THOMAS J. VILSACK
GOVERNOR

OFFICE OF THE GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

May 12, 2005

The Honorable Chester Culver
Secretary of State
State Capitol Building
L O C A L

Dear Mr. Secretary:

I hereby transmit:

House File 841, an Act relating to health care reform, including provisions relating to the medical assistance program, providing appropriations, providing effective dates, and providing for retroactive applicability.

The above House File is hereby approved this date.

Sincerely,

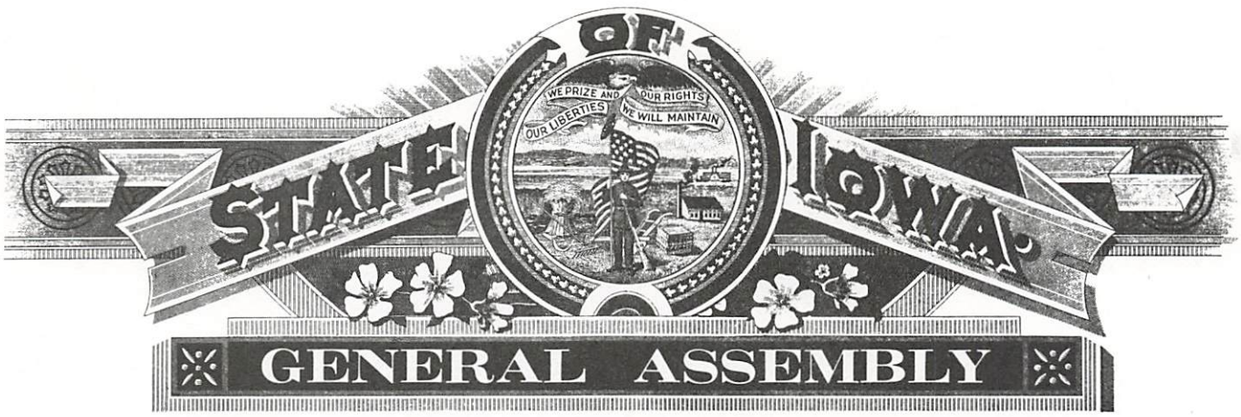
Thomas J. Vilsack

Thomas J. Vilsack
Governor

TJV:jmc

cc: Secretary of the Senate
Chief Clerk of the House

STATE CAPITOL DES MOINES, IOWA 50319 515 281-5211 FAX 515-281-6611



HOUSE FILE 841

AN ACT

RELATING TO HEALTH CARE REFORM, INCLUDING PROVISIONS RELATING TO THE MEDICAL ASSISTANCE PROGRAM, PROVIDING APPROPRIATIONS, PROVIDING EFFECTIVE DATES, AND PROVIDING FOR RETROACTIVE APPLICABILITY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

IOWACARE

Section 1. NEW SECTION. 249J.1 TITLE.

This chapter shall be known and may be cited as the "Iowacare Act".

Sec. 2. NEW SECTION. 249J.2 FEDERAL FINANCIAL PARTICIPATION -- CONTINGENT IMPLEMENTATION.

This chapter shall be implemented only to the extent that federal matching funds are available for nonfederal expenditures under this chapter. The department shall not expend funds under this chapter, including but not limited to expenditures for reimbursement of providers and program administration, if appropriated nonfederal funds are not matched by federal financial participation.

Sec. 3. NEW SECTION. 249J.3 DEFINITIONS.

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

1. "Clean claim" means a claim submitted by a provider included in the expansion population provider network that may be adjudicated as paid or denied.

2. "Department" means the department of human services.

3. "Director" means the director of human services.

4. "Expansion population" means the individuals who are eligible solely for benefits under the medical assistance program waiver as provided in this chapter.

5. "Full benefit dually eligible Medicare Part D beneficiary" means a person who is eligible for coverage for Medicare Part D drugs and is simultaneously eligible for full medical assistance benefits pursuant to chapter 249A, under any category of eligibility.

6. "Full benefit recipient" means an adult who is eligible for full medical assistance benefits pursuant to chapter 249A under any category of eligibility.

7. "Iowa Medicaid enterprise" means the centralized medical assistance program infrastructure, based on a business enterprise model, and designed to foster collaboration among all program stakeholders by focusing on quality, integrity, and consistency.

8. "Medical assistance" or "Medicaid" means payment of all or part of the costs of care and services provided to an individual pursuant to chapter 249A and Title XIX of the federal Social Security Act.

9. "Medicare Part D" means the Medicare Part D program established pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173.

10. "Minimum data set" means the minimum data set established by the centers for Medicare and Medicaid services of the United States department of health and human services for nursing home resident assessment and care screening.

11. "Nursing facility" means a nursing facility as defined in section 135C.1.

12. "Public hospital" means a hospital licensed pursuant to chapter 135B and governed pursuant to chapter 145A, 226, 347, 347A, or 392.

Sec. 4. NEW SECTION. 249J.4 PURPOSE.

It is the purpose of this chapter to propose a variety of initiatives to increase the efficiency, quality, and effectiveness of the health care system; to increase access to appropriate health care; to provide incentives to consumers to engage in responsible health care utilization and personal health care management; to reward providers based on quality of care and improved service delivery; and to encourage the utilization of information technology, to the greatest extent possible, to reduce fragmentation and increase coordination of care and quality outcomes.

DIVISION II

MEDICAID EXPANSION

Sec. 5. NEW SECTION. 249J.5 EXPANSION POPULATION ELIGIBILITY.

1. Except as otherwise provided in this chapter, an individual nineteen through sixty-four years of age shall be eligible solely for the expansion population benefits described in this chapter when provided through the expansion population provider network as described in this chapter, if the individual meets all of the following conditions:

a. The individual is not eligible for coverage under the medical assistance program in effect on or after April 1, 2005.

b. The individual has a family income at or below two hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

c. The individual fulfills all other conditions of participation for the expansion population described in this chapter, including requirements relating to personal financial responsibility.

2. Individuals otherwise eligible solely for family planning benefits authorized under the medical assistance family planning services waiver, effective January 1, 2005, as described in 2004 Iowa Acts, chapter 1175, section 116, subsection 8, may also be eligible for expansion population benefits provided through the expansion population provider network.

3. Individuals with family incomes below three hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services shall also be eligible for obstetrical and newborn care under the expansion population if deductions for the medical expenses of all family members would reduce the family income to two hundred percent of the federal poverty level or below. Such individuals shall be eligible for the same benefits as those provided to individuals eligible under section 135.152. Eligible individuals may choose to receive the appropriate level of care at any licensed hospital or health care facility, with the exception of individuals in need of such

care residing in the counties of Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, and Washington, who shall be provided care at the university of Iowa hospitals and clinics.

4. Enrollment for the expansion population may be limited, closed, or reduced and the scope and duration of expansion population services provided may be limited, reduced, or terminated if the department determines that federal medical assistance program matching funds or appropriated state funds will not be available to pay for existing or additional enrollment.

5. Eligibility for the expansion population shall not include individuals who have access to group health insurance, unless the reason for not accessing group health insurance is allowed by rule of the department.

6. Each expansion population member shall provide to the department all insurance information required by the health insurance premium payment program.

7. The department shall contract with the county general assistance directors to perform intake functions for the expansion population, but only at the discretion of the individual county general assistance director.

8. If the department provides intake services at the location of a provider included in the expansion population provider network, the department shall consider subcontracting with local nonprofit agencies to promote greater understanding between providers, under the medical assistance program and included in the expansion population provider network, and their recipients and members.

Sec. 6. NEW SECTION. 249J.6 EXPANSION POPULATION BENEFITS.

1. Beginning July 1, 2005, the expansion population shall be eligible for all of the following expansion population services:

a. Inpatient hospital procedures described in the diagnostic related group codes or other applicable inpatient hospital reimbursement methods designated by the department.

b. Outpatient hospital services described in the ambulatory patient groupings or noninpatient services designated by the department.

c. Physician and advanced registered nurse practitioner services described in the current procedural terminology codes specified by the department.

d. Dental services described in the dental codes specified by the department.

e. Limited pharmacy benefits provided by an expansion population provider network hospital pharmacy and solely related to an appropriately billed expansion population service.

f. Transportation to and from an expansion population provider network provider only if the provider offers such transportation services or the transportation is provided by a volunteer.

2. a. Beginning no later than March 1, 2006, within ninety days of enrollment in the expansion population, each expansion population member shall participate, in conjunction with receiving a single comprehensive medical examination and completing a personal health improvement plan, in a health risk assessment coordinated by a health consortium representing providers, consumers, and medical education institutions. An expansion population member who enrolls in the expansion population prior to March 1, 2006, shall participate in the health risk assessment, receive the single comprehensive medical examination, and complete the personal health improvement plan by June 1, 2006. The criteria for the health risk assessment, the comprehensive medical examination and the personal health improvement plan shall be developed and applied in a manner that takes into consideration cultural variations that may exist within the expansion population.

b. The health risk assessment shall be a web-based electronic system capable of capturing and integrating basic data to provide an individualized personal health improvement plan for each expansion population member. The health risk assessment shall provide a preliminary diagnosis of current and prospective health conditions and recommendations for improving health conditions with an individualized wellness program. The health risk assessment shall be made available to the expansion population member and the provider specified in paragraph "c" who performs the comprehensive medical examination and provides the individualized personal health improvement plan.

c. The single comprehensive medical examination and personal health improvement plan may be provided by an expansion population provider network physician, advanced registered nurse practitioner, or physician assistant or any other physician, advanced registered nurse practitioner, or physician assistant, available to any full benefit recipient including but not limited to such providers available through a free clinic or rural health clinic under a contract with the department to provide these services, through federally qualified health centers that employ a physician, or through any other nonprofit agency qualified or deemed to be qualified by the department to perform these services.

3. Beginning no later than July 1, 2006, expansion population members shall be provided all of the following:

a. Access to a pharmacy assistance clearinghouse program to match expansion population members with free or discounted prescription drug programs provided by the pharmaceutical industry.

b. Access to a medical information hotline, accessible twenty-four hours per day, seven days per week, to assist expansion population members in making appropriate choices about the use of emergency room and other health care services.

4. Membership in the expansion population shall not preclude an expansion population member from eligibility for services not covered under the expansion population for which the expansion population member is otherwise entitled under state or federal law.

5. Members of the expansion population shall not be considered full benefit dually eligible Medicare Part D beneficiaries for the purposes of calculating the state's payment under Medicare Part D, until such time as the expansion population is eligible for all of the same benefits as full benefit recipients under the medical assistance program.

Sec. 7. NEW SECTION. 249J.7 EXPANSION POPULATION PROVIDER NETWORK.

1. Expansion population members shall only be eligible to receive expansion population services through a provider included in the expansion population provider network. Except as otherwise provided in this chapter, the expansion

population provider network shall be limited to a publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand, the university of Iowa hospitals and clinics, and the state hospitals for persons with mental illness designated pursuant to section 226.1 with the exception of the programs at such state hospitals for persons with mental illness that provide substance abuse treatment, serve gero-psychiatric patients, or treat sexually violent predators.

2. Expansion population services provided to expansion population members by providers included in the expansion population provider network shall be payable at the full benefit recipient rates.

3. Providers included in the expansion population provider network shall submit clean claims within twenty days of the date of provision of an expansion population service to an expansion population member.

4. Unless otherwise prohibited by law, a provider under the expansion population provider network may deny care to an individual who refuses to apply for coverage under the expansion population.

5. Notwithstanding the provision of section 347.16, subsection 2, requiring the provision of free care and treatment to the persons described in that subsection, the publicly owned acute care teaching hospital described in subsection 1 may require any sick or injured person seeking care or treatment at that hospital to be subject to financial participation, including but not limited to copayments or premiums, and may deny nonemergent care or treatment to any person who refuses to be subject to such financial participation.

Sec. 8. NEW SECTION. 249J.8 EXPANSION POPULATION MEMBERS -- FINANCIAL PARTICIPATION.

1. Beginning July 1, 2005, each expansion population member whose family income equals or exceeds one hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services shall pay a monthly premium not to exceed one-twelfth of five percent of the member's annual family income, and each expansion population member whose family income is less than

one hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services shall pay a monthly premium not to exceed one-twelfth of two percent of the member's annual family income. All premiums shall be paid on the last day of the month of coverage. The department shall deduct the amount of any monthly premiums paid by an expansion population member for benefits under the healthy and well kids in Iowa program when computing the amount of monthly premiums owed under this subsection. An expansion population member shall pay the monthly premium during the entire period of the member's enrollment. However, regardless of the length of enrollment, the member is subject to payment of the premium for a minimum of four consecutive months. Timely payment of premiums, including any arrearages accrued from prior enrollment, is a condition of receiving any expansion population services. Premiums collected under this subsection shall be deposited in the premiums subaccount of the account for health care transformation created pursuant to section 249J.22. An expansion population member shall also pay the same copayments required of other adult recipients of medical assistance.

2. The department may reduce the required out-of-pocket expenditures for an individual expansion population member based upon the member's increased wellness activities such as smoking cessation or compliance with the personal health improvement plan completed by the member. The department shall also waive the required out-of-pocket expenditures for an individual expansion population member based upon a hardship that would accrue from imposing such required expenditures.

3. The department shall submit to the governor and the general assembly by March 15, 2006, a design for each of the following:

a. An insurance cost subsidy program for expansion population members who have access to employer health insurance plans, provided that the design shall require that no less than fifty percent of the cost of such insurance shall be paid by the employer.

b. A health care account program option for individuals eligible for enrollment in the expansion population. The

health care account program option shall be available only to adults who have been enrolled in the expansion population for at least twelve consecutive calendar months. Under the health care account program option, the individual would agree to exchange one year's receipt of benefits under the expansion population, to which the individual would otherwise be entitled, for a credit to obtain any medical assistance program covered service up to a specified amount. The balance in the health care account at the end of the year, if any, would be available for withdrawal by the individual.

4. The department shall track the impact of the out-of-pocket expenditures on patient enrollment and shall report the findings on at least a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.19. The findings shall include estimates of the number of expansion population members complying with payment of required out-of-pocket expenditures, the number of expansion population members not complying with payment of required out-of-pocket expenditures and the reasons for noncompliance, any impact as a result of the out-of-pocket requirements on the provision of services to the populations previously served, the administrative time and cost associated with administering the out-of-pocket requirements, and the benefit to the state resulting from the out-of-pocket expenditures. To the extent possible, the department shall track the income level of the member, the health condition of the member, and the family status of the member relative to the out-of-pocket information.

Sec. 9. NEW SECTION. 249J.9 FUTURE EXPANSION POPULATION, BENEFITS, AND PROVIDER NETWORK GROWTH.

1. POPULATION. The department shall contract with the division of insurance of the department of commerce or another appropriate entity to track, on an annual basis, the number of uninsured and underinsured Iowans, the cost of private market insurance coverage, and other barriers to access to private insurance for Iowans. Based on these findings and available funds, the department shall make recommendations, annually, to the governor and the general assembly regarding further expansion of the expansion population.

2. BENEFITS.

a. The department shall not provide services to expansion population members that are in addition to the services originally designated by the department pursuant to section 249J.6, without express authorization provided by the general assembly.

b. The department, upon the recommendation of the clinicians advisory panel established pursuant to section 249J.17, may change the scope and duration of any of the available expansion population services, but this subsection shall not be construed to authorize the department to make expenditures in excess of the amount appropriated for benefits for the expansion population.

3. EXPANSION POPULATION PROVIDER NETWORK.

a. The department shall not expand the expansion population provider network unless the department is able to pay for expansion population services provided by such providers at the full benefit recipient rates.

b. The department may limit access to the expansion population provider network by the expansion population to the extent the department deems necessary to meet the financial obligations to each provider under the expansion population provider network. This subsection shall not be construed to authorize the department to make any expenditure in excess of the amount appropriated for benefits for the expansion population.

Sec. 10. NEW SECTION. 249J.10 MAXIMIZATION OF FUNDING FOR INDIGENT PATIENTS.

1. Unencumbered certified local matching funds may be used to cover the state share of the cost of services for the expansion population.

2. The department of human services shall include in its annual budget submission, recommendations relating to a disproportionate share hospital and graduate medical education allocation plan that maximizes the availability of federal funds for payments to hospitals for the care and treatment of indigent patients.

3. If state and federal law and regulations so provide and if federal disproportionate share hospital funds and graduate medical education funds are available under Title XIX of the federal Social Security Act, federal disproportionate share hospital funds and graduate medical education funds shall be

distributed as specified by the department.

DIVISION III

REBALANCING LONG-TERM CARE

Sec. 11. NEW SECTION. 249J.11 NURSING FACILITY LEVEL OF CARE DETERMINATION FOR FACILITY-BASED AND COMMUNITY-BASED SERVICES.

The department shall amend the medical assistance state plan to provide for all of the following:

1. That nursing facility level of care services under the medical assistance program shall be available to an individual admitted to a nursing facility on or after July 1, 2005, who meets eligibility criteria for the medical assistance program pursuant to section 249A.3, if the individual also meets any of the following criteria:

a. Based upon the minimum data set, the individual requires limited assistance, extensive assistance, or has total dependence on assistance, provided by the physical assistance of one or more persons, with three or more activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems".

b. Based on the minimum data set, the individual requires the establishment of a safe, secure environment due to moderate or severe impairment of cognitive skills for daily decision making.

c. The individual has established a dependency requiring residency in a medical institution for more than one year.

2. That an individual admitted to a nursing facility prior to July 1, 2005, and an individual applying for home and community-based services waiver services at the nursing facility level of care on or after July 1, 2005, who meets the eligibility criteria for the medical assistance program pursuant to section 249A.3, shall also meet any of the following criteria:

a. Based on the minimum data set, the individual requires supervision, or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems".

b. Based on the minimum data set, the individual requires the establishment of a safe, secure environment due to modified independence or moderate impairment of cognitive skills for daily decision making.

3. That, beginning July 1, 2005, if nursing facility level of care is determined to be medically necessary for an individual and the individual meets the nursing facility level of care requirements for home and community-based services waiver services under subsection 2, but appropriate home and community-based services are not available to the individual in the individual's community at the time of the determination or the provision of available home and community-based services to meet the skilled care requirements of the individual is not cost-effective, the criteria for admission of the individual to a nursing facility for nursing facility level of care services shall be the criteria in effect on June 30, 2005. The department of human services shall establish the standard for determining cost-effectiveness of home and community-based services under this subsection.

4. The department shall develop a process to allow individuals identified under subsection 3 to be served under the home and community-based services waiver at such time as appropriate home and community-based services become available in the individual's community.

Sec. 12. NEW SECTION. 249J.12 SERVICES FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES.

1. The department, in cooperation with the Iowa state association of counties, the Iowa association of community providers, the governor's developmental disabilities council, and other interested parties, shall develop a plan for a case-mix adjusted reimbursement system under the medical assistance program for both institution-based and community-based services for persons with mental retardation or developmental disabilities for submission to the general assembly by January 1, 2007. The department shall not implement the case-mix adjusted reimbursement system plan without express authorization by the general assembly.

2. The department, in consultation with the Iowa state association of counties, the Iowa association of community providers, the governor's developmental disabilities council, and other interested parties, shall develop a plan for

submission to the governor and the general assembly no later than July 1, 2007, to enhance alternatives for community-based care for individuals who would otherwise require care in an intermediate care facility for persons with mental retardation. The plan shall not be implemented without express authorization by the general assembly.

Sec. 13. NEW SECTION. 249J.13 CHILDREN'S MENTAL HEALTH WAIVER SERVICES.

The department shall provide medical assistance waiver services to not more than three hundred children who meet the eligibility criteria for the medical assistance program pursuant to section 249A.3, and also meet the criteria specified in section 234.7, subsection 2, if enacted in the 2005 legislative session.

Sec. 14. CASE MANAGEMENT FOR THE FRAIL ELDERLY.

1. The department of human services shall submit an amendment to the home and community-based services waiver for the elderly to the centers for Medicare and Medicaid services of the United States department of health and human services to provide for inclusion of case management as a medical assistance covered service. The department of human services shall develop the amendment in collaboration with the department of elder affairs.

2. If the request for an amendment to the waiver is approved, the department of elder affairs shall use existing funding for case management as nonfederal matching funds. The department of elder affairs, in collaboration with the department of human services, shall determine the amount of existing funding that would be eligible for use as nonfederal matching funds so that sufficient funding is retained to also provide case management services for frail elders who are not eligible for the medical assistance program.

3. The department of human services, in collaboration with the department of elder affairs, shall establish a reimbursement rate for case management for the frail elderly such that the amount of state funding necessary to pay for such case management does not exceed the amount appropriated to the department of elder affairs for case management for the frail elderly in the fiscal year beginning July 1, 2005. Any state savings realized from including case management under the home and community-based services waiver for the elderly

shall be used for services for the frail elderly and for substitute decision-making services to eligible individuals pursuant to chapter 231E, if enacted by the Eighty-first General Assembly.

4. The department of human services, in collaboration with the department of elder affairs, shall determine whether case management for the frail elderly should continue to be provided through a sole source contract or if a request for proposals process should be initiated to provide the services. The departments shall submit their recommendations to the general assembly by January 1, 2006.

DIVISION IV

HEALTH PROMOTION PARTNERSHIPS

Sec. 15. NEW SECTION. 249J.14 HEALTH PROMOTION PARTNERSHIPS.

1. SERVICES FOR ADULTS AT STATE MENTAL HEALTH INSTITUTES. Beginning July 1, 2005, inpatient and outpatient hospital services at the state hospitals for persons with mental illness designated pursuant to section 226.1 shall be covered services under the medical assistance program.

2. DIETARY COUNSELING. By July 1, 2006, the department shall design and begin implementation of a strategy to provide dietary counseling and support to child and adult recipients of medical assistance and to expansion population members to assist these recipients and members in avoiding excessive weight gain or loss and to assist in development of personal weight loss programs for recipients and members determined by the recipient's or member's health care provider to be clinically overweight.

3. ELECTRONIC MEDICAL RECORDS. By October 1, 2006, the department shall develop a practical strategy for expanding utilization of electronic medical recordkeeping by providers under the medical assistance program and the expansion population provider network. The plan shall focus, initially, on medical assistance program recipients and expansion population members whose quality of care would be significantly enhanced by the availability of electronic medical recordkeeping.

4. PROVIDER INCENTIVE PAYMENT PROGRAMS. By January 1, 2007, the department shall design and implement a provider incentive payment program for providers under the medical

assistance program and providers included in the expansion population provider network based upon evaluation of public and private sector models.

5. HEALTH ASSESSMENT FOR MEDICAL ASSISTANCE RECIPIENTS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES. The department shall work with the university of Iowa colleges of medicine, dentistry, nursing, pharmacy, and public health, and the university of Iowa hospitals and clinics to determine whether the physical and dental health of recipients of medical assistance who are persons with mental retardation or developmental disabilities are being regularly and fully addressed and to identify barriers to such care. The department shall report the department's findings to the governor and the general assembly by January 1, 2007.

6. SMOKING CESSATION. The department, in collaboration with Iowa department of public health programs relating to tobacco use prevention and cessation, shall implement a program with the goal of reducing smoking among recipients of medical assistance who are children to less than one percent and among recipients of medical assistance and expansion population members who are adults to less than ten percent, by July 1, 2007.

7. DENTAL HOME FOR CHILDREN. By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the early and periodic screening, diagnostic, and treatment program.

8. REPORTS. The department shall report on a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.19 and the council created pursuant to section 249A.4, subsection 8, regarding the health promotion partnerships described in this section. To the greatest extent feasible, and if applicable to a data set, the data reported shall include demographic information concerning the population served including but not limited to factors, such as race and economic status, as specified by the department.

Sec. 16. NEW SECTION. 249J.14A TASK FORCE ON INDIGENT CARE.

1. The department shall convene a task force on indigent care to identify any growth in uncompensated care due to the implementation of this chapter and to identify any local funds that are being used to pay for uncompensated care that could be maximized through a match with federal funds.

2. Any public, governmental or nongovernmental, private, for-profit, or not-for-profit health services provider or payor, whether or not enrolled in the medical assistance program, and any organization of such providers or payors, may become a member of the task force. Membership on the task force shall require that an entity agree to provide accurate, written information and data relating to each of the following items for the fiscal year of the entity ending on or before June 30, 2005, and for each fiscal year thereafter during which the entity is a member:

a. The definition of indigent care used by the member for purposes of reporting the data described in this subsection.

b. The actual cost of indigent care as determined under Medicare principles of accounting or any accounting standard used by the member to report the member's financial status to its governing body, owner, members, creditors, or the public.

c. The usual and customary charge that would otherwise be applied by the member to the indigent care provided.

d. The number of individuals and the age, sex, and county of residence of the individuals receiving indigent care reported by the member and a description of the care provided.

e. To the extent practical, the health status of the individuals receiving the indigent care reported by the member.

f. The funding source of payment for the indigent care including revenue from property tax or other tax revenue, local funding, and other sources.

g. The extent to which any part of the cost of indigent care reported by the member was paid for by the individual on a sliding fee scale or other basis, by an insurer, or by another third-party payor.

h. The means by which the member covered any of the costs of indigent care not covered by those sources described in paragraph "g".

3. The department shall convene the task force for a minimum of eight meetings during the fiscal year beginning

July 1, 2005, and during each fiscal year thereafter. For the fiscal year beginning July 1, 2005, the department shall convene at least six of the required meetings prior to March 1, 2006. The meetings shall be held in geographically balanced venues throughout the state that are representative of distinct rural, urban, and suburban areas.

4. The department shall provide the medical assistance projections and assessment council created pursuant to section 249J.19 with all of the following, at intervals established by the council:

a. A list of the members of the task force.

b. A copy of each member's written submissions of data and information to the task force.

c. A copy of the data submitted by each member.

d. Any observations or recommendations of the task force regarding the data.

e. Any observations and recommendations of the department regarding the data.

5. The task force shall transmit an initial, preliminary report of its efforts and findings to the governor and the general assembly by March 1, 2006. The task force shall submit an annual report to the governor and the general assembly by December 31 of each year.

6. The department shall, to the extent practical, assist task force members in assembling and reporting the data required of members, by programming the department's systems to accept, but not pay, claims reported on standard medical assistance claims forms for the indigent care provided by the members.

7. All meetings of the task force shall comply with chapter 21.

8. Information and data provided by a member to the task force shall be protected to the extent required under the federal Health Insurance Portability and Accountability Act of 1996.

9. The department shall inform the members of the task force that costs associated with the work of the task force and with the required activities of members may not be eligible for federal matching funds.

DIVISION V

IOWA MEDICAID ENTERPRISE

Sec. 17. NEW SECTION. 249J.15 COST AND QUALITY PERFORMANCE EVALUATION.

Beginning July 1, 2005, the department shall contract with an independent consulting firm to do all of the following:

1. Annually evaluate and compare the cost and quality of care provided by the medical assistance program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state.

2. Annually evaluate the improvements by the medical assistance program and the expansion population in the cost and quality of services provided to Iowans over the cost and quality of care provided in the prior year.

Sec. 18. NEW SECTION. 249J.16 OPERATIONS -- PERFORMANCE EVALUATION.

Beginning July 1, 2006, the department shall submit a report of the results of an evaluation of the performance of each component of the Iowa Medicaid enterprise using the performance standards contained in the contracts with the Iowa Medicaid enterprise partners.

Sec. 19. NEW SECTION. 249J.17 CLINICIANS ADVISORY PANEL -- CLINICAL MANAGEMENT.

1. Beginning July 1, 2005, the medical director of the Iowa Medicaid enterprise, with the approval of the administrator of the division of medical services of the department, shall assemble and act as chairperson for a clinicians advisory panel to recommend to the department clinically appropriate health care utilization management and coverage decisions for the medical assistance program and the expansion population which are not otherwise addressed by the Iowa medical assistance drug utilization review commission created pursuant to section 249A.24 or the medical assistance pharmaceutical and therapeutics committee established pursuant to section 249A.20A. The meetings shall be conducted in accordance with chapter 21 and shall be open to the public except to the extent necessary to prevent the disclosure of confidential medical information.

2. The medical director of the Iowa Medicaid enterprise shall report on a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.19 and the council created pursuant to section

249A.4, subsection 8, any recommendations made by the panel and adopted by rule of the department pursuant to chapter 17A regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.

3. The medical director of the Iowa Medicaid enterprise shall prepare an annual report summarizing the recommendations made by the panel and adopted by rule of the department regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.

Sec. 20. NEW SECTION. 249J.18 HEALTH CARE SERVICES PRICING AND REIMBURSEMENT OF PROVIDERS.

The department shall annually collect data on third-party payor rates in the state and, as appropriate, the usual and customary charges of health care providers, including the reimbursement rates paid to providers and by third-party payors participating in the medical assistance program and through the expansion population. The department shall consult with the division of insurance of the department of commerce in adopting administrative rules specifying the reporting format and guaranteeing the confidentiality of the information provided by the providers and third-party payors. The department shall review the data and make recommendations to the governor and the general assembly regarding pricing changes and reimbursement rates annually by January 1. Any recommended pricing changes or changes in reimbursement rates shall not be implemented without express authorization by the general assembly.

DIVISION VI

GOVERNANCE

Sec. 21. NEW SECTION. 249J.19 MEDICAL ASSISTANCE PROJECTIONS AND ASSESSMENT COUNCIL.

1. A medical assistance projections and assessment council is created consisting of the following members:

a. The co-chairpersons and ranking members of the legislative joint appropriations subcommittee on health and human services, or a member of the appropriations subcommittee designated by the co-chairperson or ranking member.

b. The chairpersons and ranking members of the human resources committees of the senate and the house of

representatives, or a member of the committee designated by the chairperson or ranking member.

c. The chairpersons and ranking members of the appropriations committees of the senate and the house of representatives, or a member of the committee designated by the chairperson or ranking member.

2. The council shall meet as often as deemed necessary, but shall meet at least quarterly. The council may use sources of information deemed appropriate, and the department and other agencies of state government shall provide information to the council as requested. The legislative services agency shall provide staff support to the council.

3. The council shall select a chairperson, annually, from its membership. A majority of the members of the council shall constitute a quorum.

4. The council shall do all of the following:

a. Make quarterly cost projections for the medical assistance program and the expansion population.

b. Review quarterly reports on all initiatives under this chapter, including those provisions in the design, development, and implementation phases, and make additional recommendations for medical assistance program and expansion population reform on an annual basis.

c. Review annual audited financial statements relating to the expansion population submitted by the providers included in the expansion population provider network.

d. Review quarterly reports on the success of the Iowa Medicaid enterprise based upon the contractual performance measures for each Iowa Medicaid enterprise partner.

e. Assure that the expansion population is managed at all times within funding limitations. In assuring such compliance, the council shall assume that supplemental funding will not be available for coverage of services provided to the expansion population.

5. The department of human services, the department of management, and the legislative services agency shall utilize a joint process to arrive at an annual consensus projection for medical assistance program and expansion population expenditures for submission to the council. By December 15 of each fiscal year, the council shall agree to a projection of expenditures for the fiscal year beginning the following July

1, based upon the consensus projection submitted.

DIVISION VII

ENHANCING THE FEDERAL-STATE FINANCIAL PARTNERSHIP

Sec. 22. NEW SECTION. 249J.20 PAYMENTS TO HEALTH CARE PROVIDERS BASED ON ACTUAL COSTS.

Payments, including graduate medical education payments, under the medical assistance program and the expansion population to each public hospital and each public nursing facility shall not exceed the actual medical assistance costs of each such facility reported on the Medicare hospital and hospital health care complex cost report submitted to the centers for Medicare and Medicaid services of the United States department of health and human services. Each public hospital and each public nursing facility shall retain one hundred percent of the medical assistance payments earned under state reimbursement rules. State reimbursement rules may provide for reimbursement at less than actual cost.

Sec. 23. NEW SECTION. 249J.21 INDEPENDENT ANNUAL AUDIT.

The department shall contract with a certified public accountant to provide an analysis, on an annual basis, to the governor and the general assembly regarding compliance of the Iowa medical assistance program with each of the following:

1. That the state has not instituted any new provider taxes as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.

2. That public hospitals and public nursing facilities are not paid more than the actual costs of care for medical assistance program and disproportionate share hospital program recipients based upon Medicare program principles of accounting and cost reporting.

3. That the state is not recycling federal funds provided under Title XIX of the Social Security Act as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.

Sec. 24. NEW SECTION. 249J.22 ACCOUNT FOR HEALTH CARE TRANSFORMATION.

1. An account for health care transformation is created in the state treasury under the authority of the department. Moneys received through the physician payment adjustment as described in 2003 Iowa Acts, chapter 112, section 11,

subsection 1, and through the adjustment to hospital payments to provide an increased base rate to offset the high costs incurred for providing services to medical assistance patients as described in 2004 Iowa Acts, chapter 1175, section 86, subsection 2, paragraph "b", shall be deposited in the account. The account shall include a separate premiums subaccount. Revenue generated through payment of premiums by expansion population members as required pursuant to section 249J.8 shall be deposited in the separate premiums subaccount within the account.

2. Moneys in the account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys deposited in the account are not subject to section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes specified in this section. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the account shall be credited to the account.

3. Moneys deposited in the account for health care transformation shall be used only as provided in appropriations from the account for the costs associated with certain services provided to the expansion population pursuant to section 249J.6, certain initiatives to be designed pursuant to section 249J.8, the case-mix adjusted reimbursement system for persons with mental retardation or developmental disabilities pursuant to section 249J.12, certain health promotion partnership activities pursuant to section 249J.14, the cost and quality performance evaluation pursuant to section 249J.15, auditing requirements pursuant to section 249J.21, the provision of additional indigent patient care and treatment, and administrative costs associated with this chapter.

Sec. 25. NEW SECTION. 249J.23 IOWACARE ACCOUNT.

1. An Iowacare account is created in the state treasury under the authority of the department of human services. Moneys appropriated from the general fund of the state to the account, moneys received as federal financial participation funds under the expansion population provisions of this chapter and credited to the account, moneys received for disproportionate share hospitals and credited to the account,

moneys received for graduate medical education and credited to the account, proceeds transferred from the county treasurer as specified in subsection 6, and moneys from any other source credited to the account shall be deposited in the account. Moneys deposited in or credited to the account shall be used only as provided in appropriations or distributions from the account for the purposes specified in the appropriation or distribution. Moneys in the account shall be appropriated to the university of Iowa hospitals and clinics, to a publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand, and to the state hospitals for persons with mental illness designated pursuant to section 226.1 for the purposes provided in the federal law making the funds available or as specified in the state appropriation and shall be distributed as determined by the department.

2. The account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys in the account shall not be considered revenue of the state, but rather shall be funds of the account. The moneys in the account are not subject to section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes of this chapter. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the account shall be credited to the account.

3. The department shall adopt rules pursuant to chapter 17A to administer the account.

4. The treasurer of state shall provide a quarterly report of activities and balances of the account to the director.

5. Notwithstanding section 262.28 or any provision of this chapter to the contrary, payments to be made to participating public hospitals under this section shall be made on a prospective basis in twelve equal monthly installments based upon the amount appropriated or allocated, as applicable to a specific public hospital, in a specific fiscal year. After the close of the fiscal year, the department shall determine the amount of the payments attributable to the state general fund, federal financial participation funds collected for expansion population services, graduate medical education funds, and disproportionate share hospital funds, based on claims data and actual expenditures.

6. Notwithstanding any provision to the contrary, from each semiannual collection of taxes levied under section 347.7 for which the collection is performed after July 1, 2005, the county treasurer of a county with a population over three hundred fifty thousand in which a publicly owned acute care teaching hospital is located shall transfer the proceeds collected pursuant to section 347.7 in a total amount of thirty-four million dollars annually, which would otherwise be distributed to the county hospital, to the treasurer of state for deposit in the Iowacare account under this section. The board of trustees of the acute care teaching hospital identified in this subsection and the department shall execute an agreement under chapter 28E by July 1, 2005, and annually by July 1, thereafter, to specify the requirements relative to transfer of the proceeds and the distribution of moneys to the hospital from the Iowacare account. The agreement shall include provisions relating to exceptions to the deadline for submission of clean claims as required pursuant to section 249J.7 and provisions relating to data reporting requirements regarding the expansion population. The agreement may also include a provision allowing such hospital to limit access to such hospital by expansion population members based on residency of the member, if such provision reflects the policy of such hospital regarding indigent patients existing on April 1, 2005, as adopted by its board of hospital trustees pursuant to section 347.14, subsection 4. Notwithstanding the specified amount of proceeds to be transferred under this subsection, if the amount allocated that does not require federal matching funds under an appropriation in a subsequent fiscal year to such hospital for medical and surgical treatment of indigent patients, for provision of services to expansion population members, and for medical education, is reduced from the amount allocated that does not require federal matching funds under the appropriation for the fiscal year beginning July 1, 2005, the amount of proceeds required to be transferred under this subsection in that subsequent fiscal year shall be reduced in the same amount as the amount allocated that does not require federal matching funds under that appropriation.

7. The state board of regents, on behalf of the university of Iowa hospitals and clinics, and the department shall

execute an agreement under chapter 28E by July 1, 2005, and annually by July 1, thereafter, to specify the requirements relating to distribution of moneys to the hospital from the Iowacare account. The agreement shall include provisions relating to exceptions to the deadline for submission of clean claims as required pursuant to section 249J.7 and provisions relating to data reporting requirements regarding the expansion population.

8. The state and any county utilizing the acute care teaching hospital located in a county with a population over three hundred fifty thousand for mental health services prior to July 1, 2005, shall annually enter into an agreement with such hospital to pay a per diem amount that is not less than the per diem amount paid for those mental health services in effect for the fiscal year beginning July 1, 2004, for each individual including each expansion population member accessing mental health services at that hospital on or after July 1, 2005. Any payment made under such agreement for an expansion population member pursuant to this chapter, shall be considered by the department to be payment by a third-party payor.

DIVISION VIII

LIMITATIONS

Sec. 26. NEW SECTION. 249J.24 LIMITATIONS.

1. The provisions of this chapter shall not be construed, are not intended as, and shall not imply a grant of entitlement for services to individuals who are eligible for assistance under this chapter or for utilization of services that do not exist or are not otherwise available on the effective date of this Act. Any state obligation to provide services pursuant to this chapter is limited to the extent of the funds appropriated or distributed for the purposes of this chapter.

2. The provisions of this chapter shall not be construed and are not intended to affect the provision of services to recipients of medical assistance existing on the effective date of this Act.

Sec. 27. NEW SECTION. 249J.25 AUDIT -- FUTURE REPEAL.

1. The state auditor shall complete an audit of the provisions implemented pursuant to this chapter during the fiscal year beginning July 1, 2009, and shall submit the

results of the audit to the governor and the general assembly by January 1, 2010.

2. This chapter is repealed June 30, 2010.

Sec. 28. IMPLEMENTATION COSTS. Payment of any one-time costs specifically associated with the implementation of chapter 249J, as enacted in this Act, shall be made in the manner specified by, and at the discretion of, the department.

DIVISION IX

CORRESPONDING PROVISIONS

Sec. 29. Section 97B.52A, subsection 1, paragraph c, Code 2005, is amended to read as follows:

c. For a member whose first month of entitlement is July 2000 or later, the member does not return to any employment with a covered employer until the member has qualified for at least one calendar month of retirement benefits, and the member does not return to covered employment until the member has qualified for no fewer than four calendar months of retirement benefits. For purposes of this paragraph, effective July 1, 2000, any employment with a covered employer does not include employment as an elective official or member of the general assembly if the member is not covered under this chapter for that employment. For purposes of determining a bona fide retirement under this paragraph and for a member whose first month of entitlement is July 2004 or later, but before July 2006, covered employment does not include employment as a licensed health care professional by a public hospital as defined in section ~~249I.3~~ 249J.3, with the exception of public hospitals governed pursuant to chapter 226.

Sec. 30. Section 218.78, subsection 1, Code 2005, is amended to read as follows:

1. All institutional receipts of the department of human services, including funds received from client participation at the state resource centers under section 222.78 and at the state mental health institutes under section 230.20, shall be deposited in the general fund except for reimbursements for services provided to another institution or state agency, for receipts deposited in the revolving farm fund under section 904.706, for deposits into the medical assistance fund under section 249A.11, for any deposits into the medical assistance fund of any medical assistance payments received through the

expansion population program pursuant to chapter 249J, and rentals charged to employees or others for room, apartment, or house and meals, which shall be available to the institutions.

Sec. 31. Section 230.20, subsection 2, paragraph a, Code 2005, is amended to read as follows:

a. The superintendent shall certify to the department the billings to each county for services provided to patients chargeable to the county during the preceding calendar quarter. The county billings shall be based on the average daily patient charge and other service charges computed pursuant to subsection 1, and the number of inpatient days and other service units chargeable to the county. However, a county billing shall be decreased by an amount equal to reimbursement by a third party payor or estimation of such reimbursement from a claim submitted by the superintendent to the third party payor for the preceding calendar quarter. When the actual third party payor reimbursement is greater or less than estimated, the difference shall be reflected in the county billing in the calendar quarter the actual third party payor reimbursement is determined. For the purposes of this paragraph, "third-party payor reimbursement" does not include reimbursement provided under chapter 249J.

Sec. 32. Section 230.20, subsections 5 and 6, Code 2005, are amended to read as follows:

5. An individual statement shall be prepared for a patient on or before the fifteenth day of the month following the month in which the patient leaves the mental health institute, and a general statement shall be prepared at least quarterly for each county to which charges are made under this section. Except as otherwise required by sections 125.33 and 125.34 the general statement shall list the name of each patient chargeable to that county who was served by the mental health institute during the preceding month or calendar quarter, the amount due on account of each patient, and the specific dates for which any third party payor reimbursement received by the state is applied to the statement and billing, and the county shall be billed for eighty percent of the stated charge for each patient specified in this subsection. For the purposes of this subsection, "third-party payor reimbursement" does not include reimbursement provided under chapter 249J. The statement prepared for each county shall be certified by the

department and a duplicate statement shall be mailed to the auditor of that county.

6. All or any reasonable portion of the charges incurred for services provided to a patient, to the most recent date for which the charges have been computed, may be paid at any time by the patient or by any other person on the patient's behalf. Any payment ~~so~~ made by the patient or other person, and any federal financial assistance received pursuant to Title XVIII or XIX of the federal Social Security Act for services rendered to a patient, shall be credited against the patient's account and, if the charges ~~so~~ paid as described in this subsection have previously been billed to a county, reflected in the mental health institute's next general statement to that county. However, any payment made under chapter 249J shall not be reflected in the mental health institute's next general statement to that county.

Sec. 33. Section 249A.11, Code 2005, is amended to read as follows:

249A.11 PAYMENT FOR PATIENT CARE SEGREGATED.

A state resource center or mental health institute, upon receipt of any payment made under this chapter for the care of any patient, shall segregate an amount equal to that portion of the payment which is required by law to be made from nonfederal funds except for any nonfederal funds received through the expansion population program pursuant to chapter 249J which shall be deposited in the Iowacare account created pursuant to section 249J.23. The money segregated shall be deposited in the medical assistance fund of the department of human services.

Sec. 34. Section 249H.4, Code 2005, is amended by adding the following new subsection:

NEW SUBSECTION. 7. The director shall amend the medical assistance state plan to eliminate the mechanism to secure funds based on skilled nursing facility prospective payment methodologies under the medical assistance program and to terminate agreements entered into with public nursing facilities under this chapter, effective June 30, 2005.

Sec. 35. 2004 Iowa Acts, chapter 1175, section 86, subsection 2, paragraph b, unnumbered paragraph 2, and subparagraphs (1), (2), and (3), are amended to read as follows:

~~Of the amount appropriated in this lettered paragraph, $25,950,166 shall be considered encumbered and shall not be expended for any purpose until January 1, 2005.~~

(1) ~~However, if~~ If the department of human services adjusts hospital payments to provide an increased base rate to offset the high cost incurred for providing services to medical assistance patients on or prior to ~~January~~ July 1, 2005, a portion of the amount specified in this unnumbered paragraph equal to the increased Medicaid payment shall ~~revert to the general fund of the state. Notwithstanding section 8.54, subsection 7, the amount required to revert under this subparagraph shall not be considered to be appropriated for purposes of the state general fund expenditure limitation for the fiscal year beginning July 1, 2004.~~

~~(2) If the adjustment described in subparagraph (1) to increase the base rate is not made prior to January 1, 2005, the amount specified in this unnumbered paragraph shall no longer be considered encumbered, may be expended, and shall be available for the purposes originally specified~~ be transferred by the university of Iowa hospitals and clinics to the medical assistance fund of the department of human services. Of the amount transferred, an amount equal to the federal share of the payments shall be transferred to the account for health care transformation created in section 249J.22.

~~(3)~~ (2) Any incremental increase in the base rate made pursuant to subparagraph (1) shall not be used in determining the university of Iowa hospital and clinics disproportionate share rate or when determining the statewide average base rate for purposes of calculating indirect medical education rates.

Sec. 36. 2003 Iowa Acts, chapter 112, section 11, subsection 1, is amended to read as follows:

1. For the fiscal ~~year~~ years beginning July 1, 2003, and ending June 30, 2004, and beginning July 1, 2004, and ~~for each fiscal year thereafter~~ ending June 30, 2005, the department of human services shall institute a supplemental payment adjustment applicable to physician services provided to medical assistance recipients at publicly owned acute care teaching hospitals. The adjustment shall generate supplemental payments to physicians which are equal to the difference between the physician's charge and the physician's fee schedule under the medical assistance program. To the

extent of the supplemental payments, a qualifying hospital shall, after receipt of the payments, transfer to the department of human services an amount equal to the actual supplemental payments that were made in that month. The department of human services shall deposit these payments in the department's medical assistance account. The department of human services shall amend the medical assistance state plan as necessary to implement this section. The department may adopt emergency rules to implement this section. The department of human services shall amend the medical assistance state plan to eliminate this provision effective June 30, 2005.

Sec. 37. TRANSITION FROM INSTITUTIONAL SETTINGS TO HOME AND COMMUNITY-BASED SERVICES. The department, in consultation with provider and consumer organizations, shall explore additional opportunities under the medical assistance program to assist individuals in transitioning from institutional settings to home and community-based services. The department shall report any opportunities identified to the governor and the general assembly by December 31, 2005.

Sec. 38. CORRESPONDING DIRECTIVES TO DEPARTMENT. The department shall do all of the following:

1. Withdraw the request for the waiver and the medical assistance state plan amendment submitted to the centers for Medicare and Medicaid services of the United States department of health and human services regarding the nursing facility quality assurance assessment as directed pursuant to 2003 Iowa Acts, chapter 112, section 4, 2003 Iowa Acts, chapter 179, section 162, and 2004 Iowa Acts, chapter 1085, sections 8, 10, and 11.

2. Amend the medical assistance state plan to eliminate the mechanism to secure funds based on hospital inpatient and outpatient prospective payment methodologies under the medical assistance program, effective June 30, 2005.

3. Amend the medical assistance state plan to eliminate the mechanisms to receive supplemental disproportionate share hospital and graduate medical education funds as originally submitted, effective June 30, 2005.

4. Amend the medical assistance state plan amendment to adjust hospital payments to provide an increased base rate to offset the high cost incurred for providing services to

medical assistance patients at the university of Iowa hospitals and clinics as originally submitted based upon the specifications of 2004 Iowa Acts, chapter 1175, section 86, subsection 2, paragraph "b", unnumbered paragraph 2, and subparagraphs (1), (2), and (3), to be approved for the fiscal year beginning July 1, 2004, and ending June 30, 2005, only, and to be eliminated June 30, 2005.

5. Amend the medical assistance state plan amendment to establish a physician payment adjustment from the university of Iowa hospitals and clinics, as originally submitted as described in 2003 Iowa Acts, chapter 112, section 11, subsection 1, to be approved for the state fiscal years beginning July 1, 2003, and ending June 30, 2004, and beginning July 1, 2004, and ending June 30, 2005, and to be eliminated effective June 30, 2005.

6. Amend the medical assistance state plan to eliminate the mechanism to secure funds based on skilled nursing facility prospective payment methodologies under the medical assistance program, effective June 30, 2005.

7. Request a waiver from the centers for Medicare and Medicaid services of the United States department of health and human services of the provisions relating to the early and periodic screening, diagnostic, and treatment program requirements as described in section 1905(a)(5) of the federal Social Security Act relative to the expansion population.

Sec. 39. Chapter 249I, Code 2005, is repealed.

Sec. 40. Sections 249A.20B and 249A.34, Code 2005, are repealed.

Sec. 41. 2003 Iowa Acts, chapter 112, section 4, 2003 Iowa Acts, chapter 179, section 162, and 2004 Iowa Acts, chapter 1085, section 8, and section 10, subsection 5, are repealed.

DIVISION X

PHARMACY COPAYMENTS

Sec. 42. COPAYMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAL ASSISTANCE PROGRAM. The department of human services shall require recipients of medical assistance to pay the following copayments on each prescription filled for a covered prescription drug, including each refill of such prescription, as follows:

1. A copayment of $1 for each covered nonpreferred generic prescription drug.

2. A copayment of $1 for each covered preferred brand-name or generic prescription drug.

3. A copayment of $1 for each covered nonpreferred brand-name prescription drug for which the cost to the state is up to and including $25.

4. A copayment of $2 for each covered nonpreferred brand-name prescription drug for which the cost to the state is more than $25 and up to and including $50.

5. A copayment of $3 for each covered nonpreferred brand-name prescription drug for which the cost to the state is more than $50.

DIVISION XI

MEDICAL AND SURGICAL TREATMENT OF INDIGENT PERSONS AND OBSTETRICAL AND NEWBORN INDIGENT PATIENT CARE

Sec. 43. NEW SECTION. 135.152 STATEWIDE OBSTETRICAL AND NEWBORN INDIGENT PATIENT CARE PROGRAM.

1. The department shall establish a statewide obstetrical and newborn indigent patient care program to provide obstetrical and newborn care to medically indigent residents of this state at the appropriate and necessary level, at a licensed hospital or health care facility closest and most available to the residence of the indigent individual.

2. The department shall administer the program, and appropriations by the general assembly for the program shall be allocated to the obstetrical and newborn patient care fund within the department to be utilized for the obstetrical and newborn indigent patient care program.

3. The department shall adopt administrative rules pursuant to chapter 17A to administer the program.

4. The department shall establish a patient quota formula for determining the maximum number of obstetrical and newborn patients eligible for the program, annually, from each county. The formula used shall be based upon the annual appropriation for the program, the average number of live births in each county for the most recent three-year period, and the per capita income for each county for the most recent year. The formula shall also provide for reassignment of an unused county quota allotment on April 1 of each year.

5. a. The department, in collaboration with the department of human services and the Iowa state association of counties, shall adopt rules pursuant to chapter 17A to

establish minimum standards for eligibility for obstetrical and newborn care, including physician examinations, medical testing, ambulance services, and inpatient transportation services under the program. The minimum standards shall provide that the individual is not otherwise eligible for assistance under the medical assistance program or for assistance under the medically needy program without a spend-down requirement pursuant to chapter 249A, or for expansion population benefits pursuant to chapter 249J. If the individual is eligible for assistance pursuant to chapter 249A or 249J, or if the individual is eligible for maternal and child health care services covered by a maternal and child health program, the obstetrical and newborn indigent patient care program shall not provide the assistance, care, or covered services provided under the other program.

b. The minimum standards for eligibility shall provide eligibility for persons with family incomes at or below one hundred eighty-five percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services, and shall provide, but shall not be limited to providing, eligibility for uninsured and underinsured persons financially unable to pay for necessary obstetrical and newborn care. The minimum standards may include a spend-down provision. The resource standards shall be set at or above the resource standards under the federal supplemental security income program. The resource exclusions allowed under the federal supplemental security income program shall be allowed and shall include resources necessary for self-employment.

c. The department in cooperation with the department of human services, shall develop a standardized application form for the program and shall coordinate the determination of eligibility for the medical assistance and medically needy programs under chapter 249A, the medical assistance expansion under chapter 249J, and the obstetrical and newborn indigent patient care program.

6. The department shall establish application procedures and procedures for certification of an individual for obstetrical and newborn care under this section.

7. An individual certified for obstetrical and newborn care under this division may choose to receive the appropriate

level of care at any licensed hospital or health care facility.

8. The obstetrical and newborn care costs of an individual certified for such care under this division at a licensed hospital or health care facility or from licensed physicians shall be paid by the department from the obstetrical and newborn patient care fund.

9. All providers of services to obstetrical and newborn patients under this division shall agree to accept as full payment the reimbursements allowable under the medical assistance program established pursuant to chapter 249A, adjusted for intensity of care.

10. The department shall establish procedures for payment for providers of services to obstetrical and newborn patients under this division from the obstetrical and newborn patient care fund. All billings from such providers shall be submitted directly to the department. However, payment shall not be made unless the requirements for application and certification for care pursuant to this division and rules adopted by the department are met.

11. Moneys encumbered prior to June 30 of a fiscal year for a certified eligible pregnant woman scheduled to deliver in the next fiscal year shall not revert from the obstetrical and newborn patient care fund to the general fund of the state. Moneys allocated to the obstetrical and newborn patient care fund shall not be transferred nor voluntarily reverted from the fund within a given fiscal year.

Sec. 44. Section 135B.31, Code 2005, is amended to read as follows:

135B.31 EXCEPTIONS.

~~Nothing in this~~ This division is not intended ~~or should~~ and shall not affect in any way ~~that~~ the obligation of public hospitals under chapter 347 or municipal hospitals~~, as well as the state hospital at Iowa City,~~ to provide ~~medical or obstetrical and newborn care for indigent persons under chapter 255 or 255A, wherein~~ medical care or treatment ~~is provided by hospitals of that category~~ to patients of certain entitlement, nor ~~to~~ the operation by the state of mental or other hospitals authorized by law. ~~Nothing herein~~ This division shall not in any way affect or limit the practice of dentistry or the practice of oral surgery by a dentist.

Sec. 45. Section 144.13A, subsection 3, Code 2005, is amended to read as follows:

3. If the person responsible for the filing of the certificate of birth under section 144.13 is not the parent, the person is entitled to collect the fee from the parent. The fee shall be remitted to the state registrar. If the expenses of the birth are reimbursed under the medical assistance program established by chapter 249A~~,-or-paid-for-under-the-statewide-indigent-patient-care-program-established-by-chapter-255,-or-paid-for-under-the-obstetrical-and-newborn-indigent-patient-care-program-established-by-chapter-255A,~~ or if the parent is indigent and unable to pay the expenses of the birth and no other means of payment is available to the parent, the registration fee and certified copy fee are waived. If the person responsible for the filing of the certificate is not the parent, the person is discharged from the duty to collect and remit the fee under this section if the person has made a good faith effort to collect the fee from the parent.

Sec. 46. Section 249A.4, subsection 12, Code 2005, is amended by striking the subsection.

UNIVERSITY OF IOWA HOSPITALS AND CLINICS

Sec. 47. NEW SECTION. 263.18 TREATMENT OF PATIENTS -- USE OF EARNINGS FOR NEW FACILITIES.

1. The university of Iowa hospitals and clinics authorities may at their discretion receive patients into the hospital for medical, obstetrical, or surgical treatment or hospital care. The university of Iowa hospitals and clinics ambulances and ambulance personnel may be used for the transportation of such patients at a reasonable charge if specialized equipment is required.

2. The university of Iowa hospitals and clinics authorities shall collect from the person or persons liable for support of such patients reasonable charges for hospital care and service and deposit payment of the charges with the treasurer of the university for the use and benefit of the university of Iowa hospitals and clinics.

3. Earnings of the university of Iowa hospitals and clinics shall be administered so as to increase, to the greatest extent possible, the services available for patients, including acquisition, construction, reconstruction,

completion, equipment, improvement, repair, and remodeling of medical buildings and facilities, additions to medical buildings and facilities, and the payment of principal and interest on bonds issued to finance the cost of medical buildings and facilities as authorized by the provisions of chapter 263A.

4. The physicians and surgeons on the staff of the university of Iowa hospitals and clinics who care for patients provided for in this section may charge for the medical services provided under such rules, regulations, and plans approved by the state board of regents. However, a physician or surgeon who provides treatment or care for an expansion population member pursuant to chapter 249J shall not charge or receive any compensation for the treatment or care except the salary or compensation fixed by the state board of regents to be paid from the hospital fund.

Sec. 48. NEW SECTION. 263.19 PURCHASES.

Any purchase in excess of ten thousand dollars, of materials, appliances, instruments, or supplies by the university of Iowa hospitals and clinics, when the price of the materials, appliances, instruments, or supplies to be purchased is subject to competition, shall be made pursuant to open competitive quotations, and all contracts for such purchases shall be subject to chapter 72. However, purchases may be made through a hospital group purchasing organization provided that the university of Iowa hospitals and clinics is a member of the organization.

Sec. 49. NEW SECTION. 263.20 COLLECTING AND SETTLING CLAIMS FOR CARE.

Whenever a patient or person legally liable for the patient's care at the university of Iowa hospitals and clinics has insurance, an estate, a right of action against others, or other assets, the university of Iowa hospitals and clinics, through the facilities of the office of the attorney general, may file claims, institute or defend suit in court, and use other legal means available to collect accounts incurred for the care of the patient, and may compromise, settle, or release such actions under the rules and procedures prescribed by the president of the university and the office of the attorney general. If a county has paid any part of such patient's care, a pro rata amount collected, after deduction

for cost of collection, shall be remitted to the county and the balance shall be credited to the hospital fund.

Sec. 50. NEW SECTION. 263.21 TRANSFER OF PATIENTS FROM STATE INSTITUTIONS.

The director of the department of human services, in respect to institutions under the director's control, the administrator of any of the divisions of the department, in respect to the institutions under the administrator's control, the director of the department of corrections, in respect to the institutions under the department's control, and the state board of regents, in respect to the Iowa braille and sight saving school and the Iowa school for the deaf, may send any inmate, student, or patient of an institution, or any person committed or applying for admission to an institution, to the university of Iowa hospitals and clinics for treatment and care. The department of human services, the department of corrections, and the state board of regents shall respectively pay the traveling expenses of such patient, and when necessary the traveling expenses of an attendant for the patient, out of funds appropriated for the use of the institution from which the patient is sent.

Sec. 51. NEW SECTION. 263.22 MEDICAL CARE FOR PAROLEES AND PERSONS ON WORK RELEASE.

The director of the department of corrections may send former inmates of the institutions provided for in section 904.102, while on parole or work release, to the university of Iowa hospitals and clinics for treatment and care. The director may pay the traveling expenses of any such patient, and when necessary the traveling expenses of an attendant of the patient, out of funds appropriated for the use of the department of corrections.

Sec. 52. Section 271.6, Code 2005, is amended to read as follows:

271.6 INTEGRATED TREATMENT OF UNIVERSITY HOSPITAL PATIENTS.

The authorities of the Oakdale campus may authorize patients for admission to the hospital on the Oakdale campus who are referred from the university hospitals and who shall retain the same status, classification, and authorization for care which they had at the university hospitals. Patients referred from the university hospitals to the Oakdale campus

shall be deemed to be patients of the university hospitals. ~~Chapters 255 and 255A and the~~ The operating policies of the university hospitals shall apply to the patients ~~and to the payment for their care~~ the same as the provisions apply to patients who are treated on the premises of the university hospitals.

Sec. 53. Section 331.381, subsection 9, Code 2005, is amended by striking the subsection.

Sec. 54. Section 331.502, subsection 17, Code 2005, is amended by striking the subsection.

Sec. 55. Section 331.552, subsection 13, Code 2005, is amended to read as follows:

13. Make transfer payments to the state for school expenses for blind and deaf children~~,~~ and support of persons with mental illness~~, and hospital care for the indigent~~ as provided in sections 230.21, ~~255.26,~~ 269.2, and 270.7.

Sec. 56. Section 331.653, subsection 26, Code 2005, is amended by striking the subsection.

Sec. 57. Section 331.756, subsection 53, Code 2005, is amended by striking the subsection.

Sec. 58. Section 602.8102, subsection 48, Code 2005, is amended by striking the subsection.

Sec. 59. Chapters 255 and 255A, Code 2005, are repealed.

Sec. 60. OBLIGATIONS TO INDIGENT PATIENTS. The provisions of this Act shall not be construed and are not intended to change, reduce, or affect the obligation of the university of Iowa hospitals and clinics existing on April 1, 2005, to provide care or treatment at the university of Iowa hospitals and clinics to indigent patients and to any inmate, student, patient, or former inmate of a state institution as specified in sections 263.21 and 263.22 as enacted in this Act, with the exception of the specific obligation to committed indigent patients as specified pursuant to section 255.16, Code 2005, repealed in this Act.

Sec. 61. INMATES, STUDENTS, PATIENTS, AND FORMER INMATES OF STATE INSTITUTIONS -- REVIEW.

1. The director of human services shall convene a workgroup comprised of the director, the director of the department of corrections, the president of the state board of regents, and a representative of the university of Iowa hospitals and clinics to review the provision of treatment and

care to the inmates, students, patients, and former inmates specified in sections 263.21 and 263.22, as enacted in this Act. The review shall determine all of the following:

a. The actual cost to the university of Iowa hospitals and clinics to provide care and treatment to the inmates, students, patients, and former inmates on an annual basis. The actual cost shall be determined utilizing Medicare cost accounting principles.

b. The number of inmates, students, patients, and former inmates provided treatment at the university of Iowa hospitals and clinics, annually.

c. The specific types of treatment and care provided to the inmates, students, patients, and former inmates.

d. The existing sources of revenue that may be available to pay for the costs of providing care and treatment to the inmates, students, patients, and former inmates.

e. The cost to the department of human services, the Iowa department of corrections, and the state board of regents to provide transportation and staffing relative to provision of care and treatment to the inmates, students, patients, and former inmates at the university of Iowa hospitals and clinics.

f. The effect of any proposed alternatives for provision of care and treatment for inmates, students, patients, or former inmates, including the proposed completion of the hospital unit at the Iowa state penitentiary at Fort Madison.

2. The workgroup shall submit a report of its findings to the governor and the general assembly no later than December 31, 2005. The report shall also include any recommendations for improvement in the provision of care and treatment to inmates, students, patients, and former inmates, under the control of the department of human services, the Iowa department of corrections, and the state board of regents.

DIVISION XII

STATE MEDICAL INSTITUTION

Sec. 62. NEW SECTION. 218A.1 STATE MEDICAL INSTITUTION.

1. All of the following shall be collectively designated as a single state medical institution:

a. The mental health institute, Mount Pleasant, Iowa.

b. The mental health institute, Independence, Iowa.

c. The mental health institute, Clarinda, Iowa.

d. The mental health institute, Cherokee, Iowa.

e. The Glenwood state resource center.

f. The Woodward state resource center.

2. Necessary portions of the institutes and resource centers shall remain licensed as separate hospitals and as separate intermediate care facilities for persons with mental retardation, and the locations and operations of the institutes and resource centers shall not be subject to consolidation to comply with this chapter.

3. The state medical institution shall qualify for payments described in subsection 4 for the fiscal period beginning July 1, 2005, and ending June 30, 2010, if the state medical institution and the various parts of the institution comply with the requirements for payment specified in subsection 4, and all of the following conditions are met:

a. The total number of beds in the state medical institution licensed as hospital beds is less than fifty percent of the total number of all state medical institution beds. In determining compliance with this requirement, however, any reduction in the total number of beds that occurs as the result of reduction in census due to an increase in utilization of home and community-based services shall not be considered.

b. An individual is appointed by the director of human services to serve as the director of the state medical institution and an individual is appointed by the director of human services to serve as medical director of the state medical institution. The individual appointed to serve as the director of the state medical institution may also be an employee of the department of human services or of a component part of the state medical institution. The individual appointed to serve as medical director of the state medical institution may also serve as the medical director of one of the component parts of the state medical institution.

c. A workgroup comprised of the director of human services or the director's designee, the director of the state medical institution, the directors of all licensed intermediate care facilities for persons with mental retardation in the state, and representatives of the Iowa state association of counties, the Iowa association of community providers, and other

interested parties develops and presents a plan, for submission to the centers for Medicare and Medicaid services of the United States department of health and human services, to the general assembly no later than July 1, 2007, to reduce the number of individuals in intermediate care facilities for persons with mental retardation in the state and concurrently to increase the number of individuals with mental retardation and developmental disabilities in the state who have access to home and community-based services. The plan shall include a proposal to redesign the home and community-based services waivers for persons with mental retardation and persons with brain injury under the medical assistance program. The department shall not implement the plan without express authorization by the general assembly.

4. The department of human services shall submit a waiver to the centers for Medicare and Medicaid services of the United States department of health and human services to provide for all of the following:

a. Coverage under the medical assistance program, with appropriate federal matching funding, for inpatient and outpatient hospital services provided to eligible individuals by any part of the state medical institution that maintains a state license as a hospital.

b. Disproportionate share hospital payments for services provided by any part of the state medical institution that maintains a state license as a hospital.

c. Imposition of an assessment on intermediate care facilities for persons with mental retardation on any part of the state medical institution that provides intermediate care facility for persons with mental retardation services.

DIVISION XIII

APPROPRIATIONS AND EFFECTIVE DATES

Sec. 63. APPROPRIATIONS FROM IOWACARE ACCOUNT.

1. There is appropriated from the Iowacare account created in section 249J.23 to the university of Iowa hospitals and clinics for the fiscal year beginning July 1, 2005, and ending June 30, 2006, the following amount, or so much thereof as is necessary, to be used for the purposes designated:

For salaries, support, maintenance, equipment, and miscellaneous purposes, for the provision of medical and surgical treatment of indigent patients, for provision of

services to members of the expansion population pursuant to chapter 249J, as enacted in this Act, and for medical education:

..... $ 27,284,584

2. There is appropriated from the Iowacare account created in section 249J.23 to a publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand for the fiscal year beginning July 1, 2005, and ending June 30, 2006, the following amount, or so much thereof as is necessary, to be used for the purposes designated:

For the provision of medical and surgical treatment of indigent patients, for provision of services to members of the expansion population pursuant to chapter 249J, as enacted in this Act, and for medical education:

..... $ 40,000,000

Notwithstanding any provision of this Act to the contrary, of the amount appropriated in this subsection, $37,000,000 shall be allocated in twelve equal monthly payments as provided in section 249J.23, as enacted in this Act. Any amount appropriated in this subsection in excess of $37,000,000 shall be allocated only if federal funds are available to match the amount allocated.

3. There is appropriated from the Iowacare account created in section 249J.23 to the state hospitals for persons with mental illness designated pursuant to section 226.1 for the fiscal year beginning July 1, 2005, and ending June 30, 2006, the following amounts, or so much thereof as is necessary, to be used for the purposes designated:

a. For the state mental health institute at Cherokee, for salaries, support, maintenance, full-time equivalent positions, and miscellaneous purposes including services to members of the expansion population pursuant to chapter 249J, as enacted in this Act:

..... $ 9,098,425

b. For the state mental health institute at Clarinda, for salaries, support, maintenance, full-time equivalent positions, and miscellaneous purposes including services to members of the expansion population pursuant to chapter 249J, as enacted in this Act:

..... $ 1,977,305

c. For the state mental health institute at Independence, for salaries, support, maintenance, full-time equivalent positions, and miscellaneous purposes including services to members of the expansion population pursuant to chapter 249J, as enacted in this Act:

..... $ 9,045,894

d. For the state mental health institute at Mount Pleasant, for salaries, support, maintenance, full-time equivalent positions, and miscellaneous purposes including services to members of the expansion population designation pursuant to chapter 249J, as enacted in this Act:

..... $ 5,752,587

Sec. 64. APPROPRIATIONS FROM ACCOUNT FOR HEALTH CARE TRANSFORMATION. There is appropriated from the account for health care transformation created in section 249J.22, as enacted in this Act, to the department of human services, for the fiscal year beginning July 1, 2005, and ending June 30, 2006, the following amounts, or so much thereof as is necessary, to be used for the purposes designated:

1. For the costs of medical examinations and development of personal health improvement plans for the expansion population pursuant to section 249J.6, as enacted in this Act:

..... $ 136,500

2. For the provision of a medical information hotline for the expansion population as provided in section 249J.6, as enacted in this Act:

..... $ 150,000

3. For the insurance cost subsidy program pursuant to section 249J.8, as enacted in this Act:

..... $ 150,000

4. For the health care account program option pursuant to section 249J.8, as enacted in this Act:

..... $ 50,000

5. For the use of electronic medical records by medical assistance program and expansion population provider network providers pursuant to section 249J.14, as enacted in this Act:

..... $ 100,000

6. For other health partnership activities pursuant to section 249J.14, as enacted in this Act:

..... $ 550,000

7. For the costs related to audits, performance evaluations, and studies required by this Act:
..... $ 100,000

8. For administrative costs associated with this Act:
..... $ 910,000

Sec. 65. TRANSFER FROM ACCOUNT FOR HEALTH CARE TRANSFORMATION. There is transferred from the account for health care transformation created pursuant to section 249J.22, as enacted in this Act, to the Iowacare account created in section 249J.23, as enacted in this Act, a total of $2,000,000 for the fiscal year beginning July 1, 2005, and ending June 30, 2006.

Sec. 66. EFFECTIVE DATES -- CONTINGENT REDUCTION -- RULES -- RETROACTIVE APPLICABILITY.

1. The provisions of this Act requiring the department of human services to request waivers from the centers for Medicare and Medicaid services of the United States department of health and human services and to amend the medical assistance state plan, and the provisions relating to execution of chapter 28E agreements in section 249J.23, as enacted in this Act, being deemed of immediate importance, take effect upon enactment.

2. The remaining provisions of this Act, with the exception of the provisions described in subsection 1, shall not take effect unless the department of human services receives approval of all waivers and medical assistance state plan amendments required under this Act. If all approvals are received, the remaining provisions of this Act shall take effect July 1, 2005, or on the date specified in the waiver or medical assistance state plan amendment for a particular provision. The department of human services shall notify the Code editor of the date of receipt of the approvals.

3. If this Act is enacted and if the Eighty-first General Assembly enacts legislation appropriating moneys from the general fund of the state to the department of human services for the fiscal year beginning July 1, 2005, and ending June 30, 2006, for the state hospitals for persons with mental illness designated pursuant to section 226.1, for salaries, support, maintenance, and miscellaneous purposes and for full-time equivalent positions, the appropriations shall be reduced in the following amounts and the amounts shall be transferred

to the medical assistance fund of the department of human services to diminish the effect of intergovernmental transfer reductions:

a. For the state mental health institute at Cherokee:
..... $ 9,098,425

b. For the state mental health institute at Clarinda:
..... $ 1,977,305

c. For the state mental health institute at Independence:
..... $ 9,045,894

d. For the state mental health institute at Mount Pleasant:
..... $ 5,752,587

4. If this Act is enacted and if the Eighty-first General Assembly enacts legislation appropriating moneys from the general fund of the state to the state university of Iowa for the fiscal year beginning July 1, 2005, and ending June 30, 2006, for the university hospitals for salaries, support, maintenance, equipment, and miscellaneous purposes and for medical and surgical treatment of indigent patients as provided in chapter 255, for medical education, and for full-time equivalent positions, the appropriation is reduced by $27,284,584 and the amount shall be transferred to the medical assistance fund of the department of human services to diminish the effect of intergovernmental transfer reductions.

5. If this Act is enacted, and if the Eighty-first General Assembly enacts 2005 Iowa Acts, House File 816, and 2005 Iowa Acts, House File 816 includes a provision relating to medical assistance supplemental amounts for disproportionate share hospital and indirect medical education, the provision in House File 816 shall not take effect.

6. If this Act is enacted, and if the Eighty-first General Assembly enacts 2005 Iowa Acts, House File 825, and 2005 Iowa Acts, House File 825, includes a provision appropriating moneys from the hospital trust fund created in section 249I.4 to the department of human services for the fiscal year beginning July 1, 2005, and ending June 30, 2006, to be used to supplement the appropriations made for the medical assistance program for that fiscal year, the appropriation is reduced by $22,900,000.

7. The department of human services may adopt emergency rules pursuant to chapter 17A to implement and administer the provisions of this Act.

8. The department of human services may procure sole source contracts to implement any provision of this Act. In addition to sole source contracting, the department may contract with local nonprofit agencies to provide services enumerated in this Act. The department shall utilize nonprofit agencies to the greatest extent possible in the delivery of the programs and services enumerated in this Act to promote greater understanding between providers, under the medical assistance program and included in the expansion population provider network, and their recipients and members.

9. The provisions of this Act amending 2003 Iowa Acts, chapter 112, section 11, and repealing section 249A.20B, are retroactively applicable to May 2, 2003.

10. The section of this Act amending 2004 Iowa Acts, chapter 1175, section 86, is retroactively applicable to May 17, 2004.

CHRISTOPHER C. RANTS
Speaker of the House

JOHN P. KIBBIE
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 841, Eighty-first General Assembly.

MARGARET THOMSON
Chief Clerk of the House

Approved May 12, 2005

THOMAS J. VILSACK
Governor