House Study Bill 757

HOUSE FILE _____
BY (PROPOSED COMMITTEE ON HUMAN RESOURCES BILL BY CHAIRPERSON SMITH)

Passed House, Date _____ Passed Senate, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to health care reform including health care coverage intended for children, health information technology, end=of=life care promotion, preexisting conditions and dependent children coverage, and medical homes, providing an appropriation, and including an applicability provision.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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DIVISION I
HEALTH CARE COVERAGE INTENT

Section 1. DECLARATION OF INTENT.

1. It is the intent of the general assembly, as funding becomes available, to progress toward achievement of the goal that all Iowans have health care coverage which meets certain standards of quality and affordability with the initial priority being that all children have such health care coverage by December 31, 2010.

2. It is also the intent of the general assembly that if sufficient funding is available, and if federal reauthorization of the state children's health insurance program provides sufficient federal allocations to the state and authorization to cover such children as an option under the state children's health insurance program, the department of human services may expand coverage under the state children's health insurance program to cover children with family incomes up to three hundred percent of the federal poverty level.

DIVISION II
IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

Sec. 2. NEW SECTION. 8.70 DEFINITIONS.

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

1. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business of in the practice of a profession.

2. "Health information technology" means the application of information processing, involving both computer hardware and software, that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication, decision making, quality, safety, and efficiency of clinical practice, and may include but is not limited to:

a. An electronic health record that electronically compiles and maintains health information that may be derived from multiple sources about the health status of an individual and may include a core subset of each care delivery organization's electronic medical record such as a continuity of care record or a continuity of care document, computerized physician order entry, electronic prescribing, or clinical decision support.

b. A personal health record through which an individual and any other person authorized by the individual can maintain and manage the individual's health information.

c. An electronic medical record that is used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery

organization, is the legal record of the patient's encounter with the care delivery organization, and is owned by the care delivery organization.

d. A computerized provider order entry function that permits the electronic ordering of diagnostic and treatment services, including prescription drugs.

e. A decision support function to assist physicians and other health care providers in making clinical decisions by providing electronic alerts and reminders to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments.

f. Tools to allow for the collection, analysis, and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction, and other health care=related performance measures.

3. "Interoperability" means the ability of two or more systems or components to exchange information or data in an accurate, effective, secure, and consistent manner and to use the information or data that has been exchanged and includes but is not limited to:

a. The capacity to connect to a network for the purpose of exchanging information or data with other users.

b. The ability of a connected, authenticated user to demonstrate appropriate permissions to participate in the instant transaction over the network.

c. The capacity of a connected, authenticated user to access, transmit, receive, and exchange usable information with other users.

4. "Recognized interoperability standard" means interoperability standards recognized by the office of the national coordinator for health information technology of the United States department of health and human services.

Sec. 3. NEW SECTION. 8.71 IOWA ELECTRONIC HEALTH == PRINCIPLES == GOALS.

1. Health information technology is rapidly evolving so that it can contribute to the goals of improving access to and quality of health care, enhancing efficiency, and reducing costs.

2. To be effective, the health information technology system shall comply with all of the following principles:

a. Be patient=centered and market=driven.

b. Be based on approved standards developed with input from all stakeholders.

c. Protect the privacy of consumers and the security and confidentiality of all health information.

d. Promote interoperability.

e. Ensure the accuracy, completeness, and uniformity of data.

3. Widespread adoption of health information technology is critical to a successful health information technology system and is best achieved when all of the following occur:

a. The market provides a variety of certified products from which to choose in order to best fit the needs of the user.

b. The system provides incentives for health care professionals to utilize the health information technology and provides rewards for any improvement in quality and efficiency resulting from such utilization.

c. The system provides protocols to address critical problems.

d. The system is financed by all who benefit from the improved quality, efficiency, savings, and other benefits that result from use of health information technology.

Sec. 4. NEW SECTION. 8.72 IOWA ELECTRONIC HEALTH INFORMATION COMMISSION.

1. a. An electronic health information commission is created as a public and private collaborative effort to promote the adoption and use of health information technology in this state in order to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals with comprehensive, real=time medical information to provide continuity of care and make the best health care decisions. The commission shall provide oversight for the development, implementation, and coordination of an interoperable electronic health records system, telehealth expansion efforts, the health information technology infrastructure, and other health information technology initiatives in this state. The commission shall be guided by the principles and goals specified in section 8.71.

b. All health information technology efforts shall endeavor to represent the interests and meet the needs of consumers and the health care sector, protect the privacy of individuals and the confidentiality of individuals' information, promote physician best practices, and make information easily accessible to the appropriate parties. The system developed shall be consumer=driven, flexible, and expandable.

2. The commission shall consist of five voting members who are individuals with broad experience and vision in health care and health technology, and four members of the general assembly who shall serve as ex officio, nonvoting members. The voting members shall be appointed by the governor, subject to confirmation by the senate. The legislative members of the commission shall be appointed by the majority leader of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives.

3. a. The voting members shall serve terms of three years beginning and ending as provided in section 69.19. Voting member appointments shall comply with sections 69.16 and 69.16A. Voting members shall receive reimbursement for actual expenses incurred while serving in their official capacity and voting members may also be eligible to receive compensation as provided in section 7E.6. Legislative members shall be paid the per diem and expenses specified in section 2.10. Vacancies shall be filled by the original appointing authority and in the manner of the original appointments. A person appointed to fill a vacancy for a member shall serve only for the unexpired portion of the term. A voting member is eligible for reappointment for two successive terms.

b. The voting members shall select a chairperson, annually, from among the membership. The commission shall meet at least quarterly and at the call of the chairperson. A majority of the voting members of the commission constitutes a quorum. Any action taken by the commission must be adopted by the affirmative vote of a majority of its voting membership.

c. The commission is located for administrative purposes within the department of management. The department shall provide office space, staff assistance, administrative support, and necessary supplies and equipment for the commission.

4. The commission shall do all of the following:

a. Establish a technical advisory group which shall consist of the representatives of entities involved in the electronic health records system task force established pursuant to section 217.41A, Code 2007, and any other members the commission determines necessary to assist in the commission's duties at various stages of development of the electronic health information system. Executive branch agencies shall also be included as necessary to assist in the duties of the commission. Public members of the technical advisory group shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent. Any legislative members shall be paid the per diem and expenses specified in section 2.10.

b. Adopt a statewide health information technology plan by January 1, 2009. In developing the plan, the commission shall seek the input of providers, payers, and consumers. Standards and policies developed for the plan shall promote and be consistent with national standards developed by the office of the national coordinator for health information technology of the United States department of health and human services and shall address or provide for all of the following:

(1) The effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvement. The commission shall adopt requirements for interoperable electronic health records in this state including a recognized interoperability standard.

(2) Education of the public and health care sector about the value of health information technology in improving patient care, and methods to promote increased support and collaboration of state and local public health agencies, health care professionals, and consumers in health information technology initiatives.

(3) Standards for the exchange of health care information and interoperable electronic health records.

(4) Policies relating to the protection of privacy of patients and the security and confidentiality of patient

information.
(5) Policies relating to information ownership.
(6) Policies relating to governance of the various facets of the health information technology system.
(7) A single patient identifier or alternative mechanism to share secure patient information. If no alternative mechanism is acceptable to the commission, all health care professionals shall utilize the mechanism selected by the commission by January 1, 2010.
(8) A standard continuity of care record and other issues related to the content of electronic transmissions. All health care professionals shall utilize the standard continuity of care record by January 1, 2010.
(9) Requirements for electronic prescribing.
(10) Economic incentives and support to facilitate participation in an interoperable system by health care professionals.
c. Identify existing and potential health information technology efforts in this state, regionally, and nationally, and integrate existing efforts to avoid incompatibility between efforts and avoid duplication.
d. Coordinate public and private efforts to provide the network backbone infrastructure for the health information technology system. In coordinating these efforts, the commission shall do all of the following:
(1) Adopt policies to effectuate the logical cost effective usage of and access to the state=owned network, and support of telecommunication carrier products, where applicable.
(2) Consult with the Iowa communications network, private fiberoptic networks, and any other communications entity to seek collaboration, avoid duplication, and leverage opportunities in developing a backbone network.
(3) Establish protocols to ensure compliance with any applicable federal standards.
(4) Determine costs for accessing the network at a level that provides sufficient funding for the network.
e. Promote the use of telemedicine.
(1) Examine existing barriers to the use of telemedicine and make recommendations for eliminating these barriers.
(2) Examine the most efficient and effective systems of technology for use and make recommendations based on the findings.
f. Address the workforce needs generated by increased use of health information technology.
g. Adopt rules in accordance with chapter 17A to implement all aspects of the statewide plan and the network.
h. Coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in this state.
i. Seek and apply for any federal or private funding to assist in the implementation and support of the health information technology system and make recommendations for funding mechanisms for the ongoing development and maintenance costs of the health information technology system.
j. Identify state laws and rules that present barriers to the development of the health information technology system and recommend any changes to the governor and the general assembly.
Sec. 5. Section 217.41A, Code 2007, is repealed.

DIVISION III

END=OF=LIFE CARE PROMOTION

Sec. 6. NEW SECTION. 231.62 END=OF=LIFE CARE PROMOTION.
1. The department shall consult with the Iowa medical society, the Iowa end=of=life coalition, the Iowa hospice organization, the university of Iowa palliative care program, and other health care professionals whose scope of practice includes end=of=life care to develop educational and patient=centered information on end=of=life care for terminally ill patients and health care professionals.
2. For the purposes of this section, "end=of=life care" means care provided to meet the physical, psychological, social, spiritual, and practical needs of terminally ill patients and their caregivers.

DIVISION IV

HEALTH CARE COVERAGE

Sec. 7. Section 509.3, Code 2007, is amended by adding the following new subsection:
NEW SUBSECTION. 8. A provision that the insurer will permit continuation of existing coverage for an unmarried dependent child of an insured or enrollee who so elects, at

least through the age of twenty=five years old or so long as the dependent child maintains full=time status as a student in an accredited institution of postsecondary education, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Sec. 8. Section 513B.2, subsection 6, paragraph b, Code Supplement 2007, is amended to read as follows:

b. A small employer carrier ~~may~~ shall establish additional groupings under each of the subparagraphs in paragraph "a" on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs. A small employer carrier shall offer health insurance coverage to a bona fide association as defined in section 509.1, subsection 8, paragraph "b", that utilizes the rating bands devised pursuant to the additional groupings established.

Sec. 9. Section 513C.7, subsection 2, paragraph a, Code 2007, is amended to read as follows:

~~a.~~ The individual basic or standard health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition shall not be defined more restrictively than any of the following:

~~(1)~~ a. A condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage.

~~(2)~~ b. A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

~~(3)~~ c. A pregnancy existing on the effective date of coverage.

Sec. 10. Section 513C.7, subsection 2, paragraph b, Code 2007, is amended by striking the paragraph.

Sec. 11. NEW SECTION. 514A.3B ADDITIONAL REQUIREMENTS.

1. An insurer which accepts an individual for coverage under an individual policy or contract of accident and health insurance shall waive any time period applicable to a preexisting condition exclusion or limitation period requirement of the policy or contract with respect to particular services in an individual health benefit plan for the period of time the individual was previously covered by qualifying previous coverage as defined in section 513C.3 that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty=three days prior to the effective date of the new policy or contract. For purposes of this section, periods of coverage under medical assistance provided pursuant to chapter 249A or 514I, or Medicare coverage provided pursuant to Title XVIII of the federal Social Security Act shall not be counted with respect to the sixty=three=day requirement.

2. An insurer issuing an individual policy or contract of accident and health insurance which provides coverage for dependent children of the insured shall permit continuation of coverage for an unmarried dependent child of an insured or enrollee who so elects, at least through the age of twenty=five years old or so long as the dependent child maintains full=time status as a student in an accredited institution of postsecondary education, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Sec. 12. APPLICABILITY. This division of this Act applies to policies or contracts of accident and health insurance delivered or issued for delivery or continued or renewed in this state on or after July 1, 2008.

DIVISION V
MEDICAL HOME

Sec. 13. NEW SECTION. 135.154 DEFINITIONS.

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

1. "Department" means the department of public health.

2. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

3. "Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the primary care physician and other health care professionals, and where appropriate,

the patient's family; utilizes the partnership to access all medical and nonmedical health=related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health=related services to promote continuity of care; and has all of the characteristics specified in section 135.155.

4. "Medical home commission" or "commission" means the medical home commission created in section 135.156.

5. "National committee for quality assurance" means the nationally recognized, independent nonprofit organization that measures the quality and performance of health care and health care plans in the United States; provides accreditation, certification, and recognition programs for health care plans and programs; and is recognized in Iowa as an accrediting organization for commercial and Medicaid=managed care organizations.

6. "Nonphysician primary care professionals" means providers of health care other than physicians who render some primary care services including advanced registered nurse practitioners, physician assistants, pharmacists, and other health care professionals.

7. "Personal provider" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health needs, and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.

8. "Primary care" means health care which emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.

9. "Primary care physician" means a generalist physician who is specifically trained to provide primary care at the point of first contact, and takes continuing responsibility for providing the patient's care.

Sec. 14. NEW SECTION. 135.155 MEDICAL HOME PURPOSES == CHARACTERISTICS.

1. The purposes of a medical home are the following:

a. To reduce disparities in health care access, delivery, and health care outcomes.

b. To improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage and to provide for the sustainability of the health care system.

c. To provide a tangible method to document if each Iowan has access to health care.

2. A medical home has all of the following characteristics:

a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.

b. A provider=directed medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.

c. Whole person orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end=of=life care.

d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients get the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

e. Quality and safety. The following are quality and safety components of the medical home:

(1) Provider=directed medical practices advocate for their patients to support the attainment of optimal, patient=centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.

(2) Evidence=based medicine and clinical decision=support tools guide decision making.

(3) Providers in the medical practice accept accountability for continuous quality improvement through

voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient=centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

g. Payment. The payment system appropriately recognizes the added value provided to patients who have a patient=centered medical home. The payment structure framework of the medical home provides all of the following:

(1) Reflects the value of provider and nonprovider staff and patient=centered care management work that is in addition to the face=to=face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of physician work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee=for=service payments for face=to=face visits. Payments for health care management services that are in addition to the face=to=face visit do not result in a reduction in the payments for face=to=face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider=guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

Sec. 15. NEW SECTION. 135.156 MEDICAL HOME COMMISSION.

1. A medical home commission is created consisting of the following members:

a. The director of public health, or the director's designee, who shall act as chairperson of the commission.

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

c. The commissioner of insurance, or the commissioner's designee.

d. A representative of health insurers.

e. A representative of the Iowa dental association.

f. A representative of the Iowa nurses association.

g. A family physician who is a member of the Iowa academy of family physicians.

h. A health care consumer.

i. A representative of the Iowa collaborative safety net provider network established pursuant to section 135.153.

j. A representative of the Iowa pharmacy association.

2. a. Members of the commission from the organizations specified in subsection 1 shall be selected by the respective organization. Terms of public members of the commission shall begin and end as provided by section 69.19. Any vacancy shall be filled in the same manner as regular appointments are made for the unexpired portion of the regular term. Public members shall serve terms of three years. A member is eligible for reappointment for two successive terms.

b. Public members of the commission shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

c. The commission shall meet at least quarterly and in accordance with rules adopted by the commission.

d. A majority of the members of the commission constitutes a quorum. Any action taken by the commission must be adopted

by the affirmative vote of a majority of its voting membership.

e. The commission is located for administrative purposes within the division of health promotion and chronic disease management within the department. The commission shall coordinate efforts with other divisions, bureaus, and offices within the department including but not limited to the office of multicultural health established in section 135.12 and oral health bureau established in section 135.15, in order to avoid duplication of efforts. The department shall provide office space, staff assistance, administrative support, and necessary supplies and equipment to the commission.

3. The commission may adopt rules pursuant to chapter 17A to administer the programs of the commission.

Sec. 16. NEW SECTION. 135.157 MEDICAL HOME SYSTEM == DEVELOPMENT AND IMPLEMENTATION.

1. The commission shall develop a plan for implementation of a statewide medical home system. The initial phase shall focus on providing a medical home for children, beginning with those children who are recipients of medical assistance or the hawk=i program, and expanding to children covered through the exchange created pursuant to section 514M.4. The second phase shall focus on providing a medical home to the expansion population under the IowaCare program and to adult recipients of medical assistance. The third phase shall focus on providing a medical home to adults covered through the exchange created pursuant to section 514M.4. The commission, in collaboration with parents, schools, communities, health plans, and providers, shall endeavor to increase healthy outcomes for children and adults by linking the children and adults with a medical home, identifying health improvement goals for children and adults, and linking reimbursement strategies to increasing healthy outcomes for children and adults. The plan shall provide that the medical home system shall do all of the following:

a. Coordinate and provide access to evidence=based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well=child health services.

b. Provide access to appropriate specialty care and inpatient services.

c. Provide quality=driven and cost=effective health care.

d. Provide access to pharmacist=delivered medication reconciliation and medication therapy management services, where appropriate.

e. Promote strong and effective medical management including but not limited to planning treatment strategies, monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of service.

f. Emphasize patient and provider accountability.

g. Prioritize local access to the continuum of health care services in the most appropriate setting.

h. Establish a baseline for medical home goals and establish performance measures that indicate a child or adult has an established and effective medical home. For children, these goals and performance measures may include but are not limited to childhood immunizations rates, well=child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and preventive oral health service utilization.

i. For children, coordinate with and integrate guidelines, data, and information from existing newborn and child health programs and entities, including but not limited to the healthy opportunities to experience, success=healthy families Iowa program, the community empowerment program, the center for congenital and inherited disorders screening and health care programs, standards of care for pediatric health guidelines, the office of multicultural health established in section 135.12, the oral health bureau established in section 135.15, and other similar programs and services.

2. The commission shall develop an organizational structure for the medical home system in this state. The organizational structure plan shall integrate existing resources, provide a strategy to coordinate health care services, provide for monitoring and data collection on medical homes, provide for training and education to health care professionals and families, and provide for transition of children to the adult medical care system. The organizational structure may be based on collaborative teams of stakeholders throughout the state such as local public health agencies, the

collaborative safety net provider network established in section 135.153, or a combination of statewide organizations. Care coordination may be provided through regional offices or through individual provider practices. The organizational structure may also include the use of telemedicine resources, and may provide for partnering with pediatric and family practice residency programs to improve access to preventive care for children. The organizational structure shall also address the need to organize and provide health care to increase accessibility for patients including using venues more accessible to patients and having hours of operation that are conducive to the population served.

3. The commission shall adopt standards and a process to certify medical homes based on the national committee for quality assurance standards. The certification process and standards shall provide mechanisms to monitor performance and to evaluate, promote, and improve the quality of health of and health care delivered to patients through a medical home. The mechanism shall require participating providers to monitor clinical progress and performance in meeting applicable standards and to provide information in a form and manner specified by the commission. The evaluation mechanism shall be developed with input from consumers, providers, and payers. At a minimum the evaluation shall determine any increased quality in health care provided and any decrease in cost resulting from the medical home system compared with other health care delivery systems. The standards and process shall also include a mechanism for other ancillary service providers to become affiliated with a certified medical home.

4. The commission shall adopt education and training standards for health care professionals participating in the medical home system.

5. The commission shall provide for system simplification through the use of universal referral forms, internet=based tools for providers, and a central medical home internet site for providers.

6. The commission shall determine a rate of reimbursement and recommend incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In adopting the incentives, the commission shall consider, at a minimum, providing incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the reimbursement system and incentives, the commission shall analyze, at a minimum, the feasibility of all of the following:

a. Reimbursement under the medical assistance program to promote wellness and prevention, provide care coordination, and provide chronic care management.

b. Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations.

c. Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and primary care services.

d. Increased funding for efforts to transform medical practices into certified medical homes, including emphasizing the implementation of the use of electronic health records.

e. Targeted reimbursement to providers linked to health care quality improvement measures established by the commission.

f. Reimbursement for specified ancillary support services such as transportation for medical appointments and other such services.

g. Providing reimbursement for medication reconciliation and medication therapy management service, where appropriate.

7. The commission shall coordinate the requirements and activities of the medical home system with the requirements and activities of the dental home for children as described in section 249J.14, subsection 7, and shall recommend financial incentives for dentists and nondental providers to promote oral health care coordination through preventive dental intervention, early identification of oral disease risk, health care coordination and data tracking, treatment, chronic care management, education and training, parental guidance, and oral health promotions for children.

8. The commission shall integrate the recommendations and policies developed by the prevention and chronic care management advisory council into the medical home system.

9. Implementation phases.

a. Initial implementation shall require participation in

the medical home system of children who are recipients of the medical assistance or the hawk=i programs and children who have health insurance coverage through the exchange created in section 514M.4. The commission shall develop an enhanced reimbursement methodology for recipients of medical assistance and hawk=i to compensate providers who participate in the medical home system. The department of human services shall submit any state plan amendments or request any waivers necessary from the centers for Medicare and Medicaid services of the United States department of health and human services for approval of the reimbursement methodology. The commission shall work with the exchange to develop an enhanced reimbursement methodology for children covered through the exchange to compensate providers who participate in the medical home system.

b. The commission shall work with the department of human services and with the exchange to expand the medical home system to adult recipients of medical assistance, the expansion population under the IowaCare program, and adults covered through the exchange. The commission shall work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system.

c. The commission shall work with the department of administrative services to allow state employees to utilize the medical home system.

d. The commission shall work with insurers and self=insured companies, if requested, to make the medical home system available to individuals with private health care coverage.

10. The commission shall provide oversight for all certified medical homes. The commission shall review the progress of the medical home system at each meeting and recommend improvements to the system, as necessary.

11. The commission shall annually evaluate the medical home system and make recommendations to the governor and the general assembly regarding improvements to and continuation of the system.

Sec. 17. Section 249J.14, subsection 7, Code 2007, is amended to read as follows:

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

EXPLANATION

This bill relates to health care reform including health information technology, end=of=life care promotion, preexisting conditions, dependent care coverage, and medical homes.

Division I of the bill provides the intent of the general assembly that all Iowans have health care coverage, as funding becomes available, and that the initial priority is that all children have health care coverage by December 31, 2010. Additionally, the bill provides that it is the intent of the general assembly that if the federal reauthorization of the state children's health insurance program provides sufficient allocations and authorization, the department of human services may expand coverage of children to cover children with family incomes up to 300 percent of the federal poverty level.

Division II of the bill provides definitions, principles, and goals for the Iowa health information technology system. The bill creates an electronic health information commission as a public and private collaborative effort and directs the commission to establish a technical advisory group to assist the commission in its duties; to adopt a statewide health information technology plan by January 1, 2009; to identify existing efforts and integrate these efforts to avoid incompatibility and duplication; to coordinate public and private efforts to provide the network backbone; to promote the use of telemedicine; to address the workforce needs generated by increased use of health information technology; to adopt necessary rules; to coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in the state; to seek and apply for federal or private funding to assist in implementing the system; and to identify state laws and rules that present barriers to the development of the health

information technology system in the state.

Division II requires that by January 1, 2010, all health care professionals utilize the single patient identifier or alternative mechanism and continuity of care record specified by the commission.

Division III directs the department of elder affairs to consult with the Iowa medical society, the Iowa end=of=life coalition, the Iowa hospice organization, the university of Iowa palliative care program, and other health care professionals whose scope of practice includes end=of=life care to develop educational and patient=centered information on end=of=life care for terminally ill patients and health care professionals. The division also defines "end=of=life care".

Division IV of the bill amends Code section 509.3 to require a group policy of accident or health insurance to permit continuation of existing coverage for an unmarried dependent child of an insured or enrollee who so elects, until the dependent is 25 years old or for as long as the dependent is a full=time college student, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Division IV also amends Code section 513B.2(6)(b) to require an insurance carrier that provides small group health care coverage to establish additional groupings of small employers on the basis of underwriting criteria which are expected to produce substantial variation in health care costs, and to offer health insurance coverage to a bona fide association utilizing the rating bands devised pursuant to the additional groupings established. Division IV amends Code section 513C.7(2)(b) by striking the paragraph, whose content is now included in new Code section 514A.3B.

Division IV creates new Code section 514A.3B which requires an insurer which accepts an individual for coverage under an individual policy or contract of accident and health insurance to waive any time period applicable to a preexisting condition exclusion or limitation period of the policy or contract with respect to particular services in an individual health benefit plan for the period of time the individual was previously covered by qualifying previous coverage that was continuous to a date not more than 63 days prior to the effective date of the new policy or contract.

New Code section 514A.3B also requires an individual policy or contract of accident and sickness insurance to permit continuation of existing coverage for an unmarried dependent child of an insured or enrollee who so elects, until the dependent is 25 years old or for as long as the dependent is a full=time college student, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Division IV applies to policies or contracts of accident and health insurance delivered or issued for delivery or continued or renewed in this state on or after July 1, 2008.

Division V of the bill relates to medical homes. The division provides definitions, including the definition of a medical home which is a team approach to providing health care that originates in a primary care setting, and provides for continuity in and coordination of care. The division specifies the characteristics of a medical home, and creates a medical home commission. The commission is directed to develop a plan for implementation of a statewide medical home system. Implementation is to take place in phases, beginning with children who are recipients of medical assistance (Medicaid) or the hawk=i program and expanding to children covered through the exchange created in the division. The second phase would provide a medical home to adults under the IowaCare program and adult recipients of Medicaid. The third phase would provide for a medical home for adults covered through the exchange.

The division specifies the duties of the medical home commission and the organizational structure for the medical home system. The division directs the commission to adopt standards and a process to certify medical homes based on national standards, to adopt education and training standards for health care professionals participating in the medical home system, to provide for system simplification, to determine a rate of reimbursement and recommend incentives for participation in the medical home system, and to coordinate efforts with the dental home for children, and integrate the recommendations of the prevention and chronic care management advisory council into the medical home system.

In addition to the phased=in implementation, the division

also directs the commission to work with the department of administrative services to allow state employees to utilize the medical home system, to work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system and to work with insurers and self=insured companies to allow those with private insurance to access the medical home system. The commission is directed to provide oversight for the medical home system and to evaluate and make recommendations regarding improvements to and continuation of the medical home system.

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