MAR 1 8 2003

Place On Calendar

HOUSE FILE 619

BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO HSB 292)

Passed House, Date ____________ Passed Senate, Date ____________

Vote: Ayes _______ Nays _______ Vote: Ayes _______ Nays _______

Approved ______________________________

A BILL FOR

1 An Act relating to health care including reimbursement of health
2 care facilities based on resident program eligibility.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
4

HF 619 - Veteran Eligibility (LSB 3175 HV)
Analyst: Jennifer Vermeer (Phone: (515) 281-4611) (jennifer.vermeer@legis.state.ia.us)
Fiscal Note Version — New

Description

House File 619 requires nursing facilities to assist the Iowa Commission of Veterans Affairs in determining prospective residents eligibility for federal Veterans Affairs benefits, prior to admission to the facility.

Assumptions

1. Enrolling veterans for their veterans' benefits when they first enter a nursing facility will delay their eligibility for Medicaid and will likely result in State savings.
2. The number of veterans identified and enrolled, and the impact of the benefits on their assets, however, is unknown. In addition, the federal Veterans' Affairs application processing period is currently six to nine months.
3. As a result, there will likely be minimal savings in FY 2004. Savings in FY 2005 cannot be determined due to the lack of data discussed above.

Fiscal Impact

The fiscal impact of HF 619 cannot be determined.

Sources

Department of Human Services
Legislative Fiscal Bureau analysis

/s/ Dennis C Prouty

April 2, 2003

TLSB 3175HV 80
pf/sh/8

HF 619

S.F. ________ H.F. 619

1 Section 1. NEW SECTION. 135C.31A ASSESSMENT OF RESIDENTS
2 -- PROGRAM ELIGIBILITY.
3 Beginning July 1, 2003, a health care facility receiving
4 reimbursement through the medical assistance program under
5 chapter 249A shall assist the Iowa commission of veterans
6 affairs in determining, prior to the initial admission of a
7 resident, the prospective resident's eligibility for benefits
8 through the federal department of veterans affairs. The
9 health care facility shall also assist the Iowa commission of
10 veterans affairs in determining such eligibility for residents
11 residing in the facility on July 1, 2003. The department
12 shall adopt rules to administer this section, including a
13 provision that ensures that if a resident is eligible for
14 benefits through the federal department of veterans affairs or
15 other third-party payor, the payor of last resort for
16 reimbursement to the health care facility is the medical
17 assistance program. This section shall not apply to the
18 admission of an individual to a state mental health institute
19 for acute psychiatric care.
20 EXPLANATION
21 This bill requires that a licensed health care facility
22 assist the Iowa commission of veterans affairs in determining,
23 prior to initial admission of a resident, the prospective
24 resident's eligibility for benefits through the United States
25 department of veterans affairs. The bill also requires that
26 the health care facility assist the Iowa commission of
27 veterans affairs in determining the eligibility of current
28 residents.
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LSB 3175HV 80
pf/sh/8

1 Amend House File 619 as follows:
2 1. Page 1, by inserting before line 1, the
3 following:
4 "Section 1. NEW SECTION. 135.131 INTERAGENCY
5 PHARMACEUTICALS BULK PURCHASING COUNCIL.
6 1. For the purposes of this section, "interagency
7 pharmaceuticals bulk purchasing council" or "council"
8 means the interagency pharmaceuticals bulk purchasing
9 council created in this section.
10 2. An interagency pharmaceuticals bulk purchasing
11 council is created within the Iowa department of
12 public health. The department shall provide staff
13 support to the council and the department of
14 pharmaceutical care of the university of Iowa
15 hospitals and clinics shall act in an advisory
16 capacity to the council. The council shall be
17 composed of all of the following members:
18 a. The director of public health, or the
19 director's designee.
20 b. The director of human services, or the
21 director's designee.
22 c. The director of the department of personnel, or
23 the director's designee.
24 d. A representative of the state board of regents.
25 e. The director of the department of corrections,
26 or the director's designee.
27 f. The director, or the director's designee, of
28 any other agency that purchases pharmaceuticals
29 designated to be included as a member by the director
30 of public health.
31 3. The council shall select a chairperson annually
32 from its membership. A majority of the members of the
33 council shall constitute a quorum.
34 4. The council shall do all of the following:
35 a. Develop procedures that member agencies must
36 follow in purchasing pharmaceuticals. However, a
37 member agency may elect not to follow the council's
38 procedures if the agency is able to purchase the
39 pharmaceuticals for a lower price than the price
40 available through the council. An agency that does
41 not follow the council's procedures shall report all
42 of the following to the council:
43 (1) The purchase price for the pharmaceuticals.
44 (2) The name of the wholesaler, retailer, or
45 manufacturer selling the pharmaceuticals.
46 b. Designate a member agency as the central
47 purchasing agency for purchasing of pharmaceuticals.
48 c. Use existing distribution networks, including
49 wholesale and retail distributors, to distribute the
50 pharmaceuticals.

1 d. Investigate options that maximize purchasing
2 power, including expanding purchasing under the
3 medical assistance program, qualifying for
4 participation in purchasing programs under 42 U.S.C. ¤
5 256b, as amended, and utilizing rebate programs,
6 hospital disproportionate share purchasing, multistate
7 purchasing alliances, and health department and
8 federally qualified health center purchasing.
9 e. In collaboration with the department of
10 pharmaceutical care of the university of Iowa
11 hospitals and clinics, make recommendations to member
12 agencies regarding drug utilization review, prior
13 authorization, the use of restrictive formularies, the
14 use of mail order programs, and copayment structures.
15 This paragraph shall not apply to the medical
16 assistance program but only to the operations of the
17 member agencies.
18 5. The central purchasing agency may enter into
19 agreements with a local governmental entity to
20 purchase pharmaceuticals for the local governmental
21 entity.
22 6. The council shall develop procedures under
23 which the council may disclose information relating to
24 the prices manufacturers or wholesalers charge for
25 pharmaceuticals by category of pharmaceutical. The
26 procedure shall prohibit the council from disclosing
27 information that identifies a specific manufacturer or
28 wholesaler or the prices charged by a specific
29 manufacturer or wholesaler for a specific
30 pharmaceutical."
31 2. Page 1, line 11, by inserting after the word
32 "department" the following: "of inspections and
33 appeals, in cooperation with the department of human
34 services,".
35 3. Page 1, by inserting after line 19, the
36 following:
37 "Sec. ___. NEW SECTION. 155A.4A PHARMACEUTIC
38 MARKETERS -- PROHIBITION OF GIFTS.
39 1. A pharmaceutical marketer shall not offer or
40 provide to any practitioner, hospital, health care
41 facility, pharmacist, health benefit plan
42 administrator, or any other person in this state
43 authorized or licensed to prescribe, dispense,
44 distribute, or purchase prescription drugs, any gift
45 not otherwise exempt under this section.
46 2. The following gifts are exempt from the
47 prohibition of this section:
48 a. Free samples of prescription drugs intended for
49 distribution to patients.
50 b. The payment of reasonable compensation and

1 reimbursement of expenses in connection with bona fide
2 clinical trials. As used in this paragraph, "clinical
3 trial" means an approved clinical trial conducted in
4 connection with a research study designed to answer
5 specific questions about vaccines, new therapies, or
6 new ways of utilizing known treatments.
7 c. Any gift, fee, payment, subsidy, or other
8 economic benefit the value of which is less than
9 twenty-five dollars.
10 d. A scholarship or other support for medical
11 students, residents, or fellows to attend a
12 significant educational, scientific, or policymaking
13 conference of a national, regional, or specialty
14 medical or other professional association if the
15 recipient of the scholarship or other support is
16 selected by the association.
17 3. a. Annually on or before January 1, every
18 pharmaceutical manufacturing company shall disclose to
19 the board the value, nature, and purpose of any gift,
20 fee, payment, subsidy, or other economic benefit
21 provided in connection with detailing, promotional, or
22 other marketing activities by the company, directly or
23 through its pharmaceutical marketers, to any
24 practitioner, hospital, health care facility,
25 pharmacist, health benefit plan administrator, or any
26 other person in this state authorized to prescribe,
27 dispense, distribute, or purchase prescription drugs
28 in this state. Disclosure shall be made on a form and
29 in a manner prescribed by the board and shall be made
30 for the period beginning July 1 and ending June 30 of
31 the previous state fiscal year. An initial disclosure
32 shall be made on January 15, 2004, for the period
33 beginning July 1, 2003, and ending December 31, 2003.
34 The board shall provide to the office of the attorney
35 general complete access to the information required to
36 be disclosed under this subsection. The office of the
37 attorney general shall report annually on the
38 disclosures made under this section to the governor
39 and the general assembly on or before March 1.
40 b. Each company subject to the provisions of this
41 section shall also disclose to the board, on or before
42 January 1, 2004, and annually thereafter, the name and
43 address of the individual responsible for the
44 company's compliance with this section.
45 c. The board and the office of the attorney
46 general shall keep confidential all trade secrets as
47 defined in section 550.2. The disclosure form
48 prescribed by the board shall permit the company to
49 identify any information that is a trade secret.
50 d. The company is exempt from disclosure of any

1 gifts that are exempt from the prohibition pursuant to
2 subsection 2.
3 e. The attorney general may bring an action for
4 injunctive relief, costs, and attorney fees, and may
5 impose a civil penalty of not more than ten thousand
6 dollars per violation on a company that fails to
7 disclose information as required by this subsection.
8 Each failure to disclose constitutes a separate
9 violation.
10 4. For the purposes of this section:
11 a. "Pharmaceutical manufacturing company" means
12 any entity engaged in the production, preparation,
13 propagation, compounding, conversion, or processing of
14 prescription drugs, either directly or indirectly by
15 extraction from substances of natural origin, or
16 independently by means of chemical synthesis, or by a
17 combination of extraction and chemical synthesis, or
18 any entity engaged in the packaging, repackaging,
19 labeling, relabeling, or distribution of prescription
20 drugs. The term does not include a wholesaler or a
21 pharmacist licensed under this chapter.
22 b. "Pharmaceutical marketer" means a person who,
23 while employed by or under contract to represent a
24 pharmaceutical manufacturing company, engages in
25 pharmaceutical detailing, promotional activities, or
26 other marketing of prescription drugs in this state to
27 any practitioner, hospital, health care facility,
28 pharmacist, health benefit plan administrator, or any
29 other person licensed or authorized to prescribe,
30 dispense, distribute, or purchase prescription drugs.
31 "Pharmaceutical marketer" does not include a
32 wholesaler or a wholesale salesperson.
33 Sec. ___. NEW SECTION. 249A.20A PREFERRED DR
34 LIST PROGRAM.
35 1. The department shall establish and implement a
36 preferred drug list program under the medical
37 assistance program. The department shall submit a
38 medical assistance state plan amendment to the centers
39 for Medicare and Medicaid services of the United
40 States department of health and human services, no
41 later than May 1, 2003, to implement the program.
42 2. A medical assistance pharmaceutical and
43 therapeutics committee shall be established within the
44 department by July 1, 2003, for the purpose of
45 developing and providing ongoing review of the
46 preferred drug list. The committee shall be comprised
47 of members as specified in 42 U.S.C. ¤ 1396r-8,
48 appointed by the governor. The members shall be
49 appointed to terms of two years. Members may be
50 appointed to more than one term. The department shall

1 provide staff support to the committee. Committee
2 members shall select a chairperson and vice
3 chairperson annually from the committee membership.
4 3. The pharmaceutical and therapeutics committee
5 shall recommend a preferred drug list to the
6 department. The committee shall develop the preferred
7 drug list by considering each drug's clinically
8 meaningful therapeutic advantages in terms of safety,
9 effectiveness, and clinical outcome. The committee
10 shall use evidence-based research methods in selecting
11 the drugs to be included on the preferred drug list.
12 The committee shall periodically review all drug
13 classes included on the preferred drug list and may
14 amend the list to ensure that the list provides for
15 medically appropriate drug therapies for medical
16 assistance recipients and achieves cost savings to the
17 medical assistance program. The department may
18 procure a sole source contract with an outside entity
19 or contractor to provide professional administrative
20 support to the pharmaceutical and therapeutics
21 committee in researching and recommending drugs to be
22 placed on the preferred drug list.
23 4. Prescribing and dispensing of prescription
24 drugs not included on the preferred drug list shall be
25 subject to prior authorization.
26 5. The preferred drug list program shall provide
27 that if a medical assistance program recipient is
28 being prescribed a mental health-related drug or
29 antiretroviral drug prior to the implementation of the
30 preferred drug list and the prescription drug is not
31 included on the preferred drug list, prescribing and
32 dispensing of the prescription drug is not subject to
33 prior authorization. The preferred drug list program
34 shall also provide that certain prescription drugs for
35 age-related populations that are not included on the
36 preferred drug list are not subject to prior
37 authorization.
38 6. The department may negotiate supplemental
39 rebates from manufacturers that are in addition to
40 those required by Title XIX of the federal Social
41 Security Act. The committee shall consider a product
42 for inclusion on the preferred drug list if the
43 manufacturer provides a supplemental rebate. The
44 department may procure a sole source contract with an
45 outside entity or contractor to conduct negotiations
46 for supplemental rebates.
47 7. The department shall publish and disseminate
48 the preferred drug list to all medical assistance
49 providers in this state.
50 8. Until such time as the pharmaceutical and

1 therapeutics committee is operational, the department
2 shall adopt and utilize a preferred drug list
3 developed by a midwestern state that has received
4 approval for its medical assistance state plan
5 amendment from the centers for Medicare and Medicaid
6 services of the United States department of health and
7 human services.
8 9. The department may procure a sole source
9 contract with an outside entity or contactor to
10 participate in a pharmaceutical pooling program with
11 midwestern or other states to provide for an enlarged
12 pool of individuals for the purchase of pharmaceutical
13 products and services for medical assistance
14 recipients.
15 10. The department may adopt administrative rules
16 under section 17A.4, subsection 2, and section 17A.5,
17 subsection 2, paragraph "b", to implement this
18 section.
19 11. Any savings realized under this section may be
20 used to the extent necessary to pay the costs
21 associated with implementation of this section prior
22 to reversion to the medical assistance program. The
23 department shall report the amount of any savings
24 realized and the amount of any costs paid to the
25 chairpersons of the joint appropriations subcommittee
26 on health and human services.
27 Sec. ___. NEW SECTION. 249A.20B NURSING FACI
28 QUALITY ASSURANCE ASSESSMENT.
29 1. The department may assess nursing facilities a
30 quality assurance assessment not to exceed six percent
31 of the total annual revenue of the facility.
32 2. The quality assurance assessment shall be paid
33 to the department in equal monthly amounts on or
34 before the fifteenth day of each month. The
35 department may deduct the monthly assessment amount
36 from medical assistance payments to a nursing
37 facility. The amount deducted from payments shall not
38 exceed the total amount of the fee due.
39 3. Revenue generated from the quality assurance
40 assessment shall be deposited in the senior living
41 trust fund created in section 249H.4. The revenues
42 shall only be used for services for which federal
43 financial participation under the medical assistance
44 program is available to match state funds.
45 4. If federal financial participation to match the
46 assessments made under subsection 1 becomes
47 unavailable under federal law, the department shall
48 terminate the imposition of the assessment beginning
49 on the date that the federal statutory, regulatory, or
50 interpretive change takes effect.

1 5. The department may procure a sole source
2 contract to implement the provisions of this section.
3 6. For the purposes of this section, "nursing
4 facility" means nursing facility as defined in section
5 135C.1, excluding residential care facilities and
6 nursing facilities that are operated by the state.
7 7. The department may adopt administrative rules
8 under section 17A.4, subsection 2, and section 17A.5,
9 subsection 2, paragraph "b", to implement this
10 section.
11 Sec. ___. NEW SECTION. 249A.29A HOME AND
12 COMMUNITY-BASED SERVICES WAIVER -- ELIGIBILITY
13 DETERMINATIONS.
14 1. A level of care eligibility determination of an
15 individual seeking approval by the department to
16 receive services under a waiver shall be completed
17 only by a person not participating as a provider of
18 services under a waiver. For the purposes of this
19 section, "provider" and "waiver" mean provider and
20 waiver as defined in section 249A.29.
21 2. Funds appropriated to the department of elder
22 affairs for the purpose of conducting level of care
23 eligibility determinations shall be transferred and
24 made available to the department of human services.
25 3. The department of human services may procure a
26 sole source contract with an outside entity or
27 contractor to conduct level-of-care eligibility
28 determinations.
29 4. The department may adopt administrative rules
30 under section 17A.4, subsection 2, and section 17A.5,
31 subsection 2, paragraph "b", to implement this
32 section.
33 Sec. ___. Section 249B.3, subsection 1, unnumbered
34 paragraph 1, Code 2003, is amended to read as follows:
35 The department ~~may~~ shall issue a notice
36 establishing and demanding payment of an accrued or
37 accruing spousal support debt due and owing to the
38 department. The notice shall be served upon the
39 community spouse in accordance with the rules of civil
40 procedure. The notice shall include all of the
41 following:
42 Sec. ___. MEDICAL ASSISTANCE PROGRAM --
43 PHARMACEUTICALS -- RECIPIENT REQUIREMENTS.
44 1. The department of human services shall
45 reimburse pharmacy dispensing fees using a single rate
46 of $4.26 per prescription or the pharmacy's usual and
47 customary fee, whichever is lower.
48 2. The department of human services shall require
49 recipients of medical assistance to pay the following
50 copayment on each prescription filled for a covered

1 prescription drug, including on each refill of such
2 prescription, as follows:
3 a. A copayment of $1 for each covered generic
4 prescription drug.
5 b. A copayment of 50 cents for each covered brand-
6 name prescription drug for which the cost to the state
7 is $10 or less.
8 c. A copayment of $1 for each covered brand-name
9 prescription drug for which the cost to the state is
10 more than $10 and up to and including $25.
11 d. A copayment of $2 for each covered brand-name
12 prescription drug for which the cost to the state is
13 more than $25 and up to and including $50.
14 e. A copayment of $3 for each covered brand-name
15 prescription drug for which the cost to the state is
16 over $50.
17 3. The department of human services shall
18 establish an ingredient reimbursement basis equal to
19 the average wholesale price minus 12 percent for
20 pharmacy reimbursement for prescription drugs under
21 the medical assistance program.
22 4. a. The department of human services shall
23 continue the sole source contract relative to the
24 state maximum allowable cost (SMAC) program as
25 authorized in 2001 Iowa Acts, chapter 191, section 31,
26 subsection 1, paragraph "b", subparagraph (5). The
27 department shall expand the state maximum allowable
28 cost program for prescription drugs to the greatest
29 extent possible as determined under the contract.
30 b. Pharmacies and providers that are enrolled in
31 the medical assistance program shall make available
32 drug acquisition cost information, product
33 availability information, and other information deemed
34 necessary by the department for the determination of
35 reimbursement rates and the efficient operation of the
36 pharmacy benefit. Pharmacies and providers shall
37 produce and submit the requested information in the
38 manner and format requested by the department or its
39 designee at no cost to the department or designee.
40 Pharmacies and providers shall submit information to
41 the department or its designee within thirty days
42 following receipt of a request for information unless
43 the department or its designee grants an extension
44 upon written request of the pharmacy or provider.
45 c. The state maximum allowable cost shall be
46 established at the average wholesale acquisition cost
47 for a prescription drug and all equivalent products,
48 adjusted by a multiplier of 1.4. The department shall
49 update the state maximum allowable cost every two
50 months, or more often if necessary, to ensure adequate

1 product availability.
2 d. The department shall review its current method
3 for determining which prescription drugs are to be
4 included in the SMAC program and shall adjust the
5 method to maximize the cost savings realized through
6 the SMAC program.
7 5. The department of human services shall require
8 recipients of medical assistance to pay a copayment of
9 $3 for each physician office visit.
10 6. The department of human services shall maximize
11 expansion of prior authorization of prescription drugs
12 under the medical assistance program beyond the 25
13 current categories of medications.
14 7. The department of human services shall
15 establish a fixed-fee reimbursement schedule for home
16 health agencies under the medical assistance program.
17 8. The department may adopt emergency rules to
18 implement this section.
19 Sec. ___. HOME AND COMMUNITY-BASED SERVICES
20 WAIVERS CONSOLIDATION -- BUDGET NEUTRALITY. It is the
21 intent of the general assembly that the consolidation
22 of home and community-based services waivers by the
23 department of human services be designed in a manner
24 that does not result in additional cost, with the
25 exception of any services added to the waivers through
26 legislative enactment. The department of human
27 services shall submit an initial report regarding the
28 cost neutrality and status of the waiver consolidation
29 to the legislative fiscal committee no later than
30 January 31, 2004, and a subsequent report no later
31 than July 31, 2004.
32 Sec. ___. NURSING FACILITY REIMBURSEMENT.
33 Notwithstanding 2001 Iowa Acts, chapter 192, section
34 4, subsection 2, paragraph "c", and subsection 3,
35 paragraph "a", subparagraph (2), if the appropriation
36 provided for reimbursement of nursing facilities for
37 the fiscal year beginning July 1, 2003, is
38 insufficient to reimburse nursing facilities in
39 accordance with the reimbursement rate specified in
40 2001 Iowa Acts, chapter 192, section 4, subsection 2,
41 paragraph "c", the department shall adjust the
42 inflation factor of the reimbursement rate calculation
43 to provide reimbursement within the amount
44 appropriated.
45 Sec. ___. UTILIZATION MANAGEMENT AND TARGETED
46 AUDITS.
47 1. The department of human services shall conduct
48 ongoing review of recipients and providers of medical
49 assistance services to determine the appropriateness
50 of the scope, duration, and utilization of services.

1 If inappropriate usage is identified, the department
2 shall implement procedures necessary to restrict
3 utilization.
4 2. The department of human services shall conduct
5 a review of selected medical assistance services
6 categories and providers for state fiscal years
7 beginning July 1, 2001, July 1, 2002, and July 1,
8 2003. The review shall include intense data analysis
9 to test compliance with rules, regulations, and
10 policies and selected on-site audits.
11 3. The review required under subsection 2 shall
12 attempt to identify any incorrectly paid billings or
13 claims for the state medical assistance program. If
14 inappropriate payments are identified, provider
15 billings shall be adjusted accordingly. If there is
16 substantiated evidence to suggest fraudulent activity,
17 the department shall submit the audit data regarding
18 the medical assistance provider or recipient to the
19 department of inspections and appeals for further
20 action.
21 4. The department of human services may procure a
22 sole source contract to implement the provisions of
23 this section.
24 5. Any savings realized under this section may be
25 used to the extent necessary to pay the costs
26 associated with implementation of this section prior
27 to reversion to the medical assistance program. The
28 department shall report the amount of any savings
29 realized and the amount of any costs paid to the
30 chairpersons of the joint appropriations subcommittee
31 on health and human services.
32 Sec. ___. MEDICAL ASSISTANCE -- CERTAIN PUBLICLY
33 OWNED HOSPITALS -- PHYSICIAN SUPPLEMENTAL PAYMENTS.
34 1. For the fiscal year beginning July 1, 2003, and
35 for each fiscal year thereafter, the department of
36 human services shall institute a supplemental payment
37 adjustment applicable to physician services provided
38 to medical assistance recipients at publicly owned
39 acute care teaching hospitals. The adjustment shall
40 generate supplemental payments to physicians which are
41 equal to the difference between the physician's charge
42 and the physician's fee schedule under the medical
43 assistance program. To the extent of the supplemental
44 payments, a qualifying hospital shall, after receipt
45 of the payments, transfer to the department of human
46 services an amount equal to the actual supplemental
47 payments that were made in that month. The department
48 of human services shall deposit these payments in the
49 department's medical assistance account. The
50 department of human services shall amend the medical

1 assistance state plan as necessary to implement this
2 section. The department may adopt emergency rules to
3 implement this section.
4 2. The department may use any savings realized
5 under this section to the extent necessary to pay the
6 costs associated with implementation of this section
7 prior to reversion to the medical assistance program.
8 The department shall report the amount of any savings
9 realized and the amount of any costs paid to the
10 chairpersons of the joint appropriations subcommittee
11 on health and human services.
12 Sec. ___. IOWA CHRONIC CARE CONSORTIUM.
13 1. The department of human services shall
14 aggressively pursue chronic disease management in
15 order to improve care and reduce costs under the
16 medical assistance program.
17 2. The department of human services, in
18 cooperation with the department's fiscal agent and in
19 consultation with a chronic care management resource
20 group, shall profile medical assistance recipients
21 within a select number of disease diagnosis
22 categories. The assessment shall focus on those
23 diagnosis areas that present the greatest opportunity
24 for impact to improved care and cost reduction.
25 3. The department of human services, in
26 consultation with a chronic care management resource
27 group, shall conduct a chronic disease management
28 pilot project for a select number of individuals who
29 are participants in the medical assistance program.
30 The project shall focus on a select number of chronic
31 diseases which may include congestive heart failure,
32 diabetes, and asthma. The initial pilot project shall
33 be implemented by October 1, 2003.
34 4. The department of human services may procure a
35 sole source contract with a vendor to manage
36 individuals with select chronic diseases following the
37 conclusion of the profiling of medical assistance
38 recipients. The management of chronic diseases for
39 individuals under this subsection may be coordinated
40 with the pilot project established in subsection 3.
41 5. The department of human services shall amend
42 the medical assistance state plan and seek any waivers
43 necessary from the centers for Medicare and Medicaid
44 services of the United States department of health and
45 human services to implement this section.
46 6. The department of human services shall submit a
47 progress report regarding chronic disease management
48 measures undertaken pursuant to this section to the
49 governor and the general assembly by November 1, 2003.
50 The report shall include recommendations regarding

1 incorporating chronic disease management programming
2 into the medical assistance system and the potential
3 improvements in care and reductions in costs that may
4 be obtained through chronic disease management.
5 7. The department of human services may adopt
6 emergency rules to implement this section.
7 8. Any savings realized under this section may be
8 used as necessary to pay the costs associated with
9 implementation of this section prior to reversion to
10 the medical assistance program. The department shall
11 report the amount of any savings realized and the
12 amount of any costs paid to the chairpersons of the
13 joint appropriations subcommittee on health and human
14 services.
15 Sec. ___. EFFECTIVE DATES.
16 1. The section of this Act enacting section
17 249A.20A takes effect upon enactment.
18 2. The section of this Act enacting section
19 249A.20B, being deemed of immediate importance, takes
20 effect upon enactment.
21 3. The section of this Act relating to physician
22 supplemental payments at certain publicly owned
23 hospitals, being deemed of immediate importance, takes
24 effect upon enactment.
25 4. The section of this Act relating to chronic
26 disease management, being deemed of immediate
27 importance, takes effect upon enactment."
28 4. Title page, line 2, by inserting after the
29 word "eligibility" the following: "and providing
30 effective dates".
31 5. By renumbering as necessary.

By CARROLL of Poweshiek
FOEGE of Linn
HEATON of Henry

H-1216 FILED APRIL 1, 2003
Adopted 4/2/03 C-2

HOUSE FILE 619

H-1236

1 Amend the amendment, H-1216, to House File 619
2 follows:
3 1. Page 6, by inserting after line 31, the
4 following:
5 "1A. The department of human services shall submit
6 a medical assistance state plan amendment to the
7 centers for Medicare and Medicaid services of the
8 United States department of health and human services
9 to effectuate the nursing facility quality assurance
10 assessment.
11 1B. The department of human services shall submit
12 an application to the secretary of the United States
13 department of health and human services to request a
14 waiver of the uniform tax requirement pursuant to 42
15 U.S.C. ¤ 1396b(w)(3)(E) and 42 C.F.R. ¤ 433.68(e)(2)."
16 2. Page 12, by inserting after line 14, the
17 following:
18 "Sec. ___. CONTINGENT EFFECTIVE DATE.
19 1. Section 249A.20B, as enacted in this Act, shall
20 not take effect unless the department of human
21 services receives approval of both the medical
22 assistance state plan amendment from the centers for
23 Medicare and Medicaid services of the United States
24 department of health and human services to effectuate
25 the nursing facility quality assurance assessment and
26 of the application to the secretary of the United
27 States department of health and human services for a
28 waiver of the uniform tax requirement pursuant to 42
29 U.S.C. ¤ 1396b(w)(3)(E) and 42 C.F.R. ¤ 433.68(e)(2).
30 If both approvals are received, section 249A.20B shall
31 take effect upon the date that both approvals have
32 been received by the department and the department
33 shall notify the Code editor of the date of receipt of
34 the approvals.
35 2. If both approvals described in subsection 1 are
36 not received by June 30, 2004, the section of this Act
37 enacting section 249A.20B shall not take effect."
38 3. Page 12, by striking lines 18 through 20.
39 4. Page 12, by inserting after line 27, the
40 following:
41 "4A. The portions of the section of this Act
42 enacting section 249A.20B relating to directing the
43 department of human services to submit a medical
44 assistance state plan amendment to the centers for
45 Medicare and Medicaid services of the United States
46 department of health and human services to effectuate
47 the nursing facility quality assurance assessment and
48 directing the department of human services to submit
49 an application to the secretary of the United States
50 department of health and human services for a waiver

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1 of the uniform tax requirement pursuant to 42 U.S.C. ¤
2 1396b(w)(3)(E) and 42 C.F.R. ¤ 433.68(e)(2), being
3 deemed of immediate importance, take effect upon
4 enactment."
5 5. Page 12, line 30, by inserting after the word
6 "dates" the following: "and a contingent effective
7 date".
8 6. By renumbering as necessary.

By CARROLL of Poweshiek

H-1236 FILED APRIL 2, 2003
ADOPTED 4/2/03

HOUSE FILE 619

H-1225
1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 5, line 23, by striking the word
4 "Prescribing" and inserting the following: "With the
5 exception of drugs prescribed for the treatment of
6 mental illness, human immunodeficiency virus or
7 acquired immune deficiency syndrome, transplantation,
8 or cancer, prescribing".
9 2. Page 5, by striking lines 26 through 37.
10 3. By renumbering as necessary.

By SMITH of Marshall

H-1225 FILED APRIL 2, 2003
OUT OF ORDER

HOUSE FILE 619

H-1229
1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 11, lines 34 and 35, by striking the
4 words "may procure a sole source contract with a
5 vendor" and inserting the following: "shall issue a
6 request for proposals or otherwise solicit bids from
7 potential vendors".

By EICHHORN of Hamilton

H-1229 FILED APRIL 2, 2003
ADOPTED 4/3/03

HOUSE FILE 619

H-1231

1 Amend the amendment, H-1216, to House File 619, as
2 follows:
3 1. Page 11, by striking line 12, and inserting
4 the following:
5 "Sec. ___. CHRONIC CARE MANAGEMENT."

By EICHHORN of Hamilton

H-1231 FILED APRIL 2, 2003
ADOPTED 4/2/03

HOUSE FILE 619

H-1239

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 9, by inserting after line 16, the
4 following:
5 "7A. The department of human services shall
6 continue the pharmaceutical case management program.
7 The university of Iowa college of public health, in
8 cooperation with the university of Iowa colleges of
9 pharmacy and medicine, shall provide oversight for the
10 pharmaceutical case management program and shall
11 submit annual reports regarding program savings and
12 quality improvement to the chairpersons of the joint
13 appropriations subcommittee on health and human
14 services of the general assembly."

By OSTERHAUS of Jackson

H-1239 FILED APRIL 2, 2003
LOST 4/2/03

HOUSE FILE 619

H-1240

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 7, line 44, by inserting after the figure
4 "1." the following: "a."
5 2. Page 7, by inserting after line 47, the
6 following:
7 "b. The department of human services in
8 collaboration with the university of Iowa pharmacy
9 division of pharmaceutical socioeconomics shall
10 conduct a cost of dispensing study. Notwithstanding
11 paragraph "a" based on the results of the dispensing
12 study, the department shall establish a pharmacy
13 dispensing fee equal to one hundred five percent of
14 the average dispensing fee."

By OSTERHAUS of Jackson

H-1240 FILED APRIL 2, 2003
LOST 4/2/03

HOUSE FILE 619

H-1250

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. By striking page 2, line 37, through page 4,
4 line 32.
5 2. By striking page 4, line 42, through page 5,
6 line 3, and inserting the following:
7 "2. a. A medical assistance pharmaceutical and
8 therapeutics committee shall be established within the
9 department by July 1, 2003, for the purpose of
10 developing and providing ongoing review of the
11 preferred drug list.
12 b. (1) The members of the committee shall be
13 appointed by the governor and shall include health
14 care professionals who possess recognized knowledge
15 and expertise in one or more of the following:
16 (a) The clinically appropriate prescribing of
17 covered outpatient drugs.
18 (b) The clinically appropriate dispensing and
19 monitoring of covered outpatient drugs.
20 (c) Drug use review, evaluation, and intervention.
21 (d) Medical quality assurance.
22 (2) The membership of the committee shall be
23 comprised of at least one third but not more than
24 fifty-one percent licensed and actively practicing
25 physicians and at least one third licensed and
26 actively practicing pharmacists.
27 c. The members shall be appointed to terms of two
28 years. Members may be appointed to more than one
29 term. The department shall provide staff support to
30 the committee. Committee members shall select a
31 chairperson and vice chairperson annually from the
32 committee membership."
33 3. Page 5, by striking lines 27 through 29, and
34 inserting the following: "that if a medical
35 assistance program recipient was prescribed a mental
36 health-related drug, an antiretroviral drug, or a drug
37 related to the treatment of transplantation or cancer,
38 prior to the implementation of the".
39 4. Page 6, by striking lines 25 and 26, and
40 inserting the following: "legislative fiscal
41 committee on a quarterly basis."
42 5. Page 9, by inserting after line 6 the
43 following:
44 "e. The department shall report any savings
45 realized through the SMAC program to the legislative
46 fiscal committee on a monthly basis."
47 6. Page 9, by striking lines 35 through 38, and
48 inserting the following: "paragraph "a", subparagraph
49 (2), if projected state fund expenditures for
50 reimbursement of nursing facilities for the fiscal

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1 year beginning July 1, 2003, in".
2 7. Page 9, line 41, by inserting before the words
3 "the department" the following: "exceeds
4 $147,252,856,".
5 8. Page 9, by striking line 44, and inserting the
6 following: "projected."
7 9. Page 11, by inserting after line 11 the
8 following:
9 "3. The department of human services shall, in any
10 compilation of data or other report distributed to the
11 public concerning payments to providers under the
12 medical assistance program, set forth reimbursements
13 to physicians of the university of Iowa college of
14 medicine through supplemental adjustments as a
15 separate item and shall not include such payments in
16 the amounts otherwise reported as the reimbursement to
17 a physician for services to medical assistance
18 recipients."
19 10. Page 12, by inserting after line 20, the
20 following:
21 "___. The portion of the section of this Act
22 relating to the state maximum allowable cost (SMAC)
23 program, being deemed of immediate importance, takes
24 effect upon enactment."

By CARROLL of Poweshiek

H-1250 FILED APRIL 2, 2003
A-ADOPTED B-WITHDRAWN C-ADOPTED 4/2/03

HOUSE FILE 619

H-1249
1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 9, by inserting after line 16, the
4 following:
5 "7A. The department shall reimburse the dispensing
6 of prescription drugs for long-term care facility
7 residents at two cents per unit dose in addition to
8 the regular dispensing fee."
9 2. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1249 FILED APRIL 2, 2003
LOST 4/2/03

HOUSE FILE 619

H-1252

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 7, line 46, by striking the figure "4.26"
4 and inserting the following: "4.50".

By OSTERHAUS of Jackson

H-1252 FILED APRIL 2, 2003
LOST 4/2/03

HOUSE FILE 619

H-1253

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 8, line 19, by striking the figure "12"
4 and inserting the following: "11".

By OSTERHAUS of Jackson

H-1253 FILED APRIL 2, 2003
LOST 4/2/03

HOUSE FILE 619

H-1254

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 8, by striking lines 30 through 44.
4 2. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1254 FILED APRIL 2, 2003
LOST 4/2/03

HOUSE FILE 619

H-1257

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 5, line 23, by striking the word
4 "Prescribing" and inserting the following: "With the
5 exception of drugs prescribed for the treatment of
6 human immunodeficiency virus or acquired immune
7 deficiency syndrome, transplantation, or cancer and
8 drugs prescribed for mental illness with the exception
9 of drugs and drug compounds that do not have a
10 significant variation in a therapeutic profile or side
11 affect profile within a therapeutic class,
12 prescribing".
13 2. Page 5, by striking lines 26 through 37.
14 3. By renumbering as necessary.

By CARROLL of Poweshiek

H-1257 FILED APRIL 2, 2003
ADOPTED 4/2/03

H-1251

1 Amend the amendment, H-1216, to House File 619 as
2 follows:
3 1. Page 4, by inserting before line 33, the
4 following:
5 "Sec. ___. NEW SECTION. 155B.1 SHORT TITLE.
6 This chapter shall be known and may be cited as the
7 "Pharmacy Benefits Manager Regulation Act".
8 Sec. ___. NEW SECTION. 155B.2 PURPOSE AND
9 INTENT.
10 The purposes of this chapter are:
11 1. To establish standards and criteria for the
12 regulation and licensing of pharmacy benefits
13 managers.
14 2. To promote, preserve, and protect the public
15 health, safety, and welfare by and through effective
16 regulation and licensing of pharmacy benefits
17 managers.
18 Sec. ___. NEW SECTION. 155B.3 DEFINITIONS.
19 For purposes of this chapter, unless the context
20 otherwise requires:
21 1. "Board of pharmacy" or "board" means the board
22 of pharmacy examiners.
23 2. "Cease and desist order" means an order of the
24 board prohibiting a pharmacy benefits manager or other
25 person from continuing a particular course of conduct
26 which violates this chapter or the rules adopted under
27 this chapter.
28 3. "Commissioner" means the commissioner of
29 insurance.
30 4. "Enrollee" means an individual who is enrolled
31 in a pharmacy benefits management plan.
32 5. "Health insurance plan or contract" means a
33 third-party payment provider contract or policy that
34 is an individual or group policy of accident or health
35 insurance or individual or group hospital or health
36 care services contract issued pursuant to chapter 509,
37 509A, 514, or 514A, or an individual or group health
38 maintenance organization contract issued and regulated
39 under chapter 514B.
40 6. "Insolvent" or "insolvency" means a financial
41 situation in which, based upon the financial
42 information required by this chapter for the
43 preparation of a pharmacy benefits manager's annual
44 statement, the assets of the pharmacy benefits manager
45 are less than the sum of all the company's liabilities
46 and required reserves.
47 7. "Maintenance drug" means a drug prescribed by a
48 practitioner who is licensed to prescribe drugs and
49 used to treat a medical condition for a period of more
50 than thirty days.

1 8. "Multisource drug" means a drug that is stocked
2 and is available from three or more suppliers.
3 9. "Pharmacist" means pharmacist as defined in
4 section 155A.3.
5 10. "Pharmacists' services" include drug therapy
6 and other patient care services provided by a licensed
7 pharmacist intended to achieve outcomes related to the
8 cure or prevention of a disease, elimination or
9 reduction of a patient's symptoms, or arresting or
10 slowing of a disease process as defined by rule of the
11 board.
12 11. "Pharmacy" means pharmacy as defined in
13 section 155A.3.
14 12. "Pharmacy benefits management plan" means an
15 arrangement for the delivery of prescription services
16 in which a pharmacy benefits manager provides,
17 arranges for, pays for, or reimburses any of the costs
18 of prescription services for an enrollee on a prepaid
19 or insured basis which provides all of the following:
20 a. Contains one or more incentive arrangements
21 intended to influence the cost or level of
22 prescription services between the plan sponsor and one
23 or more pharmacies with respect to the delivery of
24 prescription services.
25 b. Requires or creates benefit payment
26 differential incentives for enrollees to use under
27 contract with the pharmacy benefits manager.
28 "Pharmacy benefits management plan" does not mean
29 an employee welfare benefit plan as defined in the
30 federal Employee Retirement Income Security Act of
31 1974, 29 U.S.C. ¤ 1002(1), which is self-insured or
32 self-funded.
33 13. "Pharmacy benefits manager" or "company" means
34 an entity that administers the prescription drug or
35 device portion of a health insurance plan or contract
36 on behalf of the sponsors of the health insurance plan
37 or contract.
38 14. "Plan sponsor" means an employer, insurance
39 company, union, or health maintenance organization
40 that contracts with a pharmacy benefits manager for
41 delivery of prescription services.
42 15. "Usual and customary price" means the price
43 the pharmacist would have charged a cash-paying
44 patient for the same services on the same date
45 inclusive of any discounts applicable.
46 Sec. ___. NEW SECTION. 155B.4 CERTIFICATE OF
47 AUTHORITY.
48 1. A person shall not establish or operate as a
49 pharmacy benefits manager in this state to provide
50 pharmacy benefits management plans without first

1 obtaining a certificate of authority from the board of
2 pharmacy examiners. A pharmacy benefits manager
3 providing pharmacy benefits management plans in this
4 state shall obtain a certificate of authority from the
5 board every four years.
6 2. A person may apply to the board to obtain a
7 certificate of authority to establish and operate as a
8 pharmacy benefits manager in compliance with this
9 chapter if the person obtains an annual license to do
10 business in this state from the commissioner under
11 section 155B.5.
12 3. The board may suspend or revoke a certificate
13 of authority issued to a pharmacy benefits manager
14 under this chapter or may deny an application for a
15 certificate of authority if the board finds any of the
16 following:
17 a. The pharmacy benefits manager is operating
18 significantly in contravention of its basic
19 organizational document.
20 b. The pharmacy benefits manager does not arrange
21 for pharmacists' services.
22 c. The pharmacy benefits manager has failed to
23 meet the requirements for issuance of a certificate of
24 authority established in this chapter.
25 d. The pharmacy benefits manager is unable to
26 fulfill its obligation to furnish pharmacists'
27 services as required under its pharmacy benefits
28 management plan.
29 e. The pharmacy benefits manager is no longer
30 financially responsible and may reasonably be expected
31 to be unable to meet its obligations to enrollees or
32 prospective enrollees.
33 f. The pharmacy benefits manager, or any person on
34 the company's behalf, has advertised or merchandised
35 its services in an untrue, misrepresentative,
36 misleading, deceptive, or unfair manner.
37 g. The continued operation of the pharmacy
38 benefits manager would be hazardous to its enrollees.
39 h. The pharmacy benefits manager has failed to
40 file an annual statement with the commissioner in a
41 timely manner.
42 i. The pharmacy benefits manager has otherwise
43 failed to substantially comply with this chapter.
44 4. When the certificate of authority of a pharmacy
45 benefits manager is revoked, the company shall
46 proceed, immediately following the effective date of
47 the order of revocation, to conclude the company's
48 affairs and shall conduct no further business except
49 as may be essential to the orderly conclusion of the
50 affairs of the company. The board may permit further

1 operation of the company as the board may find to be
2 in the best interest of enrollees so that the
3 enrollees will be afforded the greatest practical
4 opportunity to obtain pharmacists' services.
5 Sec. ___. NEW SECTION. 155B.5 LICENSE TO DO
6 BUSINESS.
7 1. The commissioner shall not issue an annual
8 license to do business in this state to any pharmacy
9 benefits manager providing pharmacy benefits
10 management plans until the commissioner is satisfied
11 that the pharmacy benefits manager has complied with
12 all of the following:
13 a. Paid all fees, taxes, and charges required by
14 law.
15 b. Has made any deposit required by this chapter.
16 c. Has met the minimum capital and surplus
17 requirements specified by the commissioner.
18 d. Has filed any necessary financial statement and
19 any reports, certificates, or other documents the
20 commissioner considers necessary to secure a full and
21 accurate knowledge of the company's affairs and
22 financial condition.
23 e. Is solvent, and the company's financial
24 condition, method of operation, and manner of doing
25 business satisfy the commissioner that the company can
26 meet the company's obligations to all enrollees.
27 f. Has otherwise complied with all the
28 requirements of law.
29 2. The license shall be in addition to the
30 certificate of authority required by the board. A
31 nonrefundable license application fee of five hundred
32 dollars shall accompany each application for a license
33 to transact business in this state. The fee shall be
34 collected by the commissioner and shall be deposited
35 in the pharmacy benefits manager fund created in
36 section 155B.16.
37 3. The license shall be signed by the commissioner
38 or the commissioner's agent and shall expire on the
39 next June 30 after the date on which the license
40 becomes effective.
41 4. A pharmacy benefits manager providing pharmacy
42 benefits management plans shall obtain an annual
43 renewal of the company's license from the
44 commissioner. The commissioner may refuse to renew
45 the license of any pharmacy benefits manager or may
46 renew the license, subject to any restrictions
47 considered appropriate by the commissioner, if the
48 commissioner finds an impairment of required capital
49 and surplus, or if the commissioner finds that the
50 pharmacy benefits manager has not satisfied all the

1 conditions specified in this chapter. The
2 commissioner shall not fail to renew the license of
3 any pharmacy benefits manager to transact business in
4 this state without providing the pharmacy benefits
5 manager ten days' notice and providing the company an
6 opportunity to be heard. The hearing may be informal,
7 and the commissioner and the pharmacy benefits manager
8 may waive the required notice.
9 Sec. ___. NEW SECTION. 155B.6 ANNUAL STATEMENT.
10 1. A pharmacy benefits manager providing pharmacy
11 management benefits plans in this state shall file a
12 statement with the commissioner annually by March 1.
13 The statement shall be verified by at least two
14 principal officers of the pharmacy benefits manager
15 and shall cover the preceding calendar year. The
16 pharmacy benefits manager shall also submit a copy of
17 the statement to the board.
18 2. The statement shall be on forms prescribed by
19 the commissioner and shall include all of the
20 following:
21 a. A financial statement of the company, including
22 its balance sheet and income statement for the
23 preceding year.
24 b. The number of persons enrolled during the year,
25 the number of enrollees as of the end of the year, and
26 the number of enrollments terminated during the year.
27 c. Any other information relating to the
28 operations of the pharmacy benefits manager required
29 by the commissioner pursuant to this chapter.
30 3. If the pharmacy benefits manager is audited
31 annually by an independent certified public
32 accountant, a copy of the certified audit report shall
33 be filed annually with the commissioner by June 30.
34 4. The commissioner may extend the time prescribed
35 for any pharmacy benefits manager for filing an annual
36 statement or other reports, or exhibits of the
37 statement or report for good cause shown. However,
38 the commissioner shall not extend the time for filing
39 annual statements beyond sixty days after the time
40 prescribed by subsection 1. A pharmacy benefits
41 manager which fails to file its annual statement
42 within the time prescribed by this section may have
43 its licensed revoked by the commissioner or its
44 certificate of authority revoked or suspended by the
45 board until the annual statement is filed. The
46 commission may waive the requirements for a pharmacy
47 benefits manager to file financial information if an
48 affiliate of the pharmacy benefits manager is also
49 required to file the same information.
50 Sec. ___. NEW SECTION. 155B.7 FINANCIAL

1 EXAMINATION.
2 1. In lieu of or in addition to performing a
3 financial examination of a pharmacy benefits manager,
4 the commissioner may accept the report of a financial
5 examination by another person responsible for pharmacy
6 benefits managers under the laws of another state who
7 is certified by the insurance supervisory official,
8 similar regulatory agency, or the state health
9 commissioner of the other state.
10 2. The commissioner shall coordinate financial
11 examinations of pharmacy benefits managers that
12 provide pharmacy management benefits plans in this
13 state to ensure an appropriate level of regulatory
14 oversight and to avoid any undue duplication of effort
15 or regulation. The pharmacy benefits manager being
16 examined shall pay the cost of the examination.
17 Payments of the cost of the examination shall be
18 collected by the commissioner and shall be deposited
19 in the pharmacy benefits manager fund created in
20 section 155B.16.
21 Sec. ___. NEW SECTION. 155B.8 ASSESSMENT.
22 1. The expense of administering this chapter,
23 including the costs incurred by the commissioner and
24 the board, shall be assessed annually by the board
25 against all pharmacy benefits managers operating in
26 this state. Before determining the assessment, the
27 board shall request from the commissioner an estimate
28 of all expenses for the regulation, supervision, and
29 examination of all companies subject to regulation
30 under this chapter. The assessment shall be in
31 proportion to the business done in this state.
32 2. Assessments shall be collected by the
33 commissioner and shall be deposited in the pharmacy
34 benefits manager fund created in section 155B.16.
35 3. The board shall provide each pharmacy benefits
36 manager notice of the assessment, which shall be paid
37 to the board on or before March 1 of each year. A
38 pharmacy benefits manager that fails to pay the
39 assessment on or before the date prescribed shall be
40 subject to a penalty imposed by the board which is ten
41 percent of the assessment and interest for the period
42 between the due date and the date of full payment. If
43 a payment is made in an amount later found to be in
44 error, the following shall apply:
45 a. If the error found is an underpayment and an
46 additional amount is due, the commission shall notify
47 the company of the additional amount and the company
48 shall pay the additional amount within fourteen days
49 of the date of the notice.
50 b. If the error found is an overpayment, a refund

1 shall be ordered.
2 4. If an assessment made under this chapter is not
3 paid to the board by the prescribed date, the amount
4 of the assessment, penalty, and interest may be
5 recovered from the defaulting company on motion of the
6 board made in the name and for the use of the state in
7 the appropriate court after ten days' notice to the
8 company. The certificate of authority of a defaulting
9 company to transact business in this state may be
10 revoked or suspended by the board until the company
11 has paid the assessment.
12 Sec. ___. NEW SECTION. 155B.9 PHARMACY BENEFITS
13 MANAGER CONTRACTS.
14 1. A pharmacy benefits manager that contracts with
15 a pharmacy or pharmacist to provide pharmacists'
16 services through a pharmacy management plan for
17 enrollees in this state shall file the contract with
18 the board thirty days before the execution of the
19 contract. The contract shall be deemed approved
20 unless the board disapproves the contract within
21 thirty days after the contract is filed with the
22 board.
23 2. Disapproval of the contract shall be in
24 writing, stating the reasons for the disapproval, and
25 a copy of the written disapproval shall be delivered
26 to the pharmacy benefits manager.
27 3. The board, consistent with the board's
28 responsibility for protecting the public interest,
29 shall develop formal criteria for the approval and
30 disapproval of pharmacy benefits manager contracts.
31 4. The pharmacy benefits manager shall provide a
32 contract to the pharmacy or pharmacist that is written
33 in plain language that is generally understood by
34 pharmacists.
35 5. A pharmacy benefits manager that contracts with
36 a pharmacy or pharmacist to provide pharmacist
37 services through a pharmacy benefits management plan
38 for enrollees in this state on behalf of any health
39 plan sponsors shall be identified as the agent of the
40 health plan sponsor. The health plan fiduciary
41 responsibilities shall transfer to the contracting
42 pharmacy benefits manager.
43 6. A contract shall apply the same coinsurance,
44 copayment, and deductible to covered drug
45 prescriptions filled by any pharmacy or pharmacist who
46 participates in the network.
47 7. This section shall not be construed to prohibit
48 a contract from applying different coinsurance,
49 copayment, and deductible factors between generic and
50 brand-name drugs that an enrollee may obtain with a

1 prescription if the limits are applied uniformly to
2 all pharmacies or pharmacists in the health insurance
3 plan or contract network.
4 8. A pharmacy benefits management plan shall not
5 require a pharmacy or pharmacist to change an
6 enrollee's maintenance drug unless the prescribing
7 physician and the enrollee agree to the change.
8 9. A pharmacy's or pharmacist's participation in
9 any plan or network offered by a pharmacy benefits
10 manager is optional and at the discretion of the
11 pharmacy or pharmacist. The pharmacy's or
12 pharmacist's participation or lack of participation in
13 one plan shall not affect the pharmacy's or
14 pharmacist's participation in any other plan or
15 network ordered by the pharmacy benefits manager.
16 10. A pharmacy benefits manager that initiates an
17 audit of a pharmacy or pharmacist under the provisions
18 of the contract shall limit the methods and procedures
19 that are recognized as fair and equitable for both the
20 pharmacy benefits manager and the pharmacy or
21 pharmacist. An audit shall not allow for
22 extrapolation calculations. A pharmacy benefits
23 manager shall not recoup any moneys due from an audit
24 by setoff from future remittances until the results of
25 the audit are resolved and finalized by both the
26 pharmacy benefits manager and the pharmacy or
27 pharmacist. If the findings of an audit cannot be
28 finalized and agreed to by both parties, the
29 commissioner shall establish an independent review
30 board to adjudicate unresolved grievances.
31 11. a. Prior to terminating a pharmacy or
32 pharmacist from the network, a pharmacy benefits
33 manager shall provide the pharmacy or pharmacist with
34 a written explanation of the reason for the
35 termination at least thirty days before the actual
36 termination unless the contract termination action is
37 taken as the result of any of the following:
38 (1) Loss of the pharmacy's or pharmacist's license
39 to practice pharmacy or loss of professional liability
40 insurance.
41 (2) Conviction of fraud or misrepresentation in
42 regard to the contract.
43 b. A pharmacy or pharmacist may request and
44 receive, within thirty days, a review of the proposed
45 termination by the board prior to the termination.
46 12. The pharmacy or pharmacist shall not be held
47 responsible for actions of the pharmacy benefits
48 manager or plan sponsors and the pharmacy benefits
49 manager or plan sponsors shall not be held responsible
50 for the actions of the pharmacy or pharmacist.

1 Sec. ___. NEW SECTION. 155B.10 ENFORCEMENT.
2 1. The board shall develop formal investigation
3 and compliance procedures for responding to complaints
4 by health insurance plans or contract sponsors,
5 pharmacists, or enrollees concerning the failure of a
6 pharmacy benefits manager to comply with this chapter.
7 If, based upon an investigation or complaint, the
8 board has reason to believe that there is a violation
9 of this chapter, the board shall issue and serve upon
10 the pharmacy benefits manager concerned a statement of
11 the charges and a notice of a hearing to be held at a
12 time and place fixed in the notice, which shall not be
13 less than thirty days after notice is served. The
14 notice shall require the pharmacy benefits manager to
15 show cause why an order should not be issued directing
16 the company to cease and desist from the violation.
17 At the hearing, the pharmacy benefits manager shall
18 have an opportunity to be heard and to show cause why
19 an order should not be issued requiring the pharmacy
20 benefits manager to cease and desist from the
21 violation.
22 2. The board may perform an examination concerning
23 the quality of services of any pharmacy benefits
24 manager and providers with whom the pharmacy benefits
25 manager has contracts, agreements, or other
26 arrangements pursuant to its pharmacy benefits
27 management plan as often as the board deems necessary
28 for the protection of the interests of the people of
29 this state. The pharmacy benefits manager being
30 examined shall pay the cost of the examination.
31 Sec. ___. NEW SECTION. 155B.11 PRESCRIPTION DRUG
32 REIMBURSEMENT COSTS.
33 Pharmacy benefits managers shall use a current and
34 nationally recognized benchmark on which to base
35 reimbursements for prescription drugs and products
36 dispensed by pharmacies and pharmacists as follows:
37 1. For brand-name, single-source products, the
38 average wholesale price as listed in first data bank
39 or facts and comparisons correct and current on the
40 date the service was provided shall be used as the
41 index.
42 2. For generic drug, multisource products, maximum
43 allowable cost shall be established by referencing
44 first data bank facts and comparisons baseline prices.
45 Only products that are compliant with pharmacy laws as
46 equivalent and generically interchangeable with a
47 federal food and drug administration orange book
48 rating of "A-B" shall be reimbursed from a maximum
49 allowable cost price methodology. In the event a
50 multisource product has no baseline price, the product

1 shall be treated as a single-source branded drug for
2 the purpose of valuing reimbursement.
3 Sec. ___. NEW SECTION. 155B.12 PROHIBITED
4 PRACTICES.
5 1. A pharmacy benefits manager or its
6 representative shall not cause or knowingly permit any
7 of the following:
8 a. The use of advertising that is untrue or
9 misleading.
10 b. Solicitation that is untrue or misleading.
11 c. Any form of evidence of coverage that is
12 deceptive.
13 2. A pharmacy benefits manager, unless licensed as
14 an insurer, shall not use in its name, contracts, or
15 literature any of the following:
16 a. Any form of the word "insurance", "casualty",
17 "surety", or "mutual".
18 b. Any other words descriptive of the insurance,
19 casualty, or surety business, or deceptively similar
20 to the name or description of any insurer or fidelity
21 and surety insurer, doing business in this state.
22 3. A pharmacy benefits manager shall not
23 discriminate on the basis of race, creed, color, sex,
24 or religion in the selection of pharmacies or
25 pharmacists with whom the company does business.
26 4. A pharmacy benefits manager shall not unfairly
27 discriminate against pharmacists when contracting for
28 pharmacists' services.
29 5. A pharmacy benefits manager shall be entitled
30 access to usual and customary pricing only for
31 comparison to the reimbursement of a specific claims
32 payment made by the pharmacy benefits manager. Usual
33 and customary pricing is confidential and a pharmacy
34 benefits manager is prohibited from any other use or
35 disclosure of usual and customary pricing.
36 6. A pharmacy benefits manager shall not move a
37 plan to another payment network unless the pharmacy
38 benefits manager receives written consent from the
39 plan sponsor.
40 7. A pharmacy benefits manager shall not receive
41 or accept any rebate, kickback, or any special payment
42 or favor or advantage of any valuable consideration or
43 inducement for changing a patient's drug product
44 unless the change is specified in a written contract
45 that has been filed with the commissioner at least
46 thirty days prior to the execution of the contract.
47 8. A claim paid by a pharmacy benefits manager
48 shall not be retroactively denied or adjusted after
49 seven days from adjudication of the claim.
50 Acknowledgement of eligibility shall not be

1 retroactively reversed. A pharmacy benefits manager
2 may retroactively deny or adjust a claim only if the
3 original claim was submitted fraudulently, the
4 original claim payment was incorrect because the
5 provider was previously paid for services rendered, or
6 the services were not rendered by the pharmacist.
7 9. A pharmacy benefits manager shall not terminate
8 a pharmacy from a network based on any of the
9 following:
10 a. The pharmacy expresses disagreement with the
11 pharmacy benefits manager's decision to deny or limit
12 benefits to an enrollee.
13 b. A pharmacist employed by the pharmacy discusses
14 with a current, former, or prospective enrollee any
15 aspect of the person's medical condition or treatment
16 alternatives whether or not the service is a covered
17 service.
18 c. A pharmacist employed by the pharmacy makes a
19 personal recommendation regarding selecting a pharmacy
20 benefits manager based on the pharmacist's personal
21 knowledge of the health needs of the individual.
22 d. The pharmacy protests or expresses disagreement
23 with a medical decision, medical policy, or medical
24 practice of a pharmacy benefits manager.
25 e. The pharmacy has in good faith communicated
26 with or advocated on behalf of one or more of the
27 pharmacy's current, former, or prospective enrollees
28 regarding the provisions, terms, or requirements of
29 the pharmacy benefits manager's health benefit plans
30 as they relate to the needs of the individual
31 regarding the method by which the pharmacy is
32 compensated for services provided under the agreement
33 with the pharmacy benefits manager.
34 10. A pharmacy benefits manager shall not
35 terminate a pharmacy from a network or otherwise
36 penalize a pharmacy solely because of the pharmacy's
37 invoking of the pharmacy's right under the contract or
38 applicable law or regulation.
39 11. A pharmacy benefits manager's termination due
40 to incompetence or unprofessional behavior shall not
41 release the pharmacy benefits manager from the
42 obligation to make any payment due to the pharmacy for
43 services provided in special circumstances post-
44 termination to the enrollees at less than agreed-upon
45 rates.
46 12. Participation or lack of participation by a
47 pharmacy in a plan or network shall not affect
48 participation in any other plan or network offered by
49 a pharmacy benefits manager.
50 Sec. ___. NEW SECTION. 155B.13 DISCLOSURES.

1 1. The following shall be provided to the pharmacy
2 benefits manager enrollees at the time of enrollment
3 or at the time the contract is issued and shall be
4 made available upon request or at least annually:
5 a. A list of the names and locations of all
6 affiliated pharmacists' services providers.
7 b. A description of the service area or areas
8 within which the pharmacy benefits manager provides
9 prescription services.
10 c. A description of the method of resolving
11 complaints of enrollees, including a description of
12 any arbitration procedure if complaints may be
13 resolved through a specified arbitration agreement.
14 d. Notice that the pharmacy benefits manager is
15 subject to regulation in this state by both the board
16 of pharmacy examiners and the commissioner of
17 insurance.
18 e. A prominent notice included within the evidence
19 of coverage, providing substantially the following:
20 "If you have any questions regarding an appeal or
21 grievance concerning the pharmacists' services that
22 you have been provided, which have not been
23 satisfactorily addressed by your plan, you may contact
24 the board of pharmacy examiners." The notice shall
25 also provide the toll-free telephone number, mailing
26 address, and electronic mail address of the board of
27 pharmacy examiners.
28 2. Any disclosure from a pharmacy benefits manager
29 to enrollees shall be written plainly, using terms
30 generally understood by the general public and a copy
31 of the disclosure shall be provided to all pharmacies
32 that are members of the network.
33 Sec. ___. NEW SECTION. 155B.14 PRIVACY.
34 An enrollee has the right to privacy and
35 confidentiality in the provision of pharmacists'
36 services. This right may be expressly waived in
37 writing by the enrollee or the enrollee's guardian.
38 Sec. ___. NEW SECTION. 155B.15 INSOLVENCY.
39 1. If a pharmacy benefits manager becomes
40 insolvent or ceases to be a company in this state in
41 any assessable or license year, the company shall
42 remain liable for the payment of the assessment for
43 the period in which the company operated as a pharmacy
44 benefits manager in this state.
45 2. If a pharmacy benefits manager becomes
46 insolvent, the commissioner may, after notice and
47 hearing, levy an assessment, in addition to an
48 assessment pursuant to section 155B.8, on pharmacy
49 benefits managers licensed to do business in this
50 state. The assessments shall be paid quarterly to the

1 commissioner, and upon receipt by the commissioner
2 shall be paid over into an escrow account in the
3 pharmacy benefits manager fund. The escrow account
4 shall be used solely for the benefit of enrollees of
5 the insolvent pharmacy benefits manager.
6 Sec. ___. NEW SECTION. 155B.16 PHARMACY BENEFITS
7 MANAGER FUND -- USES -- ESCROW ACCOUNT.
8 1. A pharmacy benefits manager fund is created in
9 the state treasury under the authority of the
10 commissioner of insurance. Moneys received from
11 licensure of pharmacy benefits managers pursuant to
12 section 155B.5, from examinations collected pursuant
13 to section 155B.7, and from assessments collected
14 pursuant to section 155B.8 shall be deposited in the
15 fund. Moneys in the fund shall be used and an amount
16 necessary is appropriated, annually, to the division
17 of insurance of the department of commerce for the
18 purposes of enforcing this chapter.
19 2. An escrow account is created in the pharmacy
20 benefits manager fund. Assessments collected pursuant
21 to section 155B.15 shall be deposited in the account
22 and are appropriated to the division of insurance of
23 the department of commerce to be used solely for the
24 benefit of the enrollees of an insolvent pharmacy
25 benefits manager."
26 2. By renumbering as necessary.

By JOCHUM of Dubuque

H-1251 FILED APRIL 2, 2003
LOST 4/2/03

HF 619 - Veteran Eligibility (LSB 3175 HV.1)
Analyst: Jennifer Vermeer (Phone: (515) 281-4611) (jennifer.vermeer@legis.state.ia.us)
Fiscal Note Version — As Amended by H-1216
Requestor by Representative Carroll

Description

House File 619, as amended by H-1216, makes various programmatic changes within the Medical Assistance Program (Medicaid), including:

- Implementation of a Preferred Drug List and other changes in prescription drug reimbursements.
- Expanding co-payments for prescription drugs and physician visits to the maximum level allowed under federal regulations.
- Reducing the statutory inflation adjustment used in re-basing the acuity-based reimbursement rates for nursing facilities.
- Conducting targeted audits of claims and provider reimbursements, and evaluating the utilization of services.
- Implementing a Disease Management Pilot Program.

The Medical Assistance Program (Medicaid) provides payment for health care services to specified groups of low-income individuals, such as children, pregnant women, the elderly, the disabled, and parents with dependent children.

Assumptions

4. The fiscal impact of the Interagency Bulk Purchasing Council cannot be determined. The impact depends on the number of agencies that elect to participate and the level of prescription drug discounts that can be negotiated.
5. The fiscal impact of requiring nursing facilities to assist in determining veterans' eligibility cannot be determined. Enrolling veterans for their veterans' benefits when they first enter a nursing facility will delay their eligibility for Medicaid and will likely result in state savings. The number of veterans identified and enrolled, and the impact of the benefits on their assets, however, is unknown. In addition, the federal Veterans' Administration application processing period is currently six to nine months. As a result, there will likely be minimal savings in FY 2004. Savings in FY 2005 cannot be determined due to the lack of data discussed above.
6. Prohibition of gifts from pharmaceutical manufacturers to health care practitioners and facilities is estimated to have no fiscal impact in FY 2004 or FY 2005.
7. The Bill requires the Department of Human Services (DHS) to submit a state plan amendment to the Centers for Medicare and Medicaid (CMS) by May 1, 2003, and to implement a Preferred Drug List (PDL). The intent is for DHS to adopt the state of Michigan's PDL and enter into an agreement with Michigan to join their multi-state purchasing coalition. Currently, four other states have signed agreements with Michigan to provide prescription drugs to a total of 2.8 million Medicaid recipients. Based on a larger purchasing pool and based on Michigan's experience in implementing a PDL, the estimated savings is 10% of brand name drug expenditures in the Medicaid Program. This results in a General Fund savings of $7.0 million in FY 2004 and FY 2005. Inflation and growth in the number of eligibles could increase the savings in FY 2005.
8. The Bill allows DHS to assess a quality assurance fee on nursing facilities not to exceed 6.0% of total annual revenues, and deposits the fee revenue into the Senior Living Trust Fund. The specific requirements of how the program will be implemented are unknown

at this time. As a result, the fiscal impact of the quality assurance fee cannot be determined.

9. Preventing providers of services under the Home and Community-Based Services Waiver from performing Medicaid eligibility assessments is estimated to have no fiscal impact in FY 2004 and FY 2005.
10. Changing the requirement for DHS to issue a notice demanding payment of accrued child support from "may" to "shall" is estimated to have no fiscal impact in FY 2004 and FY 2005.
11. Decreasing the dispensing fee paid to pharmacists for each Medicaid prescription from \$5.17 to \$4.26 is estimated to save \$622,000 from the General Fund in FY 2004 and FY 2005. The current average dispensing fee paid to pharmacists is \$5.17.
12. The current co-payment required for each prescription in the Medicaid Program is \$1. The Bill increases the co-payments to the maximum level allowed under federal regulations (ranging from 50 cents to \$3 based on the cost of the prescription). The Bill also adds a co-payment for physician services of \$3. The increase in co-payments is estimated to save \$854,000 from the General Fund.
13. Reducing the ingredient reimbursement for prescription drugs from Average Wholesale Price (AWP) minus 10.0% to AWP minus 12.0% is estimated to save \$2.0 million from the General Fund.
14. Expanding the State Maximum Allowable Cost (SMAC) Program is estimated to save \$1.9 million in FY 2004 and FY 2005 from the General Fund. The SMAC Program provides reimbursement to pharmacists for generic drugs at the pharmacist's acquisition cost plus a profit margin. Under the current SMAC list, pharmacists receive the acquisition cost plus a multiplier of 2.1 (cost plus 110.0%). The Bill reduces the multiplier to 1.4 (cost plus 40.0%). The savings estimate is also based on an expansion of the number of drug groups on the SMAC list from 53 to 84.
15. Establishing a fixed fee schedule for home health agencies is estimated to have no fiscal impact.
16. The Bill states legislative intent that consolidation of the Home and Community Based Services Waivers be designed in a manner that will not result in additional state costs. This provision is estimated to have no fiscal impact.
17. Nursing facility costs are expected to increase by \$10.7 million (6.0%) in FY 2004 due to re-basing the acuity-based reimbursement rates and a required inflation adjustment. The DHS has pursued rule changes related to nursing facilities crossover claims and bed hold reimbursement that will take effect on May 1, 2003, and result in an estimated savings of \$1.7 million from the General Fund. In addition, a hold harmless provision that was in place during the last three fiscal years will expire pursuant to Iowa Code at the end of FY 2003, for a savings of \$5.1 million from the General Fund. A change in reimbursement related to dual certification is estimated to save \$1.0 million from the General Fund. When these savings initiatives are compared to the increase for the re-base, a net cost of \$3.0 million remains. The Bill decreases the inflation factor used in the re-base to ensure that expenditures for nursing facilities remains at the same level as FY 2003. This results in a decrease of \$3.0 million. If the increase for the re-base is less than \$10.7 million, the decrease in the inflation adjustment would be less.
18. Conducting targeted audits of claims data and provider reimbursements and reviews of the appropriateness of the scope, duration, and utilization of services is estimated to result in savings of \$2.0 million in FY 2004 and FY 2005 from the General Fund.
19. The Bill increases physician reimbursements for public teaching hospitals (University of Iowa Hospital and Broadlawns Hospital). The hospitals are then required to return the supplemental payments to DHS through an intergovernmental transfer, as allowed under federal regulations. This program is estimated to result in savings of \$13.5 million in FY 2004 from the General Fund for the University of Iowa portion of the program. Operational changes are required at Broadlawns that will not be complete until after the start of FY 2004. As a result, savings from implementing this policy at Broadlawns will not be received until FY 2005. The amount of the savings has not yet been determined due to a lack of information.

20. The Bill requires DHS to pursue a chronic disease management pilot program, in consultation with the fiscal agent and with a chronic care management resource group. Disease management involves monitoring patient care and ensuring timely preventive services to improve patient outcomes and reduce costs. Disease management programs have resulted in savings in other states; however, a savings estimate for Iowa cannot be determined. The diseases and number of persons in the pilot program have not been identified.
21. The provisions in the Bill result in a total savings of $31.9 million. In addition to savings in the Bill, further savings of $13.9 million are assumed by the Bill due to rule changes and changes in reimbursement policies, for a total savings of $44.8 million.
22. The forecasted General Fund expenditure level for the Medicaid Program is $595.9 million for FY 2004. When savings of $44.8 million are deducted from the forecasted expenditure level, the net General Fund cost of the Medicaid Program is $551.1 million. This is approximately $1.8 million less than the expenditure level recommended by the Governor for FY 2004.

Fiscal Impact

The provisions of HF 619, as amended by H-1216, for which a fiscal impact can be determined are estimated to result in a state General Fund savings of $31.9 million in FY 2004 and FY 2005. The total annual savings for FY 2004 and FY 2005 is $44.8 million, when the $13.9 million for rule changes and other reimbursement changes that are outside HF 619, as amended by H-1216, are included.

In addition to the savings estimates above, other sections of the Bill are anticipated to result in savings, but the savings amount cannot be determined.

Sources

Department of Human Services
Legislative Fiscal Bureau analysis

/s/ Dennis C Prouty

April 2, 2003

HF 619 - Veteran Eligibility (LSB 3175 HV.2)
Analyst: Jennifer Vermeer (Phone: (515) 281-4611) (jennifer.vermeer@legis.state.ia.us)
Fiscal Note Version — As Amended by H-1216 - Revised
Requestor by Representative Carroll

Description

House File 619, as amended by H-1216, makes various programmatic changes within the Medical Assistance Program (Medicaid), including:

- Implementation of a Preferred Drug List and other changes in prescription drug reimbursements.
- Expanding co-payments for prescription drugs and physician visits to the maximum level allowed under federal regulations.
- Reducing the statutory inflation adjustment used in re-basing the acuity-based reimbursement rates for nursing facilities.
- Conducting targeted audits of claims and provider reimbursements, and evaluating the utilization of services.
- Implementing a Disease Management Pilot Program.

The Medical Assistance Program (Medicaid) provides payment for health care services to specified groups of low-income individuals, such as children, pregnant women, the elderly, the disabled, and parents with dependent children.

Assumptions

23. The fiscal impact of the Interagency Bulk Purchasing Council cannot be determined. The impact depends on the number of agencies that elect to participate and the level of prescription drug discounts that can be negotiated.
24. The fiscal impact of requiring nursing facilities to assist in determining veterans' eligibility cannot be determined. Enrolling veterans for their veterans' benefits when they first enter a nursing facility will delay their eligibility for Medicaid and will likely result in state savings. The number of veterans identified and enrolled, and the impact of the benefits on their assets, however, is unknown. In addition, the federal Veterans' Administration application processing period is currently six to nine months. As a result, there will likely be minimal savings in FY 2004. Savings in FY 2005 cannot be determined due to the lack of data discussed above.
25. Prohibition of gifts from pharmaceutical manufacturers to health care practitioners and facilities is estimated to have no fiscal impact in FY 2004 or FY 2005.
26. The Bill requires the Department of Human Services (DHS) to submit a state plan amendment to the Centers for Medicare and Medicaid (CMS) by May 1, 2003, and to implement a Preferred Drug List (PDL). The intent is for DHS to adopt the state of Michigan's PDL and enter into an agreement with Michigan to join their multi-state purchasing coalition. Currently, four other states have signed agreements with Michigan to provide prescription drugs to a total of 2.8 million Medicaid recipients. Based on a larger purchasing pool and based on Michigan's experience in implementing a PDL, the estimated savings is 10% of brand name drug expenditures in the Medicaid Program. This results in a General Fund savings of $7.0 million in FY 2004 and FY 2005. Inflation and growth in the number of eligibles could increase the savings in FY 2005.
27. The Bill allows DHS to assess a quality assurance fee on nursing facilities not to exceed 6.0% of total annual revenues, and deposits the fee revenue into the Senior Living Trust Fund. The specific requirements of how the program will be implemented are unknown

at this time. As a result, the fiscal impact of the quality assurance fee cannot be determined.

28. Preventing providers of services under the Home and Community-Based Services Waiver from performing Medicaid eligibility assessments is estimated to have no fiscal impact in FY 2004 and FY 2005.
29. Changing the requirement for DHS to issue a notice demanding payment of accrued child support from "may" to "shall" is estimated to have no fiscal impact in FY 2004 and FY 2005.
30. Decreasing the dispensing fee paid to pharmacists for each Medicaid prescription from $5.17 to $4.26 is estimated to save $2.2 million from the General Fund in FY 2004 and FY 2005. The current average dispensing fee paid to pharmacists is $5.17. The previous version (LSB 3175HV.1) of this fiscal note included a General Fund savings of $622,000 for this item, which was in error.
31. The current co-payment required for each prescription in the Medicaid Program is $1. The Bill increases the co-payments to the maximum level allowed under federal regulations (ranging from 50 cents to $3 based on the cost of the prescription). The Bill also adds a co-payment for physician services of $3. The increase in co-payments is estimated to save $854,000 from the General Fund.
32. Reducing the ingredient reimbursement for prescription drugs from Average Wholesale Price (AWP) minus 10.0% to AWP minus 12.0% is estimated to save $2.0 million from the General Fund.
33. Expanding the State Maximum Allowable Cost (SMAC) Program is estimated to save $1.9 million in FY 2004 and FY 2005 from the General Fund. The SMAC Program provides reimbursement to pharmacists for generic drugs at the pharmacist's acquisition cost plus a profit margin. Under the current SMAC list, pharmacists receive the acquisition cost plus a multiplier of 2.1 (cost plus 110.0%). The Bill reduces the multiplier to 1.4 (cost plus 40.0%). The savings estimate is also based on an expansion of the number of drug groups on the SMAC list from 53 to 84.
34. Establishing a fixed fee schedule for home health agencies is estimated to have no fiscal impact.
35. The Bill states legislative intent that consolidation of the Home and Community Based Services Waivers be designed in a manner that will not result in additional state costs. This provision is estimated to have no fiscal impact.
36. Nursing facility costs are expected to increase by $10.7 million (6.0%) in FY 2004 due to re-basing the acuity-based reimbursement rates and a required inflation adjustment. The DHS has pursued rule changes related to nursing facilities crossover claims and bed hold reimbursement that will take effect on May 1, 2003, and result in an estimated savings of $1.7 million from the General Fund. In addition, a hold harmless provision that was in place during the last three fiscal years will expire pursuant to Iowa Code at the end of FY 2003, for a savings of $5.1 million from the General Fund. A change in reimbursement related to dual certification is estimated to save $1.0 million from the General Fund. When these savings initiatives are compared to the increase for the re-base, a net cost of $3.0 million remains. The Bill decreases the inflation factor used in the re-base to ensure that expenditures for nursing facilities remains at the same level as FY 2003. This results in a decrease of $3.0 million. If the increase for the re-base is less than $10.7 million, the decrease in the inflation adjustment would be less.
37. Conducting targeted audits of claims data and provider reimbursements and reviews of the appropriateness of the scope, duration, and utilization of services is estimated to result in savings of $2.0 million in FY 2004 and FY 2005 from the General Fund.
38. The Bill increases physician reimbursements for public teaching hospitals (University of Iowa Hospital and Broadlawns Hospital). The hospitals are then required to return the supplemental payments to DHS through an intergovernmental transfer, as allowed under federal regulations. This program is estimated to result in savings of $13.5 million in FY 2004 from the General Fund for the University of Iowa portion of the program. Operational changes are required at Broadlawns that will not be complete until after the start of FY 2004. As a result, savings from implementing this policy at Broadlawns will

not be received until FY 2005. The amount of the savings has not yet been determined due to a lack of information.

39. The Bill requires DHS to pursue a chronic disease management pilot program, in consultation with the fiscal agent and with a chronic care management resource group. Disease management involves monitoring patient care and ensuring timely preventive services to improve patient outcomes and reduce costs. Disease management programs have resulted in savings in other states; however, a savings estimate for Iowa cannot be determined. The diseases and number of persons in the pilot program have not been identified.

40. The provisions in the Bill result in a total savings of $32.5 million. In addition to savings in the Bill, further savings of $13.9 million are assumed by the Bill due to rule changes and changes in reimbursement policies, for a total savings of $46.4 million.

41. The forecasted General Fund expenditure level for the Medicaid Program is $595.9 million for FY 2004. When savings of $46.4 million are deducted from the forecasted expenditure level, the net General Fund cost of the Medicaid Program is $549.6 million. This is approximately $3.4 million less than the expenditure level recommended by the Governor for FY 2004.

Fiscal Impact

The provisions of HF 619, as amended by H-1216, for which a fiscal impact can be determined are estimated to result in a State General Fund savings of $32.5 million in FY 2004 and FY 2005. The total annual savings for FY 2004 and FY 2005 is $46.4 million, when the $13.9 million for rule changes and other reimbursement changes that are outside HF 619, as amended by H-1216, are included.

In addition to the savings estimates above, other sections of the Bill are anticipated to result in savings, but the savings amount cannot be determined.

Sources

Department of Human Services
Legislative Fiscal Bureau analysis

/s/ Dennis C Prouty

April 2, 2003

HOUSE FILE 619
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO HSB 292)

(As Amended and Passed by the House April 2, 2003)

Passed House, Date Passed 4/2/03 Passed Senate, Date Passed 4/14/03
Vote: Ayes ______ Nays ______ Vote: Ayes ______ Nays ______
Approved 5/2/03

A BILL FOR

1 An Act relating to health care including reimbursement of health
2 care facilities based on resident program eligibility and
3 providing effective dates and a contingent effective date.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
5
6 House Amendments ______
7
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HF 619
pf/es/25

S.F. ________ H.F. 619

1 Section 1. NEW SECTION. 135.131 INTERAGENCY
2 PHARMACEUTICALS BULK PURCHASING COUNCIL.
3 1. For the purposes of this section, "interagency
4 pharmaceuticals bulk purchasing council" or "council" means
5 the interagency pharmaceuticals bulk purchasing council
6 created in this section.
7 2. An interagency pharmaceuticals bulk purchasing council
8 is created within the Iowa department of public health. The
9 department shall provide staff support to the council and the
10 department of pharmaceutical care of the university of Iowa
11 hospitals and clinics shall act in an advisory capacity to the
12 council. The council shall be composed of all of the
13 following members:
14 a. The director of public health, or the director's
15 designee.
16 b. The director of human services, or the director's
17 designee.
18 c. The director of the department of personnel, or the
19 director's designee.
20 d. A representative of the state board of regents.
21 e. The director of the department of corrections, or the
22 director's designee.
23 f. The director, or the director's designee, of any other
24 agency that purchases pharmaceuticals designated to be
25 included as a member by the director of public health.
26 3. The council shall select a chairperson annually from
27 its membership. A majority of the members of the council
28 shall constitute a quorum.
29 4. The council shall do all of the following:
30 a. Develop procedures that member agencies must follow in
31 purchasing pharmaceuticals. However, a member agency may
32 elect not to follow the council's procedures if the agency is
33 able to purchase the pharmaceuticals for a lower price than
34 the price available through the council. An agency that does
35 not follow the council's procedures shall report all of the

1 following to the council:
2 (1) The purchase price for the pharmaceuticals.
3 (2) The name of the wholesaler, retailer, or manufacturer
4 selling the pharmaceuticals.
5 b. Designate a member agency as the central purchasing
6 agency for purchasing of pharmaceuticals.
7 c. Use existing distribution networks, including wholesale
8 and retail distributors, to distribute the pharmaceuticals.
9 d. Investigate options that maximize purchasing power,
10 including expanding purchasing under the medical assistance
11 program, qualifying for participation in purchasing programs
12 under 42 U.S.C. § 256b, as amended, and utilizing rebate
13 programs, hospital disproportionate share purchasing,
14 multistate purchasing alliances, and health department and
15 federally qualified health center purchasing.
16 e. In collaboration with the department of pharmaceutical
17 care of the university of Iowa hospitals and clinics, make
18 recommendations to member agencies regarding drug utilization
19 review, prior authorization, the use of restrictive
20 formularies, the use of mail order programs, and copayment
21 structures. This paragraph shall not apply to the medical
22 assistance program but only to the operations of the member
23 agencies.
24 5. The central purchasing agency may enter into agreements
25 with a local governmental entity to purchase pharmaceuticals
26 for the local governmental entity.
27 6. The council shall develop procedures under which the
28 council may disclose information relating to the prices
29 manufacturers or wholesalers charge for pharmaceuticals by
30 category of pharmaceutical. The procedure shall prohibit the
31 council from disclosing information that identifies a specific
32 manufacturer or wholesaler or the prices charged by a specific
33 manufacturer or wholesaler for a specific pharmaceutical.
34 Sec. 2. NEW SECTION. 135C.31A ASSESSMENT OF RESIDENTS --
35 PROGRAM ELIGIBILITY.

1 Beginning July 1, 2003, a health care facility receiving
2 reimbursement through the medical assistance program under
3 chapter 249A shall assist the Iowa commission of veterans
4 affairs in determining, prior to the initial admission of a
5 resident, the prospective resident's eligibility for benefits
6 through the federal department of veterans affairs. The
7 health care facility shall also assist the Iowa commission of
8 veterans affairs in determining such eligibility for residents
9 residing in the facility on July 1, 2003. The department of
10 inspections and appeals, in cooperation with the department of
11 human services, shall adopt rules to administer this section,
12 including a provision that ensures that if a resident is
13 eligible for benefits through the federal department of
14 veterans affairs or other third-party payor, the payor of last
15 resort for reimbursement to the health care facility is the
16 medical assistance program. This section shall not apply to
17 the admission of an individual to a state mental health
18 institute for acute psychiatric care.
19 Sec. 3. NEW SECTION. 249A.20A PREFERRED DRUG LIST
20 PROGRAM.
21 1. The department shall establish and implement a
22 preferred drug list program under the medical assistance
23 program. The department shall submit a medical assistance
24 state plan amendment to the centers for Medicare and Medicaid
25 services of the United States department of health and human
26 services, no later than May 1, 2003, to implement the program.
27 2. a. A medical assistance pharmaceutical and
28 therapeutics committee shall be established within the
29 department by July 1, 2003, for the purpose of developing and
30 providing ongoing review of the preferred drug list.
31 b. (1) The members of the committee shall be appointed by
32 the governor and shall include health care professionals who
33 possess recognized knowledge and expertise in one or more of
34 the following:
35 (a) The clinically appropriate prescribing of covered

1 outpatient drugs.
2 (b) The clinically appropriate dispensing and monitoring
3 of covered outpatient drugs.
4 (c) Drug use review, evaluation, and intervention.
5 (d) Medical quality assurance.
6 (2) The membership of the committee shall be comprised of
7 at least one third but not more than fifty-one percent
8 licensed and actively practicing physicians and at least one
9 third licensed and actively practicing pharmacists.
10 c. The members shall be appointed to terms of two years.
11 Members may be appointed to more than one term. The
12 department shall provide staff support to the committee.
13 Committee members shall select a chairperson and vice
14 chairperson annually from the committee membership.
15 3. The pharmaceutical and therapeutics committee shall
16 recommend a preferred drug list to the department. The
17 committee shall develop the preferred drug list by considering
18 each drug's clinically meaningful therapeutic advantages in
19 terms of safety, effectiveness, and clinical outcome. The
20 committee shall use evidence-based research methods in
21 selecting the drugs to be included on the preferred drug list.
22 The committee shall periodically review all drug classes
23 included on the preferred drug list and may amend the list to
24 ensure that the list provides for medically appropriate drug
25 therapies for medical assistance recipients and achieves cost
26 savings to the medical assistance program. The department may
27 procure a sole source contract with an outside entity or
28 contractor to provide professional administrative support to
29 the pharmaceutical and therapeutics committee in researching
30 and recommending drugs to be placed on the preferred drug
31 list.
32 4. With the exception of drugs prescribed for the
33 treatment of human immunodeficiency virus or acquired immune
34 deficiency syndrome, transplantation, or cancer and drugs
35 prescribed for mental illness with the exception of drugs and

1 drug compounds that do not have a significant variation in a
2 therapeutic profile or side affect profile within a
3 therapeutic class, prescribing and dispensing of prescription
4 drugs not included on the preferred drug list shall be subject
5 to prior authorization.
6 5. The department may negotiate supplemental rebates from
7 manufacturers that are in addition to those required by Title
8 XIX of the federal Social Security Act. The committee shall
9 consider a product for inclusion on the preferred drug list if
10 the manufacturer provides a supplemental rebate. The
11 department may procure a sole source contract with an outside
12 entity or contractor to conduct negotiations for supplemental
13 rebates.
14 6. The department shall publish and disseminate the
15 preferred drug list to all medical assistance providers in
16 this state.
17 7. Until such time as the pharmaceutical and therapeutics
18 committee is operational, the department shall adopt and
19 utilize a preferred drug list developed by a midwestern state
20 that has received approval for its medical assistance state
21 plan amendment from the centers for Medicare and Medicaid
22 services of the United States department of health and human
23 services.
24 8. The department may procure a sole source contract with
25 an outside entity or contactor to participate in a
26 pharmaceutical pooling program with midwestern or other states
27 to provide for an enlarged pool of individuals for the
28 purchase of pharmaceutical products and services for medical
29 assistance recipients.
30 9. The department may adopt administrative rules under
31 section 17A.4, subsection 2, and section 17A.5, subsection 2,
32 paragraph "b", to implement this section.
33 10. Any savings realized under this section may be used to
34 the extent necessary to pay the costs associated with
35 implementation of this section prior to reversion to the

1 medical assistance program. The department shall report the
2 amount of any savings realized and the amount of any costs
3 paid to the legislative fiscal committee on a quarterly basis.
4 Sec. 4. NEW SECTION. 249A.20B NURSING FACILITY QUALITY
5 ASSURANCE ASSESSMENT.
6 1. The department may assess nursing facilities a quality
7 assurance assessment not to exceed six percent of the total
8 annual revenue of the facility.
9 2. The department of human services shall submit a medical
10 assistance state plan amendment to the centers for Medicare
11 and Medicaid services of the United States department of
12 health and human services to effectuate the nursing facility
13 quality assurance assessment.
14 3. The department of human services shall submit an
15 application to the secretary of the United States department
16 of health and human services to request a waiver of the
17 uniform tax requirement pursuant to 42 U.S.C. § 1396b(w)(3)(E)
18 and 42 C.F.R. § 433.68(e)(2).
19 4. The quality assurance assessment shall be paid to the
20 department in equal monthly amounts on or before the fifteenth
21 day of each month. The department may deduct the monthly
22 assessment amount from medical assistance payments to a
23 nursing facility. The amount deducted from payments shall not
24 exceed the total amount of the fee due.
25 5. Revenue generated from the quality assurance assessment
26 shall be deposited in the senior living trust fund created in
27 section 249H.4. The revenues shall only be used for services
28 for which federal financial participation under the medical
29 assistance program is available to match state funds.
30 6. If federal financial participation to match the
31 assessments made under subsection 1 becomes unavailable under
32 federal law, the department shall terminate the imposition of
33 the assessment beginning on the date that the federal
34 statutory, regulatory, or interpretive change takes effect.
35 7. The department may procure a sole source contract to

1 implement the provisions of this section.
2 8. For the purposes of this section, "nursing facility"
3 means nursing facility as defined in section 135C.1, excluding
4 residential care facilities and nursing facilities that are
5 operated by the state.
6 9. The department may adopt administrative rules under
7 section 17A.4, subsection 2, and section 17A.5, subsection 2,
8 paragraph "b", to implement this section.
9 Sec. 5. NEW SECTION. 249A.29A HOME AND COMMUNITY-BASED
10 SERVICES WAIVER -- ELIGIBILITY DETERMINATIONS.
11 1. A level of care eligibility determination of an
12 individual seeking approval by the department to receive
13 services under a waiver shall be completed only by a person
14 not participating as a provider of services under a waiver.
15 For the purposes of this section, "provider" and "waiver" mean
16 provider and waiver as defined in section 249A.29.
17 2. Funds appropriated to the department of elder affairs
18 for the purpose of conducting level of care eligibility
19 determinations shall be transferred and made available to the
20 department of human services.
21 3. The department of human services may procure a sole
22 source contract with an outside entity or contractor to
23 conduct level-of-care eligibility determinations.
24 4. The department may adopt administrative rules under
25 section 17A.4, subsection 2, and section 17A.5, subsection 2,
26 paragraph "b", to implement this section.
27 Sec. 6. Section 249B.3, subsection 1, unnumbered paragraph
28 1, Code 2003, is amended to read as follows:
29 The department ~~may~~ shall issue a notice establishing and
30 demanding payment of an accrued or accruing spousal support
31 debt due and owing to the department. The notice shall be
32 served upon the community spouse in accordance with the rules
33 of civil procedure. The notice shall include all of the
34 following:
35 Sec. 7. MEDICAL ASSISTANCE PROGRAM -- PHARMACEUTICALS --

1 RECIPIENT REQUIREMENTS.
2 1. The department of human services shall reimburse
3 pharmacy dispensing fees using a single rate of $4.26 per
4 prescription or the pharmacy's usual and customary fee,
5 whichever is lower.
6 2. The department of human services shall require
7 recipients of medical assistance to pay the following
8 copayment on each prescription filled for a covered
9 prescription drug, including on each refill of such
10 prescription, as follows:
11 a. A copayment of $1 for each covered generic prescription
12 drug.
13 b. A copayment of 50 cents for each covered brand-name
14 prescription drug for which the cost to the state is $10 or
15 less.
16 c. A copayment of $1 for each covered brand-name
17 prescription drug for which the cost to the state is more than
18 $10 and up to and including $25.
19 d. A copayment of $2 for each covered brand-name
20 prescription drug for which the cost to the state is more than
21 $25 and up to and including $50.
22 e. A copayment of $3 for each covered brand-name
23 prescription drug for which the cost to the state is over $50.
24 3. The department of human services shall establish an
25 ingredient reimbursement basis equal to the average wholesale
26 price minus 12 percent for pharmacy reimbursement for
27 prescription drugs under the medical assistance program.
28 4. a. The department of human services shall continue the
29 sole source contract relative to the state maximum allowable
30 cost (SMAC) program as authorized in 2001 Iowa Acts, chapter
31 191, section 31, subsection 1, paragraph "b", subparagraph
32 (5). The department shall expand the state maximum allowable
33 cost program for prescription drugs to the greatest extent
34 possible as determined under the contract.
35 b. Pharmacies and providers that are enrolled in the

1 medical assistance program shall make available drug
2 acquisition cost information, product availability
3 information, and other information deemed necessary by the
4 department for the determination of reimbursement rates and
5 the efficient operation of the pharmacy benefit. Pharmacies
6 and providers shall produce and submit the requested
7 information in the manner and format requested by the
8 department or its designee at no cost to the department or
9 designee. Pharmacies and providers shall submit information
10 to the department or its designee within thirty days following
11 receipt of a request for information unless the department or
12 its designee grants an extension upon written request of the
13 pharmacy or provider.
14 c. The state maximum allowable cost shall be established
15 at the average wholesale acquisition cost for a prescription
16 drug and all equivalent products, adjusted by a multiplier of
17 1.4. The department shall update the state maximum allowable
18 cost every two months, or more often if necessary, to ensure
19 adequate product availability.
20 d. The department shall review its current method for
21 determining which prescription drugs are to be included in the
22 SMAC program and shall adjust the method to maximize the cost
23 savings realized through the SMAC program.
24 e. The department shall report any savings realized
25 through the SMAC program to the legislative fiscal committee
26 on a monthly basis.
27 5. The department of human services shall require
28 recipients of medical assistance to pay a copayment of $3 for
29 each physician office visit.
30 6. The department of human services shall maximize
31 expansion of prior authorization of prescription drugs under
32 the medical assistance program beyond the 25 current
33 categories of medications.
34 7. The department of human services shall establish a
35 fixed-fee reimbursement schedule for home health agencies

1 under the medical assistance program.
2 8. The department may adopt emergency rules to implement
3 this section.
4 Sec. 8. HOME AND COMMUNITY-BASED SERVICES WAIVERS
5 CONSOLIDATION -- BUDGET NEUTRALITY. It is the intent of the
6 general assembly that the consolidation of home and community-
7 based services waivers by the department of human services be
8 designed in a manner that does not result in additional cost,
9 with the exception of any services added to the waivers
10 through legislative enactment. The department of human
11 services shall submit an initial report regarding the cost
12 neutrality and status of the waiver consolidation to the
13 legislative fiscal committee no later than January 31, 2004,
14 and a subsequent report no later than July 31, 2004.
15 Sec. 9. NURSING FACILITY REIMBURSEMENT. Notwithstanding
16 2001 Iowa Acts, chapter 192, section 4, subsection 2,
17 paragraph "c", and subsection 3, paragraph "a", subparagraph
18 (2), if projected state fund expenditures for reimbursement of
19 nursing facilities for the fiscal year beginning July 1, 2003,
20 in accordance with the reimbursement rate specified in 2001
21 Iowa Acts, chapter 192, section 4, subsection 2, paragraph
22 "c", exceeds $147,252,856, the department shall adjust the
23 inflation factor of the reimbursement rate calculation to
24 provide reimbursement within the amount projected.
25 Sec. 10. UTILIZATION MANAGEMENT AND TARGETED AUDITS.
26 1. The department of human services shall conduct ongoing
27 review of recipients and providers of medical assistance
28 services to determine the appropriateness of the scope,
29 duration, and utilization of services. If inappropriate usage
30 is identified, the department shall implement procedures
31 necessary to restrict utilization.
32 2. The department of human services shall conduct a review
33 of selected medical assistance services categories and
34 providers for state fiscal years beginning July 1, 2001, July
35 1, 2002, and July 1, 2003. The review shall include intense

1 data analysis to test compliance with rules, regulations, and
2 policies and selected on-site audits.
3 3. The review required under subsection 2 shall attempt to
4 identify any incorrectly paid billings or claims for the state
5 medical assistance program. If inappropriate payments are
6 identified, provider billings shall be adjusted accordingly.
7 If there is substantiated evidence to suggest fraudulent
8 activity, the department shall submit the audit data regarding
9 the medical assistance provider or recipient to the department
10 of inspections and appeals for further action.
11 4. The department of human services may procure a sole
12 source contract to implement the provisions of this section.
13 5. Any savings realized under this section may be used to
14 the extent necessary to pay the costs associated with
15 implementation of this section prior to reversion to the
16 medical assistance program. The department shall report the
17 amount of any savings realized and the amount of any costs
18 paid to the chairpersons of the joint appropriations
19 subcommittee on health and human services.
20 Sec. 11. MEDICAL ASSISTANCE -- CERTAIN PUBLICLY OWNED
21 HOSPITALS -- PHYSICIAN SUPPLEMENTAL PAYMENTS.
22 1. For the fiscal year beginning July 1, 2003, and for
23 each fiscal year thereafter, the department of human services
24 shall institute a supplemental payment adjustment applicable
25 to physician services provided to medical assistance
26 recipients at publicly owned acute care teaching hospitals.
27 The adjustment shall generate supplemental payments to
28 physicians which are equal to the difference between the
29 physician's charge and the physician's fee schedule under the
30 medical assistance program. To the extent of the supplemental
31 payments, a qualifying hospital shall, after receipt of the
32 payments, transfer to the department of human services an
33 amount equal to the actual supplemental payments that were
34 made in that month. The department of human services shall
35 deposit these payments in the department's medical assistance

1 account. The department of human services shall amend the
2 medical assistance state plan as necessary to implement this
3 section. The department may adopt emergency rules to
4 implement this section.
5 2. The department may use any savings realized under this
6 section to the extent necessary to pay the costs associated
7 with implementation of this section prior to reversion to the
8 medical assistance program. The department shall report the
9 amount of any savings realized and the amount of any costs
10 paid to the chairpersons of the joint appropriations
11 subcommittee on health and human services.
12 3. The department of human services shall, in any
13 compilation of data or other report distributed to the public
14 concerning payments to providers under the medical assistance
15 program, set forth reimbursements to physicians of the
16 university of Iowa college of medicine through supplemental
17 adjustments as a separate item and shall not include such
18 payments in the amounts otherwise reported as the
19 reimbursement to a physician for services to medical
20 assistance recipients.
21 Sec. 12. CHRONIC CARE MANAGEMENT.
22 1. The department of human services shall aggressively
23 pursue chronic disease management in order to improve care and
24 reduce costs under the medical assistance program.
25 2. The department of human services, in cooperation with
26 the department's fiscal agent and in consultation with a
27 chronic care management resource group, shall profile medical
28 assistance recipients within a select number of disease
29 diagnosis categories. The assessment shall focus on those
30 diagnosis areas that present the greatest opportunity for
31 impact to improved care and cost reduction.
32 3. The department of human services, in consultation with
33 a chronic care management resource group, shall conduct a
34 chronic disease management pilot project for a select number
35 of individuals who are participants in the medical assistance

1 program. The project shall focus on a select number of
2 chronic diseases which may include congestive heart failure,
3 diabetes, and asthma. The initial pilot project shall be
4 implemented by October 1, 2003.
5 4. The department of human services shall issue a request
6 for proposals or otherwise solicit bids from potential vendors
7 to manage individuals with select chronic diseases following
8 the conclusion of the profiling of medical assistance
9 recipients. The management of chronic diseases for
10 individuals under this subsection may be coordinated with the
11 pilot project established in subsection 3.
12 5. The department of human services shall amend the
13 medical assistance state plan and seek any waivers necessary
14 from the centers for Medicare and Medicaid services of the
15 United States department of health and human services to
16 implement this section.
17 6. The department of human services shall submit a
18 progress report regarding chronic disease management measures
19 undertaken pursuant to this section to the governor and the
20 general assembly by November 1, 2003. The report shall
21 include recommendations regarding incorporating chronic
22 disease management programming into the medical assistance
23 system and the potential improvements in care and reductions
24 in costs that may be obtained through chronic disease
25 management.
26 7. The department of human services may adopt emergency
27 rules to implement this section.
28 8. Any savings realized under this section may be used as
29 necessary to pay the costs associated with implementation of
30 this section prior to reversion to the medical assistance
31 program. The department shall report the amount of any
32 savings realized and the amount of any costs paid to the
33 chairpersons of the joint appropriations subcommittee on
34 health and human services.
35 Sec. 13. CONTINGENT EFFECTIVE DATE.

1 1. Section 249A.20B, as enacted in this Act, shall not
2 take effect unless the department of human services receives
3 approval of both the medical assistance state plan amendment
4 from the centers for Medicare and Medicaid services of the
5 United States department of health and human services to
6 effectuate the nursing facility quality assurance assessment
7 and of the application to the secretary of the United States
8 department of health and human services for a waiver of the
9 uniform tax requirement pursuant to 42 U.S.C. § 1396b(w)(3)(E)
10 and 42 C.F.R. § 433.68(e)(2). If both approvals are received,
11 section 249A.20B shall take effect upon the date that both
12 approvals have been received by the department and the
13 department shall notify the Code editor of the date of receipt
14 of the approvals.
15 2. If both approvals described in subsection 1 are not
16 received by June 30, 2004, the section of this Act enacting
17 section 249A.20B shall not take effect.
18 Sec. 14. EFFECTIVE DATES.
19 1. The section of this Act enacting section 249A.20A takes
20 effect upon enactment.
21 2. The portion of the section of this Act relating to the
22 state maximum allowable cost (SMAC) program, being deemed of
23 immediate importance, takes effect upon enactment.
24 3. The section of this Act relating to physician
25 supplemental payments at certain publicly owned hospitals,
26 being deemed of immediate importance, takes effect upon
27 enactment.
28 4. The section of this Act relating to chronic disease
29 management, being deemed of immediate importance, takes effect
30 upon enactment.
31 5. The portions of the section of this Act enacting
32 section 249A.20B relating to directing the department of human
33 services to submit a medical assistance state plan amendment
34 to the centers for Medicare and Medicaid services of the
35 United States department of health and human services to

S.F. ________ H.F. 619

1 effectuate the nursing facility quality assurance assessment
2 and directing the department of human services to submit an
3 application to the secretary of the United States department
4 of health and human services for a waiver of the uniform tax
5 requirement pursuant to 42 U.S.C. § 1396b(w)(3)(E) and 42
6 C.F.R. § 433.68(e)(2), being deemed of immediate importance,
7 take effect upon enactment.
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HOUSE FILE 619

S-3209

1 Amend House File 619, as amended, passed, and
2 reprinted by the House, as follows:
3 1. Page 8, line 3, by striking the figure "$4.26"
4 and inserting the following: "$4.35".
5 2. Page 8, line 26, by striking the figure "12"
6 and inserting the following: "11".
7 3. By striking page 8, line 35, through page 9,
8 line 13.
9 4. Page 9, line 17, by striking the figure "1.4"
10 and inserting the following: "1.8".
11 5. By renumbering, redesignating, and correcting
12 internal references as necessary.

By AMANDA RAGAN, DENNIS H. BLACK, JOHN P. KIBBIE, JACK HATCH, THOMAS G. COURTNEY, JACK HOLVECK, JOE BOLKCOM, DR. JOE SENG, HERMAN C. QUIRMBACH, STEVEN H. WARNSTADT, KEITH A. KREIMAN, DARYL BEALL, MATT McCOY, WILLIAM A. DOTZLER, ROGER STEWART, ROBERT E. DVORSKY, MIKE CONNOLLY, DICK L. DEARDEN, WALLY E. HORN, EUGENE S. FRAISE, MICHAEL E. GRONSTAL

S-3209 FILED APRIL 14, 2003
LOST

HOUSE FILE 619

S-3207

1 Amend House File 619, as amended, passed, and
2 reprinted by the House, as follows:
3 1. Page 7, by striking lines 9 through 26, and
4 inserting the following:
5 "Sec. ___. CASE MANAGEMENT PROGRAM FOR FRAIL
6 ELDERS.
7 1. The general assembly finds that the existing
8 case management program for frail elders administered
9 by the department of elder affairs is an important
10 component of the long-term care system in this state.
11 The program emphasizes the independence and dignity of
12 the individual while providing services in a cost-
13 effective manner.
14 2. The purposes of the case management program for
15 frail elders include all of the following:
16 a. To provide planning, policy development,
17 coordination and administrative oversight.
18 b. To provide assistance in the form of assessment
19 and care coordination under circumstances in which an
20 elder or the elder's caregiver is experiencing
21 diminished functional capacity or other conditions
22 that require the provision of services by professional
23 service providers.
24 c. To maintain a system that focuses on the
25 delivery of home and community-based services that
26 emphasize individual independence, individual needs
27 and desires, and consumer-driven quality of services.
28 3. It is the intent of the general assembly that
29 the department of elder affairs in collaboration with
30 the department of human services, area agencies on
31 aging, advocacy groups, industry representatives, and
32 consumers submit recommendations to the general
33 assembly by December 31, 2003, regarding the
34 redesigning of the case management program for the
35 frail elderly including preadmission screening
36 methodologies, independent assessment methodologies,
37 level of care determinations and ongoing methodologies
38 for the coordination, provision, and delivery of home
39 and community-based services."
40 2. By renumbering as necessary.

By AMANDA RAGAN

S-3207 FILED APRIL 14, 2003
LOST

HOUSE FILE 619

S-3212

1 Amend House File 619, as amended, passed, and
2 reprinted by the House, as follows:
3 1. Page 3, by inserting after line 18 the
4 following:
5 "Sec. ___. NEW SECTION. 155A.4A PHARMACEUTICAL
6 MARKETERS -- PROHIBITION OF GIFTS.
7 1. A pharmaceutical marketer shall not offer or
8 provide to any practitioner, hospital, health care
9 facility, or health benefit plan administrator, or any
10 other person in this state authorized or licensed to
11 dispense, distribute, or purchase prescription drugs,
12 any gift not otherwise exempt under this section.
13 2. The following gifts are exempt from the
14 prohibition of this section:
15 a. Free samples of prescription drugs intended for
16 distribution to patients.
17 b. The payment of reasonable compensation and
18 reimbursement of expenses in connection with bona fide
19 clinical trials. As used in this paragraph, "clinical
20 trial" means an approved clinical trial conducted in
21 connection with a research study designed to answer
22 specific questions about vaccines, new therapies, or
23 new ways of utilizing known treatments.
24 c. Any gift, fee, payment, subsidy, or other
25 economic benefit the value of which is less than
26 twenty-five dollars.
27 d. A scholarship or other support for medical
28 students, residents, or fellows to attend a
29 significant educational, scientific, or policymaking
30 conference of a national, regional, or specialty
31 medical or other professional association if the
32 recipient of the scholarship or other support is
33 selected by the association.
34 3. a. Annually on or before January 1, every
35 pharmaceutical manufacturing company shall disclose to
36 the board the value, nature, and purpose of any gift,
37 fee, payment, subsidy, or other economic benefit
38 provided in connection with detailing, promotional, or
39 other marketing activities by the company, directly or
40 through its pharmaceutical marketers, to any
41 practitioner, hospital, nursing home, pharmacist,
42 health benefit plan administrator, or any other person
43 in this state authorized to prescribe, dispense, or
44 purchase prescription drugs in this state. Disclosure
45 shall be made on a form and in a manner prescribed by
46 the board and shall be made for the period beginning
47 July 1 and ending June 30 of the previous state fiscal
48 year. An initial disclosure shall be made on January
49 15, 2004, for the period beginning July 1, 2003, and
50 ending December 31, 2003. The board shall provide to

1 the office of the attorney general complete access to
2 the information required to be disclosed under this
3 subsection. The office of the attorney general shall
4 report annually on the disclosures made under this
5 section to the governor and the general assembly on or
6 before March 1.
7 b. Each company subject to the provisions of this
8 section shall also disclose to the board, on or before
9 October 1, 2003, and annually thereafter, the name and
10 address of the individual responsible for the
11 company's compliance with this section.
12 c. The board and the office of the attorney
13 general shall keep confidential all trade secrets as
14 defined in section 550.2. The disclosure form
15 prescribed by the board shall permit the company to
16 identify any information that is a trade secret.
17 d. The company is exempt from disclosure of any
18 gifts that are exempt from the prohibition pursuant to
19 subsection 2.
20 e. The attorney general may bring an action for
21 injunctive relief, costs, and attorney fees, and may
22 impose a civil penalty of not more than ten thousand
23 dollars per violation on a company that fails to
24 disclose information as required by this subsection.
25 Each failure to disclose constitutes a separate
26 violation.
27 4. For the purposes of this section:
28 a. "Pharmaceutical manufacturing company" means
29 any entity engaged in the production, preparation,
30 propagation, compounding, conversion, or processing of
31 prescription drugs, either directly or indirectly by
32 extraction from substances of natural origin, or
33 independently by means of chemical synthesis, or by a
34 combination of extraction and chemical synthesis, or
35 any entity engaged in the packaging, repackaging,
36 labeling, relabeling, or distribution of prescription
37 drugs. The term does not include a wholesaler or a
38 pharmacist licensed under this chapter.
39 b. "Pharmaceutical marketer" means a person who,
40 while employed by or under contract to represent a
41 pharmaceutical manufacturing company, engages in
42 pharmaceutical detailing, promotional activities, or
43 other marketing of prescription drugs in this state to
44 any practitioner, hospital, health care facility,
45 pharmacist, health benefit plan administrator, or any
46 other person licensed or authorized to prescribe,
47 dispense, or purchase prescription drugs.
48 "Pharmaceutical marketer" does not include a
49 wholesaler or a wholesale salesperson."
50 2. By renumbering as necessary.

SENATE CLIP SHEET APRIL 15, 2003

By JACK HOLVECK
DICK L. DEARDEN
DR. JOE SENG
ROBERT E. DVORSKY
WALLY E. HORN
JOHN P. KIBBIE
EUGENE S. FRAISE
KEITH A. KREIMAN
AMANDA RAGAN
DENNIS H. BLACK
MATT McCOY
HERMAN C. QUIRMBACH
STEVEN H. WARNSTADT
THOMAS G. COURTNEY
ROGER STEWART
WILLIAM A. DOTZLER
JOE BOLKCOM
JACK HATCH

S-3212 FILED APRIL 14, 2003
LOST

Carroll, Ch.
Heaton
Smith

Su[illegible] ied By SF 619 HSB 292
HUMAN RESOURCES

HOUSE FILE ______
BY (PROPOSED COMMITTEE ON HUMAN RESOURCES BILL BY CHAIRPERSON BODDICKER)

Passed House, Date ____________ Passed Senate, Date ____________
Vote: Ayes ______ Nays _______ Vote: Ayes ______ Nays ________
Approved ______________________________

A BILL FOR

1 An Act relating to health care including reimbursement of health
2 care facilities based on resident program eligibility.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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S.F. ________ H.F. ________

1 Section 1. NEW SECTION. 135C.31A ASSESSMENT OF RESIDENTS
2 -- PROGRAM ELIGIBILITY.
3 Beginning July 1, 2003, a health care facility receiving
4 reimbursement through the medical assistance program under
5 chapter 249A shall assist the Iowa commission of veterans
6 affairs in determining, prior to the initial admission of a
7 resident, the prospective resident's eligibility for benefits
8 through the federal department of veterans affairs. The
9 health care facility shall also assist the Iowa commission of
10 veterans affairs in determining such eligibility for residents
11 residing in the facility on July 1, 2003. The department
12 shall adopt rules to administer this section, including a
13 provision that ensures that if a resident is eligible for
14 benefits through the federal department of veterans affairs or
15 other third-party payor, the payor of last resort for
16 reimbursement to the health care facility is the medical
17 assistance program. This section shall not apply to the
18 admission of an individual to a state mental health institute
19 for acute psychiatric care.
20 EXPLANATION
21 This bill requires that a licensed health care facility
22 assist the Iowa commission of veterans affairs in determining,
23 prior to initial admission of a resident, the prospective
24 resident's eligibility for benefits through the United States
25 department of veterans affairs. The bill also requires that
26 the health care facility assist the Iowa commission of
27 veterans affairs in determining the eligibility of current
28 residents.
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HOUSE FILE 619

AN ACT

RELATING TO HEALTH CARE INCLUDING REIMBURSEMENT OF HEALTH CARE FACILITIES BASED ON RESIDENT PROGRAM ELIGIBILITY AND PROVIDING EFFECTIVE DATES AND A CONTINGENT EFFECTIVE DATE.

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

Section 1. NEW SECTION. 135.131 INTERAGENCY PHARMACEUTICALS BULK PURCHASING COUNCIL.

1. For the purposes of this section, "interagency pharmaceuticals bulk purchasing council" or "council" means the interagency pharmaceuticals bulk purchasing council created in this section.

2. An interagency pharmaceuticals bulk purchasing council is created within the Iowa department of public health. The department shall provide staff support to the council and the department of pharmaceutical care of the university of Iowa hospitals and clinics shall act in an advisory capacity to the council. The council shall be composed of all of the following members:

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

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

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

d. A representative of the state board of regents.

e. The director of the department of corrections, or the director's designee.

f. The director, or the director's designee, of any other agency that purchases pharmaceuticals designated to be included as a member by the director of public health.

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. Develop procedures that member agencies must follow in purchasing pharmaceuticals. However, a member agency may elect not to follow the council's procedures if the agency is able to purchase the pharmaceuticals for a lower price than the price available through the council. An agency that does not follow the council's procedures shall report all of the following to the council:

(1) The purchase price for the pharmaceuticals.

(2) The name of the wholesaler, retailer, or manufacturer selling the pharmaceuticals.

b. Designate a member agency as the central purchasing agency for purchasing of pharmaceuticals.

c. Use existing distribution networks, including wholesale and retail distributors, to distribute the pharmaceuticals.

d. Investigate options that maximize purchasing power, including expanding purchasing under the medical assistance program, qualifying for participation in purchasing programs under 42 U.S.C. § 256b, as amended, and utilizing rebate programs, hospital disproportionate share purchasing, multistate purchasing alliances, and health department and federally qualified health center purchasing.

e. In collaboration with the department of pharmaceutical care of the university of Iowa hospitals and clinics, make recommendations to member agencies regarding drug utilization review, prior authorization, the use of restrictive formularies, the use of mail order programs, and copayment structures. This paragraph shall not apply to the medical assistance program but only to the operations of the member agencies.

5. The central purchasing agency may enter into agreements with a local governmental entity to purchase pharmaceuticals for the local governmental entity.

6. The council shall develop procedures under which the council may disclose information relating to the prices manufacturers or wholesalers charge for pharmaceuticals by category of pharmaceutical. The procedure shall prohibit the council from disclosing information that identifies a specific manufacturer or wholesaler or the prices charged by a specific manufacturer or wholesaler for a specific pharmaceutical.

Sec. 2. NEW SECTION. 135C.31A ASSESSMENT OF RESIDENTS -- PROGRAM ELIGIBILITY.

Beginning July 1, 2003, a health care facility receiving reimbursement through the medical assistance program under chapter 249A shall assist the Iowa commission of veterans affairs in determining, prior to the initial admission of a resident, the prospective resident's eligibility for benefits through the federal department of veterans affairs. The health care facility shall also assist the Iowa commission of veterans affairs in determining such eligibility for residents residing in the facility on July 1, 2003. The department of inspections and appeals, in cooperation with the department of human services, shall adopt rules to administer this section, including a provision that ensures that if a resident is eligible for benefits through the federal department of veterans affairs or other third-party payor, the payor of last resort for reimbursement to the health care facility is the medical assistance program. This section shall not apply to the admission of an individual to a state mental health institute for acute psychiatric care.

Sec. 3. NEW SECTION. 249A.20A PREFERRED DRUG LIST PROGRAM.

1. The department shall establish and implement a preferred drug list program under the medical assistance program. The department shall submit a medical assistance state plan amendment to the centers for Medicare and Medicaid services of the United States department of health and human services, no later than May 1, 2003, to implement the program.

2. a. A medical assistance pharmaceutical and therapeutics committee shall be established within the department by July 1, 2003, for the purpose of developing and providing ongoing review of the preferred drug list.

b. (1) The members of the committee shall be appointed by the governor and shall include health care professionals who possess recognized knowledge and expertise in one or more of the following:

(a) The clinically appropriate prescribing of covered outpatient drugs.

(b) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

(c) Drug use review, evaluation, and intervention.

(d) Medical quality assurance.

(2) The membership of the committee shall be comprised of at least one third but not more than fifty-one percent licensed and actively practicing physicians and at least one third licensed and actively practicing pharmacists.

c. The members shall be appointed to terms of two years. Members may be appointed to more than one term. The department shall provide staff support to the committee. Committee members shall select a chairperson and vice chairperson annually from the committee membership.

3. The pharmaceutical and therapeutics committee shall recommend a preferred drug list to the department. The committee shall develop the preferred drug list by considering each drug's clinically meaningful therapeutic advantages in terms of safety, effectiveness, and clinical outcome. The committee shall use evidence-based research methods in selecting the drugs to be included on the preferred drug list. The committee shall periodically review all drug classes included on the preferred drug list and may amend the list to ensure that the list provides for medically appropriate drug therapies for medical assistance recipients and achieves cost savings to the medical assistance program. The department may procure a sole source contract with an outside entity or

contractor to provide professional administrative support to the pharmaceutical and therapeutics committee in researching and recommending drugs to be placed on the preferred drug list.

4. With the exception of drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation, or cancer and drugs prescribed for mental illness with the exception of drugs and drug compounds that do not have a significant variation in a therapeutic profile or side effect profile within a therapeutic class, prescribing and dispensing of prescription drugs not included on the preferred drug list shall be subject to prior authorization.

5. The department may negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the federal Social Security Act. The committee shall consider a product for inclusion on the preferred drug list if the manufacturer provides a supplemental rebate. The department may procure a sole source contract with an outside entity or contractor to conduct negotiations for supplemental rebates.

6. The department shall publish and disseminate the preferred drug list to all medical assistance providers in this state.

7. Until such time as the pharmaceutical and therapeutics committee is operational, the department shall adopt and utilize a preferred drug list developed by a midwestern state that has received approval for its medical assistance state plan amendment from the centers for Medicare and Medicaid services of the United States department of health and human services.

8. The department may procure a sole source contract with an outside entity or contactor to participate in a pharmaceutical pooling program with midwestern or other states to provide for an enlarged pool of individuals for the purchase of pharmaceutical products and services for medical assistance recipients.

9. The department may adopt administrative rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph "b", to implement this section.

10. Any savings realized under this section may be used to the extent necessary to pay the costs associated with implementation of this section prior to reversion to the medical assistance program. The department shall report the amount of any savings realized and the amount of any costs paid to the legislative fiscal committee on a quarterly basis.

Sec. 4. NEW SECTION. 249A.20B NURSING FACILITY QUALITY ASSURANCE ASSESSMENT.

1. The department may assess nursing facilities a quality assurance assessment not to exceed six percent of the total annual revenue of the facility.

2. The department of human services shall submit a medical assistance state plan amendment to the centers for Medicare and Medicaid services of the United States department of health and human services to effectuate the nursing facility quality assurance assessment.

3. The department of human services shall submit an application to the secretary of the United States department of health and human services to request a waiver of the uniform tax requirement pursuant to 42 U.S.C. § 1396b(w)(3)(E) and 42 C.F.R. § 433.68(e)(2).

4. The quality assurance assessment shall be paid to the department in equal monthly amounts on or before the fifteenth day of each month. The department may deduct the monthly assessment amount from medical assistance payments to a nursing facility. The amount deducted from payments shall not exceed the total amount of the fee due.

5. Revenue generated from the quality assurance assessment shall be deposited in the senior living trust fund created in section 249H.4. The revenues shall only be used for services for which federal financial participation under the medical assistance program is available to match state funds.

6. If federal financial participation to match the assessments made under subsection 1 becomes unavailable under federal law, the department shall terminate the imposition of the assessment beginning on the date that the federal statutory, regulatory, or interpretive change takes effect.

7. The department may procure a sole source contract to implement the provisions of this section.

8. For the purposes of this section, "nursing facility" means nursing facility as defined in section 135C.1, excluding residential care facilities and nursing facilities that are operated by the state.

9. The department may adopt administrative rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph "b", to implement this section.

Sec. 5. NEW SECTION. 249A.29A HOME AND COMMUNITY-BASED SERVICES WAIVER -- ELIGIBILITY DETERMINATIONS.

1. A level of care eligibility determination of an individual seeking approval by the department to receive services under a waiver shall be completed only by a person not participating as a provider of services under a waiver. For the purposes of this section, "provider" and "waiver" mean provider and waiver as defined in section 249A.29.

2. Funds appropriated to the department of elder affairs for the purpose of conducting level of care eligibility determinations shall be transferred and made available to the department of human services.

3. The department of human services may procure a sole source contract with an outside entity or contractor to conduct level-of-care eligibility determinations.

4. The department may adopt administrative rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph "b", to implement this section.

Sec. 6. Section 249B.3, subsection 1, unnumbered paragraph 1, Code 2003, is amended to read as follows:

The department ~~may~~ shall issue a notice establishing and demanding payment of an accrued or accruing spousal support debt due and owing to the department. The notice shall be served upon the community spouse in accordance with the rules of civil procedure. The notice shall include all of the following:

Sec. 7. MEDICAL ASSISTANCE PROGRAM -- PHARMACEUTICALS -- RECIPIENT REQUIREMENTS.

1. The department of human services shall reimburse pharmacy dispensing fees using a single rate of $4.26 per prescription or the pharmacy's usual and customary fee, whichever is lower.

2. The department of human services shall require recipients of medical assistance to pay the following copayment on each prescription filled for a covered prescription drug, including on each refill of such prescription, as follows:

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

b. A copayment of 50 cents for each covered brand-name prescription drug for which the cost to the state is $10 or less.

c. A copayment of $1 for each covered brand-name prescription drug for which the cost to the state is more than $10 and up to and including $25.

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

e. A copayment of $3 for each covered brand-name prescription drug for which the cost to the state is over $50.

3. The department of human services shall establish an ingredient reimbursement basis equal to the average wholesale price minus 12 percent for pharmacy reimbursement for prescription drugs under the medical assistance program.

4. a. The department of human services shall continue the sole source contract relative to the state maximum allowable cost (SMAC) program as authorized in 2001 Iowa Acts, chapter 191, section 31, subsection 1, paragraph "b", subparagraph

(5). The department shall expand the state maximum allowable cost program for prescription drugs to the greatest extent possible as determined under the contract.

b. Pharmacies and providers that are enrolled in the medical assistance program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department for the determination of reimbursement rates and the efficient operation of the pharmacy benefit. Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or designee. Pharmacies and providers shall submit information to the department or its designee within thirty days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

c. The state maximum allowable cost shall be established at the average wholesale acquisition cost for a prescription drug and all equivalent products, adjusted by a multiplier of 1.4. The department shall update the state maximum allowable cost every two months, or more often if necessary, to ensure adequate product availability.

d. The department shall review its current method for determining which prescription drugs are to be included in the SMAC program and shall adjust the method to maximize the cost savings realized through the SMAC program.

e. The department shall report any savings realized through the SMAC program to the legislative fiscal committee on a monthly basis.

5. The department of human services shall require recipients of medical assistance to pay a copayment of $3 for each physician office visit.

6. The department of human services shall maximize expansion of prior authorization of prescription drugs under the medical assistance program beyond the 25 current categories of medications.

7. The department of human services shall establish a fixed-fee reimbursement schedule for home health agencies under the medical assistance program.

8. The department may adopt emergency rules to implement this section.

Sec. 8. HOME AND COMMUNITY-BASED SERVICES WAIVERS CONSOLIDATION -- BUDGET NEUTRALITY. It is the intent of the general assembly that the consolidation of home and community-based services waivers by the department of human services be designed in a manner that does not result in additional cost, with the exception of any services added to the waivers through legislative enactment. The department of human services shall submit an initial report regarding the cost neutrality and status of the waiver consolidation to the legislative fiscal committee no later than January 31, 2004, and a subsequent report no later than July 31, 2004.

Sec. 9. NURSING FACILITY REIMBURSEMENT. Notwithstanding 2001 Iowa Acts, chapter 192, section 4, subsection 2, paragraph "c", and subsection 3, paragraph "a", subparagraph (2), if projected state fund expenditures for reimbursement of nursing facilities for the fiscal year beginning July 1, 2003, in accordance with the reimbursement rate specified in 2001 Iowa Acts, chapter 192, section 4, subsection 2, paragraph "c", exceeds $147,252,856, the department shall adjust the inflation factor of the reimbursement rate calculation to provide reimbursement within the amount projected.

Sec. 10. UTILIZATION MANAGEMENT AND TARGETED AUDITS.

1. The department of human services shall conduct ongoing review of recipients and providers of medical assistance services to determine the appropriateness of the scope, duration, and utilization of services. If inappropriate usage is identified, the department shall implement procedures necessary to restrict utilization.

2. The department of human services shall conduct a review of selected medical assistance services categories and providers for state fiscal years beginning July 1, 2001, July

1, 2002, and July 1, 2003. The review shall include intense data analysis to test compliance with rules, regulations, and policies and selected on-site audits.

3. The review required under subsection 2 shall attempt to identify any incorrectly paid billings or claims for the state medical assistance program. If inappropriate payments are identified, provider billings shall be adjusted accordingly. If there is substantiated evidence to suggest fraudulent activity, the department shall submit the audit data regarding the medical assistance provider or recipient to the department of inspections and appeals for further action.

4. The department of human services may procure a sole source contract to implement the provisions of this section.

5. Any savings realized under this section may be used to the extent necessary to pay the costs associated with implementation of this section prior to reversion to the medical assistance program. The department shall report the amount of any savings realized and the amount of any costs paid to the chairpersons of the joint appropriations subcommittee on health and human services.

Sec. 11. MEDICAL ASSISTANCE -- CERTAIN PUBLICLY OWNED HOSPITALS -- PHYSICIAN SUPPLEMENTAL PAYMENTS.

1. For the fiscal year beginning July 1, 2003, and for each fiscal year thereafter, 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.

2. The department may use any savings realized under this section to the extent necessary to pay the costs associated with implementation of this section prior to reversion to the medical assistance program. The department shall report the amount of any savings realized and the amount of any costs paid to the chairpersons of the joint appropriations subcommittee on health and human services.

3. The department of human services shall, in any compilation of data or other report distributed to the public concerning payments to providers under the medical assistance program, set forth reimbursements to physicians of the university of Iowa college of medicine through supplemental adjustments as a separate item and shall not include such payments in the amounts otherwise reported as the reimbursement to a physician for services to medical assistance recipients.

Sec. 12. CHRONIC CARE MANAGEMENT.

1. The department of human services shall aggressively pursue chronic disease management in order to improve care and reduce costs under the medical assistance program.

2. The department of human services, in cooperation with the department's fiscal agent and in consultation with a chronic care management resource group, shall profile medical assistance recipients within a select number of disease diagnosis categories. The assessment shall focus on those diagnosis areas that present the greatest opportunity for impact to improved care and cost reduction.

3. The department of human services, in consultation with a chronic care management resource group, shall conduct a chronic disease management pilot project for a select number of individuals who are participants in the medical assistance program. The project shall focus on a select number of

chronic diseases which may include congestive heart failure, diabetes, and asthma. The initial pilot project shall be implemented by October 1, 2003.

4. The department of human services shall issue a request for proposals or otherwise solicit bids from potential vendors to manage individuals with select chronic diseases following the conclusion of the profiling of medical assistance recipients. The management of chronic diseases for individuals under this subsection may be coordinated with the pilot project established in subsection 3.

5. The department of human services shall amend the medical assistance state plan and seek any waivers necessary from the centers for Medicare and Medicaid services of the United States department of health and human services to implement this section.

6. The department of human services shall submit a progress report regarding chronic disease management measures undertaken pursuant to this section to the governor and the general assembly by November 1, 2003. The report shall include recommendations regarding incorporating chronic disease management programming into the medical assistance system and the potential improvements in care and reductions in costs that may be obtained through chronic disease management.

7. The department of human services may adopt emergency rules to implement this section.

8. Any savings realized under this section may be used as necessary to pay the costs associated with implementation of this section prior to reversion to the medical assistance program. The department shall report the amount of any savings realized and the amount of any costs paid to the chairpersons of the joint appropriations subcommittee on health and human services.

Sec. 13. CONTINGENT EFFECTIVE DATE.

1. Section 249A.20B, as enacted in this Act, shall not take effect unless the department of human services receives

approval of both the medical assistance state plan amendment from the centers for Medicare and Medicaid services of the United States department of health and human services to effectuate the nursing facility quality assurance assessment and of the application to the secretary of the United States department of health and human services for a waiver of the uniform tax requirement pursuant to 42 U.S.C. § 1396b(w)(3)(E) and 42 C.F.R. § 433.68(e)(2). If both approvals are received, section 249A.20B shall take effect upon the date that both approvals have been received by the department and the department shall notify the Code editor of the date of receipt of the approvals.

2. If both approvals described in subsection 1 are not received by June 30, 2004, the section of this Act enacting section 249A.20B shall not take effect.

Sec. 14. EFFECTIVE DATES.

1. The section of this Act enacting section 249A.20A takes effect upon enactment.

2. The portion of the section of this Act relating to the state maximum allowable cost (SMAC) program, being deemed of immediate importance, takes effect upon enactment.

3. The section of this Act relating to physician supplemental payments at certain publicly owned hospitals, being deemed of immediate importance, takes effect upon enactment.

4. The section of this Act relating to chronic disease management, being deemed of immediate importance, takes effect upon enactment.

5. The portions of the section of this Act enacting section 249A.20B relating to directing the department of human services to submit a medical assistance state plan amendment to the centers for Medicare and Medicaid services of the United States department of health and human services to effectuate the nursing facility quality assurance assessment and directing the department of human services to submit an application to the secretary of the United States department

of health and human services for a waiver of the uniform tax requirement pursuant to 42 U.S.C. § 1396b(w)(3)(E) and 42 C.F.R. § 433.68(e)(2), being deemed of immediate importance, take effect upon enactment.

CHRISTOPHER C. RANTS
Speaker of the House

MARY E. KRAMER
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 619, Eightieth General Assembly.

MARGARET THOMSON
Chief Clerk of the House

Approved _______________, 2003

THOMAS J. VILSACK
Governor