department to compile periodic
15 reports on the numbers of individuals transferred from
16 state institutions and long-term care facilities to
17 home and community-based services, and the associated
18 savings. Any savings resulting from the transfers as
19 certified by the department shall be deposited in the
20 Medicaid reinvestment fund created in section 249A.4C.

21 d. (1) Require each Medicaid managed care
22 organization to adhere to reasonableness and service
23 authorization standards that are appropriate for and
24 do not disadvantage those individuals who have ongoing
25 chronic conditions or who require long-term services
26 and supports. Services and supports for individuals
27 with ongoing chronic conditions or who require
28 long-term services and supports shall be authorized in
29 a manner that reflects the recipient's continuing need
30 for such services and supports, and limits shall be
31 consistent with a recipient's current needs assessment
32 and person-centered service plan.

33 (2) In addition to other provisions relating to
34 community-based case management continuity of care
35 requirements, Medicaid managed care contractors shall

1 provide the option to the case manager of a Medicaid
2 recipient who retained the case manager during the
3 six months of transition to Medicaid managed care, if
4 the recipient chooses to continue to retain that case
5 manager beyond the six-month transition period and
6 if the case manager is not otherwise a participating
7 provider of the recipient's managed care organization
8 provider network, to enter into a single case agreement
9 to continue to provide case management services to the
10 Medicaid recipient.

11 e. Ensure that Medicaid recipients are provided
12 care coordination and case management by appropriately
13 trained professionals in a conflict-free manner. Care
14 coordination and case management shall be provided
15 in a patient-centered and family-centered manner
16 that requires a knowledge of community supports, a
17 reasonable ratio of care coordinators and case managers
18 to Medicaid recipients, standards for frequency of
19 contact with the Medicaid recipient, and specific and
20 adequate reimbursement.

21 f. A Medicaid managed care contract shall include
22 a provision for continuity and coordination of care
23 for a consumer transitioning to Medicaid managed care,
24 including maintaining existing provider-recipient
25 relationships and honoring the amount, duration, and
26 scope of a recipient's authorized services based on
27 the recipient's medical history and needs. In the
28 initial transition to Medicaid managed care, to ensure
29 the least amount of disruption, Medicaid managed
30 care organizations shall provide, at a minimum, a
31 one-year transition of care period for all provider
32 types, regardless of network status with an individual
33 Medicaid managed care organization.

34 g. Ensure that a Medicaid managed care organization
35 does not arbitrarily deny coverage for medically

1 necessary services based solely on financial reasons
2 and does not shift the responsibility for provision of
3 services or payment of costs of services to another
4 entity to avoid costs or attain savings.

5 h. Ensure that dental coverage, if not integrated
6 into an overall Medicaid managed care contract, is
7 part of the overall holistic, integrated coverage
8 for physical, behavioral, and long-term services and
9 supports provided to a Medicaid recipient.

10 i. Require each Medicaid managed care organization
11 to verify the offering and actual utilization of
12 services and supports and value-added services,
13 an individual recipient's encounters and the costs
14 associated with each encounter, and requests and
15 associated approvals or denials of services.
16 Verification of actual receipt of services and supports
17 and value-added services shall, at a minimum, consist
18 of comparing receipt of service against both what
19 was authorized in the recipient's benefit or service
20 plan and what was actually reimbursed. Value-added
21 services shall not be reportable as allowable medical
22 or administrative costs or factored into rate setting,
23 and the costs of value-added services shall not be
24 passed on to recipients or providers.

25 j. Provide periodic reports to the governor and
26 the general assembly regarding changes in quality of
27 care and health outcomes for Medicaid recipients under
28 managed care compared to quality of care and health
29 outcomes of the same populations of Medicaid recipients
30 prior to January 1, 2016.

31 k. Require each Medicaid managed care organization
32 to maintain records of complaints, grievances, and
33 appeals, and report the number and types of complaints,
34 grievances, and appeals filed, the resolution of each,
35 and a description of any patterns or trends identified

1 to the department of human services and the health
2 policy oversight committee created in section 2.45,
3 on a monthly basis. The department shall review and
4 compile the data on a quarterly basis and make the
5 compilations available to the public. Following review
6 of reports submitted by the department, a Medicaid
7 managed care organization shall take any corrective
8 action required by the department and shall be subject
9 to any applicable penalties.

10 1. Require Medicaid managed care organizations to
11 survey Medicaid recipients, to collect satisfaction
12 data using a uniform instrument, and to provide a
13 detailed analysis of recipient satisfaction as well as
14 various metrics regarding the volume of and timelines
15 in responding to recipient complaints and grievances as
16 directed by the department of human services.

17 m. Require managed care organizations to allow a
18 recipient to request that the managed care organization
19 enter into a single case agreement with a recipient's
20 out-of-network provider, including a provider outside
21 of the state, to provide for continuity of care when
22 the recipient has an existing relationship with the
23 provider to provide a covered benefit, or to ensure
24 adequate or timely access to a provider of a covered
25 benefit when the managed care organization provider
26 network cannot ensure such adequate or timely access.

27 2. CHILDREN.

28 a. (1) The hawk-i board shall retain all authority
29 specified under chapter 514I relative to the children
30 eligible under section 514I.8 to participate in the
31 hawk-i program, including but not limited to approving
32 any contract entered into pursuant to chapter 514I;
33 approving the benefit package design, reviewing the
34 benefit package design, and making necessary changes
35 to reflect the results of the reviews; and adopting

1 rules for the hawk-i program including those related
2 to qualifying standards for selecting participating
3 insurers for the program and the benefits to be
4 included in a health plan.

5 (2) The hawk-i board shall review benefit plans
6 and utilization review provisions and ensure that
7 benefits provided to children under the hawk-i program,
8 at a minimum, reflect those required by state law as
9 specified in section 514I.5, include both habilitative
10 and rehabilitative services, and are provided as
11 medically necessary relative to the child population
12 served and based on the needs of the program recipient
13 and the program recipient's medical history.

14 (3) The hawk-i board shall work with the department
15 of human services to coordinate coverage and care for
16 the population of children in the state eligible for
17 either Medicaid or hawk-i coverage so that, to the
18 greatest extent possible, the two programs provide for
19 continuity of care as children transition between the
20 two programs or to private health care coverage. To
21 this end, all contracts with participating insurers
22 providing coverage under the hawk-i program and with
23 all managed care organizations providing coverage for
24 children eligible for Medicaid shall do all of the
25 following:

26 (a) Specifically and appropriately address
27 the unique needs of children and children's health
28 delivery.

29 (b) Provide for the maintaining of child health
30 panels that include representatives of child health,
31 welfare, policy, and advocacy organizations in the
32 state that address child health and child well-being.

33 (c) Address early intervention and prevention
34 strategies, the provision of a child health care
35 delivery infrastructure for children with special

1 health care needs, utilization of current standards
2 and guidelines for children's health care and
3 pediatric-specific screening and assessment tools,
4 the inclusion of pediatric specialty providers in
5 the provider network, and the utilization of health
6 homes for children and youth with special health
7 care needs including intensive care coordination
8 and family support and access to a professional
9 family-to-family support system. Such contracts
10 shall utilize pediatric-specific quality measures
11 and assessment tools which shall align with existing
12 pediatric-specific measures as determined in
13 consultation with the child health panel and approved
14 by the hawk-i board.

15 (d) Provide special incentives for innovative
16 and evidence-based preventive, behavioral, and
17 developmental health care and mental health care
18 for children's programs that improve the life course
19 trajectory of these children.

20 (e) Provide that information collected from the
21 pediatric-specific assessments be used to identify
22 health risks and social determinants of health that
23 impact health outcomes. Such data shall be used in
24 care coordination and interventions to improve patient
25 outcomes and to drive program designs that improve the
26 health of the population. Aggregate assessment data
27 shall be shared with affected providers on a routine
28 basis.

29 b. In order to monitor the quality of and access
30 to health care for children receiving coverage under
31 the Medicaid program, each Medicaid managed care
32 organization shall uniformly report, in a template
33 format designated by the department of human services,
34 the number of claims submitted by providers and the
35 percentage of claims approved by the Medicaid managed

1 care organization for the early and periodic screening,
2 diagnostic, and treatment (EPSDT) benefit based
3 on the Iowa EPSDT care for kids health maintenance
4 recommendations, including but not limited to
5 physical exams, immunizations, the seven categories of
6 developmental and behavioral screenings, vision and
7 hearing screenings, and lead testing.

8 3. PROVIDER PARTICIPATION ENHANCEMENT.

9 a. Ensure that savings achieved through Medicaid
10 managed care does not come at the expense of further
11 reductions in provider rates. The department shall
12 ensure that Medicaid managed care organizations use
13 reasonable reimbursement standards for all provider
14 types and compensate providers for covered services at
15 not less than the minimum reimbursement established
16 by state law applicable to fee for service for a
17 respective provider, service, or product for a fiscal
18 year and as determined in conjunction with actuarially
19 sound rate setting procedures. Such reimbursement
20 shall extend for the entire duration of a managed care
21 contract.

22 b. To enhance continuity of care in the provision
23 of pharmacy services, Medicaid managed care
24 organizations shall utilize the same preferred drug
25 list, recommended drug list, prior authorization
26 criteria, and other utilization management strategies
27 that apply to the state program directly under fee for
28 service and shall apply other provisions of applicable
29 state law including those relating to chemically unique
30 mental health prescription drugs. Reimbursement rates
31 established under Medicaid managed care contracts for
32 ingredient cost reimbursement and dispensing fees shall
33 be subject to and shall reflect provisions of state
34 and federal law, including the minimum reimbursements
35 established in state law for fee for service for a

1 fiscal year.

2 c. Address rate setting and reimbursement of the
3 entire scope of services provided under the Medicaid
4 program to ensure the adequacy of the provider network
5 and to ensure that providers that contribute to the
6 holistic health of the Medicaid recipient, whether
7 inside or outside of the provider network, are
8 compensated for their services.

9 d. Managed care contractors shall submit financial
10 documentation to the department of human services
11 demonstrating payment of claims and expenses by
12 provider type.

13 e. Participating Medicaid providers under a managed
14 care contract shall be allowed to submit claims for up
15 to 365 days following discharge of a Medicaid recipient
16 from a hospital or following the date of service.

17 f. (1) A managed care contract entered into on
18 or after July 1, 2015, shall, at a minimum, reflect
19 all of the following provisions and requirements, and
20 shall extend the following payment rates based on the
21 specified payment floor, as applicable to the provider
22 type:

23 (a) In calculating the rates for prospective
24 payment system hospitals, the following base rates
25 shall be used:

26 (i) The inpatient diagnostic related group base
27 rates and certified unit per diem in effect on October
28 1, 2015.

29 (ii) The outpatient ambulatory payment
30 classification base rates in effect on July 1, 2015.

31 (iii) The inpatient psychiatric certified unit per
32 diem in effect on October 1, 2015.

33 (iv) The inpatient physical rehabilitation
34 certified unit per diem in effect on October 1, 2015.

35 (b) In calculating the critical access hospital

1 payment rates, the following base rates shall be used:

2 (i) The inpatient diagnostic related group base
3 rates in effect on July 1, 2015.

4 (ii) The outpatient cost-to-charge ratio in effect
5 on July 1, 2015.

6 (iii) The swing bed per diem in effect on July 1,
7 2015.

8 (c) Critical access hospitals shall receive
9 cost-based reimbursement for one hundred percent of
10 the reasonable costs for the provision of services to
11 Medicaid recipients.

12 (d) Critical access hospitals shall submit annual
13 cost reports and managed care contractors shall submit
14 annual payment reports to the department of human
15 services. The department shall reconcile the critical
16 access hospital's reported costs with the managed care
17 contractor's reported payments. The department shall
18 require the managed care contractor to retroactively
19 reimburse a critical access hospital for underpayments.

20 (e) Community mental health centers shall receive
21 one hundred percent of the reasonable costs for the
22 provision of services to Medicaid recipients.

23 (f) Federally qualified health centers shall
24 receive cost-based reimbursement for one hundred
25 percent of the reasonable costs for the provision of
26 services to Medicaid recipients.

27 (g) The reimbursement rates for substance-related
28 disorder treatment programs licensed under section
29 125.13, shall be no lower than the rates in effect for
30 the fiscal year beginning July 1, 2015.

31 (2) For managed care contract periods subsequent to
32 the initial contract period, base rates for prospective
33 payment system hospitals and critical access hospitals
34 shall be calculated using the base rate for the prior
35 contract period plus 3 percent. Prospective payment

1 system hospital and critical access hospital base rates
2 shall at no time be less than the previous contract
3 period's base rates.

4 (3) A managed care contract shall require
5 out-of-network prospective payment system hospital
6 and critical access hospital payment rates to meet or
7 exceed ninety-nine percent of the rates specified for
8 the respective in-network hospitals in accordance with
9 this paragraph "f".

10 g. If the department of human services collects
11 ownership and control information from Medicaid
12 providers pursuant to 42 C.F.R. {455.104, a managed
13 care organization under contract with the state shall
14 not also require submission of this information from
15 approved enrolled Medicaid providers.

16 h. (1) Ensure that a Medicaid managed care
17 organization develops and maintains a provider network
18 of qualified providers who meet state licensing,
19 credentialing, and certification requirements, as
20 applicable, which network shall be sufficient to
21 provide adequate access to all services covered and for
22 all populations served under the managed care contract.
23 Medicaid managed care organizations shall incorporate
24 existing and traditional providers, including but
25 not limited to those providers that comprise the Iowa
26 collaborative safety net provider network created in
27 section 135.153, into their provider networks.

28 (2) Ensure that respective Medicaid populations
29 are managed at all times within funding limitations
30 and contract terms. The department shall also
31 monitor service delivery and utilization to ensure
32 the responsibility for provision of services to
33 Medicaid recipients is not shifted to non-Medicaid
34 covered services to attain savings, and that such
35 responsibility is not shifted to mental health and

1 disability services regions, local public health
2 agencies, aging and disability resource centers,
3 or other entities unless agreement to provide, and
4 provision for adequate compensation for, such services
5 is agreed to between the affected entities in advance.

6 i. Medicaid managed care organizations shall
7 provide an enrolled Medicaid provider approved by the
8 department of human services the opportunity to be a
9 participating network provider.

10 j. Medicaid managed care organizations shall
11 include provider appeals and grievance procedures
12 that in part allow a provider to file a grievance
13 independently but on behalf of a Medicaid recipient
14 and to appeal claims denials which, if determined to
15 be based on claims for medically necessary services
16 whether or not denied on an administrative basis, shall
17 receive appropriate payment.

18 k. (1) Medicaid managed care organizations
19 shall include as primary care providers any provider
20 designated by the state as a primary care provider,
21 subject to a provider's respective state certification
22 standards, including but not limited to all of the
23 following:

24 (a) A physician who is a family or general
25 practitioner, a pediatrician, an internist, an
26 obstetrician, or a gynecologist.

27 (b) An advanced registered nurse practitioner.

28 (c) A physician assistant.

29 (d) A chiropractor licensed pursuant to chapter
30 151.

31 (2) A Medicaid managed care organization shall not
32 impose more restrictive, additional, or different scope
33 of practice requirements or standards of practice on a
34 primary care provider than those prescribed by state
35 law as a prerequisite for participation in the managed

1 care organization's provider network.

2 4. CAPITATION RATES AND MEDICAL LOSS RATIO.

3 a. Capitation rates shall be developed based on all
4 reasonable, appropriate, and attainable costs. Costs
5 that are not reasonable, appropriate, or attainable,
6 including but not limited to improper payment
7 recoveries, shall not be included in the development
8 of capitated rates.

9 b. Capitation rates for Medicaid recipients falling
10 within different rate cells shall not be expected to
11 cross-subsidize one another and the data used to set
12 capitation rates shall be relevant and timely and tied
13 to the appropriate Medicaid population.

14 c. Any increase in capitation rates for managed
15 care contractors is subject to prior statutory approval
16 and shall not exceed three percent over the existing
17 capitation rate in any one-year period or five percent
18 over the existing capitation rate in any two-year
19 period.

20 d. In addition to withholding two percent of a
21 managed care organization's annual capitation payment
22 as a pay-for-performance enforcement mechanism, the
23 department of human services shall also withhold an
24 additional two percent of a managed care organization's
25 annual capitation payment until the department is able
26 to ensure that the respective managed care organization
27 has complied with all requirements relating to data,
28 information, transparency, evaluation, and oversight
29 specified by law, rule, contract, or other basis.

30 e. The department of human services shall collect
31 an initial contribution of five million dollars from
32 each of the managed care organizations contracting
33 with the state during the fiscal year beginning July
34 1, 2015, for an aggregate amount of fifteen million
35 dollars, and shall deposit such amount in the Medicaid

1 reinvestment fund, as provided in section 249A.4C, as
2 enacted in this Act, to be used for Medicaid ombudsman
3 activities through the office of long-term care
4 ombudsman.

5 f. A managed care contract shall impose a minimum
6 Medicaid loss ratio of at least eighty-eight percent.
7 In calculating the medical loss ratio, medical costs
8 or benefit expenses shall include only those costs
9 directly related to patient medical care and not
10 ancillary expenses, including but not limited to any
11 of the following:

- 12 (1) Program integrity activities.
- 13 (2) Utilization review activities.
- 14 (3) Fraud prevention activities beyond the scope of
15 those activities necessary to recover incurred claims.
- 16 (4) Provider network development, education, or
17 management activities.
- 18 (5) Provider credentialing activities.
- 19 (6) Marketing expenses.
- 20 (7) Administrative costs associated with recipient
21 incentives.
- 22 (8) Clinical data collection activities.
- 23 (9) Claims adjudication expenses.
- 24 (10) Customer service or health care professional
25 hotline services addressing nonclinical recipient
26 questions.
- 27 (11) Value-added or cost-containment services,
28 wellness programs, disease management, and case
29 management or care coordination programs.
- 30 (12) Health quality improvement activities unless
31 specifically approved as a medical cost by state law.
32 Costs of health quality improvement activities included
33 in determining the medical loss ratio shall be only
34 those activities that are independent improvements
35 measurable in individual patients.

1 (13) Insurer claims review activities.

2 (14) Information technology costs unless they
3 directly and credibly improve the quality of health
4 care and do not duplicate, conflict with, or fail to be
5 compatible with similar health information technology
6 efforts of providers.

7 (15) Legal department costs including information
8 technology costs, expenses incurred for review and
9 denial of claims, legal costs related to defending
10 claims, settlements for wrongly denied claims, and
11 costs related to administrative claims handling
12 including salaries of administrative personnel and
13 legal costs.

14 (16) Taxes unrelated to premiums or the provision
15 of medical care. Only state and federal taxes and
16 licensing or regulatory fees relevant to actual
17 premiums collected, not including such taxes and fees
18 as property taxes, taxes on investment income, taxes on
19 investment property, and capital gains taxes, may be
20 included in determining the medical loss ratio.

21 g. (1) Provide enhanced guidance and criteria for
22 defining medical and administrative costs, recoveries,
23 and rebates including pharmacy rebates, and the
24 recording, reporting, and recoupment of such costs,
25 recoveries, and rebates realized.

26 (2) Medicaid managed care organizations shall
27 offset recoveries, rebates, and refunds against
28 medical costs, include only allowable administrative
29 expenses in the determination of administrative costs,
30 report costs related to subcontractors properly, and
31 have complete systems checks and review processes to
32 identify overpayment possibilities.

33 (3) Medicaid managed care contractors shall submit
34 publicly available, comprehensive financial statements
35 to the department of human services to verify that the

1 minimum medical loss ratio is being met and shall be
2 subject to periodic audits.

3 5. DATA AND INFORMATION, EVALUATION, AND OVERSIGHT.

4 a. Develop and administer a clear, detailed policy
5 regarding the collection, storage, integration,
6 analysis, maintenance, retention, reporting, sharing,
7 and submission of data and information from the
8 Medicaid managed care organizations and shall require
9 each Medicaid managed care organization to have in
10 place a data and information system to ensure that
11 accurate and meaningful data is available. At a
12 minimum, the data shall allow the department to
13 effectively measure and monitor Medicaid managed care
14 organization performance, quality, outcomes including
15 recipient health outcomes, service utilization,
16 finances, program integrity, the appropriateness
17 of payments, and overall compliance with contract
18 requirements; perform risk adjustments and determine
19 actuarially sound capitation rates and appropriate
20 provider reimbursements; verify that the minimum
21 medical loss ratio is being met; ensure recipient
22 access to and use of services; create quality measures;
23 and provide for program transparency.

24 b. Medicaid managed care organizations shall
25 directly capture and retain and shall report actual and
26 detailed medical claims costs and administrative cost
27 data to the department as specified by the department.
28 Medicaid managed care organizations shall allow the
29 department to thoroughly and accurately monitor the
30 medical claims costs and administrative costs data
31 Medicaid managed care organizations report to the
32 department.

33 c. Any audit of Medicaid managed care contracts
34 shall ensure compliance including with respect to
35 appropriate medical costs, allowable administrative

1 costs, the medical loss ratio, cost recoveries,
2 rebates, overpayments, and with specific contract
3 performance requirements.

4 d. The external quality review organization
5 contracting with the department shall review the
6 Medicaid managed care program to determine if the
7 state has sufficient infrastructure and controls in
8 place to effectively oversee the Medicaid managed care
9 organizations and the Medicaid program in order to
10 ensure, at a minimum, compliance with Medicaid managed
11 care organization contracts and to prevent fraud,
12 abuse, and overpayments. The results of any external
13 quality review organization review shall be submitted
14 to the governor, the general assembly, and the health
15 policy oversight committee created in section 2.45.

16 e. Publish benchmark indicators based on Medicaid
17 program outcomes from the fiscal year beginning July 1,
18 2015, to be used to compare outcomes of the Medicaid
19 program as administered by the state program prior
20 to July 1, 2015, to those outcomes of the program
21 under Medicaid managed care. The outcomes shall
22 include a comparison of actual costs of the program
23 as administered prior to and after implementation of
24 Medicaid managed care. The data shall also include
25 specific detail regarding the actual expenses incurred
26 by each managed care organization by specific provider
27 line of service.

28 f. Review and approve or deny approval of contract
29 amendments on an ongoing basis to provide for
30 continuous improvement in Medicaid managed care and
31 to incorporate any changes based on changes in law or
32 policy.

33 g. (1) Require managed care contractors to track
34 and report on a monthly basis to the department of
35 human services, at a minimum, all of the following:

1 (a) The number and details relating to prior
2 authorization requests and denials.

3 (b) The ten most common reasons for claims denials.
4 Information reported by a managed care contractor
5 relative to claims shall also include the number
6 of claims denied, appealed, and overturned based on
7 provider type and service type.

8 (c) Utilization of health care services by
9 diagnostic related group and ambulatory payment
10 classification as well as total claims volume.

11 (2) The department shall ensure the validity
12 of all information submitted by a Medicaid managed
13 care organization and shall make the monthly reports
14 available to the public.

15 h. Medicaid managed care organizations shall
16 maintain stakeholder panels comprised of an equal
17 number of Medicaid recipients and providers. Medicaid
18 managed care organizations shall provide for separate
19 provider-specific panels to address detailed payment,
20 claims, process, and other issues as well as grievance
21 and appeals processes.

22 i. Medicaid managed care contracts shall align
23 economic incentives, delivery system reforms, and
24 performance and outcome metrics with those of the state
25 innovation models initiatives and Medicaid accountable
26 care organizations. The department of human services
27 shall develop and utilize a common, uniform set of
28 process, quality, and consumer satisfaction measures
29 across all Medicaid payors and providers that align
30 with those developed through the state innovation
31 models initiative and shall ensure that such measures
32 are expanded and adjusted to address additional
33 populations and to meet population health objectives.
34 Medicaid managed care contracts shall include long-term
35 performance and outcomes goals that reward success in

1 achieving population health goals such as improved
 2 community health metrics.
 3 j. (1) Require consistency and uniformity of
 4 processes, procedures, and forms across all Medicaid
 5 managed care organizations to reduce the administrative
 6 burden to providers and consumers and to increase
 7 efficiencies in the program. Such requirements shall
 8 apply to but are not limited to areas of uniform cost
 9 and quality reporting, uniform prior authorization
 10 requirements and procedures, uniform utilization
 11 management criteria, centralized, uniform, and seamless
 12 credentialing requirements and procedures, and uniform
 13 critical incident reporting.

14 (2) The department of human services shall
 15 establish a comprehensive provider credentialing
 16 process to be recognized and utilized by all Medicaid
 17 managed care organization contractors. The process
 18 shall meet the national committee for quality assurance
 19 and other appropriate standards. The process shall
 20 ensure that credentialing is completed in a timely
 21 manner without disruption to provider billing
 22 processes.

23 k. Medicaid managed care organizations and any
 24 entity with which a managed care organization contracts
 25 for the performance of services shall disclose at no
 26 cost to the department all discounts, incentives,
 27 rebates, fees, free goods, bundling arrangements, and
 28 other agreements affecting the net cost of goods or
 29 services provided under a managed care contract.

30 Sec. _____. RETROACTIVE APPLICABILITY. The section
 31 of this division of this Act relating to directives
 32 for Medicaid program policy improvements applies
 33 retroactively to July 1, 2015.

34 Sec. _____. EFFECTIVE UPON ENACTMENT. This division
 35 of this Act, being deemed of immediate importance,

1 takes effect upon enactment.>
 2 3. Page 1, by striking line 3 and inserting:
 3 <DIVISION ____
 4 MEDICAID APPROPRIATION
 5 Sec. _____. MEDICAID APPROPRIATION. There is
 6 appropriated from the general>
 7 4. Title page, line 3, before <and> by inserting
 8 <making related program modifications,>
 9 5. Title page, line 4, after <date> by inserting
 10 <and retroactive applicability>
 11 6. By renumbering as necessary.

By HEDDENS of Story

SENATE FILE 2185

H-8142

1 Amend Senate File 2185, as passed by the Senate, as
2 follows:

3 1. Page 1, before line 1 by inserting:

4 <Section 1. NEW SECTION. 702.25 Film.

5 "Film" means capturing moving images upon a
6 membrane or other thin flexible material coated with
7 light sensitive emulsion; capturing moving images
8 electronically or digitally in such a manner that the
9 images are stored by a computer or other electronic
10 device; or receiving moving images in a continuous
11 flow.

12 Sec. ____ . Section 716.7, subsection 1, Code 2016,
13 is amended by adding the following new paragraph:

14 NEW PARAGRAPH. f. "Reasonable expectation of
15 privacy" means circumstances in which a reasonable
16 person would believe that the person could disrobe or
17 partially disrobe in privacy, without being concerned
18 that the person disrobing or partially disrobing was
19 being viewed, photographed, or filmed when doing so.>

20 2. By renumbering as necessary.

By HEARTSILL of Marion
OLSON of Polk

H-8142 FILED MARCH 23, 2016