

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

APRIL 20, 2016

HOUSE FILE 2460

H-8228

1 Amend House File 2460 as follows:
2 1. Page 85, after line 4 by inserting:
3 <REPORTING OF EXISTING DATA REQUIREMENTS, MINUTES, AND
4 RECOMMENDATIONS>
5 2. Page 92, after line 18 by inserting:
6 <DIVISION ____
7 MEDICAID MANAGED CARE ---- ADDITIONAL OVERSIGHT
8 REQUIREMENTS
9 Sec. ____ . LEGISLATIVE FINDINGS ---- GOALS AND INTENT.
10 1. The general assembly finds all of the following:
11 a. In the majority of states, Medicaid managed care
12 has been introduced on an incremental basis, beginning
13 with the enrollment of low-income children and parents
14 and proceeding in stages to include nonelderly persons
15 with disabilities and older individuals. Iowa, unlike
16 the majority of states, is implementing Medicaid
17 managed care simultaneously across a broad and diverse
18 population that includes individuals with complex
19 health care and long-term services and supports needs,
20 making these individuals especially vulnerable to
21 receiving inappropriate, inadequate, or substandard
22 services and supports.
23 b. The success or failure of Medicaid managed
24 care in Iowa depends on proper strategic planning and
25 strong oversight, and the incorporation of the core
26 values, principles, and goals of the strategic plan
27 into Medicaid managed care contractual obligations.
28 While Medicaid managed care techniques may create
29 pathways and offer opportunities toward quality
30 improvement and predictability in costs, if cost
31 savings and administrative efficiencies are the
32 primary goals, Medicaid managed care may instead erect
33 new barriers and limit the care and support options
34 available, especially to high-need, vulnerable Medicaid
35 recipients. A well-designed strategic plan and

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1 effective oversight ensure that cost savings, improved
2 health outcomes, and efficiencies are not achieved
3 at the expense of diminished program integrity, a
4 reduction in the quality or availability of services,
5 or adverse consequences to the health and well-being of
6 Medicaid recipients.

7 c. Strategic planning should include all of the
8 following:

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

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

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

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

28 d. While the contracts entered into between the
29 state and managed care organizations function as a
30 mechanism for enforcing requirements established by the
31 federal and state governments and allow states to shift
32 the financial risk associated with caring for Medicaid
33 recipients to these contractors, the state ultimately
34 retains responsibility for the Medicaid program and
35 the oversight of the performance of the program's

1 contractors. Administration of the Medicaid program
2 benefits by managed care organizations should not be
3 viewed by state policymakers and state agencies as a
4 means of divesting themselves of their constitutional
5 and statutory responsibilities to ensure that
6 recipients of publicly funded services and supports, as
7 well as taxpayers in general, are effectively served.

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

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

31 g. As with all system and program redesign efforts
32 undertaken in the state to date, the assumption
33 of the administration of Medicaid program benefits
34 by managed care organizations must involve ongoing
35 stakeholder input and earn the trust and support of

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

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

28 HEALTH POLICY OVERSIGHT COMMITTEE

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

31 6. The legislative health policy oversight
32 committee, which shall be composed of ten members of
33 the general assembly, consisting of five members from
34 each house, to be appointed by the legislative council.
35 The legislative health policy oversight committee

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

12 Sec. ____ . HEALTH POLICY OVERSIGHT COMMITTEE
13 ---- SUBJECT MATTER REVIEW FOR 2016 LEGISLATIVE
14 INTERIM. During the 2016 legislative interim, the
15 health policy oversight committee created in section
16 2.45 shall, as part of the committee's evaluation
17 of state health policy and review of all facets of
18 the Medicaid and hawk-i programs, review and make
19 recommendations regarding, at a minimum, all of the
20 following:

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

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

1 3. Prior authorization requirements relative
2 to benefits provided under the Medicaid and hawk-i
3 programs, including but not limited to pharmacy
4 benefits.

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

11 5. Provider network adequacy including the use of
12 out-of-network and out-of-state providers.

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

17 REVIEW OF PROGRAM INTEGRITY DUTIES

18 Sec. ____ REVIEW OF PROGRAM INTEGRITY DUTIES ----
19 WORKGROUP ---- REPORT.

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

35 a. Review the duties of each entity with

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

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

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

35 d. Review the capacity of state agencies, including

1 the need for specialized training and expertise, to
2 address Medicaid and managed care organization program
3 integrity and provide recommendations for the provision
4 of necessary resources and infrastructure, including
5 annual budget projections.

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

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

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

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

1 to comprehensive and effective administration and
2 oversight of the Medicaid program including under the
3 fee-for-service and managed care methodologies.

4 MEDICAID REINVESTMENT FUND

5 Sec. ____ . NEW SECTION. 249A.4C Medicaid
6 reinvestment fund.

7 1. A Medicaid reinvestment fund is created in the
8 state treasury under the authority of the department.
9 The department of human services shall collect an
10 initial contribution of five million dollars from each
11 of the managed care organizations contracting with the
12 state during the fiscal year beginning July 1, 2015,
13 for an aggregate amount of fifteen million dollars,
14 and shall deposit such amount in the fund to be used
15 for Medicaid ombudsman activities through the office
16 of long-term care ombudsman. Additionally, moneys
17 from savings realized from the movement of Medicaid
18 recipients from institutional settings to home and
19 community-based services, the portion of the capitation
20 rate withheld from and not returned to Medicaid managed
21 care organizations at the end of each fiscal year, any
22 recouped excess of capitation rates paid to Medicaid
23 managed care organizations, any overpayments recovered
24 under Medicaid managed care contracts, and any other
25 savings realized from Medicaid managed care or from
26 Medicaid program cost-containment efforts, with the
27 exception of the total amount attributable to the
28 projected savings from Medicaid managed care based on
29 the initial capitation rates established for the fiscal
30 year beginning July 1, 2015, shall be credited to the
31 Medicaid reinvestment fund.

32 2. Notwithstanding section 8.33, moneys credited
33 to the fund from any other account or fund shall
34 not revert to the other account or fund. Moneys
35 in the fund shall only be used as provided in

1 appropriations from the fund for the Medicaid program
2 and for health system transformation and integration,
3 including but not limited to providing the necessary
4 infrastructure and resources to protect the interests
5 of Medicaid recipients, maintaining adequate provider
6 participation, and ensuring program integrity. Such
7 uses may include but are not limited to:

8 a. Ensuring appropriate reimbursement of Medicaid
9 providers to maintain the type and number of
10 appropriately trained providers necessary to address
11 the needs of Medicaid recipients.

12 b. Providing home and community-based services
13 as necessary to rebalance the long-term services and
14 supports infrastructure and to reduce Medicaid home and
15 community-based services waiver waiting lists.

16 c. Ensuring that a fully functioning independent
17 Medicaid ombudsman program through the office of
18 long-term care ombudsman is available to provide
19 advocacy services and assistance to eligible and
20 potentially eligible Medicaid recipients.

21 d. Ensuring adequate and appropriate capacity of
22 the department of human services as the single state
23 agency designated to administer and supervise the
24 administration of the Medicaid program, to ensure
25 compliance with state and federal law and program
26 integrity requirements.

27 e. Addressing workforce issues to ensure a
28 competent, diverse, and sustainable health care
29 workforce and to improve access to health care in
30 underserved areas and among underserved populations,
31 recognizing long-term services and supports as an
32 essential component of the health care system.

33 f. Supporting innovation, longer-term community
34 investments, and the activities of local public health
35 agencies, aging and disability resource centers and

1 service agencies, mental health and disability services
2 regions, social services, and child welfare entities
3 and other providers of and advocates for services and
4 supports to encourage health system transformation
5 and integration through a broad range of prevention
6 strategies and population-based approaches to meet the
7 holistic needs of the population as a whole.

8 3. The department shall establish a mechanism to
9 measure and certify the amount of savings resulting
10 from Medicaid managed care and Medicaid program
11 cost-containment activities and shall ensure that such
12 realized savings are credited to the fund and used as
13 provided in appropriations from the fund.

14 MEDICAID OMBUDSMAN

15 Sec. _____. Section 231.44, Code 2016, is amended to
16 read as follows:

17 231.44 Utilization of resources ---- assistance and
18 advocacy related to long-term services and supports
19 under the Medicaid program.

20 1. The office of long-term care ombudsman ~~may~~
21 shall utilize its available resources to provide
22 assistance and advocacy services to eligible recipients
23 of long-term services and supports, or individuals
24 seeking long-term services and supports, and the
25 families or legal representatives of such eligible
26 recipients, of long term services and supports provided
27 through individuals under the Medicaid program. Such
28 assistance and advocacy shall include but is not
29 limited to all of the following:

30 a. Assisting recipients such individuals in
31 understanding the services, coverage, and access
32 provisions and their rights under Medicaid managed
33 care.

34 b. Developing procedures for the tracking and
35 reporting of the outcomes of individual requests for

1 assistance, the obtaining of necessary services and
2 supports, and other aspects of the services provided to
3 eligible recipients such individuals.

4 c. Providing advice and assistance relating to the
5 preparation and filing of complaints, grievances, and
6 appeals of complaints or grievances, including through
7 processes available under managed care plans and the
8 state appeals process, relating to long-term services
9 and supports under the Medicaid program.

10 d. Accessing the results of a review of a level
11 of care assessment or reassessment by a managed care
12 organization in which the managed care organization
13 recommends denial or limited authorization of a
14 service, including the type or level of service, the
15 reduction, suspension, or termination of a previously
16 authorized service, or a change in level of care, upon
17 the request of an affected individual.

18 e. Receiving notices of disenrollment or notices
19 that would result in a change in level of care for
20 affected individuals, including involuntary and
21 voluntary discharges or transfers, from the department
22 of human services or a managed care organization.

23 2. A representative of the office of long-term care
24 ombudsman providing assistance and advocacy services
25 authorized under this section for an individual,
26 shall be provided access to the individual, and shall
27 be provided access to the individual's medical and
28 social records as authorized by the individual or the
29 individual's legal representative, as necessary to
30 carry out the duties specified in this section.

31 3. A representative of the office of long-term care
32 ombudsman providing assistance and advocacy services
33 authorized under this section for an individual, shall
34 be provided access to administrative records related to
35 the provision of the long-term services and supports to

1 the individual, as necessary to carry out the duties
2 specified in this section.

3 4. The office of long-term care ombudsman and
4 representatives of the office, when providing
5 assistance and advocacy services under this section,
6 shall be considered a health oversight agency as
7 defined in 45 C.F.R. {164.501 for the purposes of
8 health oversight activities as described in 45 C.F.R.
9 {164.512(d) including access to the health records
10 and other appropriate information of an individual,
11 including from the department of human services or
12 the applicable Medicaid managed care organization,
13 as necessary to fulfill the duties specified under
14 this section. The department of human services,
15 in collaboration with the office of long-term care
16 ombudsman, shall adopt rules to ensure compliance
17 by affected entities with this subsection and to
18 ensure recognition of the office of long-term care
19 ombudsman as a duly authorized and identified agent or
20 representative of the state.

21 5. The department of human services and Medicaid
22 managed care organizations shall inform eligible
23 and potentially eligible Medicaid recipients of the
24 advocacy services and assistance available through the
25 office of long-term care ombudsman and shall provide
26 contact and other information regarding the advocacy
27 services and assistance to eligible and potentially
28 eligible Medicaid recipients as directed by the office
29 of long-term care ombudsman.

30 6. When providing assistance and advocacy services
31 under this section, the office of long-term care
32 ombudsman shall act as an independent agency, and the
33 office of long-term care ombudsman and representatives
34 of the office shall be free of any undue influence that
35 restrains the ability of the office or the office's

1 representatives from providing such services and
2 assistance.

3 7. The office of long-term care ombudsman shall, in
4 addition to other duties prescribed and at a minimum,
5 do all of the following in the furtherance of the
6 provision of advocacy services and assistance under
7 this section:

8 a. Represent the interests of eligible and
9 potentially eligible Medicaid recipients before
10 governmental agencies.

11 b. Analyze, comment on, and monitor the development
12 and implementation of federal, state, and local laws,
13 regulations, and other governmental policies and
14 actions, and recommend any changes in such laws,
15 regulations, policies, and actions as determined
16 appropriate by the office of long-term care ombudsman.

17 c. To maintain transparency and accountability for
18 activities performed under this section, including
19 for the purposes of claiming federal financial
20 participation for activities that are performed to
21 assist with administration of the Medicaid program:

22 (1) Have complete and direct responsibility for the
23 administration, operation, funding, fiscal management,
24 and budget related to such activities, and directly
25 employ, oversee, and supervise all paid and volunteer
26 staff associated with these activities.

27 (2) Establish separation-of-duties requirements,
28 provide limited access to work space and work
29 product for only necessary staff, and limit access to
30 documents and information as necessary to maintain the
31 confidentiality of the protected health information of
32 individuals served under this section.

33 (3) Collect and submit, annually, to the governor,
34 the health policy oversight committee created in
35 section 2.45, and the general assembly, all of the

1 following with regard to those seeking advocacy
2 services or assistance under this section:

3 (a) The number of contacts by contact type and
4 geographic location.

5 (b) The type of assistance requested including the
6 name of the managed care organization involved, if
7 applicable.

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

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

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

14 (f) The outcomes of requests to address problems or
15 concerns.

16 ~~4.~~ 8. For the purposes of this section:

17 a. "Institutional setting" includes a long-term care
18 facility, an elder group home, or an assisted living
19 program.

20 b. "Long-term services and supports" means the broad
21 range of health, health-related, and personal care
22 assistance services and supports, provided in both
23 institutional settings and home and community-based
24 settings, necessary for older individuals and persons
25 with disabilities who experience limitations in their
26 capacity for self-care due to a physical, cognitive, or
27 mental disability or condition.

28 Sec. ____ NEW SECTION. 231.44A Willful
29 interference with duties related to long-term services
30 and supports ---- penalty.

31 Willful interference with a representative of the
32 office of long-term care ombudsman in the performance
33 of official duties in accordance with section 231.44
34 is a violation of section 231.44, subject to a penalty
35 prescribed by rule. The office of long-term care

1 ombudsman shall adopt rules specifying the amount of a
2 penalty imposed, consistent with the penalties imposed
3 under section 231.42, subsection 8, and specifying
4 procedures for notice and appeal of penalties imposed.
5 Any moneys collected pursuant to this section shall be
6 deposited in the Medicaid reinvestment fund created in
7 section 249A.4C.

8 MEDICAL ASSISTANCE ADVISORY COUNCIL

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

11 249A.4B Medical assistance advisory council.

12 1. A medical assistance advisory council is
13 created to comply with 42 C.F.R. {431.12 based on
14 section 1902(a)(4) of the federal Social Security Act
15 and to advise the director about health and medical
16 care services under the ~~medical assistance~~ Medicaid
17 program, participate in Medicaid policy development
18 and program administration, and provide guidance on
19 key issues related to the Medicaid program, whether
20 administered under a fee-for-service, managed care, or
21 other methodology, including but not limited to access
22 to care, quality of care, and service delivery.

23 a. The council shall have the opportunity for
24 participation in policy development and program
25 administration, including furthering the participation
26 of recipients of the program, and without limiting this
27 general authority shall specifically do all of the
28 following:

29 (1) Formulate, review, evaluate, and recommend
30 policies, rules, agency initiatives, and legislation
31 pertaining to the Medicaid program. The council shall
32 have the opportunity to comment on proposed rules
33 prior to commencement of the rulemaking process and on
34 waivers and state plan amendment applications.

35 (2) Prior to the annual budget development process,

1 engage in setting priorities, including consideration
2 of the scope and utilization management criteria
3 for benefits, beneficiary eligibility, provider and
4 services reimbursement rates, and other budgetary
5 issues.

6 (3) Provide oversight for and review of the
7 administration of the Medicaid program.

8 (4) Ensure that the membership of the council
9 effectively represents all relevant and concerned
10 viewpoints, particularly those of consumers, providers,
11 and the general public; create public understanding;
12 and ensure that the services provided under the
13 Medicaid program meet the needs of the people served.

14 b. The council shall meet ~~no more than~~ at least
15 quarterly, and prior to the next subsequent meeting
16 of the executive committee. ~~The director of public~~
17 health The public member acting as a co-chairperson
18 of the executive committee and the professional or
19 business entity member acting as a co-chairperson of
20 the executive committee, shall serve as ~~chairperson~~
21 co-chairpersons of the council.

22 2. The council shall include all of the following
23 voting members:

24 a. The president, or the president's
25 representative, of each of the following professional
26 or business entities, or a member of each of the
27 following professional or business entities, selected
28 by the entity:

- 29 (1) The Iowa medical society.
- 30 (2) The Iowa osteopathic medical association.
- 31 (3) The Iowa academy of family physicians.
- 32 (4) The Iowa chapter of the American academy of
33 pediatrics.
- 34 (5) The Iowa physical therapy association.
- 35 (6) The Iowa dental association.

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

1 association for retarded citizens of Iowa.

2 (37) The national alliance for the mentally ill on
3 mental illness of Iowa.

4 (38) The Iowa state association of counties.

5 (39) The Iowa developmental disabilities council.

6 (40) The Iowa chiropractic society.

7 (41) The Iowa academy of nutrition and dietetics.

8 (42) The Iowa behavioral health association.

9 (43) The midwest association for medical equipment
10 services or an affiliated Iowa organization.

11 (44) The Iowa public health association.

12 (45) The epilepsy foundation.

13 b. Public representatives which may include members
14 of consumer groups, including recipients of medical
15 assistance or their families, consumer organizations,
16 and others, which shall be appointed by the governor
17 in equal in number to the number of representatives of
18 the professional and business entities specifically
19 represented under paragraph "a", ~~appointed by the~~
20 ~~governor~~ for staggered terms of two years each, none
21 of whom shall be members of, or practitioners of, or
22 have a pecuniary interest in any of the professional
23 or business entities specifically represented under
24 paragraph "a", and a majority of whom shall be current
25 or former recipients of medical assistance or members
26 of the families of current or former recipients.

27 3. The council shall include all of the following
28 nonvoting members:

29 ~~e.~~ a. The director of public health, or the
30 director's designee.

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

33 c. The state long-term care ombudsman, or the
34 ombudsman's designee.

35 d. The ombudsman appointed pursuant to section

1 2C.3, or the ombudsman's designee.

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

4 f. The dean of the university of Iowa college of
5 medicine, or the dean's designee.

6 g. The following members of the general assembly,
7 each for a term of two years as provided in section
8 69.16B:

9 (1) Two members of the house of representatives,
10 one appointed by the speaker of the house of
11 representatives and one appointed by the minority
12 leader of the house of representatives from their
13 respective parties.

14 (2) Two members of the senate, one appointed by the
15 president of the senate after consultation with the
16 majority leader of the senate and one appointed by the
17 minority leader of the senate.

18 ~~3.~~ 4. a. An executive committee of the council is
19 created and shall consist of the following members of
20 the council:

21 (1) As voting members:

22 (a) Five of the professional or business entity
23 members designated pursuant to subsection 2, paragraph
24 "a", and selected by the members specified under that
25 paragraph.

26 ~~(2)~~ (b) Five of the public members appointed
27 pursuant to subsection 2, paragraph "b", and selected
28 by the members specified under that paragraph. Of the
29 five public members, at least one member shall be a
30 recipient of medical assistance.

31 ~~(3)~~ (2) As nonvoting members:

32 (a) The director of public health, or the
33 director's designee.

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

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

3 (d) The ombudsman appointed pursuant to section
4 2C.3, or the ombudsman's designee.

5 b. The executive committee shall meet on a monthly
6 basis. ~~The director of public health~~ A public member
7 of the executive committee selected by the public
8 members appointed pursuant to subsection 2, paragraph
9 "b", and a professional or business entity member of
10 the executive committee selected by the professional
11 or business entity members appointed pursuant to
12 subsection 2, paragraph "a", shall serve as chairperson
13 co-chairpersons of the executive committee.

14 c. Based upon the deliberations of the council,
15 ~~and the executive committee, and the subcommittees,~~
16 the executive committee, the council, and the
17 subcommittees, respectively, shall make recommendations
18 to the director, to the health policy oversight
19 committee created in section 2.45, to the general
20 assembly's joint appropriations subcommittee on health
21 and human services, and to the general assembly's
22 standing committees on human resources regarding the
23 budget, policy, and administration of the medical
24 assistance program.

25 5. a. The council shall create the following
26 subcommittees, and may create additional subcommittees
27 as necessary to address Medicaid program policies,
28 administration, budget, and other factors and issues:

29 (1) A stakeholder safeguards subcommittee, for
30 which the co-chairpersons shall be a public member
31 of the council appointed pursuant to subsection 2,
32 paragraph "b", and selected by the public members of
33 the council, and a representative of a professional
34 or business entity appointed pursuant to subsection
35 2, paragraph "a", and selected by the professional or

1 business entity representatives of the council. The
2 mission of the stakeholder safeguards subcommittee
3 is to provide for ongoing stakeholder engagement and
4 feedback on issues affecting Medicaid recipients,
5 providers, and other stakeholders, including but not
6 limited to benefits such as transportation, benefit
7 utilization management, the inclusion of out-of-state
8 and out-of-network providers and the use of single-case
9 agreements, and reimbursement of providers and
10 services.

11 (2) The long-term services and supports
12 subcommittee which shall be chaired by the state
13 long-term care ombudsman, or the ombudsman's designee.
14 The mission of the long-term services and supports
15 subcommittee is to be a resource and to provide advice
16 on policy development and program administration
17 relating to Medicaid long-term services and supports
18 including but not limited to developing outcomes and
19 performance measures for Medicaid managed care for the
20 long-term services and supports population; addressing
21 issues related to home and community-based services
22 waivers and waiting lists; and reviewing the system of
23 long-term services and supports to ensure provision of
24 home and community-based services and the rebalancing
25 of the health care infrastructure in accordance with
26 state and federal law including but not limited to the
27 principles established in Olmstead v. L.C., 527 U.S.
28 581 (1999) and the federal Americans with Disabilities
29 Act and in a manner that reflects a sustainable,
30 person-centered approach to improve health and life
31 outcomes, supports maximum independence, addresses
32 medical and social needs in a coordinated, integrated
33 manner, and provides for sufficient resources including
34 a stable, well-qualified workforce. The subcommittee
35 shall also address and make recommendations regarding

1 the need for an ombudsman function for eligible and
2 potentially eligible Medicaid recipients beyond the
3 long-term services and supports population.

4 (3) The transparency, data, and program evaluation
5 subcommittee which shall be chaired by the director of
6 the university of Iowa public policy center, or the
7 director's designee. The mission of the transparency,
8 data, and program evaluation subcommittee is to
9 ensure Medicaid program transparency; ensure the
10 collection, maintenance, retention, reporting, and
11 analysis of sufficient and meaningful data to provide
12 transparency and inform policy development and program
13 effectiveness; support development and administration
14 of a consumer-friendly dashboard; and promote the
15 ongoing evaluation of Medicaid stakeholder satisfaction
16 with the Medicaid program.

17 (4) The program integrity subcommittee which shall
18 be chaired by the Medicaid director, or the director's
19 designee. The mission of the program integrity
20 subcommittee is to ensure that a comprehensive system
21 including specific policies, laws, and rules and
22 adequate resources and measures are in place to
23 effectively administer the program and to maintain
24 compliance with federal and state program integrity
25 requirements.

26 (5) A health workforce subcommittee, co-chaired
27 by the bureau chief of the bureau of oral and health
28 delivery systems of the department of public health,
29 or the bureau chief's designee, and the director of
30 the national alliance on mental illness of Iowa, or
31 the director's designee. The mission of the health
32 workforce subcommittee is to assess the sufficiency
33 and proficiency of the current and projected health
34 workforce; identify barriers to and gaps in health
35 workforce development initiatives and health

1 workforce data to provide foundational, evidence-based
2 information to inform policymaking and resource
3 allocation; evaluate the most efficient application
4 and utilization of roles, functions, responsibilities,
5 activities, and decision-making capacity of health
6 care professionals and other allied and support
7 personnel; and make recommendations for improvement
8 in, and alternative modes of, health care delivery in
9 order to provide a competent, diverse, and sustainable
10 health workforce in the state. The subcommittee shall
11 work in collaboration with the office of statewide
12 clinical education programs of the university of Iowa
13 Carver college of medicine, Des Moines university,
14 Iowa workforce development, and other entities with
15 interest or expertise in the health workforce in
16 carrying out the subcommittee's duties and developing
17 recommendations.

18 b. The co-chairpersons of the council shall
19 appoint members to each subcommittee from the general
20 membership of the council. Consideration in appointing
21 subcommittee members shall include the individual's
22 knowledge about, and interest or expertise in, matters
23 that come before the subcommittee.

24 c. Subcommittees shall meet at the call of the
25 co-chairpersons or chairperson of the subcommittee,
26 or at the request of a majority of the members of the
27 subcommittee.

28 4. 6. For each council meeting, executive
29 committee meeting, or subcommittee meeting, a quorum
30 shall consist of fifty percent of the membership
31 qualified to vote. Where a quorum is present, a
32 position is carried by a majority of the members
33 qualified to vote.

34 7. For each council meeting, other than those
35 held during the time the general assembly is in

1 session, each legislative member of the council shall
2 be reimbursed for actual travel and other necessary
3 expenses and shall receive a per diem as specified in
4 section 7E.6 for each day in attendance, as shall the
5 members of the council, ~~or the executive committee,~~
6 or a subcommittee, for each day in attendance at a
7 council, executive committee, or subcommittee meeting,
8 who are recipients or the family members of recipients
9 of medical assistance, regardless of whether the
10 general assembly is in session.

11 ~~5.~~ 8. The department shall provide staff support
12 and independent technical assistance to the council,
13 ~~and the executive committee, and the subcommittees.~~

14 ~~6.~~ 9. The director shall ~~consider~~ comply with
15 the requirements of this section regarding the
16 duties of the council, and the deliberations and
17 recommendations offered by of the council, and the
18 executive committee, and the subcommittees shall be
19 reflected in the director's preparation of medical
20 assistance budget recommendations to the council
21 on human services pursuant to section 217.3, and in
22 implementation of medical assistance program policies,
23 and in administration of the Medicaid program.

24 10. The council, executive committee, and
25 subcommittees shall jointly submit quarterly reports
26 to the health policy oversight committee created in
27 section 2.45 and shall jointly submit a report to the
28 governor and the general assembly initially by January
29 1, 2017, and annually, therefore, summarizing the
30 outcomes and findings of their respective deliberations
31 and any recommendations including but not limited to
32 those for changes in law or policy.

33 11. The council, executive committee, and
34 subcommittees may enlist the services of persons who
35 are qualified by education, expertise, or experience

1 to advise, consult with, or otherwise assist the
2 council, executive committee, or subcommittees in the
3 performance of their duties. The council, executive
4 committee, or subcommittees may specifically enlist
5 the assistance of entities such as the university of
6 Iowa public policy center to provide ongoing evaluation
7 of the Medicaid program and to make evidence-based
8 recommendations to improve the program. The council,
9 executive committee, and subcommittees shall enlist
10 input from the patient-centered health advisory council
11 created in section 135.159, the mental health and
12 disabilities services commission created in section
13 225C.5, the commission on aging created in section
14 231.11, the bureau of substance abuse of the department
15 of public health, the Iowa developmental disabilities
16 council, and other appropriate state and local entities
17 to provide advice to the council, executive committee,
18 and subcommittees.

19 12. The department, in accordance with 42 C.F.R.
20 {431.12, shall seek federal financial participation for
21 the activities of the council, the executive committee,
22 and the subcommittees.

23 PATIENT-CENTERED HEALTH RESOURCES AND INFRASTRUCTURE

24 Sec. ____ . Section 135.159, subsection 2, Code 2016,
25 is amended to read as follows:

26 2. a. The department shall establish a
27 patient-centered health advisory council which shall
28 include but is not limited to all of the following
29 members, selected by their respective organizations,
30 and any other members the department determines
31 necessary to assist in the ~~department's duties at~~
32 ~~various stages of~~ development of the medical home
33 system and in the transformation to a patient-centered
34 infrastructure that integrates and coordinates services
35 and supports to address social determinants of health

1 and meet population health goals:

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

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

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

8 (4) A representative of the Iowa dental
9 association.

10 (5) A representative of the Iowa nurses
11 association.

12 (6) A physician and an osteopathic physician
13 licensed pursuant to chapter 148 who are family
14 physicians and members of the Iowa academy of family
15 physicians.

16 (7) A health care consumer.

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

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

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

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

26 (12) A representative of the Iowa pharmacy
27 association.

28 (13) A representative of the Iowa chiropractic
29 society.

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

32 (15) A representative of the Iowa public health
33 association.

34 (16) A representative of the area agencies on
35 aging.

1 (17) A representative of the mental health and
2 disability services regions.

3 (18) A representative of early childhood Iowa.

4 b. Public members of the patient-centered health
5 advisory council shall receive reimbursement for
6 actual expenses incurred while serving in their
7 official capacity only if they are not eligible for
8 reimbursement by the organization that they represent.

9 c. (1) Beginning July 1, 2016, the
10 patient-centered health advisory council shall
11 do all of the following:

12 (a) Review and make recommendations to the
13 department and to the general assembly regarding
14 the building of effective working relationships and
15 strategies to support state-level and community-level
16 integration, to provide cross-system coordination
17 and synchronization, and to more appropriately align
18 health delivery models and service sectors, including
19 but not limited to public health, aging and disability
20 services agencies, mental health and disability
21 services regions, social services, child welfare, and
22 other providers, agencies, organizations, and sectors
23 to address social determinants of health, holistic
24 well-being, and population health goals. Such review
25 and recommendations shall include a review of funding
26 streams and recommendations for blending and braiding
27 funding to support these efforts.

28 (b) Assist in efforts to evaluate the health
29 workforce to inform policymaking and resource
30 allocation.

31 (2) The patient-centered health advisory council
32 shall submit a report to the department, the health
33 policy oversight committee created in section 2.45, and
34 the general assembly, initially, on or before December
35 15, 2016, and on or before December 15, annually,

1 thereafter, including any findings or recommendations
2 resulting from the council's deliberations.

3 HAWK-I PROGRAM

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

7 NEW SUBPARAGRAPH. (17) Occupational therapy.

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

10 NEW PARAGRAPH. m. The definition of medically
11 necessary and the utilization management criteria under
12 the hawk-i program in order to ensure that benefits
13 are uniformly and consistently provided across all
14 participating insurers in the type and manner that
15 reflects and appropriately meets the needs, including
16 but not limited to the habilitative and rehabilitative
17 needs, of the child population including those children
18 with special health care needs.

19 MEDICAID PROGRAM POLICY IMPROVEMENT

20 Sec. _____. DIRECTIVES FOR MEDICAID PROGRAM POLICY
21 IMPROVEMENTS. In order to safeguard the interests
22 of Medicaid recipients, encourage the participation
23 of Medicaid providers, and protect the interests
24 of all taxpayers, the department of human services
25 shall comply with or ensure that the specified entity
26 complies with all of the following and shall amend
27 Medicaid managed care contract provisions as necessary
28 to reflect all of the following:

29 1. CONSUMER PROTECTIONS.

30 a. In accordance with 42 C.F.R. {438.420, a
31 Medicaid managed care organization shall continue a
32 recipient's benefits during an appeal process. If, as
33 allowed when final resolution of an appeal is adverse
34 to the Medicaid recipient, the Medicaid managed care
35 organization chooses to recover the costs of the

1 services furnished to the recipient while an appeal is
2 pending, the Medicaid managed care organization shall
3 provide adequate prior notice of potential recovery
4 of costs to the recipient at the time the appeal is
5 filed, and any costs recovered shall be remitted to
6 the department of human services and deposited in the
7 Medicaid reinvestment fund created in section 249A.4C.

8 b. Ensure that each Medicaid managed care
9 organization provides, at a minimum, all the benefits
10 and services deemed medically necessary that were
11 covered, including to the extent and in the same manner
12 and subject to the same prior authorization criteria,
13 by the state program directly under fee for service
14 prior to January 1, 2016. Benefits covered through
15 Medicaid managed care shall comply with the specific
16 requirements in state law applicable to the respective
17 Medicaid recipient population under fee for service.

18 c. Enhance monitoring of the reduction in or
19 suspension or termination of services provided to
20 Medicaid recipients, including reductions in the
21 provision of home and community-based services waiver
22 services or increases in home and community-based
23 services waiver waiting lists. Medicaid managed care
24 organizations shall provide data to the department
25 as necessary for the department to compile periodic
26 reports on the numbers of individuals transferred from
27 state institutions and long-term care facilities to
28 home and community-based services, and the associated
29 savings. Any savings resulting from the transfers as
30 certified by the department shall be deposited in the
31 Medicaid reinvestment fund created in section 249A.4C.

32 d. (1) Require each Medicaid managed care
33 organization to adhere to reasonableness and service
34 authorization standards that are appropriate for and
35 do not disadvantage those individuals who have ongoing

1 chronic conditions or who require long-term services
2 and supports. Services and supports for individuals
3 with ongoing chronic conditions or who require
4 long-term services and supports shall be authorized in
5 a manner that reflects the recipient's continuing need
6 for such services and supports, and limits shall be
7 consistent with a recipient's current needs assessment
8 and person-centered service plan.

9 (2) In addition to other provisions relating to
10 community-based case management continuity of care
11 requirements, Medicaid managed care contractors shall
12 provide the option to the case manager of a Medicaid
13 recipient who retained the case manager during the
14 six months of transition to Medicaid managed care, if
15 the recipient chooses to continue to retain that case
16 manager beyond the six-month transition period and
17 if the case manager is not otherwise a participating
18 provider of the recipient's managed care organization
19 provider network, to enter into a single case agreement
20 to continue to provide case management services to the
21 Medicaid recipient.

22 e. Ensure that Medicaid recipients are provided
23 care coordination and case management by appropriately
24 trained professionals in a conflict-free manner. Care
25 coordination and case management shall be provided
26 in a patient-centered and family-centered manner
27 that requires a knowledge of community supports, a
28 reasonable ratio of care coordinators and case managers
29 to Medicaid recipients, standards for frequency of
30 contact with the Medicaid recipient, and specific and
31 adequate reimbursement.

32 f. A Medicaid managed care contract shall include
33 a provision for continuity and coordination of care
34 for a consumer transitioning to Medicaid managed care,
35 including maintaining existing provider-recipient

1 relationships and honoring the amount, duration, and
2 scope of a recipient's authorized services based on
3 the recipient's medical history and needs. In the
4 initial transition to Medicaid managed care, to ensure
5 the least amount of disruption, Medicaid managed
6 care organizations shall provide, at a minimum, a
7 one-year transition of care period for all provider
8 types, regardless of network status with an individual
9 Medicaid managed care organization.

10 g. Ensure that a Medicaid managed care organization
11 does not arbitrarily deny coverage for medically
12 necessary services based solely on financial reasons
13 and does not shift the responsibility for provision of
14 services or payment of costs of services to another
15 entity to avoid costs or attain savings.

16 h. Ensure that dental coverage, if not integrated
17 into an overall Medicaid managed care contract, is
18 part of the overall holistic, integrated coverage
19 for physical, behavioral, and long-term services and
20 supports provided to a Medicaid recipient.

21 i. Require each Medicaid managed care organization
22 to verify the offering and actual utilization of
23 services and supports and value-added services,
24 an individual recipient's encounters and the costs
25 associated with each encounter, and requests and
26 associated approvals or denials of services.
27 Verification of actual receipt of services and supports
28 and value-added services shall, at a minimum, consist
29 of comparing receipt of service against both what
30 was authorized in the recipient's benefit or service
31 plan and what was actually reimbursed. Value-added
32 services shall not be reportable as allowable medical
33 or administrative costs or factored into rate setting,
34 and the costs of value-added services shall not be
35 passed on to recipients or providers.

1 j. Provide periodic reports to the governor and
2 the general assembly regarding changes in quality of
3 care and health outcomes for Medicaid recipients under
4 managed care compared to quality of care and health
5 outcomes of the same populations of Medicaid recipients
6 prior to January 1, 2016.

7 k. Require each Medicaid managed care organization
8 to maintain records of complaints, grievances, and
9 appeals, and report the number and types of complaints,
10 grievances, and appeals filed, the resolution of each,
11 and a description of any patterns or trends identified
12 to the department of human services and the health
13 policy oversight committee created in section 2.45,
14 on a monthly basis. The department shall review and
15 compile the data on a quarterly basis and make the
16 compilations available to the public. Following review
17 of reports submitted by the department, a Medicaid
18 managed care organization shall take any corrective
19 action required by the department and shall be subject
20 to any applicable penalties.

21 l. Require Medicaid managed care organizations to
22 survey Medicaid recipients, to collect satisfaction
23 data using a uniform instrument, and to provide a
24 detailed analysis of recipient satisfaction as well as
25 various metrics regarding the volume of and timelines
26 in responding to recipient complaints and grievances as
27 directed by the department of human services.

28 m. Require managed care organizations to allow a
29 recipient to request that the managed care organization
30 enter into a single case agreement with a recipient's
31 out-of-network provider, including a provider outside
32 of the state, to provide for continuity of care when
33 the recipient has an existing relationship with the
34 provider to provide a covered benefit, or to ensure
35 adequate or timely access to a provider of a covered

1 benefit when the managed care organization provider
2 network cannot ensure such adequate or timely access.

3 2. CHILDREN.

4 a. (1) The hawk-i board shall retain all authority
5 specified under chapter 514I relative to the children
6 eligible under section 514I.8 to participate in the
7 hawk-i program, including but not limited to approving
8 any contract entered into pursuant to chapter 514I;
9 approving the benefit package design, reviewing the
10 benefit package design, and making necessary changes
11 to reflect the results of the reviews; and adopting
12 rules for the hawk-i program including those related
13 to qualifying standards for selecting participating
14 insurers for the program and the benefits to be
15 included in a health plan.

16 (2) The hawk-i board shall review benefit plans
17 and utilization review provisions and ensure that
18 benefits provided to children under the hawk-i program,
19 at a minimum, reflect those required by state law as
20 specified in section 514I.5, include both habilitative
21 and rehabilitative services, and are provided as
22 medically necessary relative to the child population
23 served and based on the needs of the program recipient
24 and the program recipient's medical history.

25 (3) The hawk-i board shall work with the department
26 of human services to coordinate coverage and care for
27 the population of children in the state eligible for
28 either Medicaid or hawk-i coverage so that, to the
29 greatest extent possible, the two programs provide for
30 continuity of care as children transition between the
31 two programs or to private health care coverage. To
32 this end, all contracts with participating insurers
33 providing coverage under the hawk-i program and with
34 all managed care organizations providing coverage for
35 children eligible for Medicaid shall do all of the

1 following:

2 (a) Specifically and appropriately address
3 the unique needs of children and children's health
4 delivery.

5 (b) Provide for the maintaining of child health
6 panels that include representatives of child health,
7 welfare, policy, and advocacy organizations in the
8 state that address child health and child well-being.

9 (c) Address early intervention and prevention
10 strategies, the provision of a child health care
11 delivery infrastructure for children with special
12 health care needs, utilization of current standards
13 and guidelines for children's health care and
14 pediatric-specific screening and assessment tools,
15 the inclusion of pediatric specialty providers in
16 the provider network, and the utilization of health
17 homes for children and youth with special health
18 care needs including intensive care coordination
19 and family support and access to a professional
20 family-to-family support system. Such contracts
21 shall utilize pediatric-specific quality measures
22 and assessment tools which shall align with existing
23 pediatric-specific measures as determined in
24 consultation with the child health panel and approved
25 by the hawk-i board.

26 (d) Provide special incentives for innovative
27 and evidence-based preventive, behavioral, and
28 developmental health care and mental health care
29 for children's programs that improve the life course
30 trajectory of these children.

31 (e) Provide that information collected from the
32 pediatric-specific assessments be used to identify
33 health risks and social determinants of health that
34 impact health outcomes. Such data shall be used in
35 care coordination and interventions to improve patient

1 outcomes and to drive program designs that improve the
2 health of the population. Aggregate assessment data
3 shall be shared with affected providers on a routine
4 basis.

5 b. In order to monitor the quality of and access
6 to health care for children receiving coverage under
7 the Medicaid program, each Medicaid managed care
8 organization shall uniformly report, in a template
9 format designated by the department of human services,
10 the number of claims submitted by providers and the
11 percentage of claims approved by the Medicaid managed
12 care organization for the early and periodic screening,
13 diagnostic, and treatment (EPSDT) benefit based
14 on the Iowa EPSDT care for kids health maintenance
15 recommendations, including but not limited to
16 physical exams, immunizations, the seven categories of
17 developmental and behavioral screenings, vision and
18 hearing screenings, and lead testing.

19 3. PROVIDER PARTICIPATION ENHANCEMENT.

20 a. Ensure that savings achieved through Medicaid
21 managed care does not come at the expense of further
22 reductions in provider rates. The department shall
23 ensure that Medicaid managed care organizations use
24 reasonable reimbursement standards for all provider
25 types and compensate providers for covered services at
26 not less than the minimum reimbursement established
27 by state law applicable to fee for service for a
28 respective provider, service, or product for a fiscal
29 year and as determined in conjunction with actuarially
30 sound rate setting procedures. Such reimbursement
31 shall extend for the entire duration of a managed care
32 contract.

33 b. To enhance continuity of care in the provision
34 of pharmacy services, Medicaid managed care
35 organizations shall utilize the same preferred drug

1 list, recommended drug list, prior authorization
2 criteria, and other utilization management strategies
3 that apply to the state program directly under fee for
4 service and shall apply other provisions of applicable
5 state law including those relating to chemically unique
6 mental health prescription drugs. Reimbursement rates
7 established under Medicaid managed care contracts for
8 ingredient cost reimbursement and dispensing fees shall
9 be subject to and shall reflect provisions of state
10 and federal law, including the minimum reimbursements
11 established in state law for fee for service for a
12 fiscal year.

13 c. Address rate setting and reimbursement of the
14 entire scope of services provided under the Medicaid
15 program to ensure the adequacy of the provider network
16 and to ensure that providers that contribute to the
17 holistic health of the Medicaid recipient, whether
18 inside or outside of the provider network, are
19 compensated for their services.

20 d. Managed care contractors shall submit financial
21 documentation to the department of human services
22 demonstrating payment of claims and expenses by
23 provider type.

24 e. Participating Medicaid providers under a managed
25 care contract shall be allowed to submit claims for up
26 to 365 days following discharge of a Medicaid recipient
27 from a hospital or following the date of service.

28 f. (1) A managed care contract entered into on
29 or after July 1, 2015, shall, at a minimum, reflect
30 all of the following provisions and requirements, and
31 shall extend the following payment rates based on the
32 specified payment floor, as applicable to the provider
33 type:

34 (a) In calculating the rates for prospective
35 payment system hospitals, the following base rates

1 shall be used:

2 (i) The inpatient diagnostic related group base
3 rates and certified unit per diem in effect on October
4 1, 2015.

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

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

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

11 (b) In calculating the critical access hospital
12 payment rates, the following base rates shall be used:

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

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

17 (iii) The swing bed per diem in effect on July 1,
18 2015.

19 (c) Critical access hospitals shall receive
20 cost-based reimbursement for one hundred percent of
21 the reasonable costs for the provision of services to
22 Medicaid recipients.

23 (d) Critical access hospitals shall submit annual
24 cost reports and managed care contractors shall submit
25 annual payment reports to the department of human
26 services. The department shall reconcile the critical
27 access hospital's reported costs with the managed care
28 contractor's reported payments. The department shall
29 require the managed care contractor to retroactively
30 reimburse a critical access hospital for underpayments.

31 (e) Community mental health centers shall receive
32 one hundred percent of the reasonable costs for the
33 provision of services to Medicaid recipients.

34 (f) Federally qualified health centers shall
35 receive cost-based reimbursement for one hundred

1 percent of the reasonable costs for the provision of
2 services to Medicaid recipients.

3 (g) The reimbursement rates for substance-related
4 disorder treatment programs licensed under section
5 125.13, shall be no lower than the rates in effect for
6 the fiscal year beginning July 1, 2015.

7 (2) For managed care contract periods subsequent to
8 the initial contract period, base rates for prospective
9 payment system hospitals and critical access hospitals
10 shall be calculated using the base rate for the prior
11 contract period plus 3 percent. Prospective payment
12 system hospital and critical access hospital base rates
13 shall at no time be less than the previous contract
14 period's base rates.

15 (3) A managed care contract shall require
16 out-of-network prospective payment system hospital
17 and critical access hospital payment rates to meet or
18 exceed ninety-nine percent of the rates specified for
19 the respective in-network hospitals in accordance with
20 this paragraph "f".

21 g. If the department of human services collects
22 ownership and control information from Medicaid
23 providers pursuant to 42 C.F.R. {455.104, a managed
24 care organization under contract with the state shall
25 not also require submission of this information from
26 approved enrolled Medicaid providers.

27 h. (1) Ensure that a Medicaid managed care
28 organization develops and maintains a provider network
29 of qualified providers who meet state licensing,
30 credentialing, and certification requirements, as
31 applicable, which network shall be sufficient to
32 provide adequate access to all services covered and for
33 all populations served under the managed care contract.
34 Medicaid managed care organizations shall incorporate
35 existing and traditional providers, including but

1 not limited to those providers that comprise the Iowa
2 collaborative safety net provider network created in
3 section 135.153, into their provider networks.

4 (2) Ensure that respective Medicaid populations
5 are managed at all times within funding limitations
6 and contract terms. The department shall also
7 monitor service delivery and utilization to ensure
8 the responsibility for provision of services to
9 Medicaid recipients is not shifted to non-Medicaid
10 covered services to attain savings, and that such
11 responsibility is not shifted to mental health and
12 disability services regions, local public health
13 agencies, aging and disability resource centers,
14 or other entities unless agreement to provide, and
15 provision for adequate compensation for, such services
16 is agreed to between the affected entities in advance.

17 i. Medicaid managed care organizations shall
18 provide an enrolled Medicaid provider approved by the
19 department of human services the opportunity to be a
20 participating network provider.

21 j. Medicaid managed care organizations shall
22 include provider appeals and grievance procedures
23 that in part allow a provider to file a grievance
24 independently but on behalf of a Medicaid recipient
25 and to appeal claims denials which, if determined to
26 be based on claims for medically necessary services
27 whether or not denied on an administrative basis, shall
28 receive appropriate payment.

29 k. (1) Medicaid managed care organizations
30 shall include as primary care providers any provider
31 designated by the state as a primary care provider,
32 subject to a provider's respective state certification
33 standards, including but not limited to all of the
34 following:

35 (a) A physician who is a family or general

1 practitioner, a pediatrician, an internist, an
2 obstetrician, or a gynecologist.

3 (b) An advanced registered nurse practitioner.

4 (c) A physician assistant.

5 (d) A chiropractor licensed pursuant to chapter
6 151.

7 (2) A Medicaid managed care organization shall not
8 impose more restrictive, additional, or different scope
9 of practice requirements or standards of practice on a
10 primary care provider than those prescribed by state
11 law as a prerequisite for participation in the managed
12 care organization's provider network.

13 4. CAPITATION RATES AND MEDICAL LOSS RATIO.

14 a. Capitation rates shall be developed based on all
15 reasonable, appropriate, and attainable costs. Costs
16 that are not reasonable, appropriate, or attainable,
17 including but not limited to improper payment
18 recoveries, shall not be included in the development
19 of capitated rates.

20 b. Capitation rates for Medicaid recipients falling
21 within different rate cells shall not be expected to
22 cross-subsidize one another and the data used to set
23 capitation rates shall be relevant and timely and tied
24 to the appropriate Medicaid population.

25 c. Any increase in capitation rates for managed
26 care contractors is subject to prior statutory approval
27 and shall not exceed three percent over the existing
28 capitation rate in any one-year period or five percent
29 over the existing capitation rate in any two-year
30 period.

31 d. In addition to withholding two percent of a
32 managed care organization's annual capitation payment
33 as a pay-for-performance enforcement mechanism, the
34 department of human services shall also withhold an
35 additional two percent of a managed care organization's

1 annual capitation payment until the department is able
2 to ensure that the respective managed care organization
3 has complied with all requirements relating to data,
4 information, transparency, evaluation, and oversight
5 specified by law, rule, contract, or other basis.

6 e. The department of human services shall collect
7 an initial contribution of five million dollars from
8 each of the managed care organizations contracting
9 with the state during the fiscal year beginning July
10 1, 2015, for an aggregate amount of fifteen million
11 dollars, and shall deposit such amount in the Medicaid
12 reinvestment fund, as provided in section 249A.4C, as
13 enacted in this Act, to be used for Medicaid ombudsman
14 activities through the office of long-term care
15 ombudsman.

16 f. A managed care contract shall impose a minimum
17 Medicaid loss ratio of at least eighty-eight percent.
18 In calculating the medical loss ratio, medical costs
19 or benefit expenses shall include only those costs
20 directly related to patient medical care and not
21 ancillary expenses, including but not limited to any
22 of the following:

- 23 (1) Program integrity activities.
- 24 (2) Utilization review activities.
- 25 (3) Fraud prevention activities beyond the scope of
26 those activities necessary to recover incurred claims.
- 27 (4) Provider network development, education, or
28 management activities.
- 29 (5) Provider credentialing activities.
- 30 (6) Marketing expenses.
- 31 (7) Administrative costs associated with recipient
32 incentives.
- 33 (8) Clinical data collection activities.
- 34 (9) Claims adjudication expenses.
- 35 (10) Customer service or health care professional

1 hotline services addressing nonclinical recipient
2 questions.

3 (11) Value-added or cost-containment services,
4 wellness programs, disease management, and case
5 management or care coordination programs.

6 (12) Health quality improvement activities unless
7 specifically approved as a medical cost by state law.
8 Costs of health quality improvement activities included
9 in determining the medical loss ratio shall be only
10 those activities that are independent improvements
11 measurable in individual patients.

12 (13) Insurer claims review activities.

13 (14) Information technology costs unless they
14 directly and credibly improve the quality of health
15 care and do not duplicate, conflict with, or fail to be
16 compatible with similar health information technology
17 efforts of providers.

18 (15) Legal department costs including information
19 technology costs, expenses incurred for review and
20 denial of claims, legal costs related to defending
21 claims, settlements for wrongly denied claims, and
22 costs related to administrative claims handling
23 including salaries of administrative personnel and
24 legal costs.

25 (16) Taxes unrelated to premiums or the provision
26 of medical care. Only state and federal taxes and
27 licensing or regulatory fees relevant to actual
28 premiums collected, not including such taxes and fees
29 as property taxes, taxes on investment income, taxes on
30 investment property, and capital gains taxes, may be
31 included in determining the medical loss ratio.

32 g. (1) Provide enhanced guidance and criteria for
33 defining medical and administrative costs, recoveries,
34 and rebates including pharmacy rebates, and the
35 recording, reporting, and recoupment of such costs,

1 recoveries, and rebates realized.

2 (2) Medicaid managed care organizations shall
3 offset recoveries, rebates, and refunds against
4 medical costs, include only allowable administrative
5 expenses in the determination of administrative costs,
6 report costs related to subcontractors properly, and
7 have complete systems checks and review processes to
8 identify overpayment possibilities.

9 (3) Medicaid managed care contractors shall submit
10 publicly available, comprehensive financial statements
11 to the department of human services to verify that the
12 minimum medical loss ratio is being met and shall be
13 subject to periodic audits.

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

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

35 b. Medicaid managed care organizations shall

1 directly capture and retain and shall report actual and
2 detailed medical claims costs and administrative cost
3 data to the department as specified by the department.

4 Medicaid managed care organizations shall allow the
5 department to thoroughly and accurately monitor the
6 medical claims costs and administrative costs data
7 Medicaid managed care organizations report to the
8 department.

9 c. Any audit of Medicaid managed care contracts
10 shall ensure compliance including with respect to
11 appropriate medical costs, allowable administrative
12 costs, the medical loss ratio, cost recoveries,
13 rebates, overpayments, and with specific contract
14 performance requirements.

15 d. The external quality review organization
16 contracting with the department shall review the
17 Medicaid managed care program to determine if the
18 state has sufficient infrastructure and controls in
19 place to effectively oversee the Medicaid managed care
20 organizations and the Medicaid program in order to
21 ensure, at a minimum, compliance with Medicaid managed
22 care organization contracts and to prevent fraud,
23 abuse, and overpayments. The results of any external
24 quality review organization review shall be submitted
25 to the governor, the general assembly, and the health
26 policy oversight committee created in section 2.45.

27 e. Publish benchmark indicators based on Medicaid
28 program outcomes from the fiscal year beginning July 1,
29 2015, to be used to compare outcomes of the Medicaid
30 program as administered by the state program prior
31 to July 1, 2015, to those outcomes of the program
32 under Medicaid managed care. The outcomes shall
33 include a comparison of actual costs of the program
34 as administered prior to and after implementation of
35 Medicaid managed care. The data shall also include

1 specific detail regarding the actual expenses incurred
2 by each managed care organization by specific provider
3 line of service.

4 f. Review and approve or deny approval of contract
5 amendments on an ongoing basis to provide for
6 continuous improvement in Medicaid managed care and
7 to incorporate any changes based on changes in law or
8 policy.

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

12 (a) The number and details relating to prior
13 authorization requests and denials.

14 (b) The ten most common reasons for claims denials.
15 Information reported by a managed care contractor
16 relative to claims shall also include the number
17 of claims denied, appealed, and overturned based on
18 provider type and service type.

19 (c) Utilization of health care services by
20 diagnostic related group and ambulatory payment
21 classification as well as total claims volume.

22 (2) The department shall ensure the validity
23 of all information submitted by a Medicaid managed
24 care organization and shall make the monthly reports
25 available to the public.

26 h. Medicaid managed care organizations shall
27 maintain stakeholder panels comprised of an equal
28 number of Medicaid recipients and providers. Medicaid
29 managed care organizations shall provide for separate
30 provider-specific panels to address detailed payment,
31 claims, process, and other issues as well as grievance
32 and appeals processes.

33 i. Medicaid managed care contracts shall align
34 economic incentives, delivery system reforms, and
35 performance and outcome metrics with those of the state

1 innovation models initiatives and Medicaid accountable
2 care organizations. The department of human services
3 shall develop and utilize a common, uniform set of
4 process, quality, and consumer satisfaction measures
5 across all Medicaid payors and providers that align
6 with those developed through the state innovation
7 models initiative and shall ensure that such measures
8 are expanded and adjusted to address additional
9 populations and to meet population health objectives.
10 Medicaid managed care contracts shall include long-term
11 performance and outcomes goals that reward success in
12 achieving population health goals such as improved
13 community health metrics.

14 j. (1) Require consistency and uniformity of
15 processes, procedures, and forms across all Medicaid
16 managed care organizations to reduce the administrative
17 burden to providers and consumers and to increase
18 efficiencies in the program. Such requirements shall
19 apply to but are not limited to areas of uniform cost
20 and quality reporting, uniform prior authorization
21 requirements and procedures, uniform utilization
22 management criteria, centralized, uniform, and seamless
23 credentialing requirements and procedures, and uniform
24 critical incident reporting.

25 (2) The department of human services shall
26 establish a comprehensive provider credentialing
27 process to be recognized and utilized by all Medicaid
28 managed care organization contractors. The process
29 shall meet the national committee for quality assurance
30 and other appropriate standards. The process shall
31 ensure that credentialing is completed in a timely
32 manner without disruption to provider billing
33 processes.

34 k. Medicaid managed care organizations and any
35 entity with which a managed care organization contracts

1 for the performance of services shall disclose at no
2 cost to the department all discounts, incentives,
3 rebates, fees, free goods, bundling arrangements, and
4 other agreements affecting the net cost of goods or
5 services provided under a managed care contract.

6 Sec. _____. RETROACTIVE APPLICABILITY. The section
7 of this division of this Act relating to directives
8 for Medicaid program policy improvements applies
9 retroactively to July 1, 2015.

10 Sec. _____. EFFECTIVE UPON ENACTMENT. This division
11 of this Act, being deemed of immediate importance,
12 takes effect upon enactment.>

13 3. By renumbering as necessary.

By HEDDENS of Story

HOUSE FILE 2460

H-8229

1 Amend House File 2460 as follows:

2 1. Page 112, after line 5 by inserting:

3 <DIVISION _____

4 AUTISM SPECTRUM DISORDERS COVERAGE

5 Sec. _____. Section 225D.1, subsection 8, Code
6 2016, as otherwise amended by this Act, if enacted, is
7 amended to read as follows:

8 8. "Eligible individual" means a child less than
9 fourteen years of age who has been diagnosed with
10 autism based on a diagnostic assessment of autism,
11 is not otherwise eligible for coverage for applied
12 behavioral analysis treatment under the medical
13 assistance program, section ~~514C.28~~ 514C.31, or other
14 private insurance coverage, and whose household income
15 does not exceed five hundred percent of the federal
16 poverty level.

17 Sec. _____. Section 225D.2, subsection 2, paragraph
18 1, Code 2016, is amended to read as follows:

19 1. Proof of eligibility for the autism support
20 program that includes a written denial for coverage or
21 a benefits summary indicating that applied behavioral
22 analysis treatment is not a covered benefit for which
23 the applicant is eligible, under the Medicaid program,
24 section ~~514C.28~~ 514C.31, or other private insurance
25 coverage.

26 Sec. _____. Section 225D.2, subsection 3, Code 2016,
27 is amended to read as follows:

28 3. Moneys in the autism support fund created under
29 subsection 5 shall be expended only for eligible
30 individuals who are not eligible for coverage for
31 applied behavioral analysis treatment under the medical
32 assistance program, section ~~514C.28~~ 514C.31, or other
33 private insurance. Payment for applied behavioral
34 analysis treatment through the fund shall be limited
35 to only applied behavioral analysis treatment that is

H-8229

1 clinically relevant and only to the extent approved
2 under the guidelines established by rule of the
3 department.

4 Sec. _____. NEW SECTION. 514C.31 Autism spectrum
5 disorders coverage.

6 1. Notwithstanding the uniformity of treatment
7 requirements of section 514C.6, a group policy,
8 contract, or plan providing for third-party payment or
9 prepayment of health, medical, and surgical coverage
10 benefits shall provide coverage benefits to covered
11 individuals under twenty-two years of age for the
12 screening, diagnosis, and treatment of autism spectrum
13 disorders if the policy, contract, or plan is either
14 of the following:

15 a. A policy, contract, or plan issued by a carrier,
16 as defined in section 513B.2, or an organized delivery
17 system authorized under 1993 Iowa Acts, chapter 158,
18 to an employer who on at least fifty percent of the
19 employer's working days during the preceding calendar
20 year employed more than fifty full-time equivalent
21 employees. In determining the number of full-time
22 equivalent employees of an employer, employers who
23 are affiliated or who are able to file a consolidated
24 tax return for purposes of state taxation shall be
25 considered one employer.

26 b. A plan established pursuant to chapter 509A for
27 public employees.

28 2. As used in this section, unless the context
29 otherwise requires:

30 a. "Applied behavior analysis" means the design,
31 implementation, and evaluation of environmental
32 modifications, using behavioral stimuli and
33 consequences, to produce socially significant
34 improvement in human behavior or to prevent loss of
35 attained skill or function, including the use of direct

1 observation, measurement, and functional analysis of
2 the relations between environment and behavior.

3 b. "Autism spectrum disorder" means any of
4 the pervasive developmental disorders including
5 autistic disorder, Asperger's disorder, and pervasive
6 developmental disorders not otherwise specified. The
7 commissioner, by rule, shall define "autism spectrum
8 disorder" consistent with definitions provided in
9 the most recent edition of the American psychiatric
10 association's diagnostic and statistical manual of
11 mental disorders, as such definitions may be amended
12 from time to time. The commissioner may adopt the
13 definitions provided in such manual by reference.

14 c. "Behavioral health treatment" means counseling
15 and treatment programs, including applied behavior
16 analysis, that meet the following requirements:

17 (1) Are necessary to develop, maintain, or restore,
18 to the maximum extent practicable, the functioning of
19 an individual.

20 (2) Are provided or supervised by a behavior
21 analyst certified by a nationally recognized board, or
22 by a licensed psychologist, so long as the services are
23 performed commensurate with the psychologist's formal
24 training and supervised experience.

25 d. "Diagnosis of autism spectrum disorder" means the
26 use of medically necessary assessments, evaluations, or
27 tests to diagnose whether an individual has an autism
28 spectrum disorder.

29 e. "Pharmacy care" means medications prescribed by
30 a licensed physician and any assessment, evaluation,
31 or test prescribed or ordered by a licensed physician
32 to determine the need for or effectiveness of such
33 medications.

34 f. "Psychiatric care" means direct or consultative
35 services provided by a licensed physician who

1 specializes in psychiatry.

2 g. "Psychological care" means direct or consultative
3 services provided by a licensed psychologist.

4 h. "Therapeutic care" means services provided by
5 a licensed speech pathologist, licensed occupational
6 therapist, or licensed physical therapist.

7 i. "Treatment for autism spectrum disorder" means
8 evidence-based care and related equipment prescribed
9 or ordered for an individual diagnosed with an autism
10 spectrum disorder by a licensed physician or a licensed
11 psychologist who determines that the treatment is
12 medically necessary, including but not limited to the
13 following:

14 (1) Behavioral health treatment.

15 (2) Pharmacy care.

16 (3) Psychiatric care.

17 (4) Psychological care.

18 (5) Therapeutic care.

19 j. "Treatment plan" means a plan for the treatment
20 of an autism spectrum disorder developed by a licensed
21 physician or licensed psychologist pursuant to a
22 comprehensive evaluation or reevaluation performed
23 in a manner consistent with the most recent clinical
24 report or recommendations of the American academy of
25 pediatrics, as determined by the commissioner by rule.

26 3. Coverage for applied behavior analysis is
27 required pursuant to this section for a maximum
28 benefit amount of thirty-six thousand dollars per year.
29 Beginning in 2020, the commissioner shall, on or before
30 July 1 of each calendar year, publish an adjustment for
31 inflation to the maximum benefit required equal to the
32 percentage change in the medical care component of the
33 United States department of labor consumer price index
34 for all urban consumers in the preceding year, and the
35 published adjusted maximum benefit shall be applicable

1 to group policies, contracts, or plans subject to
2 this section that are delivered, issued for delivery,
3 continued, or renewed on or after January 1 of the
4 following calendar year. Payments made under a group
5 policy, contract, or plan subject to this section on
6 behalf of a covered individual for any treatment other
7 than applied behavior analysis shall not be applied
8 toward the maximum benefit established under this
9 subsection.

10 4. Coverage for applied behavior analysis shall
11 include the services of persons working under the
12 supervision of a behavior analyst certified by a
13 nationally recognized board or under the supervision of
14 a licensed psychologist, to provide applied behavior
15 analysis.

16 5. Coverage required pursuant to this section shall
17 not be subject to any limits on the number of visits an
18 individual may make for treatment of an autism spectrum
19 disorder.

20 6. Coverage required pursuant to this section
21 shall not be subject to dollar limits, deductibles,
22 copayments, or coinsurance provisions, or any other
23 general exclusions or limitations of a group plan
24 that are less favorable to an insured than the dollar
25 limits, deductibles, copayments, or coinsurance
26 provisions that apply to substantially all medical and
27 surgical benefits under the policy, contract, or plan,
28 except as provided in subsection 3.

29 7. Coverage required by this section shall be
30 provided in coordination with coverage required for the
31 treatment of autistic disorders pursuant to section
32 514C.22.

33 8. This section shall not be construed to limit
34 benefits which are otherwise available to an individual
35 under a group policy, contract, or plan.

1 9. This section shall not be construed as affecting
2 any obligation to provide services to an individual
3 under an individualized family service plan, an
4 individualized education program, or an individualized
5 service plan.

6 10. Except for inpatient services, if an insured is
7 receiving treatment for an autism spectrum disorder,
8 an insurer is entitled to review the treatment plan
9 annually, unless the insurer and the insured's treating
10 physician or psychologist agree that a more frequent
11 review is necessary. An agreement giving an insurer
12 the right to review the treatment plan of an insured
13 more frequently applies only to that insured and does
14 not apply to other individuals being treated for autism
15 spectrum disorders by a physician or psychologist. The
16 cost of conducting a review of a treatment plan shall
17 be borne by the insurer.

18 11. This section shall not apply to accident-only,
19 specified disease, short-term hospital or medical,
20 hospital confinement indemnity, credit, dental, vision,
21 Medicare supplement, long-term care, basic hospital
22 and medical-surgical expense coverage as defined
23 by the commissioner, disability income insurance
24 coverage, coverage issued as a supplement to liability
25 insurance, workers' compensation or similar insurance,
26 or automobile medical payment insurance, or individual
27 accident and sickness policies issued to individuals or
28 to individual members of a member association.

29 12. The commissioner shall adopt rules pursuant to
30 chapter 17A to implement and administer this section.

31 13. An insurer shall not terminate coverage of an
32 individual solely because the individual is diagnosed
33 with or has received treatment for an autism spectrum
34 disorder.

35 14. a. By February 1, 2018, and every February 1

1 thereafter, the commissioner shall submit a report to
2 the general assembly regarding implementation of the
3 coverage required under this section. The report shall
4 include information concerning but not limited to all
5 of the following:

6 (1) The total number of insureds diagnosed with
7 autism spectrum disorder in the immediately preceding
8 calendar year.

9 (2) The total cost of all claims paid out in the
10 immediately preceding calendar year for coverage
11 required under this section.

12 (3) The cost of such coverage per insured per
13 month.

14 (4) The average cost per insured per month for
15 coverage of applied behavior analysis required under
16 this section.

17 b. All third-party payment provider policies,
18 contracts, or plans, as specified in subsection 1,
19 and plans established pursuant to chapter 509A shall
20 provide the commissioner with data requested by the
21 commissioner for inclusion in the annual report.

22 15. If any provision of this section or its
23 application to any person or circumstance is held
24 invalid, the invalidity does not affect other
25 provisions or application of this section which can
26 be given effect without the invalid provision or
27 application, and to this end the provisions of this
28 section are severable.

29 16. This section applies to third-party payment
30 provider policies, contracts, or plans, as specified
31 in subsection 1, and to plans established pursuant to
32 chapter 509A, that are delivered, issued for delivery,
33 continued, or renewed in this state on or after January
34 1, 2017.

35 Sec. _____. REPEAL. Section 514C.28, Code 2016, is

1 repealed.

2 Sec. _____. EFFECTIVE DATE. The following provisions
3 of this division of this Act take effect January 1,
4 2017:

5 1. The sections of this division of this Act
6 amending sections 225D.1 and 225D.2.

7 2. The section of this division of this Act
8 repealing section 514C.28.>

9 2. By renumbering as necessary.

By HALL of Woodbury

HOUSE FILE 2460

H-8230

1 Amend the amendment, H-8223, to House File 2460 as
2 follows:

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

4 <____. Page 3, line 25, by striking <1,276,783> and
5 inserting <1,626,783>

6 _____. Page 3, line 26, by striking <17.00> and
7 inserting <~~17.00~~ 20.00>

8 _____. Page 3, after line 29 by inserting:

9 <_____. Of the funds appropriated in this section,
10 \$350,000 shall be used to provide additional long-term
11 care ombudsmen to provide assistance and advocacy
12 related to long-term services and supports under the
13 Medicaid program pursuant to section 231.44.>>

14 2. Page 2, after line 15 by inserting:

15 <____. Page 33, line 23, by striking <1,315,246,446>
16 and inserting <1,317,895,751>

17 _____. Page 36, by striking lines 15 through 27 and
18 inserting:

19 <12. a. Of the funds appropriated in this section,
20 ~~-\$2,041,939~~ \$2,649,305 is allocated for the state
21 match for a disproportionate share hospital payment of
22 ~~-\$4,544,712~~ \$6,059,710 to hospitals that meet both of
23 the conditions specified in subparagraphs (1) and (2).
24 In addition, the hospitals that meet the conditions
25 specified shall either certify public expenditures
26 or transfer to the medical assistance program an
27 amount equal to provide the nonfederal share for a
28 disproportionate share hospital payment of ~~-\$8,772,003~~
29 \$20,573,720. The hospitals that meet the conditions
30 specified shall receive and retain 100 percent of
31 the total disproportionate share hospital payment of
32 ~~-\$13,316,715~~ \$26,633,430.>>

33 3. Page 3, after line 19 by inserting:

34 <____. Page 48, line 1, by striking <88,944,956> and
35 inserting <85,945,651>

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Page 2

1 4. Page 5, after line 19 by inserting:

2 <____. Page 72, by striking lines 19 through 25 and
3 inserting:

4 <~~1. For distribution to any mental health and~~
5 ~~disability services region where 25 percent of the~~
6 ~~region's projected expenditures exceeds the region's~~
7 ~~projected fund balance:~~

8 \$ ~~480,000~~>>

9 5. Page 5, line 21, by striking <3,880,918> and
10 inserting <6,880,223>

11 6. Page 6, after line 13 by inserting:

12 <____. By striking page 80, line 11, through page
13 82, line 1.>

14 7. By renumbering as necessary.

By WESSEL-KROESCHELL of Story

H-8230

FILED APRIL 19, 2016

HOUSE FILE 2460

H-8231

1 Amend House File 2460 as follows:
2 1. Page 95, after line 32 by inserting:
3 <Sec. _____. Section 135.190, subsection 1, as
4 enacted by 2016 Iowa Acts, Senate File 2218, section 1,
5 is amended by adding the following new paragraph:
6 NEW PARAGRAPH. 0a. "Licensed health care
7 professional" means the same as defined in section
8 280.16.
9 Sec. _____. Section 135.190, subsection 1, as enacted
10 by 2016 Iowa Acts, Senate File 2218, section 1, is
11 amended by adding the following new subsection:
12 NEW SUBSECTION. 1A. Notwithstanding any other
13 provision of law to the contrary, a licensed health
14 care professional may prescribe an opioid antagonist to
15 a person in a position to assist.
16 Sec. _____. Section 135.190, subsection 3, as enacted
17 by 2016 Iowa Acts, Senate File 2218, section 1, is
18 amended to read as follows:
19 3. A person in a position to assist or a prescriber
20 of an opioid antagonist who has acted reasonably and in
21 good faith shall not be liable for any injury arising
22 from the provision, administration, or assistance in
23 the administration of an opioid antagonist as provided
24 in this section.>
25 2. Page 96, after line 10 by inserting:
26 <Sec. _____. 2016 Iowa Acts, Senate File 2218,
27 as enacted, is amended by adding the following new
28 section:
29 Sec. _____. EFFECTIVE UPON ENACTMENT. This Act,
30 being deemed of immediate importance, takes effect upon
31 enactment.>
32 3. By renumbering as necessary.

By ISENHART of Dubuque
ABDUL-SAMAD of Polk

H-8231 FILED APRIL 19, 2016

HOUSE FILE 2460

H-8232

1 Amend House File 2460 as follows:
2 1. By striking page 95, line 31, through page 96,
3 line 10.
4 2. By renumbering as necessary.

By KLEIN of Washington

H-8232 FILED APRIL 19, 2016

HOUSE FILE 2460

H-8234

1 Amend House File 2460 as follows:

2 1. Page 66, after line 33 by inserting:

3 <____. For the fiscal year beginning July 1, 2016,
4 the reimbursement rates for providers of supported
5 employment under the Medicaid program shall be adjusted
6 to increase the rates to the extent possible within
7 the \$154,300 of state funding appropriated for this
8 purpose.>

9 2. By renumbering as necessary.

By JONES of Clay

H-8234 FILED APRIL 19, 2016

HOUSE FILE 2460

H-8239

1 Amend House File 2460 as follows:

2 1. Page 22, after line 2 by inserting:

3 <____. The Iowa veterans home shall expand the
4 annual discharge report to also include applicant
5 information and to provide for the collection of
6 demographic information including but not limited to
7 the number of individuals applying for admission and
8 admitted or denied admittance and the basis for the
9 admission or denial; the age, gender, and race of such
10 individuals; and the level of care for which such
11 individuals applied for admission including residential
12 or nursing level of care.>

13 2. By renumbering as necessary.

By SMITH of Marshall

H-8239 FILED APRIL 19, 2016

HOUSE FILE 2460

H-8240

1 Amend House File 2460 as follows:

2 1. By striking page 105, line 4, through page 109,
3 line 19, and inserting:

4 <DIVISION ____
5 HOSPITAL DISCHARGE PLANNING

6 Sec. ____ . HOSPITAL DISCHARGE PLANNING. A hospital
7 licensed pursuant to chapter 135B shall comply with
8 the conditions for participation relating to discharge
9 planning specified in 42 C.F.R. {482.43 as follows:

10 The hospital must have in effect a discharge
11 planning process that applies to all patients. The
12 hospital's policies and procedures must be specified in
13 writing, and include or incorporate as standards the
14 following:

15 1. Standard: Identification of patients in need
16 of discharge planning. The hospital must identify at
17 an early stage of hospitalization all patients who
18 are likely to suffer adverse health consequences upon
19 discharge if there is no adequate discharge planning.

20 2. Standard: Discharge planning evaluation.

21 a. The hospital must provide a discharge planning
22 evaluation to the patients identified in subsection 1,
23 and to other patients upon the patient's request, the
24 request of a person acting on the patient's behalf, or
25 the request of the physician.

26 b. A registered nurse, social worker, or other
27 appropriately qualified personnel must develop, or
28 supervise the development of, the evaluation.

29 c. The discharge planning evaluation must include
30 an evaluation of the likelihood of a patient needing
31 post-hospital services and of the availability of the
32 services.

33 d. The discharge planning evaluation must include
34 an evaluation of the likelihood of a patient's capacity
35 for self-care or of the possibility of the patient

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1 being cared for in the environment from which he or she
2 entered the hospital.

3 e. The hospital personnel must complete the
4 evaluation on a timely basis so that appropriate
5 arrangements for post-hospital care are made before
6 discharge, and to avoid unnecessary delays in
7 discharge.

8 f. The hospital must include the discharge planning
9 evaluation in the patient's medical record for use in
10 establishing an appropriate discharge plan and must
11 discuss the results of the evaluation with the patient
12 or individual acting on his or her behalf.

13 3. Standard: Discharge plan.

14 a. A registered nurse, social worker, or other
15 appropriately qualified personnel must develop, or
16 supervise the development of, a discharge plan if the
17 discharge planning evaluation indicates a need for a
18 discharge plan.

19 b. In the absence of a finding by the hospital
20 that a patient needs a discharge plan, the patient's
21 physician may request a discharge plan. In such a
22 case, the hospital must develop a discharge plan for
23 the patient.

24 c. The hospital must arrange for the initial
25 implementation of the patient's discharge plan.

26 d. The hospital must reassess the patient's
27 discharge plan if there are factors that may affect
28 continuing care needs or the appropriateness of the
29 discharge plan.

30 e. As needed, the patient and family members or
31 interested persons must be counseled to prepare them
32 for post-hospital care.

33 f. The hospital must include in the discharge plan
34 a list of home health agencies or skilled nursing
35 facilities that are available to the patient, that are

1 participating in the Medicare program, and that serve
2 the geographic area, as defined by the home health
3 agency, in which the patient resides, or in the case
4 of a skilled nursing facility, in the geographic area
5 requested by the patient. Home health agencies must
6 request to be listed by the hospital as available.

7 (1) This list must only be presented to patients
8 for whom home health care or post-hospital extended
9 care services are indicated and appropriate as
10 determined by the discharge planning evaluation.

11 (2) For patients enrolled in managed care
12 organizations, the hospital must indicate the
13 availability of home health and post-hospital extended
14 care services through individuals and entities that
15 have a contract with the managed care organizations.

16 (3) The hospital must document in the patient's
17 medical record that the list was presented to the
18 patient or to the individual acting on the patient's
19 behalf.

20 g. The hospital, as part of the discharge planning
21 process, must inform the patient or the patient's
22 family of their freedom to choose among participating
23 Medicare providers of post-hospital care services
24 and must, when possible, respect patient and family
25 preferences when they are expressed. The hospital must
26 not specify or otherwise limit the qualified providers
27 that are available to the patient.

28 h. The discharge plan must identify any home health
29 agency or skilled nursing facility to which the patient
30 is referred in which the hospital has a disclosable
31 financial interest, as specified by the secretary of
32 health and human services, and any home health agency
33 or skilled nursing facility that has a disclosable
34 financial interest in a hospital under Medicare.
35 Financial interests that are disclosable under Medicare

1 are determined in accordance with the provisions of 42
2 C.F.R. pt. 420, subpt. C.

3 4. Standard: Transfer or referral. The hospital
4 must transfer or refer patients, along with necessary
5 medical information, to appropriate facilities,
6 agencies, or outpatient services, as needed, for
7 follow-up or ancillary care.

8 5. Standard: Reassessment. The hospital must
9 reassess its discharge planning process on an ongoing
10 basis. The reassessment must include a review of
11 discharge plans to ensure that they are responsive to
12 discharge needs.>

13 2. By renumbering as necessary.

By BYRNES of Mitchell

HOUSE FILE 2460

H-8243

1 Amend House File 2460 as follows:

2 1. Page 95, after line 32 by inserting:

3 <Sec. _____. Section 135.190, subsection 1, as
4 enacted by 2016 Iowa Acts, Senate File 2218, section 1,
5 is amended by adding the following new paragraph:

6 NEW PARAGRAPH. 0a. "Licensed health care
7 professional" means the same as defined in section
8 280.16.

9 Sec. _____. Section 135.190, subsection 1, as enacted
10 by 2016 Iowa Acts, Senate File 2218, section 1, is
11 amended by adding the following new subsection:

12 NEW SUBSECTION. 1A. Notwithstanding any other
13 provision of law to the contrary, a licensed health
14 care professional may prescribe an opioid antagonist to
15 a person in a position to assist.

16 Sec. _____. Section 135.190, subsection 3, as enacted
17 by 2016 Iowa Acts, Senate File 2218, section 1, is
18 amended to read as follows:

19 3. A person in a position to assist or a prescriber
20 of an opioid antagonist who has acted reasonably and in
21 good faith shall not be liable for any injury arising
22 from the provision, administration, or assistance in
23 the administration of an opioid antagonist as provided
24 in this section.>

25 2. Page 96, after line 10 by inserting:

26 <Sec. _____. 2016 Iowa Acts, Senate File 2218,
27 as enacted, is amended by adding the following new
28 section:

29 Sec. _____. EFFECTIVE UPON ENACTMENT. This Act,
30 being deemed of immediate importance, takes effect upon
31 enactment.

32 Sec. _____. EFFECTIVE DATE. This division of this
33 Act, being deemed of immediate importance, takes effect
34 upon enactment.

35 Sec. _____. RETROACTIVE APPLICABILITY. This division

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Page 2

1 of this Act applies retroactively to April 6, 2016.>

2 3. By renumbering as necessary.

By ISENHART of Dubuque

ABDUL-SAMAD of Polk

H-8243 FILED APRIL 19, 2016

HOUSE FILE 2460

H-8247

1 Amend House File 2460 as follows:

2 1. Page 41, line 14, by striking <17,045,964> and
3 inserting <19,119,864>

4 2. Page 43, after line 3 by inserting:

5 < _____. Of the funds appropriated in this section,
6 \$2,073,900 shall be used for the purposes of additional
7 Medicaid managed care oversight requirements as
8 otherwise specified in this Act, \$360,000 of which
9 shall be transferred to the appropriation in this Act
10 for the office of long-term care ombudsman to be used
11 for the purposes specified in section 231.44.

12 3. Page 85, after line 4 by inserting:

13 <REPORTING OF EXISTING DATA REQUIREMENTS, MINUTES, AND
14 RECOMMENDATIONS>

15 4. Page 92, after line 18 by inserting:

16 <DIVISION ____
17 MEDICAID MANAGED CARE ---- ADDITIONAL OVERSIGHT
18 REQUIREMENTS

19 Sec. _____. LEGISLATIVE FINDINGS ---- GOALS AND INTENT.

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

21 a. In the majority of states, Medicaid managed care
22 has been introduced on an incremental basis, beginning
23 with the enrollment of low-income children and parents
24 and proceeding in stages to include nonelderly persons
25 with disabilities and older individuals. Iowa, unlike
26 the majority of states, is implementing Medicaid
27 managed care simultaneously across a broad and diverse
28 population that includes individuals with complex
29 health care and long-term services and supports needs,
30 making these individuals especially vulnerable to
31 receiving inappropriate, inadequate, or substandard
32 services and supports.

33 b. The success or failure of Medicaid managed
34 care in Iowa depends on proper strategic planning and
35 strong oversight, and the incorporation of the core

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1 values, principles, and goals of the strategic plan
2 into Medicaid managed care contractual obligations.
3 While Medicaid managed care techniques may create
4 pathways and offer opportunities toward quality
5 improvement and predictability in costs, if cost
6 savings and administrative efficiencies are the
7 primary goals, Medicaid managed care may instead erect
8 new barriers and limit the care and support options
9 available, especially to high-need, vulnerable Medicaid
10 recipients. A well-designed strategic plan and
11 effective oversight ensure that cost savings, improved
12 health outcomes, and efficiencies are not achieved
13 at the expense of diminished program integrity, a
14 reduction in the quality or availability of services,
15 or adverse consequences to the health and well-being of
16 Medicaid recipients.

17 c. Strategic planning should include all of the
18 following:

19 (1) Guidance in establishing and maintaining a
20 robust and appropriate workforce and a provider network
21 capable of addressing all of the diverse, distinct, and
22 wide-ranging treatment and support needs of Medicaid
23 recipients.

24 (2) Developing a sound methodology for establishing
25 and adjusting capitation rates to account for all
26 essential costs involved in treating and supporting the
27 entire spectrum of needs across recipient populations.

28 (3) Addressing the sufficiency of information and
29 data resources to enable review of factors such as
30 utilization, service trends, system performance, and
31 outcomes.

32 (4) Building effective working relationships and
33 developing strategies to support community-level
34 integration that provides cross-system coordination
35 and synchronization among the various service sectors,

1 providers, agencies, and organizations to further
2 holistic well-being and population health goals.

3 d. While the contracts entered into between the
4 state and managed care organizations function as a
5 mechanism for enforcing requirements established by the
6 federal and state governments and allow states to shift
7 the financial risk associated with caring for Medicaid
8 recipients to these contractors, the state ultimately
9 retains responsibility for the Medicaid program and
10 the oversight of the performance of the program's
11 contractors. Administration of the Medicaid program
12 benefits by managed care organizations should not be
13 viewed by state policymakers and state agencies as a
14 means of divesting themselves of their constitutional
15 and statutory responsibilities to ensure that
16 recipients of publicly funded services and supports, as
17 well as taxpayers in general, are effectively served.

18 e. Overseeing the performance of Medicaid managed
19 care contractors requires a different set of skills
20 than those required for administering a fee-for-service
21 program. In the absence of the in-house capacity of
22 the department of human services to perform tasks
23 specific to Medicaid managed care oversight, the state
24 essentially cedes its responsibilities to private
25 contractors and relinquishes its accountability to the
26 public. In order to meet these responsibilities, state
27 policymakers must ensure that the state, including the
28 department of human services as the state Medicaid
29 agency, has the authority and resources, including
30 the adequate number of qualified personnel and the
31 necessary tools, to carry out these responsibilities,
32 provide effective administration, and ensure
33 accountability and compliance.

34 f. State policymakers must also ensure that
35 Medicaid managed care contracts contain, at a minimum,

1 clear, unambiguous performance standards, operating
2 guidelines, data collection, maintenance, retention,
3 and reporting requirements, and outcomes expectations
4 so that contractors and subcontractors are held
5 accountable to clear contract specifications.

6 g. As with all system and program redesign efforts
7 undertaken in the state to date, the assumption
8 of the administration of Medicaid program benefits
9 by managed care organizations must involve ongoing
10 stakeholder input and earn the trust and support of
11 these stakeholders. Medicaid recipients, providers,
12 advocates, and other stakeholders have intimate
13 knowledge of the people and processes involved in
14 ensuring the health and safety of Medicaid recipients,
15 and are able to offer valuable insight into the
16 barriers likely to be encountered as well as propose
17 solutions for overcoming these obstacles. Local
18 communities and providers of services and supports
19 have firsthand experience working with the Medicaid
20 recipients they serve and are able to identify factors
21 that must be considered to make a system successful.
22 Agencies and organizations that have specific expertise
23 and experience with the services and supports needs of
24 Medicaid recipients and their families are uniquely
25 placed to provide needed assistance in developing
26 the measures for and in evaluating the quality of the
27 program.

28 2. It is the intent of the general assembly that
29 the Medicaid program be implemented and administered,
30 including through Medicaid managed care policies
31 and contract provisions, in a manner that safeguards
32 the interests of Medicaid recipients, encourages the
33 participation of Medicaid providers, and protects
34 the interests of all taxpayers, while attaining the
35 goals of Medicaid modernization to improve quality and

1 access, promote accountability for outcomes, and create
2 a more predictable and sustainable Medicaid budget.

3 HEALTH POLICY OVERSIGHT COMMITTEE

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

6 6. The legislative health policy oversight
7 committee, which shall be composed of ten members of
8 the general assembly, consisting of five members from
9 each house, to be appointed by the legislative council.
10 The legislative health policy oversight committee
11 shall ~~receive updates and review data, public input and~~
12 ~~concerns, and make recommendations for improvements to~~
13 ~~and changes in law or rule regarding Medicaid managed~~
14 ~~care~~ meet at least four times annually to evaluate
15 state health policy and provide continuing oversight
16 for publicly funded programs, including but not limited
17 to all facets of the Medicaid and hawk-i programs
18 to, at a minimum, ensure effective and efficient
19 administration of these programs, address stakeholder
20 concerns, monitor program costs and expenditures, and
21 make recommendations relative to the programs.

22 Sec. _____. HEALTH POLICY OVERSIGHT COMMITTEE

23 ---- SUBJECT MATTER REVIEW FOR 2016 LEGISLATIVE

24 INTERIM. During the 2016 legislative interim, the
25 health policy oversight committee created in section
26 2.45 shall, as part of the committee's evaluation
27 of state health policy and review of all facets of
28 the Medicaid and hawk-i programs, review and make
29 recommendations regarding, at a minimum, all of the
30 following:

31 1. The resources and duties of the office of
32 long-term care ombudsman relating to the provision of
33 assistance to and advocacy for Medicaid recipients
34 to determine the designation of duties and level of
35 resources necessary to appropriately address the needs

1 of such individuals. The committee shall consider the
2 health consumer ombudsman alliance report submitted to
3 the general assembly in December 2015, as well as input
4 from the office of long-term care ombudsman and other
5 entities in making recommendations.

6 2. The health benefits and health benefit
7 utilization management criteria for the Medicaid
8 and hawk-i programs to determine the sufficiency
9 and appropriateness of the benefits offered and the
10 utilization of these benefits.

11 3. Prior authorization requirements relative
12 to benefits provided under the Medicaid and hawk-i
13 programs, including but not limited to pharmacy
14 benefits.

15 4. Consistency and uniformity in processes,
16 procedures, forms, and other activities across all
17 Medicaid and hawk-i program participating insurers and
18 managed care organizations, including but not limited
19 to cost and quality reporting, credentialing, billing,
20 prior authorization, and critical incident reporting.

21 5. Provider network adequacy including the use of
22 out-of-network and out-of-state providers.

23 6. The role and interplay of other advisory and
24 oversight entities, including but not limited to the
25 medical assistance advisory council and the hawk-i
26 board.

27 REVIEW OF PROGRAM INTEGRITY DUTIES

28 Sec. ____ REVIEW OF PROGRAM INTEGRITY DUTIES ----
29 WORKGROUP ---- REPORT.

30 1. The director of human services shall convene
31 a workgroup comprised of members including the
32 commissioner of insurance, the auditor of state, the
33 Medicaid director and bureau chiefs of the managed care
34 organization oversight and supports bureau, the Iowa
35 Medicaid enterprise support bureau, and the medical

1 and long-term services and supports bureau, and a
2 representative of the program integrity unit, or their
3 designees; and representatives of other appropriate
4 state agencies or other entities including but not
5 limited to the office of the attorney general, the
6 office of long-term care ombudsman, and the Medicaid
7 fraud control unit of the investigations division
8 of the department of inspections and appeals. The
9 workgroup shall do all of the following:

10 a. Review the duties of each entity with
11 responsibilities relative to Medicaid program integrity
12 and managed care organizations; review state and
13 federal laws, regulations, requirements, guidance, and
14 policies relating to Medicaid program integrity and
15 managed care organizations; and review the laws of
16 other states relating to Medicaid program integrity
17 and managed care organizations. The workgroup shall
18 determine areas of duplication, fragmentation,
19 and gaps; shall identify possible integration,
20 collaboration and coordination of duties; and shall
21 determine whether existing general state Medicaid
22 program and fee-for-service policies, laws, and
23 rules are sufficient, or if changes or more specific
24 policies, laws, and rules are required to provide
25 for comprehensive and effective administration and
26 oversight of the Medicaid program including under the
27 fee-for-service and managed care methodologies.

28 b. Review historical uses of the Medicaid
29 fraud fund created in section 249A.50 and make
30 recommendations for future uses of the moneys in the
31 fund and any changes in law necessary to adequately
32 address program integrity.

33 c. Review medical loss ratio provisions relative
34 to Medicaid managed care contracts and make
35 recommendations regarding, at a minimum, requirements

1 for the necessary collection, maintenance, retention,
2 reporting, and sharing of data and information by
3 Medicaid managed care organizations for effective
4 determination of compliance, and to identify the
5 costs and activities that should be included in the
6 calculation of administrative costs, medical costs or
7 benefit expenses, health quality improvement costs,
8 and other costs and activities incidental to the
9 determination of a medical loss ratio.

10 d. Review the capacity of state agencies, including
11 the need for specialized training and expertise, to
12 address Medicaid and managed care organization program
13 integrity and provide recommendations for the provision
14 of necessary resources and infrastructure, including
15 annual budget projections.

16 e. Review the incentives and penalties applicable
17 to violations of program integrity requirements to
18 determine their adequacy in combating waste, fraud,
19 abuse, and other violations that divert limited
20 resources that would otherwise be expended to safeguard
21 the health and welfare of Medicaid recipients, and make
22 recommendations for necessary adjustments to improve
23 compliance.

24 f. Make recommendations regarding the quarterly and
25 annual auditing of financial reports required to be
26 performed for each Medicaid managed care organization
27 to ensure that the activities audited provide
28 sufficient information to the division of insurance
29 of the department of commerce and the department
30 of human services to ensure program integrity. The
31 recommendations shall also address the need for
32 additional audits or other reviews of managed care
33 organizations.

34 g. Review and make recommendations to prohibit
35 cost-shifting between state and local and public and

1 private funding sources for services and supports
2 provided to Medicaid recipients whether directly or
3 indirectly through the Medicaid program.

4 2. The department of human services shall submit
5 a report of the workgroup to the governor, the health
6 policy oversight committee created in section 2.45,
7 and the general assembly initially, on or before
8 November 15, 2016, and on or before November 15,
9 on an annual basis thereafter, to provide findings
10 and recommendations for a coordinated approach
11 to comprehensive and effective administration and
12 oversight of the Medicaid program including under the
13 fee-for-service and managed care methodologies.

14 MEDICAID OMBUDSMAN

15 Sec. _____. Section 231.44, Code 2016, is amended to
16 read as follows:

17 231.44 Utilization of resources ---- assistance and
18 advocacy related to long-term services and supports
19 under the Medicaid program.

20 1. The office of long-term care ombudsman ~~may~~
21 shall utilize its available resources to provide
22 assistance and advocacy services to eligible recipients
23 of long-term services and supports, or individuals
24 seeking long-term services and supports, and the
25 families or legal representatives of such eligible
26 recipients, of long term services and supports provided
27 ~~through~~ individuals under the Medicaid program. Such
28 assistance and advocacy shall include but is not
29 limited to all of the following:

30 a. Assisting recipients such individuals in
31 understanding the services, coverage, and access
32 provisions and their rights under Medicaid managed
33 care.

34 b. Developing procedures for the tracking and
35 reporting of the outcomes of individual requests for

1 assistance, the obtaining of necessary services and
2 supports, and other aspects of the services provided to
3 eligible recipients such individuals.

4 c. Providing advice and assistance relating to the
5 preparation and filing of complaints, grievances, and
6 appeals of complaints or grievances, including through
7 processes available under managed care plans and the
8 state appeals process, relating to long-term services
9 and supports under the Medicaid program.

10 d. Accessing the results of a review of a level
11 of care assessment or reassessment by a managed care
12 organization in which the managed care organization
13 recommends denial or limited authorization of a
14 service, including the type or level of service, the
15 reduction, suspension, or termination of a previously
16 authorized service, or a change in level of care, upon
17 the request of an affected individual.

18 e. Receiving notices of disenrollment or notices
19 that would result in a change in level of care for
20 affected individuals, including involuntary and
21 voluntary discharges or transfers, from the department
22 of human services or a managed care organization.

23 2. A representative of the office of long-term care
24 ombudsman providing assistance and advocacy services
25 authorized under this section for an individual,
26 shall be provided access to the individual, and shall
27 be provided access to the individual's medical and
28 social records as authorized by the individual or the
29 individual's legal representative, as necessary to
30 carry out the duties specified in this section.

31 3. A representative of the office of long-term care
32 ombudsman providing assistance and advocacy services
33 authorized under this section for an individual, shall
34 be provided access to administrative records related to
35 the provision of the long-term services and supports to

1 the individual, as necessary to carry out the duties
2 specified in this section.

3 4. The office of long-term care ombudsman and
4 representatives of the office, when providing
5 assistance and advocacy services under this section,
6 shall be considered a health oversight agency as
7 defined in 45 C.F.R. {164.501 for the purposes of
8 health oversight activities as described in 45 C.F.R.
9 {164.512(d) including access to the health records
10 and other appropriate information of an individual,
11 including from the department of human services or
12 the applicable Medicaid managed care organization,
13 as necessary to fulfill the duties specified under
14 this section. The department of human services,
15 in collaboration with the office of long-term care
16 ombudsman, shall adopt rules to ensure compliance
17 by affected entities with this subsection and to
18 ensure recognition of the office of long-term care
19 ombudsman as a duly authorized and identified agent or
20 representative of the state.

21 5. The department of human services and Medicaid
22 managed care organizations shall inform eligible
23 and potentially eligible Medicaid recipients of the
24 advocacy services and assistance available through the
25 office of long-term care ombudsman and shall provide
26 contact and other information regarding the advocacy
27 services and assistance to eligible and potentially
28 eligible Medicaid recipients as directed by the office
29 of long-term care ombudsman.

30 6. When providing assistance and advocacy services
31 under this section, the office of long-term care
32 ombudsman shall act as an independent agency, and the
33 office of long-term care ombudsman and representatives
34 of the office shall be free of any undue influence that
35 restrains the ability of the office or the office's

1 representatives from providing such services and
2 assistance.

3 7. The office of long-term care ombudsman shall, in
4 addition to other duties prescribed and at a minimum,
5 do all of the following in the furtherance of the
6 provision of advocacy services and assistance under
7 this section:

8 a. Represent the interests of eligible and
9 potentially eligible Medicaid recipients before
10 governmental agencies.

11 b. Analyze, comment on, and monitor the development
12 and implementation of federal, state, and local laws,
13 regulations, and other governmental policies and
14 actions, and recommend any changes in such laws,
15 regulations, policies, and actions as determined
16 appropriate by the office of long-term care ombudsman.

17 c. To maintain transparency and accountability for
18 activities performed under this section, including
19 for the purposes of claiming federal financial
20 participation for activities that are performed to
21 assist with administration of the Medicaid program:

22 (1) Have complete and direct responsibility for the
23 administration, operation, funding, fiscal management,
24 and budget related to such activities, and directly
25 employ, oversee, and supervise all paid and volunteer
26 staff associated with these activities.

27 (2) Establish separation-of-duties requirements,
28 provide limited access to work space and work
29 product for only necessary staff, and limit access to
30 documents and information as necessary to maintain the
31 confidentiality of the protected health information of
32 individuals served under this section.

33 (3) Collect and submit, annually, to the governor,
34 the health policy oversight committee created in
35 section 2.45, and the general assembly, all of the

1 following with regard to those seeking advocacy
2 services or assistance under this section:

3 (a) The number of contacts by contact type and
4 geographic location.

5 (b) The type of assistance requested including the
6 name of the managed care organization involved, if
7 applicable.

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

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

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

14 (f) The outcomes of requests to address problems or
15 concerns.

16 ~~4.~~ 8. For the purposes of this section:

17 a. "Institutional setting" includes a long-term care
18 facility, an elder group home, or an assisted living
19 program.

20 b. "Long-term services and supports" means the broad
21 range of health, health-related, and personal care
22 assistance services and supports, provided in both
23 institutional settings and home and community-based
24 settings, necessary for older individuals and persons
25 with disabilities who experience limitations in their
26 capacity for self-care due to a physical, cognitive, or
27 mental disability or condition.

28 Sec. ____ NEW SECTION. 231.44A Willful
29 interference with duties related to long-term services
30 and supports ---- penalty.

31 Willful interference with a representative of the
32 office of long-term care ombudsman in the performance
33 of official duties in accordance with section 231.44
34 is a violation of section 231.44, subject to a penalty
35 prescribed by rule. The office of long-term care

1 ombudsman shall adopt rules specifying the amount of a
2 penalty imposed, consistent with the penalties imposed
3 under section 231.42, subsection 8, and specifying
4 procedures for notice and appeal of penalties imposed.

5 MEDICAL ASSISTANCE ADVISORY COUNCIL

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

8 249A.4B Medical assistance advisory council.

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

20 a. The council shall have the opportunity for
21 participation in policy development and program
22 administration, including furthering the participation
23 of recipients of the program, and without limiting this
24 general authority shall specifically do all of the
25 following:

26 (1) Formulate, review, evaluate, and recommend
27 policies, rules, agency initiatives, and legislation
28 pertaining to the Medicaid program. The council shall
29 have the opportunity to comment on proposed rules
30 prior to commencement of the rulemaking process and on
31 waivers and state plan amendment applications.

32 (2) Prior to the annual budget development process,
33 engage in setting priorities, including consideration
34 of the scope and utilization management criteria
35 for benefits, beneficiary eligibility, provider and

1 services reimbursement rates, and other budgetary
2 issues.

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

5 (4) Ensure that the membership of the council
6 effectively represents all relevant and concerned
7 viewpoints, particularly those of consumers, providers,
8 and the general public; create public understanding;
9 and ensure that the services provided under the
10 Medicaid program meet the needs of the people served.

11 b. The council shall meet ~~no more than~~ at least
12 quarterly, and prior to the next subsequent meeting
13 of the executive committee. ~~The director of public~~
14 health The public member acting as a co-chairperson
15 of the executive committee and the professional or
16 business entity member acting as a co-chairperson of
17 the executive committee, shall serve as ~~chairperson~~
18 co-chairpersons of the council.

19 2. The council shall include all of the following
20 voting members:

21 a. The president, or the president's
22 representative, of each of the following professional
23 or business entities, or a member of each of the
24 following professional or business entities, selected
25 by the entity:

- 26 (1) The Iowa medical society.
- 27 (2) The Iowa osteopathic medical association.
- 28 (3) The Iowa academy of family physicians.
- 29 (4) The Iowa chapter of the American academy of
- 30 pediatrics.
- 31 (5) The Iowa physical therapy association.
- 32 (6) The Iowa dental association.
- 33 (7) The Iowa nurses association.
- 34 (8) The Iowa pharmacy association.
- 35 (9) The Iowa podiatric medical society.

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

- 1 (38) The Iowa state association of counties.
- 2 (39) The Iowa developmental disabilities council.
- 3 (40) The Iowa chiropractic society.
- 4 (41) The Iowa academy of nutrition and dietetics.
- 5 (42) The Iowa behavioral health association.
- 6 (43) The midwest association for medical equipment
- 7 services or an affiliated Iowa organization.
- 8 (44) The Iowa public health association.
- 9 (45) The epilepsy foundation.

10 b. Public representatives which may include members
11 of consumer groups, including recipients of medical
12 assistance or their families, consumer organizations,
13 and others, which shall be appointed by the governor
14 in equal in number to the number of representatives of
15 the professional and business entities specifically
16 represented under paragraph "a", appointed by the
17 governor for staggered terms of two years each, none
18 of whom shall be members of, or practitioners of, or
19 have a pecuniary interest in any of the professional
20 or business entities specifically represented under
21 paragraph "a", and a majority of whom shall be current
22 or former recipients of medical assistance or members
23 of the families of current or former recipients.

24 3. The council shall include all of the following
25 nonvoting members:

- 26 ~~e.~~ a. The director of public health, or the
- 27 director's designee.
- 28 ~~d.~~ b. The director of the department on aging, or
- 29 the director's designee.
- 30 c. The state long-term care ombudsman, or the
- 31 ombudsman's designee.
- 32 d. The ombudsman appointed pursuant to section
- 33 2C.3, or the ombudsman's designee.
- 34 e. The dean of Des Moines university ---- osteopathic
- 35 medical center, or the dean's designee.

1 f. The dean of the university of Iowa college of
2 medicine, or the dean's designee.

3 g. The following members of the general assembly,
4 each for a term of two years as provided in section
5 69.16B:

6 (1) Two members of the house of representatives,
7 one appointed by the speaker of the house of
8 representatives and one appointed by the minority
9 leader of the house of representatives from their
10 respective parties.

11 (2) Two members of the senate, one appointed by the
12 president of the senate after consultation with the
13 majority leader of the senate and one appointed by the
14 minority leader of the senate.

15 ~~3.~~ 4. a. An executive committee of the council is
16 created and shall consist of the following members of
17 the council:

18 (1) As voting members:

19 (a) Five of the professional or business entity
20 members designated pursuant to subsection 2, paragraph
21 "a", and selected by the members specified under that
22 paragraph.

23 ~~(2)~~ (b) Five of the public members appointed
24 pursuant to subsection 2, paragraph "b", and selected
25 by the members specified under that paragraph. Of the
26 five public members, at least one member shall be a
27 recipient of medical assistance.

28 ~~(3)~~ (2) As nonvoting members:

29 (a) The director of public health, or the
30 director's designee.

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

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

35 (d) The ombudsman appointed pursuant to section

1 2C.3, or the ombudsman's designee.

2 b. The executive committee shall meet on a monthly
3 basis. ~~The director of public health~~ A public member
4 of the executive committee selected by the public
5 members appointed pursuant to subsection 2, paragraph
6 "b", and a professional or business entity member of
7 the executive committee selected by the professional
8 or business entity members appointed pursuant to
9 subsection 2, paragraph "a", shall serve as chairperson
10 co-chairpersons of the executive committee.

11 c. Based upon the deliberations of the council,
12 ~~and the executive committee, and the subcommittees,~~
13 the executive committee, the council, and the
14 subcommittees, respectively, shall make recommendations
15 to the director, to the health policy oversight
16 committee created in section 2.45, to the general
17 assembly's joint appropriations subcommittee on health
18 and human services, and to the general assembly's
19 standing committees on human resources regarding the
20 budget, policy, and administration of the medical
21 assistance program.

22 5. a. The council shall create the following
23 subcommittees, and may create additional subcommittees
24 as necessary to address Medicaid program policies,
25 administration, budget, and other factors and issues:

26 (1) A stakeholder safeguards subcommittee, for
27 which the co-chairpersons shall be a public member
28 of the council appointed pursuant to subsection 2,
29 paragraph "b", and selected by the public members of
30 the council, and a representative of a professional
31 or business entity appointed pursuant to subsection
32 2, paragraph "a", and selected by the professional or
33 business entity representatives of the council. The
34 mission of the stakeholder safeguards subcommittee
35 is to provide for ongoing stakeholder engagement and

1 feedback on issues affecting Medicaid recipients,
2 providers, and other stakeholders, including but not
3 limited to benefits such as transportation, benefit
4 utilization management, the inclusion of out-of-state
5 and out-of-network providers and the use of single-case
6 agreements, and reimbursement of providers and
7 services.

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

1 (3) The transparency, data, and program evaluation
2 subcommittee which shall be chaired by the director of
3 the university of Iowa public policy center, or the
4 director's designee. The mission of the transparency,
5 data, and program evaluation subcommittee is to
6 ensure Medicaid program transparency; ensure the
7 collection, maintenance, retention, reporting, and
8 analysis of sufficient and meaningful data to provide
9 transparency and inform policy development and program
10 effectiveness; support development and administration
11 of a consumer-friendly dashboard; and promote the
12 ongoing evaluation of Medicaid stakeholder satisfaction
13 with the Medicaid program.

14 (4) The program integrity subcommittee which shall
15 be chaired by the Medicaid director, or the director's
16 designee. The mission of the program integrity
17 subcommittee is to ensure that a comprehensive system
18 including specific policies, laws, and rules and
19 adequate resources and measures are in place to
20 effectively administer the program and to maintain
21 compliance with federal and state program integrity
22 requirements.

23 (5) A health workforce subcommittee, co-chaired
24 by the bureau chief of the bureau of oral and health
25 delivery systems of the department of public health,
26 or the bureau chief's designee, and the director of
27 the national alliance on mental illness of Iowa, or
28 the director's designee. The mission of the health
29 workforce subcommittee is to assess the sufficiency
30 and proficiency of the current and projected health
31 workforce; identify barriers to and gaps in health
32 workforce development initiatives and health
33 workforce data to provide foundational, evidence-based
34 information to inform policymaking and resource
35 allocation; evaluate the most efficient application

1 and utilization of roles, functions, responsibilities,
2 activities, and decision-making capacity of health
3 care professionals and other allied and support
4 personnel; and make recommendations for improvement
5 in, and alternative modes of, health care delivery in
6 order to provide a competent, diverse, and sustainable
7 health workforce in the state. The subcommittee shall
8 work in collaboration with the office of statewide
9 clinical education programs of the university of Iowa
10 Carver college of medicine, Des Moines university,
11 Iowa workforce development, and other entities with
12 interest or expertise in the health workforce in
13 carrying out the subcommittee's duties and developing
14 recommendations.

15 b. The co-chairpersons of the council shall
16 appoint members to each subcommittee from the general
17 membership of the council. Consideration in appointing
18 subcommittee members shall include the individual's
19 knowledge about, and interest or expertise in, matters
20 that come before the subcommittee.

21 c. Subcommittees shall meet at the call of the
22 co-chairpersons or chairperson of the subcommittee,
23 or at the request of a majority of the members of the
24 subcommittee.

25 4- 6. For each council meeting, executive
26 committee meeting, or subcommittee meeting, a quorum
27 shall consist of fifty percent of the membership
28 qualified to vote. Where a quorum is present, a
29 position is carried by a majority of the members
30 qualified to vote.

31 7. For each council meeting, other than those
32 held during the time the general assembly is in
33 session, each legislative member of the council shall
34 be reimbursed for actual travel and other necessary
35 expenses and shall receive a per diem as specified in

1 section 7E.6 for each day in attendance, as shall the
2 members of the council, ~~or~~ the executive committee,
3 or a subcommittee, for each day in attendance at a
4 council, executive committee, or subcommittee meeting,
5 who are recipients or the family members of recipients
6 of medical assistance, regardless of whether the
7 general assembly is in session.

8 ~~5.~~ 8. The department shall provide staff support
9 and independent technical assistance to the council,
10 ~~and~~ the executive committee, and the subcommittees.

11 ~~6.~~ 9. The director shall ~~consider~~ comply with
12 the requirements of this section regarding the
13 duties of the council, and the deliberations and
14 recommendations offered by of the council, and the
15 executive committee, and the subcommittees shall be
16 reflected in the director's preparation of medical
17 assistance budget recommendations to the council
18 on human services pursuant to section 217.3, and in
19 implementation of medical assistance program policies,
20 and in administration of the Medicaid program.

21 10. The council, executive committee, and
22 subcommittees shall jointly submit quarterly reports
23 to the health policy oversight committee created in
24 section 2.45 and shall jointly submit a report to the
25 governor and the general assembly initially by January
26 1, 2017, and annually, therefore, summarizing the
27 outcomes and findings of their respective deliberations
28 and any recommendations including but not limited to
29 those for changes in law or policy.

30 11. The council, executive committee, and
31 subcommittees may enlist the services of persons who
32 are qualified by education, expertise, or experience
33 to advise, consult with, or otherwise assist the
34 council, executive committee, or subcommittees in the
35 performance of their duties. The council, executive

1 committee, or subcommittees may specifically enlist
2 the assistance of entities such as the university of
3 Iowa public policy center to provide ongoing evaluation
4 of the Medicaid program and to make evidence-based
5 recommendations to improve the program. The council,
6 executive committee, and subcommittees shall enlist
7 input from the patient-centered health advisory council
8 created in section 135.159, the mental health and
9 disabilities services commission created in section
10 225C.5, the commission on aging created in section
11 231.11, the bureau of substance abuse of the department
12 of public health, the Iowa developmental disabilities
13 council, and other appropriate state and local entities
14 to provide advice to the council, executive committee,
15 and subcommittees.

16 12. The department, in accordance with 42 C.F.R.
17 {431.12, shall seek federal financial participation for
18 the activities of the council, the executive committee,
19 and the subcommittees.

20 PATIENT-CENTERED HEALTH RESOURCES AND INFRASTRUCTURE
21 Sec. ____. Section 135.159, subsection 2, Code 2016,
22 is amended to read as follows:

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

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

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

1 b. Public members of the patient-centered health
2 advisory council shall receive reimbursement for
3 actual expenses incurred while serving in their
4 official capacity only if they are not eligible for
5 reimbursement by the organization that they represent.

6 c. (1) Beginning July 1, 2016, the
7 patient-centered health advisory council shall
8 do all of the following:

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

25 (b) Assist in efforts to evaluate the health
26 workforce to inform policymaking and resource
27 allocation.

28 (2) The patient-centered health advisory council
29 shall submit a report to the department, the health
30 policy oversight committee created in section 2.45, and
31 the general assembly, initially, on or before December
32 15, 2016, and on or before December 15, annually,
33 thereafter, including any findings or recommendations
34 resulting from the council's deliberations.

35 HAWK-I PROGRAM

1 Sec. _____. Section 514I.5, subsection 8, paragraph
2 d, Code 2016, is amended by adding the following new
3 subparagraph:

4 NEW SUBPARAGRAPH. (17) Occupational therapy.

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

7 NEW PARAGRAPH. m. The definition of medically
8 necessary and the utilization management criteria under
9 the hawk-i program in order to ensure that benefits
10 are uniformly and consistently provided across all
11 participating insurers in the type and manner that
12 reflects and appropriately meets the needs, including
13 but not limited to the habilitative and rehabilitative
14 needs, of the child population including those children
15 with special health care needs.

16 MEDICAID PROGRAM POLICY IMPROVEMENT

17 Sec. _____. DIRECTIVES FOR MEDICAID PROGRAM POLICY
18 IMPROVEMENTS. In order to safeguard the interests
19 of Medicaid recipients, encourage the participation
20 of Medicaid providers, and protect the interests
21 of all taxpayers, the department of human services
22 shall comply with or ensure that the specified entity
23 complies with all of the following and shall amend
24 Medicaid managed care contract provisions as necessary
25 to reflect all of the following:

26 1. CONSUMER PROTECTIONS.

27 a. In accordance with 42 C.F.R. {438.420, a
28 Medicaid managed care organization shall continue a
29 recipient's benefits during an appeal process. If, as
30 allowed when final resolution of an appeal is adverse
31 to the Medicaid recipient, the Medicaid managed care
32 organization chooses to recover the costs of the
33 services furnished to the recipient while an appeal is
34 pending, the Medicaid managed care organization shall
35 provide adequate prior notice of potential recovery

1 of costs to the recipient at the time the appeal is
2 filed, and any costs recovered shall be remitted to the
3 department of human services.

4 b. Ensure that each Medicaid managed care
5 organization provides, at a minimum, all the benefits
6 and services deemed medically necessary that were
7 covered, including to the extent and in the same manner
8 and subject to the same prior authorization criteria,
9 by the state program directly under fee for service
10 prior to January 1, 2016. Benefits covered through
11 Medicaid managed care shall comply with the specific
12 requirements in state law applicable to the respective
13 Medicaid recipient population under fee for service.

14 c. Enhance monitoring of the reduction in or
15 suspension or termination of services provided to
16 Medicaid recipients, including reductions in the
17 provision of home and community-based services waiver
18 services or increases in home and community-based
19 services waiver waiting lists. Medicaid managed care
20 organizations shall provide data to the department
21 as necessary for the department to compile periodic
22 reports on the numbers of individuals transferred from
23 state institutions and long-term care facilities to
24 home and community-based services, and the associated
25 savings. Any savings resulting from the transfers as
26 certified by the department shall be remitted to the
27 department of human services.

28 d. (1) Require each Medicaid managed care
29 organization to adhere to reasonableness and service
30 authorization standards that are appropriate for and
31 do not disadvantage those individuals who have ongoing
32 chronic conditions or who require long-term services
33 and supports. Services and supports for individuals
34 with ongoing chronic conditions or who require
35 long-term services and supports shall be authorized in

1 a manner that reflects the recipient's continuing need
2 for such services and supports, and limits shall be
3 consistent with a recipient's current needs assessment
4 and person-centered service plan.

5 (2) In addition to other provisions relating to
6 community-based case management continuity of care
7 requirements, Medicaid managed care contractors shall
8 provide the option to the case manager of a Medicaid
9 recipient who retained the case manager during the
10 six months of transition to Medicaid managed care, if
11 the recipient chooses to continue to retain that case
12 manager beyond the six-month transition period and
13 if the case manager is not otherwise a participating
14 provider of the recipient's managed care organization
15 provider network, to enter into a single case agreement
16 to continue to provide case management services to the
17 Medicaid recipient.

18 e. Ensure that Medicaid recipients are provided
19 care coordination and case management by appropriately
20 trained professionals in a conflict-free manner. Care
21 coordination and case management shall be provided
22 in a patient-centered and family-centered manner
23 that requires a knowledge of community supports, a
24 reasonable ratio of care coordinators and case managers
25 to Medicaid recipients, standards for frequency of
26 contact with the Medicaid recipient, and specific and
27 adequate reimbursement.

28 f. A Medicaid managed care contract shall include
29 a provision for continuity and coordination of care
30 for a consumer transitioning to Medicaid managed care,
31 including maintaining existing provider-recipient
32 relationships and honoring the amount, duration, and
33 scope of a recipient's authorized services based on
34 the recipient's medical history and needs. In the
35 initial transition to Medicaid managed care, to ensure

1 the least amount of disruption, Medicaid managed
2 care organizations shall provide, at a minimum, a
3 one-year transition of care period for all provider
4 types, regardless of network status with an individual
5 Medicaid managed care organization.

6 g. Ensure that a Medicaid managed care organization
7 does not arbitrarily deny coverage for medically
8 necessary services based solely on financial reasons
9 and does not shift the responsibility for provision of
10 services or payment of costs of services to another
11 entity to avoid costs or attain savings.

12 h. Ensure that dental coverage, if not integrated
13 into an overall Medicaid managed care contract, is
14 part of the overall holistic, integrated coverage
15 for physical, behavioral, and long-term services and
16 supports provided to a Medicaid recipient.

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

32 j. Provide periodic reports to the governor and
33 the general assembly regarding changes in quality of
34 care and health outcomes for Medicaid recipients under
35 managed care compared to quality of care and health

1 outcomes of the same populations of Medicaid recipients
2 prior to January 1, 2016.

3 k. Require each Medicaid managed care organization
4 to maintain records of complaints, grievances, and
5 appeals, and report the number and types of complaints,
6 grievances, and appeals filed, the resolution of each,
7 and a description of any patterns or trends identified
8 to the department of human services and the health
9 policy oversight committee created in section 2.45,
10 on a monthly basis. The department shall review and
11 compile the data on a quarterly basis and make the
12 compilations available to the public. Following review
13 of reports submitted by the department, a Medicaid
14 managed care organization shall take any corrective
15 action required by the department and shall be subject
16 to any applicable penalties.

17 1. Require Medicaid managed care organizations to
18 survey Medicaid recipients, to collect satisfaction
19 data using a uniform instrument, and to provide a
20 detailed analysis of recipient satisfaction as well as
21 various metrics regarding the volume of and timelines
22 in responding to recipient complaints and grievances as
23 directed by the department of human services.

24 m. Require managed care organizations to allow a
25 recipient to request that the managed care organization
26 enter into a single case agreement with a recipient's
27 out-of-network provider, including a provider outside
28 of the state, to provide for continuity of care when
29 the recipient has an existing relationship with the
30 provider to provide a covered benefit, or to ensure
31 adequate or timely access to a provider of a covered
32 benefit when the managed care organization provider
33 network cannot ensure such adequate or timely access.

34 2. CHILDREN.

35 a. (1) The hawk-i board shall retain all authority

1 specified under chapter 514I relative to the children
2 eligible under section 514I.8 to participate in the
3 hawk-i program, including but not limited to approving
4 any contract entered into pursuant to chapter 514I;
5 approving the benefit package design, reviewing the
6 benefit package design, and making necessary changes
7 to reflect the results of the reviews; and adopting
8 rules for the hawk-i program including those related
9 to qualifying standards for selecting participating
10 insurers for the program and the benefits to be
11 included in a health plan.

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

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

33 (a) Specifically and appropriately address
34 the unique needs of children and children's health
35 delivery.

1 (b) Provide for the maintaining of child health
2 panels that include representatives of child health,
3 welfare, policy, and advocacy organizations in the
4 state that address child health and child well-being.

5 (c) Address early intervention and prevention
6 strategies, the provision of a child health care
7 delivery infrastructure for children with special
8 health care needs, utilization of current standards
9 and guidelines for children's health care and
10 pediatric-specific screening and assessment tools,
11 the inclusion of pediatric specialty providers in
12 the provider network, and the utilization of health
13 homes for children and youth with special health
14 care needs including intensive care coordination
15 and family support and access to a professional
16 family-to-family support system. Such contracts
17 shall utilize pediatric-specific quality measures
18 and assessment tools which shall align with existing
19 pediatric-specific measures as determined in
20 consultation with the child health panel and approved
21 by the hawk-i board.

22 (d) Provide special incentives for innovative
23 and evidence-based preventive, behavioral, and
24 developmental health care and mental health care
25 for children's programs that improve the life course
26 trajectory of these children.

27 (e) Provide that information collected from the
28 pediatric-specific assessments be used to identify
29 health risks and social determinants of health that
30 impact health outcomes. Such data shall be used in
31 care coordination and interventions to improve patient
32 outcomes and to drive program designs that improve the
33 health of the population. Aggregate assessment data
34 shall be shared with affected providers on a routine
35 basis.

1 b. In order to monitor the quality of and access
2 to health care for children receiving coverage under
3 the Medicaid program, each Medicaid managed care
4 organization shall uniformly report, in a template
5 format designated by the department of human services,
6 the number of claims submitted by providers and the
7 percentage of claims approved by the Medicaid managed
8 care organization for the early and periodic screening,
9 diagnostic, and treatment (EPSDT) benefit based
10 on the Iowa EPSDT care for kids health maintenance
11 recommendations, including but not limited to
12 physical exams, immunizations, the seven categories of
13 developmental and behavioral screenings, vision and
14 hearing screenings, and lead testing.

15 3. PROVIDER PARTICIPATION ENHANCEMENT.

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

29 b. To enhance continuity of care in the provision
30 of pharmacy services, Medicaid managed care
31 organizations shall utilize the same preferred drug
32 list, recommended drug list, prior authorization
33 criteria, and other utilization management strategies
34 that apply to the state program directly under fee for
35 service and shall apply other provisions of applicable

1 state law including those relating to chemically unique
2 mental health prescription drugs. Reimbursement rates
3 established under Medicaid managed care contracts for
4 ingredient cost reimbursement and dispensing fees shall
5 be subject to and shall reflect provisions of state
6 and federal law, including the minimum reimbursements
7 established in state law for fee for service for a
8 fiscal year.

9 c. Address rate setting and reimbursement of the
10 entire scope of services provided under the Medicaid
11 program to ensure the adequacy of the provider network
12 and to ensure that providers that contribute to the
13 holistic health of the Medicaid recipient, whether
14 inside or outside of the provider network, are
15 compensated for their services.

16 d. Managed care contractors shall submit financial
17 documentation to the department of human services
18 demonstrating payment of claims and expenses by
19 provider type.

20 e. Participating Medicaid providers under a managed
21 care contract shall be allowed to submit claims for up
22 to 365 days following discharge of a Medicaid recipient
23 from a hospital or following the date of service.

24 f. If the department of human services collects
25 ownership and control information from Medicaid
26 providers pursuant to 42 C.F.R. {455.104, a managed
27 care organization under contract with the state shall
28 not also require submission of this information from
29 approved enrolled Medicaid providers.

30 g. (1) Ensure that a Medicaid managed care
31 organization develops and maintains a provider network
32 of qualified providers who meet state licensing,
33 credentialing, and certification requirements, as
34 applicable, which network shall be sufficient to
35 provide adequate access to all services covered and for

1 all populations served under the managed care contract.
2 Medicaid managed care organizations shall incorporate
3 existing and traditional providers, including but
4 not limited to those providers that comprise the Iowa
5 collaborative safety net provider network created in
6 section 135.153, into their provider networks.

7 (2) Ensure that respective Medicaid populations
8 are managed at all times within funding limitations
9 and contract terms. The department shall also
10 monitor service delivery and utilization to ensure
11 the responsibility for provision of services to
12 Medicaid recipients is not shifted to non-Medicaid
13 covered services to attain savings, and that such
14 responsibility is not shifted to mental health and
15 disability services regions, local public health
16 agencies, aging and disability resource centers,
17 or other entities unless agreement to provide, and
18 provision for adequate compensation for, such services
19 is agreed to between the affected entities in advance.

20 h. Medicaid managed care organizations shall
21 provide an enrolled Medicaid provider approved by the
22 department of human services the opportunity to be a
23 participating network provider.

24 i. Medicaid managed care organizations shall
25 include provider appeals and grievance procedures
26 that in part allow a provider to file a grievance
27 independently but on behalf of a Medicaid recipient
28 and to appeal claims denials which, if determined to
29 be based on claims for medically necessary services
30 whether or not denied on an administrative basis, shall
31 receive appropriate payment.

32 j. (1) Medicaid managed care organizations
33 shall include as primary care providers any provider
34 designated by the state as a primary care provider,
35 subject to a provider's respective state certification

1 standards, including but not limited to all of the
2 following:

3 (a) A physician who is a family or general
4 practitioner, a pediatrician, an internist, an
5 obstetrician, or a gynecologist.

6 (b) An advanced registered nurse practitioner.

7 (c) A physician assistant.

8 (d) A chiropractor licensed pursuant to chapter
9 151.

10 (2) A Medicaid managed care organization shall not
11 impose more restrictive, additional, or different scope
12 of practice requirements or standards of practice on a
13 primary care provider than those prescribed by state
14 law as a prerequisite for participation in the managed
15 care organization's provider network.

16 4. CAPITATION RATES AND MEDICAL LOSS RATIO.

17 a. Capitation rates shall be developed based on all
18 reasonable, appropriate, and attainable costs. Costs
19 that are not reasonable, appropriate, or attainable,
20 including but not limited to improper payment
21 recoveries, shall not be included in the development
22 of capitated rates.

23 b. Capitation rates for Medicaid recipients falling
24 within different rate cells shall not be expected to
25 cross-subsidize one another and the data used to set
26 capitation rates shall be relevant and timely and tied
27 to the appropriate Medicaid population.

28 c. Any increase in capitation rates for managed
29 care contractors is subject to prior statutory approval
30 and shall not exceed three percent over the existing
31 capitation rate in any one-year period or five percent
32 over the existing capitation rate in any two-year
33 period.

34 d. A managed care contract shall impose a minimum
35 Medicaid loss ratio of at least eighty-eight percent.

1 In calculating the medical loss ratio, medical costs
2 or benefit expenses shall include only those costs
3 directly related to patient medical care and not
4 ancillary expenses, including but not limited to any
5 of the following:

- 6 (1) Program integrity activities.
- 7 (2) Utilization review activities.
- 8 (3) Fraud prevention activities beyond the scope of
9 those activities necessary to recover incurred claims.
- 10 (4) Provider network development, education, or
11 management activities.
- 12 (5) Provider credentialing activities.
- 13 (6) Marketing expenses.
- 14 (7) Administrative costs associated with recipient
15 incentives.
- 16 (8) Clinical data collection activities.
- 17 (9) Claims adjudication expenses.
- 18 (10) Customer service or health care professional
19 hotline services addressing nonclinical recipient
20 questions.
- 21 (11) Value-added or cost-containment services,
22 wellness programs, disease management, and case
23 management or care coordination programs.
- 24 (12) Health quality improvement activities unless
25 specifically approved as a medical cost by state law.
26 Costs of health quality improvement activities included
27 in determining the medical loss ratio shall be only
28 those activities that are independent improvements
29 measurable in individual patients.
- 30 (13) Insurer claims review activities.
- 31 (14) Information technology costs unless they
32 directly and credibly improve the quality of health
33 care and do not duplicate, conflict with, or fail to be
34 compatible with similar health information technology
35 efforts of providers.

1 (15) Legal department costs including information
2 technology costs, expenses incurred for review and
3 denial of claims, legal costs related to defending
4 claims, settlements for wrongly denied claims, and
5 costs related to administrative claims handling
6 including salaries of administrative personnel and
7 legal costs.

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

15 e. (1) Provide enhanced guidance and criteria for
16 defining medical and administrative costs, recoveries,
17 and rebates including pharmacy rebates, and the
18 recording, reporting, and recoupment of such costs,
19 recoveries, and rebates realized.

20 (2) Medicaid managed care organizations shall
21 offset recoveries, rebates, and refunds against
22 medical costs, include only allowable administrative
23 expenses in the determination of administrative costs,
24 report costs related to subcontractors properly, and
25 have complete systems checks and review processes to
26 identify overpayment possibilities.

27 (3) Medicaid managed care contractors shall submit
28 publicly available, comprehensive financial statements
29 to the department of human services to verify that the
30 minimum medical loss ratio is being met and shall be
31 subject to periodic audits.

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

33 a. Develop and administer a clear, detailed policy
34 regarding the collection, storage, integration,
35 analysis, maintenance, retention, reporting, sharing,

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

18 b. Medicaid managed care organizations shall
19 directly capture and retain and shall report actual and
20 detailed medical claims costs and administrative cost
21 data to the department as specified by the department.
22 Medicaid managed care organizations shall allow the
23 department to thoroughly and accurately monitor the
24 medical claims costs and administrative costs data
25 Medicaid managed care organizations report to the
26 department.

27 c. Any audit of Medicaid managed care contracts
28 shall ensure compliance including with respect to
29 appropriate medical costs, allowable administrative
30 costs, the medical loss ratio, cost recoveries,
31 rebates, overpayments, and with specific contract
32 performance requirements.

33 d. The external quality review organization
34 contracting with the department shall review the
35 Medicaid managed care program to determine if the

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

10 e. Publish benchmark indicators based on Medicaid
11 program outcomes from the fiscal year beginning July 1,
12 2015, to be used to compare outcomes of the Medicaid
13 program as administered by the state program prior
14 to July 1, 2015, to those outcomes of the program
15 under Medicaid managed care. The outcomes shall
16 include a comparison of actual costs of the program
17 as administered prior to and after implementation of
18 Medicaid managed care. The data shall also include
19 specific detail regarding the actual expenses incurred
20 by each managed care organization by specific provider
21 line of service.

22 f. Review and approve or deny approval of contract
23 amendments on an ongoing basis to provide for
24 continuous improvement in Medicaid managed care and
25 to incorporate any changes based on changes in law or
26 policy.

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

30 (a) The number and details relating to prior
31 authorization requests and denials.

32 (b) The ten most common reasons for claims denials.
33 Information reported by a managed care contractor
34 relative to claims shall also include the number
35 of claims denied, appealed, and overturned based on

1 provider type and service type.

2 (c) Utilization of health care services by
3 diagnostic related group and ambulatory payment
4 classification as well as total claims volume.

5 (2) The department shall ensure the validity
6 of all information submitted by a Medicaid managed
7 care organization and shall make the monthly reports
8 available to the public.

9 h. Medicaid managed care organizations shall
10 maintain stakeholder panels comprised of an equal
11 number of Medicaid recipients and providers. Medicaid
12 managed care organizations shall provide for separate
13 provider-specific panels to address detailed payment,
14 claims, process, and other issues as well as grievance
15 and appeals processes.

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

32 j. (1) Require consistency and uniformity of
33 processes, procedures, and forms across all Medicaid
34 managed care organizations to reduce the administrative
35 burden to providers and consumers and to increase

1 efficiencies in the program. Such requirements shall
2 apply to but are not limited to areas of uniform cost
3 and quality reporting, uniform prior authorization
4 requirements and procedures, uniform utilization
5 management criteria, centralized, uniform, and seamless
6 credentialing requirements and procedures, and uniform
7 critical incident reporting.

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

17 k. Medicaid managed care organizations and any
18 entity with which a managed care organization contracts
19 for the performance of services shall disclose at no
20 cost to the department all discounts, incentives,
21 rebates, fees, free goods, bundling arrangements, and
22 other agreements affecting the net cost of goods or
23 services provided under a managed care contract.

24 Sec. ____ . RETROACTIVE APPLICABILITY. The section
25 of this division of this Act relating to directives
26 for Medicaid program policy improvements applies
27 retroactively to July 1, 2015.

28 Sec. ____ . EFFECTIVE UPON ENACTMENT. This division
29 of this Act, being deemed of immediate importance,
30 takes effect upon enactment.>

31 5. By renumbering as necessary.

By HEDDENS of Story

HOUSE FILE 2460

H-8249

1 Amend House File 2460 as follows:

2 1. Page 95, after line 32 by inserting:

3 <Sec. _____. Section 135.190, subsection 2, as
4 enacted by 2016 Iowa Acts, Senate File 2218, section 1,
5 is amended to read as follows:

6 2. A person in a position to assist may be
7 prescribed an opioid antagonist pursuant to section
8 147A.18 and may possess and provide or administer an
9 opioid antagonist to an individual if the person in
10 a position to assist reasonably and in good faith
11 believes that such individual is experiencing an
12 opioid-related overdose.

13 Sec. _____. Section 147A.18, subsection 1, as enacted
14 by 2016 Iowa Acts, Senate File 2218, section 3, is
15 amended to read as follows:

16 1. a. Notwithstanding any other provision of law
17 to the contrary, a licensed health care professional
18 may prescribe an opioid antagonist in the name of
19 a service program, law enforcement agency, or fire
20 department to be maintained for use as provided in this
21 section.

22 b. Notwithstanding any other provision of law to
23 the contrary, a licensed health care professional
24 may prescribe an opioid antagonist to a person in a
25 position to assist as defined in section 135.190.>

26 2. By renumbering as necessary.

By KLEIN of Washington

H-8249 FILED APRIL 19, 2016

HOUSE FILE 2460

H-8251

1 Amend House File 2460 as follows:

2 1. By striking page 105, line 4, through page 109,
3 line 19.

4 2. By renumbering as necessary.

By L. MILLER of Scott

H-8251 FILED APRIL 19, 2016

**Senate Amendment to
HOUSE FILE 2439**

H-8246

1 Amend House File 2439, as amended, passed, and
2 reprinted by the House, as follows:
3 1. Page 4, by striking lines 9 through 15 and
4 inserting:
5 g. (1) If moneys remain in the fund after
6 fully paying all obligations under paragraphs "a",
7 "b", "c", "d", and "e", and "f", the remainder may
8 be accumulated in the fund as a carryover operating
9 surplus. an amount of up to four million four hundred
10 thousand dollars shall, for the fiscal year beginning
11 July 1, 2016, and ending June 30, 2017, be expended and
12 distributed in the following priority order:
13 (a) (i) The director, in consultation with the
14 program manager and the E911 communications council,
15 may provide grants to any public safety answering point
16 agreeing to consolidate.>
17 2. Page 4, by striking lines 30 and 31 and
18 inserting:
19 < (ii) Grants provided under this subparagraph may,
20 subject to available funding, be provided until June
21 30, 2022.>
22 3. Page 5, by striking lines 12 through 16 and
23 inserting:
24 < (c) The remaining surplus shall be used to fund
25 future network and public safety answering point
26 improvements for program manager shall allocate an
27 equal amount of moneys to each public safety answering
28 point for the following costs:>

RECEIVED FROM THE SENATE

H-8246 FILED APRIL 19, 2016

**Senate Amendment to
HOUSE FILE 2454**

H-8244

1 Amend House File 2454, as amended, passed, and
2 reprinted by the House, as follows:
3 1. Page 20, after line 20 by inserting:
4 <DIVISION ____
5 FUNDS UNDER THE CONTROL OF THE ECONOMIC DEVELOPMENT
6 AUTHORITY SPECIAL AUTHORITY GRANTED TO THE DIRECTOR TO
7 ALLOCATE MONEYS FOR FY 2016-2017
8 Sec. _____. KEEP IOWA BEAUTIFUL INITIATIVE. The
9 director of the economic development authority created
10 in section 15.105 may allocate moneys in one or more
11 funds established in section 15.106A, subsection 1,
12 paragraph "o", for the fiscal year beginning July 1,
13 2016, and ending June 30, 2017, for the purpose of
14 supporting a keep Iowa beautiful initiative in order
15 to assist communities in developing and implementing
16 beautification and community development plans.>
17 2. By renumbering as necessary.

RECEIVED FROM THE SENATE

H-8244 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8233

- 1 Amend House File 2459 as follows:
2 1. Page 1, by striking lines 3 through 8.
3 2. By renumbering as necessary.

By PETTENGILL of Benton

H-8233 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8235

- 1 Amend House File 2459 as follows:
2 1. Page 6, after line 30 by inserting:
3 <DIVISION ___
4 STATE AND COUNTY MEDICAL EXAMINERS
5 Sec. ___. Section 331.802, subsection 2, paragraph
6 c, Code 2016, is amended to read as follows:
7 c. (1) The fee and expenses of the county medical
8 examiner who performs an autopsy or conducts an
9 investigation of a any of the following persons shall
10 be paid by the state:
11 (a) A person who dies after being brought into this
12 state for emergency medical treatment by or at the
13 direction of an out-of-state law enforcement officer or
14 public authority shall be paid by the state.
15 (b) A person to whom subparagraph division (a) does
16 not apply, who dies after entering the state and who is
17 an out-of-state resident.
18 (2) A claim for payment under this paragraph "c"
19 shall be filed with the state appeal board and, if. If
20 the claim filed meets the criterion of involvement of
21 a person specified in subparagraph (1), subparagraph
22 division (a) or (b), the claim shall be authorized
23 by the board, shall be and paid out of moneys in the
24 general fund of the state not otherwise appropriated.
25 (3) A claim for payment under this paragraph "c"
26 shall not affect or delay payment of the state medical
27 examiner or other personnel of the office of the state
28 medical examiner or of the county medical examiner or
29 other personnel of the office of the county medical
30 examiner, as otherwise prescribed by rule.
31 (4) For the purposes of this paragraph "c":
32 (a) "County medical examiner" includes the state
33 medical examiner, deputy state medical examiner,
34 associate state medical examiner, or deputy county
35 medical examiner when acting as the county medical

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1 examiner, or a county medical examiner investigator.
2 (b) "Out-of-state resident" means an individual who
3 is not a resident of the state of Iowa and includes an
4 individual who is not a citizen of the United States
5 nor lawfully admitted into the United States for
6 permanent residence by the United States immigration
7 and naturalization service.

8 Sec. ____ . ADOPTION OF RULES. The state medical
9 examiner, subject to the approval of the director
10 of public health pursuant to section 691.6, shall
11 adopt administrative rules pursuant to chapter 17A to
12 implement this division of this Act.>

13 2. By renumbering as necessary.

By HEDDENS of Story

H-8235 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8236

1 Amend House File 2459 as follows:

2 1. Page 5, after line 13 by inserting:

3 <Sec. ____ . Section 915.25, subsection 3, as enacted
4 by 2016 Iowa Acts, Senate File 2288, section 16, is
5 amended to read as follows:

6 3. Notwithstanding the provisions of sections
7 232.147, 232.149, and 232.149A, an intake or juvenile
8 court officer shall disclose to the alleged victim
9 of a delinquent act, upon the request of the victim,
10 the complaint, the name and address of the child
11 who allegedly committed the delinquent act, and
12 the disposition of the complaint. If the alleged
13 delinquent act would be a ~~foreible felony~~ serious
14 misdemeanor, aggravated misdemeanor, or felony offense
15 if committed by an adult, the intake or juvenile court
16 officer shall provide notification to the victim of the
17 delinquent act as required by section 915.24.>

18 2. Page 5, after line 15 by inserting:

19 <Sec. ____ . Section 29C.24, subsection 3, paragraph
20 a, subparagraphs (3) and (6), if enacted by 2016 Iowa
21 Acts, Senate File 2306, section 2, are amended to read
22 as follows:

23 (3) The imposition of income taxes under chapter
24 422, divisions II and III, including the requirement
25 to file tax returns under sections 422.13 through
26 422.15 or section 422.36, as applicable, and
27 including the requirement to withhold and remit
28 income tax from out-of-state employees under section
29 422.16. In addition, the performance of disaster or
30 emergency-related work during a disaster response
31 period by an out-of-state business or out-of-state
32 employee shall not require an out-of-state business
33 to be included in a consolidated return under section
34 422.37, and shall not increase the amount of net income
35 of the out-of-state business allocated and apportioned

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1 to the state under ~~sections~~ section 422.8 or 422.33, as
2 applicable.

3 (6) The assessment of property taxes by the
4 department of revenue under sections 428.24 through
5 428.26, 428.28, and 428.29, or chapters 433, 434,
6 435, and 437 through 438, or by a local assessor
7 under another provision of law, on property brought
8 into the state to aid in the performance of disaster
9 or emergency-related work during a disaster response
10 period if such property does not remain in the state
11 after the conclusion of the disaster response period.

12 Sec. _____. Section 29C.24, subsection 4, if enacted
13 by 2016 Iowa Acts, Senate File 2306, section 2, is
14 amended to read as follows:

15 4. Business and employee status after a disaster
16 response period. An out-of-state business or
17 out-of-state employee that remains in the state after
18 the conclusion of the disaster response period ~~for~~
19 during which the disaster or emergency-related work
20 was performed shall be fully subject to the state's
21 standards for establishing presence, residency, or
22 doing business as otherwise provided by law, and
23 shall be responsible for any resulting taxes, fees,
24 licensing, registration, filing, or other requirements.

25 Sec. _____. Section 155A.13, subsection 3, paragraph
26 d, if enacted by 2016 Iowa Acts, Senate File 453,
27 section 3, is amended to read as follows:

28 d. An applicant seeking a special or limited-use
29 ~~pharmacy licensed~~ license for a proposed telepharmacy
30 site that does not meet the mileage requirement
31 established in paragraph "c" and is not statutorily
32 exempt from the mileage requirement may apply to the
33 board for a waiver of the mileage requirement. A
34 waiver request shall only be granted if the applicant
35 can demonstrate to the board that the proposed

1 telepharmacy site is located in an area where there is
2 limited access to pharmacy services and can establish
3 the existence of compelling circumstances that justify
4 waiving the mileage requirement. The board's decision
5 to grant or deny a waiver request shall be a proposed
6 decision subject to mandatory review by the director
7 ~~of the department~~ of public health. The director
8 shall review a proposed decision and shall have the
9 power to approve, modify, or veto a proposed decision.
10 The director's decision on a waiver request shall be
11 considered final agency action subject to judicial
12 review under chapter 17A.>

13 3. By renumbering as necessary.

By RIZER of Linn

HOUSE FILE 2459

H-8237

1 Amend House File 2459 as follows:

2 1. Page 6, after line 30 by inserting:

3 <DIVISION ____

4 AREA EDUCATION AGENCY FUNDING

5 Sec. ____ . SPECIAL EDUCATION SUPPORT SERVICES

6 FUNDING. Notwithstanding the provisions of section
7 257.35, subsection 11, and section 257.37, subsection
8 6, for the budget year beginning July 1, 2016, an area
9 education agency shall use the total amount determined
10 to be available to the area education agency under
11 section 257.35 and any unreserved fund balances for
12 media services or education services that exceed
13 an amount equal to 5 percent of the area education
14 agency's budget for media services and education
15 services for that budget year, and including funds
16 that exceed the payment for special education support
17 services pursuant to section 257.35, in a manner to
18 best maintain the level of required area education
19 agency special education support services.

20 Sec. ____ . EFFECTIVE UPON ENACTMENT. This division
21 of this Act, being deemed of immediate importance,
22 takes effect upon enactment.>

23 2. Title page, line 2, by striking <and>

24 3. Title page, line 3, by striking <atters> and
25 inserting <atters, and including effective date
26 provisions>

27 4. By renumbering, redesignating, and correcting
28 internal references as necessary.

By RIZER of Linn

H-8237 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8238

1 Amend House File 2459 as follows:

2 1. Page 5, by striking line 10 and inserting
3 <medical clinics at the university of Iowa that is paid
4 by moneys from the general fund of the state through
5 the state appeal board shall be reimbursed by>

By RIZER of Linn

H-8238 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8241

1 Amend House File 2459 as follows:

2 1. Page 4, after line 19 by inserting:

3 <Sec. _____. Section 135.190, subsection 1, as
4 enacted by 2016 Iowa Acts, Senate File 2218, section 1,
5 is amended by adding the following new paragraph:

6 NEW PARAGRAPH. 0a. "Licensed health care
7 professional" means the same as defined in section
8 280.16.

9 Sec. _____. Section 135.190, subsection 1, as enacted
10 by 2016 Iowa Acts, Senate File 2218, section 1, is
11 amended by adding the following new subsection:

12 NEW SUBSECTION. 1A. Notwithstanding any other
13 provision of law to the contrary, a licensed health
14 care professional may prescribe an opioid antagonist to
15 a person in a position to assist.

16 Sec. _____. Section 135.190, subsection 3, as enacted
17 by 2016 Iowa Acts, Senate File 2218, section 1, is
18 amended to read as follows:

19 3. A person in a position to assist or a prescriber
20 of an opioid antagonist who has acted reasonably and in
21 good faith shall not be liable for any injury arising
22 from the provision, administration, or assistance in
23 the administration of an opioid antagonist as provided
24 in this section.>

25 2. Page 5, after line 13 by inserting:

26 <Sec. _____. 2016 Iowa Acts, Senate File 2218,
27 as enacted, is amended by adding the following new
28 section:

29 NEW SECTION. SEC. _____. EFFECTIVE UPON ENACTMENT.
30 This Act, being deemed of immediate importance, takes
31 effect upon enactment.

32 Sec. _____. EFFECTIVE UPON ENACTMENT. The following
33 provision or provisions of this division of this Act,
34 being deemed of immediate importance, takes effect upon
35 enactment:

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1 1. The sections of this division of this Act
2 amending section 135.190.

3 2. The section of this division of this Act
4 amending 2016 Iowa Acts, [Senate File 2218](#).

5 Sec. ____ . RETROACTIVE APPLICABILITY. The following
6 provision or provisions of this division of this Act
7 apply retroactively to April 6, 2016:

8 1. The sections of this division of this Act
9 amending section 135.190.

10 2. The section of this division of this Act
11 amending 2016 Iowa Acts, [Senate File 2218](#).

12 3. Title page, line 3, after < matters > by inserting
13 <, and including effective date and retroactive
14 applicability date provisions >

15 4. By renumbering as necessary.

By ISENHART of Dubuque

H-8241 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8242

1 Amend House File 2459 as follows:

2 1. Page 6, after line 30 by inserting:

3 <DIVISION _____

4 SCHOOL DISTRICT FUNDING

5 Sec. _____. Section 257.2, subsection 2, Code 2016,
6 is amended by striking the subsection.

7 Sec. _____. NEW SECTION. 257.14A District cost per
8 pupil equity ---- budget adjustment.

9 1. The board of directors of a school district
10 with a regular program district cost per pupil that is
11 less than the highest regular program district cost
12 per pupil among all school districts in the state for
13 the same budget year that wishes to receive the budget
14 adjustment under this section may adopt a resolution
15 by May 15 preceding the budget year and shall notify
16 the department of management of the adoption of the
17 resolution and the amount of the budget adjustment
18 to be received. The resolution adopted by the board
19 of directors shall specify the board's intent to use
20 such funds authorized under subsection 2, paragraph
21 "b", without any corresponding increase to the school
22 district's cash reserve levy or other property tax levy
23 of the school district for the current budget year or
24 any future budget year to replenish such amounts.

25 2. a. For budget years beginning on or after July
26 1, 2016, but before July 1, 2019, each school district
27 that satisfies the requirements of subsection 1 shall
28 be eligible for a budget adjustment for that budget
29 year in an amount not to exceed the difference between
30 the school district's regular program district cost
31 per pupil and the highest regular program district
32 cost per pupil among all school districts in the state
33 multiplied by the district's budget enrollment. The
34 resolution adopted under subsection 1 may specify a
35 budget adjustment amount that is less than the maximum

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1 amount authorized under this paragraph "a".

2 b. The school district shall fund the budget
3 adjustment either by using moneys from its unexpended
4 fund balance or by using cash reserve moneys.

5 3. A budget adjustment received under this section
6 shall not affect the eligibility for or amount of any
7 other budget adjustment authorized by law for the same
8 budget year. In addition, a budget adjustment under
9 this section shall be limited to the budget year for
10 which the adjustment was authorized and shall not be
11 included in any computation of a school district's cost
12 for any future budget year.

13 Sec. _____. Section 257.34, Code 2016, is amended to
14 read as follows:

15 257.34 Cash reserve information.

16 1. If a school district receives less state school
17 foundation aid under section 257.1 than is due under
18 that section for a base year and the school district
19 uses funds from its cash reserve during the base year
20 to make up for the amount of state aid not paid, the
21 board of directors of the school district shall include
22 in its general fund budget document information about
23 the amount of the cash reserve used to replace state
24 school foundation aid not paid.

25 2. If a school district uses funds from its
26 cash reserve during the base year to fund a budget
27 adjustment under section 257.14A, the board of
28 directors of the school district shall include in its
29 general fund budget document information about the
30 amount of the cash reserve used for such purpose.

31 Sec. _____. IMPLEMENTATION. Notwithstanding the
32 deadline for adopting a resolution to approve the
33 budget adjustment in section 257.14A, subsection 1,
34 for the school budget year beginning July 1, 2016,
35 the resolution of the board of directors of a school

-2-

1 district shall be approved not later than June 10,
2 2016.

3 Sec. _____. EFFECTIVE UPON ENACTMENT. This division
4 of this Act, being deemed of immediate importance,
5 takes effect upon enactment.>

6 2. Title page, line 2, by striking <and>

7 3. Title page, line 3, after <atters> by inserting
8 <, and including effective date provisions>

9 4. By renumbering as necessary.

By THEDE of Scott
WINCKLER of Scott
LYKAM of Scott

HOUSE FILE 2459

H-8245

1 Amend the amendment, H-8227, to House File 2459, as
2 follows:

3 1. By striking page 1, line 1, through page 6, line
4 24, and inserting:

5 <Amend House File 2459 as follows:

6 1. By striking everything after the enacting clause
7 and inserting:

8 <DIVISION I

9 STANDING APPROPRIATIONS AND RELATED MATTERS

10 Section 1. 2015 Iowa Acts, chapter 138, is amended
11 by adding the following new section:

12 NEW SECTION. SEC. 5A. GENERAL ASSEMBLY.

13 1. The appropriations made pursuant to section
14 2.12 for the expenses of the general assembly and
15 legislative agencies for the fiscal year beginning July
16 1, 2016, and ending June 30, 2017, are reduced by the
17 following amount:

18 \$ 5,850,000

19 2. The budgeted amounts for the general assembly
20 and legislative agencies for the fiscal year beginning
21 July 1, 2016, may be adjusted to reflect the unexpended
22 budgeted amounts from the previous fiscal year.

23 Sec. 2. 2015 Iowa Acts, chapter 138, is amended by
24 adding the following new section:

25 NEW SECTION. SEC. 7A. Section 257.35, Code 2016,
26 is amended by adding the following new subsection:

27 NEW SUBSECTION. 10A. Notwithstanding subsection 1,
28 and in addition to the reduction applicable pursuant
29 to subsection 2, the state aid for area education
30 agencies and the portion of the combined district cost
31 calculated for these agencies for the fiscal year
32 beginning July 1, 2016, and ending June 30, 2017, shall
33 be reduced by the department of management by fifteen
34 million dollars. The reduction for each area education
35 agency shall be prorated based on the reduction that

H-8245

1 the agency received in the fiscal year beginning July
2 1, 2003.

3 Sec. 3. Section 2.48, subsection 3, Code 2016, is
4 amended by adding the following new paragraph:

5 NEW PARAGRAPH. Of. In 2016:

6 (1) The homestead tax credit under chapter 425.

7 (2) The elderly and disabled property tax credit
8 under chapter 425.

9 (3) The agricultural land tax credit under chapter
10 426.

11 (4) The military service tax credit under chapter
12 426A.

13 (5) The business property tax credit under chapter
14 426C.

15 (6) The commercial and industrial property tax
16 replacement claims under section 441.21A.

17 Sec. 4. Section 230.8, Code 2016, is amended to
18 read as follows:

19 230.8 Transfers of persons with mental illness ----
20 expenses.

21 The transfer to any state hospitals or to the places
22 of their residence of persons with mental illness who
23 have no residence in this state or whose residence is
24 unknown and deemed to be a state case, shall be made
25 according to the directions of the administrator,
26 and when practicable by employees of the state
27 hospitals. The actual and necessary expenses of such
28 transfers shall be paid by the department on itemized
29 vouchers sworn to by the claimants and approved by
30 the administrator, ~~and the amount of the expenses is~~
31 ~~appropriated to the department from any funds in the~~
32 ~~state treasury not otherwise appropriated.~~

33 Sec. 5. Section 820.24, Code 2016, is amended to
34 read as follows:

35 820.24 Expenses ---- how paid.

1 When the punishment of the crime shall be the
 2 confinement of the criminal in the penitentiary, the
 3 expenses shall be paid ~~out of the state treasury, on~~
 4 ~~the certificate of the governor and warrant of the~~
 5 ~~director of the department of administrative services~~
 6 by the department of corrections; and in all other
 7 cases they shall be paid out of the county treasury in
 8 the county wherein the crime is alleged to have been
 9 committed. The expenses shall be the fees paid to the
 10 officers of the state on whose governor the requisition
 11 is made, and all necessary and actual traveling
 12 expenses incurred in returning the prisoner.

DIVISION II

MISCELLANEOUS PROVISIONS

Sec. 6. MISCELLANEOUS APPROPRIATIONS.

16 1. If, following the close of the fiscal year
 17 ending June 30, 2016, moneys are transferred to the
 18 general fund of the state pursuant to section 8.55,
 19 subsection 2, paragraph "b", in an amount that exceeds
 20 \$60,000,000, there is appropriated from the general
 21 fund of the state to the following departments and
 22 agencies for the fiscal year beginning July 1, 2016,
 23 and ending July 1, 2017, the following amounts, or
 24 so much thereof as is necessary, to be used for the
 25 purposes designated:

a. COLLEGE STUDENT AID COMMISSION

27 For purposes of providing skilled workforce shortage
 28 tuition grants in accordance with section 261.130:
 29 \$ 2,500,000

b. DEPARTMENT OF EDUCATION

31 For deposit in the gap tuition assistance fund
 32 established pursuant to section 260I.2:
 33 \$ 1,000,000

c. DEPARTMENT OF HUMAN SERVICES

35 For an Iowa food bank association selected by the

1 department of human services for the purchase of food
2 on behalf of an Iowa emergency feeding organization or
3 for the distribution of moneys to the Iowa emergency
4 feeding organizations for the purchase of food:

5 \$ 100,000

6 d. DEPARTMENT OF PUBLIC HEALTH

7 For an association dedicated to supporting persons
8 suffering from Alzheimer's disease:

9 \$ 100,000

10 2. Notwithstanding section 8.33, moneys
11 appropriated in this section that remain unencumbered
12 or unobligated at the close of the fiscal year shall
13 not revert but shall remain available for expenditure
14 for the purposes designated until the close of the
15 fiscal year ending June 30, 2018.

16 Sec. 7. WATER QUALITY ---- IOWA FINANCE
17 AUTHORITY. There is appropriated from the general fund
18 of the state to the Iowa finance authority for the
19 fiscal year beginning July 1, 2016, and ending June 30,
20 2017, the following amount, or so much thereof as is
21 necessary, to be used for the purpose designated:

22 For deposit in the water quality financial
23 assistance fund created in section 16.134A, if enacted
24 by 2016 Iowa Acts, [House File 2451](#):

25 \$ 2,000,000

26 Sec. 8. WATER QUALITY INTERIM STUDY COMMITTEE. The
27 legislative council is requested to appoint an interim
28 study committee to examine issues and funding related
29 to water quality in the state. The committee shall
30 submit a report to the general assembly by January 1,
31 2017.

32 Sec. 9. INDEPENDENT STUDY OF STUDENT DEBT ----
33 APPROPRIATION.

34 1. There is appropriated from the general fund of
35 the state to the college student aid commission for the

1 fiscal year beginning July 1, 2016, and ending June 30,
2 2017, the following amount, or so much thereof as is
3 necessary, to be used for purposes of commissioning the
4 study of student debt in accordance with this section:

5 \$ 100,000

6 2. The college student aid commission, in
7 collaboration with the state board of regents, the
8 department of education, and the economic development
9 authority, shall use funds appropriated pursuant
10 to this section to commission an independent study
11 of student debt at Iowa's public postsecondary
12 institutions and of the impact of student debt on
13 Iowa's citizens and economy.

14 3. The study shall include but not be limited to
15 the following matters:

16 a. The reasons average student loan debt at Iowa's
17 public postsecondary institutions is generally higher
18 than the national average.

19 b. The lifetime impact of student debt on the
20 individual's assets and net worth and the impact on
21 family finances in general.

22 c. The economic impact of student debt on the
23 economy of the state and on Iowa families, workforce,
24 communities, housing market, and business climate.

25 d. Measures to reduce student debt levels, increase
26 the affordability and attainment of a postsecondary
27 education, and to improve financial aid practices
28 and financial aid funding at the state's public
29 postsecondary institutions.

30 e. Measures to increase consumer education and
31 provide financial counseling to students considering
32 education loans, along with measures to provide
33 academic support for students at risk of dropping out.

34 f. Measures to relieve the financial burden of
35 student debt on an individual.

1 g. Measures to encourage recent college graduates
2 to remain in Iowa.

3 h. The demographic characteristics of student
4 borrowers and the impact family income has on the
5 amount of student debt incurred by college graduates.

6 i. Any issues deemed relevant by the entity
7 conducting the study in order to fully examine the
8 socioeconomic impact of student debt in Iowa.

9 4. The state board of regents and its universities,
10 the department of education and the community colleges,
11 and the economic development authority shall cooperate
12 with the commission and with the entity conducting
13 the study and shall provide to the entity any data
14 requested by the entity except as limited by chapter
15 22 and by the federal Family Educational Rights and
16 Privacy Act, 20 U.S.C. {1232g.

17 5. The commission shall submit a report of the
18 findings of the study along with recommendations,
19 if any, of the entity conducting the study, and
20 recommendations, if any, of the commission, the state
21 board of regents, the department of education, and the
22 economic development authority, in a report to the
23 general assembly by January 14, 2017.

24 Sec. 10. SALARY MODEL ADMINISTRATOR. The salary
25 model administrator shall work in conjunction with
26 the legislative services agency to maintain the
27 state's salary model used for analyzing, comparing,
28 and projecting state employee salary and benefit
29 information, including information relating to
30 employees of the state board of regents. The
31 department of revenue, the department of administrative
32 services, the five institutions under the jurisdiction
33 of the state board of regents, the judicial district
34 departments of correctional services, and the state
35 department of transportation shall provide salary data

1 to the department of management and the legislative
2 services agency to operate the state's salary
3 model. The format and frequency of provision of the
4 salary data shall be determined by the department of
5 management and the legislative services agency. The
6 information shall be used in collective bargaining
7 processes under chapter 20 and in calculating the
8 funding needs contained within the annual salary
9 adjustment legislation. A state employee organization
10 as defined in section 20.3, subsection 4, may request
11 information produced by the model, but the information
12 provided shall not contain information attributable to
13 individual employees.

14 Sec. 11. Section 24.32, Code 2016, is amended to
15 read as follows:

16 24.32 Decision certified.

17 After a hearing upon the appeal, the state board
18 shall certify its decision to the county auditor and
19 to the parties to the appeal as provided by rule, and
20 the decision shall be final. The county auditor shall
21 make up the records in accordance with the decision and
22 the levying board shall make its levy in accordance
23 with the decision. Upon receipt of the decision, the
24 certifying board shall correct its records accordingly,
25 if necessary. Final disposition of all appeals shall
26 be made by the state board ~~on or before April 30 of~~
27 each year within forty-five days after the date of the
28 appeal hearing.

29 Sec. 12. Section 418.12, subsection 5, Code 2016,
30 is amended to read as follows:

31 5. If the department of revenue determines that
32 the revenue accruing to the fund or accounts within
33 the fund exceeds thirty million dollars for a fiscal
34 year or exceeds the amount necessary for the purposes
35 of this chapter if the amount necessary is less than

1 thirty million dollars for a fiscal year, then those
2 excess moneys shall be credited by the department of
3 revenue for deposit in the general fund of the state.
4 Sec. 13. NEW SECTION. 915.46 Sexual assault kit
5 reporting.

6 If a statewide secure web-based sexual assault kit
7 tracking system is implemented, by January 31, of each
8 year the division shall submit an annual report to the
9 general assembly regarding the status of sexual assault
10 kits. The report shall include but not be limited to
11 all of the following:

- 12 1. The total number of kits statewide and by
13 judicial district.
- 14 2. The average and median length of time for kits
15 to be submitted for forensic analysis after being added
16 to the system.
- 17 3. The average and median length of time for
18 forensic analysis to be completed on kits after being
19 submitted.
- 20 4. The total number of kits destroyed or removed
21 from the system.
- 22 5. The total number of kits that have not been
23 analyzed after six months of being added to the system.
- 24 6. The total number of kits that have not been
25 analyzed after one year or longer of being added to the
26 system.

27 Sec. 14. 2016 Iowa Acts, House File 2420, section
28 1, subsection 5, is amended by adding the following new
29 paragraph:

30 NEW PARAGRAPH. c. The report shall also include
31 details of a plan that provides for the issuance
32 of a request for proposals for the operation of a
33 statewide secure web-based sexual assault kit tracking
34 system. The plan shall include provisions to protect
35 the identity of the victims. The plan may include

1 contracting with public and private entities. The plan
2 must include all of the following:

3 (1) Allowing for the tracking of location and
4 status of sexual assault kits throughout the criminal
5 justice process.

6 (2) A method for the following entities to access
7 the system to update and track the status of kits:

8 (a) Medical facilities that perform the sexual
9 assault forensic examinations.

10 (b) Law enforcement agencies and prosecutors.

11 (c) The division of criminal investigation of the
12 department of public safety.

13 (d) The crime victim assistance division of the
14 department of justice.

15 (3) A method to address allowing victims of sexual
16 assault to anonymously track or receive updates
17 regarding the status of their kit.

18 (4) A method for phasing in the plan if necessary.

19

DIVISION III

20

CORRECTIVE PROVISIONS

21 Sec. 15. Section 229.13, subsection 7, paragraph a,
22 subparagraph (1), if enacted by 2016 Iowa Acts, Senate
23 File 2259, section 1, is amended to read as follows:

24 (1) The respondent's mental health professional
25 acting within the scope of the mental health
26 professional's practice shall notify the committing
27 court, with preference given to the committing judge,
28 if available, in the appropriate county ~~who~~ and the
29 court shall enter a written order directing that
30 the respondent be taken into immediate custody by
31 the appropriate sheriff or sheriff's deputy. The
32 appropriate sheriff or sheriff's deputy shall exercise
33 all due diligence in taking the respondent into
34 protective custody to a hospital or other suitable
35 facility.

1 Sec. 16. Section 272.25, subsection 3, Code 2016,
2 as amended by 2016 Iowa Acts, [Senate File 2196](#), section
3 3, is amended to read as follows:

4 3. A requirement that the program include
5 instruction in skills and strategies to be used in
6 classroom management of individuals, and of small and
7 large groups, under varying conditions; skills for
8 communicating and working constructively with pupils,
9 teachers, administrators, and parents; preparation in
10 reading theory, knowledge, strategies, and approaches,
11 and for integrating literacy instruction ~~in~~ into
12 content areas in accordance with section 256.16; and
13 skills for understanding the role of the board of
14 education and the functions of other education agencies
15 in the state. The requirement shall be based upon
16 recommendations of the department of education after
17 consultation with teacher education faculty members in
18 colleges and universities.

19 Sec. 17. Section 598C.102, subsection 8, paragraph
20 b, if enacted by 2016 Iowa Acts, [Senate File 2233](#),
21 section 2, is amended to read as follows:

22 b. An individual who has custodial responsibility
23 for a child under a law of this state other than this
24 chapter.

25 Sec. 18. 2016 Iowa Acts, [House File 2269](#), section
26 20, subsection 1, is amended to read as follows:

27 1. It is amended, rescinded, or supplemented by the
28 affirmative action of the executive ~~council~~ committee
29 of the Iowa beef cattle producers association created
30 in section 181.3, as amended in this Act.

31 Sec. 19. 2016 Iowa Acts, [Senate File 378](#), section
32 2, is amended to read as follows:

33 SEC. 2. REPEAL. Section 80.37, Code ~~2015~~ 2016, is
34 repealed.

35 Sec. 20. 2016 Iowa Acts, [Senate File 2185](#), section

1 2, if enacted, is amended by striking the section and
2 inserting in lieu thereof the following:

3 SEC. 2. Section 709.21, subsection 3, Code 2016, is
4 amended to read as follows:

5 3. A person who violates this section commits a
6 ~~serious~~ an aggravated misdemeanor.

7 DIVISION IV

8 SERVICE CONTRACT RECIPIENTS

9 Sec. 21. Section 8F.3, subsection 1, paragraphs b
10 and d, Code 2016, are amended to read as follows:

11 b. Information regarding the training and education
12 received by the members of the governing body of
13 the recipient entity relating to the duties and
14 legal responsibilities of the governing body. The
15 information shall also include certification that
16 the members of the governing body have completed a
17 training program established pursuant to section 19B.7,
18 subsection 3.

19 d. Information regarding any policies adopted
20 by the governing body of the recipient entity that
21 prohibit taking adverse employment action against
22 employees of the recipient entity who disclose
23 information about a service contract, to include
24 information about the pay and benefits received by
25 an employee of a recipient entity, to the oversight
26 agency, the auditor of state, the office of the
27 attorney general, or the office of ombudsman and
28 that state whether those policies are substantially
29 similar to the protection provided to state employees
30 under section 70A.28. The information provided shall
31 state whether employees of the recipient entity are
32 informed on a regular basis of their rights to disclose
33 information to the oversight agency, the office of
34 ombudsman, the auditor of state, or the office of the
35 attorney general and the telephone numbers of those

1 organizations.

2 Sec. 22. Section 19B.7, Code 2016, is amended by
3 adding the following new subsection:

4 NEW SUBSECTION. 3. The department of
5 administrative services, in coordination with
6 the Iowa civil rights commission, shall establish a
7 training program for prospective recipient entities, as
8 defined in section 8F.2, concerning the requirements
9 of this section, and chapter 216, relative to the
10 administration and promotion of equal opportunity and
11 the prohibition of discriminatory and unfair practices
12 within any program receiving or benefiting from state
13 financial assistance. The program shall specifically
14 include guidance relative to unfair employment
15 practices as described in section 216.6, and wage
16 discrimination in employment prohibitions as described
17 in section 216.6A.

18 DIVISION V

19 WAGE DISCRIMINATION IN EMPLOYMENT

20 Sec. 23. Section 216.6A, Code 2016, is amended by
21 adding the following new subsection:

22 NEW SUBSECTION. 2A. It shall be an unfair or
23 discriminatory practice for any employer or agent of
24 any employer to do any of the following:

25 a. Require, as a condition of employment, that
26 an employee refrain from disclosing, discussing,
27 or sharing information about the amount of the
28 employee's wages, benefits, or other compensation or
29 from inquiring, discussing, or sharing information
30 about any other employee's wages, benefits, or other
31 compensation.

32 b. Require, as a condition of employment, that an
33 employee sign a waiver or other document that requires
34 an employee to refrain from engaging in any of the
35 activities permitted under paragraph "a".

1 c. Discriminate or retaliate against an employee
2 for engaging in any of the activities permitted under
3 paragraph "a".

4 d. Seek salary history information, including
5 but not limited to information on compensation and
6 benefits, from a potential employee as a condition of a
7 job interview or employment. This paragraph shall not
8 be construed to prohibit a prospective employer from
9 asking a prospective employee what salary level the
10 prospective employee would require in order to accept
11 a job.

12 e. Release the salary history, including but
13 not limited to information on compensation and
14 benefits, of any current or former employee to any
15 prospective employer in response to a request as part
16 of an interview or hiring process without written
17 authorization from such current or former employee.

18 f. Publish, list, or post within the employer's
19 organization, with any employment agency, job-listing
20 service, or internet site, or in any other public
21 manner, an advertisement to recruit candidates for hire
22 or independent contractors to fill a position within
23 the employer's organization without including the
24 minimum rate of pay of the position. The rate of pay
25 may be by the hour, shift, day, week, salary, piece,
26 commission, or other applicable rate. The rate of pay
27 shall include overtime and allowances, if any, claimed
28 as part of the minimum wage, including but not limited
29 to tipped wages.

30 g. Pay a newly hired employee at less than the
31 rate of pay advertised for the employee's position as
32 required under paragraph "f".

33 DIVISION VI
34 WAGE DISCRIMINATION ---- EQUAL PAY TASK FORCE AND REPORT
35 Sec. 24. EQUAL PAY TASK FORCE AND REPORT.

- 1 1. An equal pay task force is created. The task
- 2 force shall consist of the following members:
- 3 a. The director of the civil rights commission, or
- 4 the director's designee.
- 5 b. The director of the department of human rights,
- 6 or the director's designee.
- 7 c. An employee of the labor market information
- 8 division of the department of workforce development
- 9 designated by the director of the department.
- 10 d. A representative of the association of business
- 11 and industry, appointed by the president of the
- 12 association.
- 13 e. A member of a statewide labor organization
- 14 designated by the legislative council, appointed by the
- 15 president of the organization.
- 16 f. Two representatives of organizations whose
- 17 objectives include the elimination of pay disparities
- 18 between men and women and minorities and nonminorities
- 19 and that have undertaken advocacy, educational, or
- 20 legislative initiatives in pursuit of such objectives
- 21 appointed by the director of the civil rights
- 22 commission in consultation with the leadership of those
- 23 organizations.
- 24 g. Two representatives of postsecondary education
- 25 institutions who have experience and expertise in
- 26 the collection and analysis of data concerning pay
- 27 disparities between men and women and minorities and
- 28 nonminorities and whose research has been used in
- 29 efforts to promote the elimination of such disparities
- 30 appointed by the director of the civil rights
- 31 commission in consultation with the leadership of those
- 32 institutions.
- 33 h. Four members of the general assembly serving
- 34 as ex officio, nonvoting members, one representative
- 35 to be appointed by the speaker of the house of

1 representatives, one representative to be appointed by
2 the minority leader of the house of representatives,
3 one senator to be appointed by the majority leader of
4 the senate, and one senator to be appointed by the
5 minority leader of the senate.

6 2. The task force shall study all of the following:

7 a. The extent of wage disparities, both in the
8 public and private sectors, between men and women and
9 between minorities and nonminorities.

10 b. Factors that cause, or which tend to cause, such
11 disparities, including segregation between women and
12 men and between minorities and nonminorities across
13 and within occupations, payment of lower wages for
14 work in female-dominated occupations, child-rearing
15 responsibilities, the number of women who are heads of
16 households, education, hours worked, and years on the
17 job.

18 c. The consequences of such disparities on the
19 economy and affected families.

20 d. Actions likely to lead to the elimination and
21 prevention of such disparities.

22 3. The civil rights commission shall provide
23 staffing services for the task force.

24 4. The voting members shall elect a chairperson
25 from the voting membership of the task force. A
26 majority of the voting members of the task force
27 constitutes a quorum.

28 5. Voting members of the task force shall receive
29 reimbursement for actual expenses incurred while
30 serving in their official capacity only if they are not
31 eligible for reimbursement by the organization that
32 they represent. Legislative members shall be paid the
33 per diem and expenses specified in section 2.10.

34 6. The task force shall submit a report regarding
35 its findings and its recommendations regarding

-15-

1 potential actions for the elimination and prevention
2 of disparities in wages between men and women and
3 minorities and nonminorities to the governor and the
4 general assembly no later than December 22, 2017.>

5 2. By renumbering as necessary.>

By HALL of Woodbury

HOUSE FILE 2459

H-8248

1 Amend House File 2459 as follows:

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

3 <DIVISION I

4 EQUAL PAY TASK FORCE AND REPORT

5 Section 1. EQUAL PAY.

6 1. An equal pay task force is created. The task
7 force shall consist of seven members appointed by the
8 governor.

9 2. The task force shall study wage discrepancies
10 within public and private employment and between public
11 and private employers.

12 3. The task force shall submit a report regarding
13 its findings and its recommendations regarding
14 potential actions for the elimination and prevention
15 of such discrepancies to the governor and the general
16 assembly no later than December 22, 2017.>

17 2. By renumbering as necessary.

By FORRISTALL of Pottawattamie

H-8248 FILED APRIL 19, 2016

HOUSE FILE 2459

H-8250

1 Amend the amendment, H-8248, to House File 2459 as
2 follows:

3 1. Page 1, by striking lines 1 through 17 and
4 inserting:

5 <Amend House File 2459 as follows:

6 _____. Page 1, before line 1 by inserting:

7 <DIVISION ____

8 EQUAL PAY TASK FORCE AND REPORT

9 Section 1. EQUAL PAY.

10 1. An equal pay task force is created. The task
11 force shall consist of seven members appointed by the
12 governor.

13 2. The task force shall study wage discrepancies
14 within public and private employment and between public
15 and private employers.

16 3. The task force shall submit a report regarding
17 its findings and its recommendations regarding
18 potential actions for the elimination and prevention
19 of such discrepancies to the governor and the general
20 assembly no later than December 22, 2017.

21 DIVISION ____

22 MISCELLANEOUS PROVISIONS ---- WAGE DISCRIMINATION

23 Sec. _____. ADDITIONAL UNFAIR OR DISCRIMINATORY

24 PRACTICE ---- WAGE DISCRIMINATION IN EMPLOYMENT.

25 1. As stated in chapter 216, the general assembly
26 finds that the practice of discriminating against any
27 employee because of the age, race, creed, color, sex,
28 sexual orientation, gender identity, national origin,
29 religion, or disability of such employee by paying
30 wages to such employee at a rate less than the rate
31 paid to other employees does all of the following:

32 a. Unjustly discriminates against the person
33 receiving the lesser rate.

34 b. Leads to low employee morale, high turnover, and
35 frequent labor unrest.

H-8250

1 c. Discourages employees paid at lesser wage rates
2 from training for higher level jobs.

3 d. Curtails employment opportunities, decreases
4 employees' mobility, and increases labor costs.

5 e. Impairs purchasing power and threatens the
6 maintenance of an adequate standard of living by such
7 employees and their families.

8 f. Prevents optimum utilization of the state's
9 available labor resources.

10 g. Threatens the well-being of citizens of this
11 state and adversely affects the general welfare.

12 2. As stated in section 216.6A, it remains
13 unfair or discriminatory practice for any employer
14 or agent of any employer to discriminate against
15 any employee because of the age, race, creed, color,
16 sex, sexual orientation, gender identity, national
17 origin, religion, or disability of such employee by
18 paying wages to such employee at a rate less than the
19 rate paid to other employees who are employed within
20 the same establishment for equal work on jobs, the
21 performance of which requires equal skill, effort, and
22 responsibility, and which are performed under similar
23 working conditions. As also stated in section 216.6A,
24 an employer or agent of an employer who is paying wages
25 to an employee at a rate less than the rate paid to
26 other employees in violation of this section shall not
27 remedy the violation by reducing the wage rate of any
28 employee.>

29 2. By renumbering as necessary.

By FORRISTALL of Pottawattamie



HF 2439 – E911 Surcharge Fund (LSB6014HZ.1)

Analyst: Alice Wisner (Phone: 515-281-6764) (alice.wisner@legis.iowa.gov)

Fiscal Note Version – As amended by **S-5135**

Description

House File 2439 relates to the distribution and expenditures of the E911 Emergency Communications Service surcharge. The bill establishes a priority of funding, increases the amount of moneys allocated for funding to the public safety answering points (PSAPs), and limits the carryover amount to \$3.5 million annually. The bill also requires the Department of Homeland Security and Emergency Management (DHSEM) to conduct a study by January 15, 2017, to determine the most efficient method to consolidate the PSAPs.

Amendment **S-5135** limits the amount that can be spent for consolidation and other grants to the PSAPs, and the development of public awareness and educational programs to \$4.4 million in FY 2017. This will allow a carryover amount of \$8.7 million in FY 2017 and \$5.4 million in FY 2018. In FY 2019 and subsequent years, the carryover amount is limited to \$3.5 million for a catastrophic event.

Background

Currently, 46.0% of the total amount of E911 surcharge generated per calendar quarter is distributed to the PSAPs. There are 114 PSAPs in the state, including the Department of Public Safety. This bill changes the initial distribution to PSAPs to 60.0% of the total amount of E911 surcharge generated per calendar quarter. The allocation of revenue will continue in proportion to the PSAP square mileage and the number of wireless E911 calls received by each PSAP. The bill also eliminates the accumulation of a carryover operating surplus in the fund by directing the program manager to expend and distribute all of the funds except for \$3.5 million. This is the amount needed in reserve in case of a catastrophic occurrence within the system.

The priority order for distributing funds from the E911 Emergency Communications Fund upon enactment of **HF 2349** will be:

1. An amount appropriated by the General Assembly to implement, support, and maintain the functions of the director and program manager and employ the State Auditor to perform an annual audit of the E911 fund. This amount has previously been set at \$250,000 per fiscal year.
2. Sixty percent allocated to the individual PSAPs based on a formula. This formula allocates 65.0% in proportion to the square miles of the PSAP service area to the total square miles in the state, and 35.0% allocated in proportion to the wireless E911 calls received at the PSAP to the total calls received statewide. This amount is estimated to be \$16.8 million beginning in FY 2017. No PSAP will receive less than \$1,000 per quarter.
3. Ten percent of the total amount of surcharge revenue is available to the wireless carriers to recover their costs to deliver E911 Phase I services.
4. Reimbursement of communications service providers on a quarterly basis for their eligible transport costs.
5. Wire-line carriers and third-party E911 automatic location information costs.
6. Grants to any PSAP agreeing to consolidate. Grants will not exceed one-half of the projected cost of consolidation, or \$200,000, whichever is less.

7. An amount not to exceed \$100,000 for development of public awareness and educational programs for personnel responsible for the maintenance, operation, and upgrading of local E911 systems.
8. Any remaining funds will be distributed equally to the PSAPs to fund future network improvements and the receipt and disposition of 911 calls, for costs related to accessing the state's interoperable communications system; and costs related to the receipt and disposition of E911 calls, and wireless carriers' transport costs related to wireless E911 services, if those costs are not otherwise recovered.

Under amendment [S-5135](#), items 6, 7, and 8 listed above will be limited to a total expenditure of \$4.4 million for FY 2017. This is reflected in the table below.

Assumptions

- Revenues will continue to be generated as they have been in past years, and are estimated to be \$28.1 million annually.
- Beginning in FY 2017, annual projected expenses (other than direct payments to the PSAPs) are estimated to be \$6.7 million through FY 2019 and \$6.5 million through FY 2024.

Fiscal Impact

There is no impact to the General Fund, as all revenues are from the E911 wireless surcharge. The following table summarizes the revenues and expenses projected under this bill.

**Projected Revenue and Expenditures – E911 Emergency Communications Fund
HF 2439 as amended by S-5135**

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Projected Revenue	\$ 28,075,000	\$ 28,075,000	\$ 28,075,000	\$ 28,075,000	\$ 28,075,000
Carryover Fund Brought Forward	19,798,811	8,734,811	5,445,811	3,500,000	3,500,000
Total Revenue	<u>47,873,811</u>	<u>36,809,811</u>	<u>33,520,811</u>	<u>31,575,000</u>	<u>31,575,000</u>
Projected Expenses	13,149,000	6,664,000	6,664,000	6,664,000	6,464,000
PSAP 60% Pass Through	12,880,000	16,800,000	16,800,000	16,800,000	16,800,000
Total Expenses	<u>26,029,000</u>	<u>23,464,000</u>	<u>23,464,000</u>	<u>23,464,000</u>	<u>23,264,000</u>
Total Projected Operating Surplus	\$ 21,844,811	\$ 13,345,811	\$ 10,056,811	\$ 8,111,000	\$ 8,311,000
Catastrophic Reserve	\$ 3,500,000	\$ 3,500,000	\$ 3,500,000	\$ 3,500,000	\$ 3,500,000
Grant Amount Legislated or Available	\$ 9,610,000	\$ 4,400,000	\$ 6,556,811	\$ 4,611,000	\$ 4,811,000
Carryover Amount	\$ 8,734,811	\$ 5,445,811	\$ 3,500,000	\$ 3,500,000	\$ 3,500,000

The funding increase or decrease by individual PSAP will vary.

Source

Homeland Security and Emergency Management Department

/s/ Holly M. Lyons

April 19, 2016

The fiscal note for this bill was prepared pursuant to [Joint Rule 17](#) and the Iowa Code. Data used in developing this fiscal note is available from the Fiscal Services Division of the LSA upon request.
