Senate File 2390 - Introduced

SENATE FILE _____
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SSB 3140)

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

A BILL FOR

An Act relating to health care reform in Iowa including the Iowa choice health care coverage program; continuation of dependent health care coverage; the bureau of health insurance oversight; medical homes; prevention and chronic care management; the Iowa health information technology system; long=term living and patient autonomy; health care quality, consumer information, cost=containment, and health care access; the certificate of need program; and health care transparency; and including an applicability provision.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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DIVISION I
IOWA CHOICE HEALTH CARE COVERAGE PROGRAM

Section 1. DECLARATION OF INTENT. It is the intent of the general assembly in enacting this division of this Act, if sufficient funding is available, to progress toward achievement of the goal that all Iowans have health care coverage with the following priorities:

1. The goal that all children in the state have qualified health care coverage which meets certain standards of quality and affordability with the following priorities:

a. Covering all children who are declared eligible for medical assistance, the state children's health insurance program, and hawk=i no later than January 1, 2011.

b. Subsidizing qualified health care coverage which meets certain standards of quality and affordability, for the remaining uninsured children less than nineteen years of age with a family income from two hundred percent to less than three hundred percent of the federal poverty level, under a sliding=scale contribution requirement based on family income no later than January 1, 2011.

c. Moving toward a requirement that all parents of children less than nineteen years of age must provide proof of qualified health care coverage which meets certain standards of quality and affordability no later than January 1, 2011.

2. The goal of providing unsubsidized options for low=income adult Iowans with family income up to four hundred percent of the federal poverty level to purchase qualified health care coverage which meets certain standards of quality and affordability.

3. The goal of decreasing health care costs and health care coverage costs by:

a. Instituting health insurance reforms that assure the availability of private health insurance coverage for all Iowans by addressing issues involving guaranteed availability and issuance of insurance to applicants, preexisting condition exclusions, portability, and allowable or required pooling and rating classifications.

b. Requiring every child who has public health care coverage under a public program administered by the state or is insured by a plan created by the Iowa choice health care coverage program to have a medical home.

c. Establishing a statewide telehealth system.

d. Implementing cost containment strategies such as disease management programs, advance medical directives, initiatives such as end=of=life planning, and transparency in

health care cost and quality information.

Sec. 2. Section 514E.1, Code 2007, is amended by adding the following new subsections:

NEW SUBSECTION. 6A. "Eligible individual" means an individual who satisfies the eligibility requirements for participation in the Iowa choice health care coverage program as provided by the association by rule.

NEW SUBSECTION. 14A. "Iowa choice health care coverage program" means the Iowa choice health care coverage program established in this chapter.

NEW SUBSECTION. 14B. "Iowa choice health care policy" means an individual or group policy issued by the association that provides the coverage set forth in the benefit plans adopted by the association's board of directors and approved by the commissioner for the Iowa choice health care coverage program.

NEW SUBSECTION. 14C. "Iowa choice health insurance" means the health insurance product established by the Iowa choice health care coverage program that is offered by a private health insurance carrier.

NEW SUBSECTION. 14D. "Iowa choice health insurance carrier" means any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the association to provide health insurance coverage to eligible individuals under the Iowa choice health care coverage program.

NEW SUBSECTION. 21. "Qualified health care coverage" means creditable coverage which meets minimum standards of quality and affordability as determined by the association by rule.

Sec. 3. Section 514E.2, subsections 1 and 3, Code 2007, are amended to read as follows:

1. The Iowa comprehensive health insurance association is established as a nonprofit corporation. The association shall assure that benefit plans as authorized in section 514E.1, subsection 2, for an association policy, are made available to each eligible Iowa resident and each federally eligible individual applying to the association for coverage. The association shall also be responsible for administering the Iowa individual health benefit reinsurance association pursuant to all of the terms and conditions contained in chapter 513C. The association shall also assure that benefit plans as authorized in section 514E.1, subsection 14C, for an Iowa choice health care policy are made available to each eligible individual applying to the association for coverage.

a. All carriers and all organized delivery systems licensed by the director of public health providing health insurance or health care services in Iowa, whether on an individual or group basis, and all other insurers designated by the association's board of directors and approved by the commissioner shall be members of the association.

b. The association shall operate under a plan of operation established and approved under subsection 3 and shall exercise its powers through a board of directors established under this section.

3. The association shall submit to the commissioner a plan of operation for the association and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation shall include provisions for the issuance of Iowa choice health care policies and shall include provisions for the implementation of the Iowa choice health care coverage program established in section 514E.5. The plan of operation becomes effective upon approval in writing by the commissioner prior to the date on which the coverage under this chapter must be made available. After notice and hearing, the commissioner shall approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association, and provides for the sharing of association losses, if any, on an equitable and proportionate basis among the member carriers. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or if at any later time the association fails to submit suitable amendments to the plan, the commissioner shall adopt, pursuant to chapter 17A, rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the

commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

a. The handling and accounting of assets and moneys of the association.

b. The amount and method of reimbursing members of the board.

c. Regular times and places for meeting of the board of directors.

d. Records to be kept of all financial transactions, and the annual fiscal reporting to the commissioner.

e. Procedures for selecting the board of directors and submitting the selections to the commissioner for approval.

f. The periodic advertising of the general availability of health insurance coverage from the association.

g. Additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 4. NEW SECTION. 514E.5 IOWA CHOICE HEALTH CARE COVERAGE PROGRAM.

1. The association shall establish the Iowa choice health care coverage program to provide access to qualified health care coverage to all Iowa children less than nineteen years of age with the following priorities:

a. As funding becomes available, all children who are declared eligible for medical assistance, the state children's health insurance program, and hawk=i shall be enrolled in such programs no later than January 1, 2011. Implementation of this requirement may include a coverage reporting requirement on Iowa income tax returns or during school registration.

b. As funding becomes available, all uninsured children less than nineteen years of age with a family income of up to three hundred percent of the federal poverty level, who are not declared eligible for a program under paragraph "a", shall receive a premium subsidy determined using a sliding=scale contribution requirement based on family income as provided in subsection 3, to purchase qualified health care coverage from the Iowa choice health care coverage program no later than January 1, 2011. Implementation of this requirement may include a coverage reporting requirement on Iowa income tax returns or during school registration.

c. All children less than nineteen years of age shall be required to have qualified health care coverage no later than January 1, 2011. All parents or legal guardians of children less than nineteen years of age may be required to provide proof that each child has qualified health care coverage at a time and in a manner as specified by the association by rule. Implementation of this requirement may include a coverage reporting requirement on Iowa income tax returns or during school registration. This paragraph "c" is not applicable to a child whose parent or legal guardian submits a signed affidavit to the association stating that the requirement to have health care coverage conflicts with a genuine and sincere religious belief.

2. The association shall define what constitutes qualified health care coverage for children less than nineteen years of age. An Iowa choice health care policy shall provide qualified health care coverage for such children. For the purposes of this definition and for designing Iowa choice health care policies, requirements for coverage and benefits shall include but are not limited to all of the following:

a. Inpatient hospital services including medical, surgical, intensive care unit, mental health, and substance abuse services.

b. Nursing care services including skilled nursing facility services.

c. Outpatient hospital services including emergency room, surgery, lab, and x=ray services and other services.

d. Physician services, including surgical and medical, office visits, newborn care, well=baby and well=child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits.

e. Ambulance services.

f. Physical therapy.

g. Speech therapy.

h. Durable medical equipment.

i. Home health care.

j. Hospice services.

k. Prescription drugs.

l. Dental services including preventive services.

m. Medically necessary hearing services.

n. Vision services including corrective lenses.

o. No underwriting requirements and no preexisting condition exclusions.

3. The association shall establish a methodology to subsidize qualified health care coverage through the Iowa choice health care coverage program for children less than nineteen years of age with a family income from two hundred percent to less than three hundred percent of the federal poverty level, using a sliding=scale contribution requirement for premiums based on family income. The contribution requirement for premiums shall be an amount that is no more than two percent of family income per each child covered, up to a maximum of six and one=half percent of family income per family. The program shall require a ten dollar copayment for all services received under an Iowa choice health care policy that covers a child who has a family income of more than two hundred percent of the federal poverty level.

4. The association may develop an Iowa choice health care policy that is available for purchase by adults and families who are not eligible for a public program administered by the state or subsidized coverage and have a family income that is less than four hundred percent of the federal poverty level. An Iowa choice health care policy that is offered for purchase to such adults and families shall include, at a minimum, benefits package options with premiums that do not exceed six and one=half percent of family incomes that are less than four hundred percent of the federal poverty level.

5. The Iowa choice health care coverage program shall provide for health benefits coverage through private health insurance carriers that apply to the association and meet the qualifications described in this section and any additional qualifications established by rules of the association. The Iowa choice health care program shall provide for the sale of Iowa choice health care policies by licensed insurance producers that apply to the association and meet the qualifications established by rules of the association. The association shall collaborate with potential Iowa choice health insurance carriers to do the following, including but not limited to:

a. Assure the availability of private qualified health care coverage to all eligible individuals by designing solutions to issues relating to guaranteed issuance of insurance, preexisting condition exclusions, portability, and allowable pooling and rating classifications.

b. Formulate principles that ensure fair and appropriate practices relating to issues involving individual Iowa choice health care policies such as recision and preexisting condition clauses, and that provide for a binding third=party review process to resolve disputes related to such issues.

c. Design affordable, portable Iowa choice health care policies that specifically meet the needs of eligible individuals.

6. The Iowa choice health care coverage program may administer or contract to administer under section 125 of the Internal Revenue Code plans for employers and employees of employers with ten employees or less participating in the program, including medical expense reimbursement accounts and dependent care reimbursement accounts.

7. The association may implement initiatives such as uniform health care insurance applications and other standardized administrative procedures that make the purchase of health insurance coverage easier and lower administrative costs.

8. The association, in administering the Iowa choice health care coverage program, may do any of the following:

a. Seek and receive any grant funding from the federal government, departments, or agencies of this state, and private foundations.

b. Contract with professional service firms as may be necessary, and fix their compensation.

c. Employ persons necessary to carry out the duties of the program.

d. Design a premium schedule to be published by the association by December 1 of each year, which accounting for maximum pricing in all rating factors with an exception for age, includes the lowest premium on the market for which an individual would be eligible for qualified health care coverage. The schedule shall publish premiums allowing variance for age and rate basis type.

9. The association shall submit an annual report to the governor and the general assembly at the end of the Iowa choice health care coverage program's fiscal year of all the

activities of the program including but not limited to membership in the program, the administrative expenses of the program, the extent of coverage, the effect on premiums, the number of covered lives, the number of Iowa choice health care policies issued or renewed, and Iowa choice health care coverage program premiums earned and claims incurred by Iowa choice health insurance carriers offering Iowa choice health care policies. The association shall also report specifically on the impact of the program on the small group and individual health insurance markets and any reduction in the number of uninsured individuals in the state.

10. The association may grant not more than two six=month extensions of the deadlines established in this section as deemed necessary by the association to promote orderly administration of the program and to facilitate public outreach and information concerning the program.

11. This chapter shall not be construed, is not intended as, and shall not imply a grant of entitlement for services to persons who are eligible for participation in the Iowa choice health care coverage program based upon eligibility consistent with the requirements of this section. Any state obligation to provide services pursuant to this section is limited to the extent of the funds appropriated or provided for implementation of this section.

12. Section 514E.7 is not applicable to Iowa choice health care policies issued pursuant to this section.

Sec. 5. NEW SECTION. 514E.6 IOWA CHOICE HEALTH CARE COVERAGE PROGRAM FUND == APPROPRIATION.

The Iowa choice health care coverage program fund is created in the state treasury as a separate fund under the control of the association for deposit of any funds for initial operating expenses of the Iowa choice health care coverage program, payments made by employers and individuals, and any funds received from any public or private source. All moneys credited to the fund are appropriated and available to the association to be used for the purposes of the Iowa choice health care coverage program. Notwithstanding section 8.33, any balance in the fund on June 30 of each fiscal year shall not revert to the general fund of the state, but shall be available for the purposes set forth for the program in this chapter in subsequent years.

Sec. 6. DIRECTIVE TO DEPARTMENT OF HUMAN SERVICES == EXPANSION OF STATE CHILDREN'S HEALTH INSURANCE COVERAGE. 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 shall 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
CONTINUATION OF DEPENDENT 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. NEW SECTION. 514A.3B CONTINUATION OF DEPENDENT COVERAGE REQUIREMENT.

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 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. 9. 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 III

BUREAU OF HEALTH INSURANCE OVERSIGHT

Sec. 10. NEW SECTION. 505.8A BUREAU OF HEALTH INSURANCE OVERSIGHT.

1. The bureau of health insurance oversight is created in the insurance division of the department of commerce to promote uniformity and transparency in the administrative and operational business requirements and practices that are imposed by health insurers upon health care providers for the purpose of maximizing administrative efficiencies and minimizing administrative costs of health care providers that contract with or otherwise have business relationships with health insurers.

2. The bureau of health insurance oversight shall have jurisdiction over administrative and operational policies, processes, and practices of health insurers that are imposed upon or otherwise affect health care providers, including but not limited to eligibility determinations; coordination of benefits; claims administration; noncompliance with contract terms and conditions; preauthorization, notification, or accreditation programming; notice to providers; and sanctions.

3. The commissioner of insurance shall establish a process for the filing, receipt, and investigation of complaints by health care providers regarding administrative and operational requirements and practices of health insurers that impede administrative efficiency, add administrative costs, or otherwise impair the provider's ability to provide affordable, quality health care services. For purposes of this section, complaints may be filed on behalf of such providers by a professional society that advocates on behalf of the interests of their provider members.

4. The commissioner shall require health insurers to file with the bureau of health insurance oversight each contract the insurer offers to health care providers in this state, at least ninety days prior to offering that contract to a health care provider. The filed contracts shall be accessible to the public upon request.

5. The commissioner may, from time to time, convene representatives of health insurers, health care providers, and other interested persons, to discuss administrative or operational policies, processes, or practices of health insurers that affect health care providers and to recommend ways to improve upon such policies, processes, or practices to foster uniformity and transparency and to minimize administrative costs to health care providers.

6. The commissioner shall identify administrative and operational policies, processes, or practices that merit regulatory intervention or direction by the commissioner and shall take action as appropriate within the commissioner's authority to effectuate the purposes of this section.

7. The commissioner may make recommendations to the general assembly and the governor regarding legislation affecting health insurers' administrative and operational business requirements and practices imposed upon health care providers for the purpose of furthering uniformity, advancing health insurer transparency of such requirements and practices, and lessening administrative costs to health care providers.

8. The commissioner shall adopt rules under chapter 17A as necessary to carry out the provisions of this section.

9. As used in this section, unless the context requires otherwise:

a. "Health care provider" means a physician licensed under chapter 148, 150, or 150A.

b. "Health insurer" means any entity which provides a health benefit plan.

DIVISION IV
MEDICAL HOME
DIVISION XXI
MEDICAL HOME

Sec. 11. 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 laws 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 pharmacists, nurse practitioners, physician assistants, 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. "Primary care" is usually provided by general and family practitioners, internists, obstetricians, pediatricians, and certain nonprimary care professionals who are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem origin, organ system, or diagnosis. "Primary care" includes health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses. "Primary care" also provides patient advocacy in the health care system to accomplish cost=effective care through coordination of health care services, promotion of effective communication with patients, and encouragement of the role of the patient as a partner in health care.

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. 12. 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 and team are responsible for ensuring that all of the patient's health care needs are met through direct provision of services or by appropriately arranging for 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. 13. 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.

k. A representative of the Iowa osteopathic association.

l. A representative of the Iowa chiropractic society.

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. 14. 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 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 in=patient 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 immunization rates, well=child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and 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 recommend a reimbursement methodology and incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In developing the recommendations for 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 recommendations for the reimbursement methodology 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 services, 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 program and children who have health insurance coverage through the Iowa choice health care coverage program created in section 514E.5. The commission shall work with the department of human services and shall recommend to the general assembly a reimbursement methodology to compensate providers participating under the medical assistance program for participation in the medical home system. The commission shall work with the Iowa choice health care coverage program to develop an enhanced reimbursement methodology for children covered through the program to compensate providers who participate in the medical home system.

b. The commission shall work with the department of human services and with the Iowa choice health care coverage program to expand the medical home system to adult recipients of medical assistance, the expansion population under the IowaCare program, and adults covered through the Iowa choice health care coverage program. 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. 15. Section 249J.14, subsection 7, Code 2007, is amended to read as follows:

7. DENTAL HOME FOR CHILDREN. By ~~July 1, 2008~~ December 31, 2010, 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, diagnostic services, treatment services, and emergency services as defined under the early and periodic screening, diagnostic, and treatment program.

DIVISION V

PREVENTION AND CHRONIC CARE MANAGEMENT

DIVISION XXII

PREVENTION AND CHRONIC CARE MANAGEMENT

Sec. 16. NEW SECTION. 135.158 DEFINITIONS.

For the purpose of this division, unless the context otherwise requires:

1. "Chronic care" means health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.

2. "Chronic care information system" means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.

3. "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self=care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan

emphasizing prevention of complications utilizing evidence=based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

4. "Chronic care plan" means a plan of care between an individual and the individual's principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient's own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.

5. "Chronic care resources" means health care professionals, advocacy groups, health departments, schools of public health and medicine, health plans, and others with expertise in public health, health care delivery, health care financing, and health care research.

6. "Chronic condition" means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.

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

8. "Director" means the director of public health.

9. "Eligible individual" means a resident of this state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance, is a member of the expansion population pursuant to chapter 249J, is an inmate of a correctional institution in this state, or is an individual who has qualified health care coverage through the Iowa choice health care coverage program created in section 514E.5.

10. "Health care professional" means health care professional as defined in section 135.154.

11. "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

12. "State initiative for prevention and chronic care management" or "state initiative" means the state's plan for developing a chronic care organizational structure for prevention and chronic care management, including coordinating the efforts of health care professionals and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self=care efforts, providing systemic support for the health care professional=patient relationship and options for channeling chronic care resources and support to health care professionals, providing for community development and outreach and education efforts, and coordinating information technology initiatives with the chronic care information system.

Sec. 17. NEW SECTION. 135.159 PREVENTION AND CHRONIC CARE MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management.

2. The director may accept grants and donations and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative or as directed by the source of the grant or donation.

3. The director shall establish and convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence=based prevention and chronic care management strategies into the public and private health care systems, including the medical home system. The advisory council, at a minimum, shall include all of the following members:

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

b. The director of the department of elder affairs, or the director's designee.

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

d. A representative of the Iowa medical society.

e. A representative of the Iowa hospital association.

f. A representative of health insurers.
g. A medical social worker or home care professional.
h. A patient advocate.
i. A primary care physician.
j. A representative of the Iowa pharmacy association.
k. A specialist in public health and epidemiology.
l. An expert in health outcomes research.
m. A representative of an entity that is taking a leading role in health information technology.
n. A representative of the Iowa college of public health at the university of Iowa.
o. A representative of Des Moines university == osteopathic medical center.
p. A representative of the Iowa chiropractic society.
4. a. Members of the advisory council from the organizations specified in subsection 3 shall be selected by the respective organization. Terms of the public members 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 public member is eligible for reappointment for two successive terms.
b. Public members 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 advisory council shall meet at least quarterly and in accordance with the rules adopted by the advisory council.
d. A majority of the voting members of the advisory council constitutes a quorum. Any action taken by the advisory council must be adopted by the affirmative vote of a majority of its membership.
e. The advisory council is located for administrative purposes within the division of health promotion and chronic disease management within the department. The department shall provide administrative support to the advisory council.
5. The advisory council shall elicit input from a variety of health care professionals, health care professional organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.
6. The advisory council shall submit initial recommendations to the director for the state initiative for prevention and chronic care management no later than July 1, 2009. The recommendations shall address all of the following:
a. The recommended organizational structure for integrating prevention and chronic care management into the private and public health care systems. The organizational structure recommended shall align with the organizational structure established for the medical home system developed pursuant to division XXI. The advisory council shall also review existing prevention and chronic care management strategies used in the health insurance market and in private and public programs and recommend ways to expand the use of such strategies throughout the health insurance market and in the private and public health care systems.
b. A process for identifying leading health care professionals and existing prevention and chronic care management programs in the state, and coordinating care among these health care professionals and programs.
c. A prioritization of the chronic conditions for which prevention and chronic care management services should be provided, taking into consideration the prevalence of specific chronic conditions and the factors that may lead to the development of chronic conditions; the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals; the availability of workable, evidence=based approaches to chronic care for the chronic condition; and public input into the selection process. The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and shall also specify a timeline for inclusion of additional specific chronic conditions in the initiative.
d. A method to involve health care professionals in identifying eligible patients for prevention and chronic care management services, which includes but is not limited to the use of a health risk assessment.
e. The methods for increasing communication between health care professionals and patients, including patient education,

patient self=management, and patient follow=up plans.

f. The educational, wellness, and clinical management protocols and tools to be used by health care professionals, including management guideline materials for health care delivery.

g. The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks such as the best in class estimates utilized in the national healthcare quality report of the agency for health care research and quality of the United States department of health and human services, to provide performance feedback for health care professionals and information on the quality of health care, including patient satisfaction and health status outcomes.

h. Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of health care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

i. Methods to involve public and private groups, health care professionals, insurers, third=party administrators, associations, community and consumer groups, and other entities to facilitate and sustain the initiative.

j. Alignment of any chronic care information system or other information technology needs with other health care information technology initiatives.

k. Involvement of appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

l. Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care professionals, health insurers, and the public.

m. A method to periodically determine the percentage of health care professionals who are participating, the success of the empowerment=of=patients approach, and any results of health outcomes of the patients participating.

n. A means of collaborating with the health professional licensing boards under chapter 147 to review prevention and chronic care management education provided to licensees, as appropriate, and recommendations regarding education resources and curricula for integration into existing and new education and training programs.

o. The establishment of a health and wellness strategies consortium to act as a catalyst in advancing voluntarily adopted strategies to improve quality of care, increase access to services, reduce disparities in health care delivery and contain costs while emphasizing population health and wellness. The core membership of the consortium shall include representatives of health care purchasers, payers, and providers. The consortium shall direct strategies for health care payers and providers to adopt which may include but are not limited to strategies to promote wellness which may include:

(1) Providing smoking cessation programs as a standard health care benefit including reimbursement for treatment and support services.

(2) Providing obesity prevention services as a standard health care benefit.

(3) Increasing immunization rates for pneumococcus and influenza which may include approving an administration fee for all qualified providers of influenza and pneumococcal vaccinations.

(4) Providing health care benefit incentives for consumers who participate in wellness programs.

(5) Assuring that health care coverage for children includes primary, preventive, and developmental health services.

7. Following submission of the initial recommendations to the director by July 1, 2009, and initial implementation among the population of eligible individuals, the director shall work with the department of human services, insurers, health care professional organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in this

state. The advisory council shall continue to review and make recommendations to the director regarding improvements in the initiative.

8. The director of human services shall obtain any federal waivers or state plan amendments necessary to implement the prevention and chronic care management initiative within the medical assistance, hawk=i, and IowaCare populations.

Sec. 18. NEW SECTION. 135.160 CLINICIANS ADVISORY PANEL.

1. The director shall convene a clinicians advisory panel to advise and recommend to the department clinically appropriate, evidence=based best practices regarding the implementation of the medical home as defined in section 135.154 and the prevention and chronic care management initiative pursuant to section 135.159. The director shall act as chairperson of the advisory panel.

2. The clinicians advisory panel shall consist of nine members representing licensed medical health care providers selected by their respective professional organizations. Terms of members shall begin and end as provided in 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. Members shall serve terms of three years. A member is eligible for reappointment for three successive terms.

3. The clinicians advisory panel shall meet on a quarterly basis to receive updates from the director regarding strategic planning and implementation progress on the medical home and the prevention and chronic care management initiative and shall provide clinical consultation to the department regarding the medical home and the initiative.

Sec. 19. NEW SECTION. 8A.440 PREVENTION AND CHRONIC CARE MANAGEMENT == HEALTH BENEFIT PLAN.

The department shall include in any request for proposals for the administration of the health benefit plans for state employees a request for a description of any prevention and chronic care management program provided by the entity offering the health benefit plan. The department shall also work with the department of public health regarding how and when to align the state employees' health benefit plan with the provisions developed for the prevention and chronic care management initiative created in chapter 135, division XXII.

DIVISION VI

IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

Sec. 20. NEW SECTION. 8.70 DEFINITIONS.

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

1. "Health care professional" means health care professional as defined in section 135.154.

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. 21. NEW SECTION. 8.71 IOWA ELECTRONIC HEALTH == PRINCIPLES == GOALS.

1. Health information technology is rapidly evolving so that it can contribute to the goal 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. 22. 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.

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 the following voting members:

a. Individuals with broad experience and vision in health care and health technology and one member representing the health care consumer. The voting members shall be appointed

by the governor, subject to confirmation by the senate. The voting members shall include all of the following:

(1) The director of the Iowa communications network.

(2) Two members who are the chief information officers of the two largest private health care systems.

(3) One member who is the chief information officer of a public health care system.

(4) A representative of the private telecommunications industry.

(5) A representative of a rural hospital that is a member of the Iowa hospital association.

(6) A consumer advocate.

(7) A representative of the Iowa safety net provider network created in section 135.153.

3. a. The members shall select a chairperson, annually, from among the membership, and 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. Vacancies shall be filled by the original appointing authority and in the manner of the original appointments. 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. A person appointed to fill a vacancy for a member shall serve only for the unexpired portion of the term. A member is eligible for reappointment for two successive terms.

b. 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 an advisory council 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 including but not limited to consumers and consumer advocacy organizations; physicians and health care professionals; pharmacists; leadership of community hospitals and major integrated health care delivery networks; state agencies including the department of public health, the department of human services, the department of elder affairs, the division of insurance of the department of commerce, and the office of the attorney general; health plans and health insurers; legal experts; academics and ethicists; business leaders; and professional associations.

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.

(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) Complete a memorandum of understanding with the Iowa communications network for governmental access usage, with private fiber optic networks for core backbone usage of private fiber optic networks, and with any other communications entity for state=subsidized usage of the communications entity's products to access any 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. 23. Section 8D.13, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 20. Access shall be offered to the Iowa hospital association for the collection, maintenance, and dissemination of health and financial data for hospitals and for hospital educational services. The Iowa hospital association shall be responsible for all costs associated with becoming part of the network, as determined by the commission.

Sec. 24. Section 217.41A, Code 2007, is repealed.

DIVISION VII

LONG=TERM CARE PLANNING AND PATIENT AUTONOMY IN HEALTH CARE

Sec. 25. NEW SECTION. 231.62 END=OF=LIFE DECISION MAKING.

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 address the physical, psychological, social, spiritual, and practical needs of terminally ill

patients and their caregivers.

Sec. 26. LONG=TERM LIVING PLANNING TOOLS == PUBLIC EDUCATION CAMPAIGN. The legal services development and substitute decision maker programs of the department of elder affairs, in collaboration with other appropriate agencies and interested parties, shall research existing long=term living planning tools that are designed to increase quality of life and contain health care costs and recommend a public education campaign strategy on long=term living to the general assembly by January 1, 2009.

Sec. 27. LONG=TERM CARE OPTIONS PUBLIC EDUCATION CAMPAIGN. The department of elder affairs, in collaboration with the insurance division of the department of commerce, shall implement a long=term care options public education campaign. The campaign may utilize such tools as the "Own Your Future Planning Kit" administered by the centers for Medicare and Medicaid services, the administration on aging, and the office of the assistant secretary for planning and evaluation of the United States department of health and human services, and other tools developed through the aging and disability resource center program of the administration on aging and the centers for Medicare and Medicaid services designed to promote health and independence as Iowans age, assist older Iowans in making informed choices about the availability of long=term care options, including alternatives to facility=based care, and to streamline access to long=term care.

Sec. 28. HOME AND COMMUNITY=BASED SERVICES PUBLIC EDUCATION CAMPAIGN. The department of elder affairs shall work with other public and private agencies to identify resources that may be used to continue the work of the aging and disability resource center established by the department through the aging and disability resource center grant program efforts of the administration on aging and the centers for Medicare and Medicaid services of the United States department of health and human services, beyond the federal grant period ending September 30, 2008.

Sec. 29. PATIENT AUTONOMY IN HEALTH CARE DECISIONS PILOT PROJECT.

1. The department of public health shall establish a two=year community coalition for patient treatment wishes across the health care continuum pilot project, beginning July 1, 2008, and ending June 30, 2010, in a county with a population of between fifty thousand and one hundred thousand. The pilot project shall utilize the process based upon the national physicians orders for life sustaining treatment program initiative, including use of a standardized physician order for scope of treatment form. The pilot project may include applicability to chronically ill, frail, and elderly or terminally ill individuals in hospitals licensed pursuant to chapter 135B, nursing facilities or residential care facilities licensed pursuant to chapter 135C, or hospice programs licensed pursuant to chapter 135J.

2. The department of public health shall convene an advisory council, consisting of representatives of entities with interest in the pilot project, including but not limited to the Iowa hospital association, the Iowa medical society, organizations representing health care facilities, representatives of health care providers, and the Iowa trial lawyers association, to develop recommendations for expanding the pilot project statewide. The advisory council shall hold meetings throughout the state to obtain input regarding the pilot project and its statewide application. Based on information collected regarding the pilot project and information obtained through its meetings, the advisory council shall report its findings and recommendations, including recommendations for legislation, to the governor and the general assembly by January 1, 2010.

3. The pilot project shall not alter the rights of individuals who do not execute a physician order for scope of treatment.

a. If an individual is a qualified patient as defined in section 144A.2, the individual's declaration executed under chapter 144A shall control health care decision making for the individual in accordance with chapter 144A. A physician order for scope of treatment shall not supersede a declaration executed pursuant to chapter 144A. If an individual has not executed a declaration pursuant to chapter 144A, health care decision making relating to life=sustaining procedures for the individual shall be governed by section 144A.7.

b. If an individual has executed a durable power of attorney for health care pursuant to chapter 144B, the

individual's durable power of attorney for health care shall control health care decision making for the individual in accordance with chapter 144B. A physician order for scope of treatment shall not supersede a durable power of attorney for health care executed pursuant to chapter 144B.

c. In the absence of actual notice of the revocation of a physician order for scope of treatment, a physician, health care provider, or any other person who complies with a physician order for scope of treatment shall not be subject to liability, civil or criminal, for actions taken under this section which are in accordance with reasonable medical standards. Any physician, health care provider, or other person against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose the restriction on liability in this paragraph as an absolute defense.

DIVISION VIII

OFFICE OF HEALTH CARE QUALITY, COST CONTAINMENT, AND CONSUMER INFORMATION

Sec. 30. NEW SECTION. 135.29A OFFICE OF HEALTH CARE QUALITY, COST CONTAINMENT, AND CONSUMER INFORMATION.

1. An office of health care quality, cost containment, and consumer information is created in the department.

2. The office shall, at a minimum, do all of the following:

a. Develop and implement cost=containment measures that help to contain costs while improving quality in the health care system.

b. Provide for coordination of public and private cost=containment, quality, and safety efforts in this state, including but not limited to efforts of the Iowa healthcare collaborative and the Iowa health buyers' alliance.

c. Carry out other health care price, quality, and safety=related research as directed by the governor and the general assembly.

d. Develop strategies to contain health care costs which may include:

(1) Promoting adoption of health information technology through provider incentives.

(2) Considering a four=tier prescription drug copayment system within a prescription drug benefit that includes a zero copayment tier for select medications to improve patient compliance.

(3) Providing a standard medication therapy management program as a prescription drug benefit to optimize high=risk patients' medication outcomes.

(4) Investigating whether pooled purchasing for prescription drug benefits, such as a common statewide preferred drug list, would decrease costs.

e. Develop strategies to increase the public's role and responsibility in personal health care choices and decisions which may include:

(1) Creating a public awareness campaign to educate consumers on smart health care choices.

(2) Promoting public reporting of quality performance measures.

f. Develop implementation strategies which may include piloting the various quality, cost=containment, and public involvement strategies utilizing publicly funded health care coverage groups such as the medical assistance program, state of Iowa employee group health plans, and regents institutions health care plans, consistent with collective bargaining agreements in effect.

g. Develop a method for health care providers to provide a patient, upon request, with a reasonable estimate of charges for the services.

h. Identify the process and time frames for implementation of any initiatives, identify any barriers to implementation of initiatives, and recommend any changes in law or rules necessary to eliminate the barriers and to implement the initiatives.

DIVISION V

BUREAU OF HEALTH CARE ACCESS

Sec. 31. NEW SECTION. 135.45 BUREAU OF HEALTH CARE ACCESS.

A bureau of health care access is created to coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well=qualified, diverse, and sustainable health care workforce in this state. The bureau shall, at a minimum, do all of the following:

1. Develop a strategic plan for health care delivery infrastructure and health care workforce resources in this state.

2. Provide for the continuous collection of data to provide a basis for health care strategic planning and health care policymaking.

3. Make recommendations regarding the health care delivery infrastructure and the workforce that assist in monitoring current needs, predicting future trends, and informing policymaking.

4. Administer the certificate of need program and provide support to the health facilities council established in section 135.62.

Sec. 32. NEW SECTION. 135.46 STRATEGIC PLAN.

1. The strategic plan for health care delivery infrastructure and health care workforce resources shall describe the existing health care system, describe and provide a rationale for the desired health care system, provide an action plan for implementation, and provide methods to evaluate the system. The plan shall incorporate expenditure control methods and integrate criteria for evidence=based health care. The bureau of health care access shall do all of the following in developing the strategic plan for health care delivery infrastructure and health care workforce resources:

a. Conduct strategic health planning activities related to preparation of the strategic plan.

b. Develop a computerized system for accessing, analyzing, and disseminating data relevant to strategic health planning. The bureau may enter into data sharing agreements and contractual arrangements necessary to obtain or disseminate relevant data.

c. Conduct research and analysis or arrange for research and analysis projects to be conducted by public or private organizations to further the development of the strategic plan.

d. Establish a technical advisory committee to assist in the development of the strategic plan. The members of the committee may include but are not limited to health economists, health planners, representatives of health care purchasers, representatives of state and local agencies that regulate entities involved in health care, representatives of health care providers and health care facilities, and consumers.

2. The strategic plan shall include statewide health planning policies and goals related to the availability of health care facilities and services, the quality of care, and the cost of care. The policies and goals shall be based on the following principles:

a. That a strategic health planning process, responsive to changing health and social needs and conditions, is essential to the health, safety, and welfare of Iowans. The process shall be reviewed and updated as necessary to ensure that the strategic plan addresses all of the following:

(1) Promoting and maintaining the health of all Iowans.

(2) Providing accessible health care services through the maintenance of an adequate supply of health facilities and an adequate workforce.

(3) Controlling excessive increases in costs.

(4) Applying specific quality criteria and population health indicators.

(5) Recognizing prevention and wellness as priorities in health care programs to improve quality and reduce costs.

(6) Addressing periodic priority issues including disaster planning, public health threats, and public safety dilemmas.

(7) Coordinating health care delivery and resource development efforts among state agencies including those tasked with facility, services, and professional provider licensure; state and federal reimbursement; health service utilization data systems; and others.

b. That both consumers and providers throughout the state must be involved in the health planning process, outcomes of which shall be clearly articulated and available for public review and use.

c. That the supply of a health care service has a substantial impact on utilization of the service, independent of the effectiveness, medical necessity, or appropriateness of the particular health care service for a particular individual.

d. That given that health care resources are not unlimited, the impact of any new health care service or facility on overall health expenditures in this state must be

considered.

e. That excess capacity of health care services and facilities places an increased economic burden on the public.

f. That the likelihood that a requested new health care facility, service, or equipment will improve health care quality and outcomes must be considered.

g. That development and ongoing maintenance of current and accurate health care information and statistics related to cost and quality of health care and projections of the need for health care facilities and services are necessary to developing an effective health care planning strategy.

h. That the certificate of need program as a component of the health care planning regulatory process must balance considerations of access to quality care at a reasonable cost for all Iowans, optimal use of existing health care resources, fostering of expenditure control, and elimination of unnecessary duplication of health care facilities and services, while supporting improved health care outcomes.

i. That strategic health care planning must be concerned with the stability of the health care system, encompassing health care financing, quality, and the availability of information and services for all residents.

3. The health care delivery infrastructure and resources strategic plan developed by the bureau shall include all of the following:

a. A health care system assessment and objectives component that does all of the following:

(1) Describes state and regional population demographics, health status indicators, and trends in health status and health care needs.

(2) Identifies key policy objectives for the state health care system related to access to care, health care outcomes, quality, and cost=effectiveness.

b. A health care facilities and services plan that assesses the demand for health care facilities and services to inform state health care planning efforts and direct certificate of need determinations, for those facilities and services subject to certificate of need. The plan shall include all of the following:

(1) An inventory of each geographic region's existing health care facilities and services.

(2) Projections of the need for each category of health care facility and service, including those subject to certificate of need.

(3) Policies to guide the addition of new or expanded health care facilities and services to promote the use of quality, evidence=based, cost=effective health care delivery options, including any recommendations for criteria, standards, and methods relevant to the certificate of need review process.

(4) An assessment of the availability of health care providers, public health resources, transportation infrastructure, and other considerations necessary to support the needed health care facilities and services in each region.

c. (1) A health care data resources plan that identifies data elements necessary to properly conduct planning activities and to review certificate of need applications, including data related to inpatient and outpatient utilization and outcomes information, and financial and utilization information related to charity care, quality, and cost.

(2) The plan shall inventory existing data resources, both public and private, that store and disclose information relevant to the health care planning process, including information necessary to conduct certificate of need activities. The plan shall identify any deficiencies in the inventory of existing data resources and the data necessary to conduct comprehensive health care planning activities. The plan may recommend that the bureau be authorized to access existing data sources and conduct appropriate analyses of such data or that other agencies expand their data collection activities as statutory authority permits. The plan may identify any computing infrastructure deficiencies that impede the proper storage, transmission, and analysis of health care planning data.

(3) The plan shall provide recommendations for increasing the availability of data related to health care planning to provide greater community involvement in the health care planning process and consistency in data used for certificate of need applications and determinations. The plan shall also integrate the requirements for annual reports by hospitals and health care facilities pursuant to section 135.75, the

provisions relating to analyses and studies by the department pursuant to section 135.76, the data compilation provisions of section 135.78, and the provisions for contracts for assistance with analyses, studies, and data pursuant to section 135.83.

d. An assessment of emerging trends in health care delivery and technology as they relate to access to health care facilities and services, quality of care, and costs of care. The assessment shall recommend any changes to the scope of health care facilities and services covered by the certificate of need program that may be warranted by these emerging trends. In addition, the assessment may recommend any changes to criteria used by the department to review certificate of need applications, as necessary.

e. A rural health resources plan to assess the availability of health resources in rural areas of the state, assess the unmet needs of these communities, and evaluate how federal and state reimbursement policies can be modified, if necessary, to more efficiently and effectively meet the health care needs of rural communities. The plan shall consider the unique health care needs of rural communities, the adequacy of the rural health workforce, and transportation needs for accessing appropriate care.

f. A health care workforce resources plan to assure a competent, diverse, and sustainable health care workforce in Iowa and to improve access to health care in underserved areas and among underserved populations. The plan shall include the establishment of an advisory council to inform and advise the bureau, the department, and policymakers regarding issues relevant to the health care workforce in Iowa.

4. The bureau shall submit the initial statewide health care delivery infrastructure and resources strategic plan to the governor and the general assembly by January 1, 2010, and shall submit an updated strategic plan to the governor and the general assembly every two years thereafter.

DIVISION IX

CERTIFICATE OF NEED PROGRAM

Sec. 33. Section 135.62, subsection 2, unnumbered paragraph 1, Code 2007, is amended to read as follows:

There is established a state health facilities council consisting of ~~five~~ seven persons appointed by the governor, one of whom shall be a health economist, one of whom shall be an actuary, and at least one of whom shall be a health care consumer. The council shall be within the department for administrative and budgetary purposes.

DIVISION X

HEALTH CARE TRANSPARENCY

DIVISION XXIII

HEALTH CARE TRANSPARENCY

Sec. 34. NEW SECTION. 135.161 HEALTH CARE TRANSPARENCY == REPORTING REQUIREMENTS.

1. A hospital licensed pursuant to chapter 135B and a physician licensed pursuant to chapter 148, 150, or 150A shall report quality indicators, annually, to the Iowa healthcare collaborative as defined in section 135.40. The indicators shall be developed by the Iowa healthcare collaborative in accordance with evidence=based practice parameters and appropriate sample size for statistical validation.

2. A manufacturer or supplier of durable medical equipment or medical supplies doing business in the state shall submit a price list to the department of human services, annually, for use in comparing prices for such equipment and supplies with rates paid under the medical assistance program. The price lists submitted shall be made available to the public.

EXPLANATION

DIVISION I == IOWA CHOICE HEALTH CARE COVERAGE PROGRAM. Division I of this bill relates to the establishment of the Iowa choice health care coverage program with the intent to progress toward achievement of the goal that all Iowans have health care coverage with the following specified priorities:

1. The goal that all children in the state have qualified health care coverage which meets certain standards of quality and affordability by covering all children who are declared eligible for medical assistance, the state children's health insurance program, and hawk=i no later than January 1, 2011;

2. subsidizing qualified health care coverage for the remaining uninsured children less than 19 years of age with a family income from 200 percent to less than 300 percent of the federal poverty level, under a sliding=scale contribution requirement based on family income no later than January 1, 2011; and requiring all parents of children less than 19 years

of age to provide proof of qualified health care coverage for their children no later than January 1, 2011.

2. The goal of providing unsubsidized options for low=income adult Iowans with family income up to 400 percent of the federal poverty level to purchase qualified health care coverage.

3. The goal of decreasing health care costs and health care coverage costs by instituting health insurance reforms that assure the availability of private health insurance coverage for all Iowans by addressing issues involving guaranteed availability and issuance of insurance to applicants, preexisting condition exclusions, portability, and allowable or required pooling and rating classifications; requiring every child who has public health care coverage under a public program administered by the state or is insured by the Iowa choice health care coverage program to have a medical home; establishing a statewide telehealth system; and implementing cost containment strategies such as disease management programs, advance medical directives, initiatives such as end=of=life planning, and transparency in health care cost and quality information.

The Iowa choice health care coverage program (Iowa choice program) is established in Code chapter 514E under the authority of the Iowa comprehensive health insurance association (HIPIowa). The association is charged with the responsibility to assure that health benefit plans are made available to eligible individuals under the program and to prepare and submit a plan of operation for the Iowa choice program to the commissioner of insurance.

The Iowa choice program is established to provide access to qualified health care coverage to all Iowa children less than 19 years of age, as funding becomes available, by enrolling all eligible children in medical assistance, the state children's health insurance program, and hawk=i no later than January 1, 2011; and by providing a premium subsidy using a sliding=scale contribution requirement to uninsured children with a family income up to 300 percent of the federal poverty level who are not eligible for enrollment in public programs, to purchase qualified health care coverage from the Iowa choice program, no later than January 1, 2011.

The bill also requires all parents of children less than 19 years of age to provide proof of qualified health care coverage for their children no later than January 1, 2011. Implementation of this requirement may include a coverage reporting requirement on Iowa income tax returns or during school registration.

The association defines what constitutes qualified health care coverage for children. Policies issued through the Iowa choice program must include coverage and benefits specified in the bill. The association must establish a methodology to subsidize coverage for eligible children.

The association is authorized to develop an unsubsidized Iowa choice health care policy that is available for purchase by adults and families who are not eligible for a public program or subsidized coverage and have a family income that is less than 400 percent of the federal poverty level. This policy must include minimum benefits package options with premiums that do not exceed 6.5 percent of family incomes that are less than 400 percent of the federal poverty level.

Iowa choice health care policies shall be provided by private health insurance carriers and sold by licensed insurance producers that apply to the association and meet qualifications established by rules adopted by the association. The association shall collaborate with the carriers to design affordable, portable policies that meet the needs of eligible individuals.

The Iowa choice program may administer or contract to administer plans under section 125 of the Internal Revenue Code for employers and employees of employers with less than 10 employees, including medical expense reimbursement accounts and dependent care reimbursement accounts.

The association may implement initiatives that make the purchase of health insurance coverage easier and decrease administrative costs and may perform various duties in administering the Iowa choice program, including designing and publishing an annual premium schedule.

The Iowa comprehensive health insurance association is required to submit an annual report to the governor and the general assembly regarding the Iowa choice program. The association may grant not more than two six=month extensions of the deadlines established for implementation of the program

as deemed necessary to promote orderly administration of the program and to facilitate public outreach and information concerning the program.

An Iowa choice health care coverage program fund is established in the state treasury under the control of the Iowa comprehensive health insurance association for the deposit of any funds for initial operating expenses of the Iowa choice program and any other funds that are received or appropriated to the program.

The department of human services is directed to expand coverage under the state children's health insurance program to cover children with family incomes up to 300 percent of the federal poverty level 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.

DIVISION II == CONTINUATION OF DEPENDENT HEALTH CARE COVERAGE. Division II of the bill amends Code section 509.3 to require a group policy of accident and 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 student, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Division II also creates new Code section 514A.3B which 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, under the same conditions as for group policies.

Division II 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 III == BUREAU OF HEALTH INSURANCE OVERSIGHT. Division III of the bill creates new Code section 505.8A establishing the bureau of health insurance oversight in the insurance division of the department of commerce. The bureau is created to promote uniformity and transparency in the administrative and operational business requirements and practices that are imposed by health insurers upon health care providers for the purpose of maximizing administrative efficiencies and minimizing administrative costs of health care providers that contract with or have other business relationships with health insurers.

The commissioner of insurance is required to establish a process for the filing, receipt, and investigation of complaints by health care providers regarding such administrative and operational requirements and practices of health insurers. Health insurers are required to file each contract offered to health care providers in this state with the commissioner at least 90 days prior to offering the contract.

The commissioner may convene representatives of health insurers, health care providers, and other interested persons to discuss ways to improve administrative or operational policies, processes, or practices of health insurers that affect health care providers. The commissioner shall identify such policies, processes, or practices that merit regulatory intervention or direction and take appropriate action. The commissioner may recommend legislation affecting such requirements and practices imposed upon health care providers to encourage uniformity, advance health insurer transparency of such requirements and practices, and lessen administrative costs. For the purposes of the new Code section, a health care provider is a physician licensed under Code chapter 148, 150, or 150A.

DIVISION IV == MEDICAL HOME. Division IV of the bill relates to medical homes. The bill 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 bill 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, 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 recommend a reimbursement methodology and incentives for participation in the medical home system, and to coordinate efforts with the

dental home for children, and to integrate the recommendations of the prevention and chronic care management advisory council into the medical home system.

Implementation is to take place in phases, beginning with children who are recipients of medical assistance (Medicaid) and children who have health insurance coverage through the Iowa choice health care coverage program. The second phase would provide a medical home to adults under the IowaCare program, adult recipients of Medicaid, and adults covered through the Iowa choice health care coverage program. In addition to the phased=in implementation, the bill 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.

Division IV also amends provisions relating to the dental home for children under the Medicaid program to extend the date by which having a medical home for children is required from July 1, 2008, to December 31, 2010, and provides that the dental home is to provide the screenings and services required under the early and periodic screening, diagnostic and treatment program.

DIVISION V == PREVENTION AND CHRONIC CARE MANAGEMENT. Division V relates to prevention and chronic care management. The bill provides definitions relating to chronic conditions and chronic care and for the state initiative for prevention and chronic care management.

The division creates an advisory council to assist the director of public health in developing the state initiative. The advisory council is directed to elicit input from a variety of health care professionals, organizations, insurers, businesses, and consumers and is to submit initial recommendations to the director by July 1, 2009. The recommendations are to address the organizational structure for integrating chronic care management into the public and private health care systems, a process for identifying leading health care professionals and existing programs to coordinate efforts, prioritization of services directed to chronic conditions, a method to involve health care professionals in identifying individuals with chronic conditions, methods to increase communication between health care professionals and patients with chronic conditions, protocols and tools for health care providers to utilize, outcomes measures and benchmarks, payment methodologies and incentives, ways to involve public and private entities in facilitating and sustaining the initiative, alignment of information technology, involvement of health resources and researchers to collect data and evaluate the initiative, a marketing campaign, a means of determining participation in the initiative, a means to integrate chronic care management into education resources and curricula for existing and new education and training programs, and the establishment of a health and wellness strategies consortium.

The division provides that following initial recommendations and implementation among the eligible population of individuals (residents of the state who have been diagnosed with a chronic condition or who are at elevated risk for a chronic condition and who are recipients of medical assistance or IowaCare; an inmate of a correctional institution; or an individual who has qualified health care coverage through the Iowa choice health care coverage program), the director is required to work with various entities to implement the initiative as an integral part of the health care delivery system in the state.

The division also requires the director of public health to convene a clinicians advisory panel to advise and recommend to the department of public health clinically appropriate, evidence=based best practices regarding the implementation of the medical home and the prevention and chronic care management initiatives.

The division directs the department of administrative services to include in any request for proposals for the administration of health benefit plans for state employees a request for a description of any prevention and chronic care

management program provided by the entity offering the health benefit plan.

DIVISION VI == IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM. Division VI relates to the Iowa health information technology system. The division provides definitions, principles, and goals for the system. The division creates an electronic health information commission as a public and private collaborative effort and directs the commission to establish an advisory council 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.

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

The division also provides that the Iowa hospital association is to be offered access to the Iowa communications network for the collection, maintenance, and dissemination of health and financial data for hospitals and for hospital educational services, subject to responsibility for all costs associated with becoming part of the network.

DIVISION VII == LONG=TERM CARE PLANNING AND PATIENT AUTONOMY IN HEALTH CARE. Division VII relates to long=term care planning and patient autonomy in health care. The division directs the department of elder affairs to consult with specified organizations to develop educational and patient=centered information on end=of=life care for terminally ill patients and health care professionals. The division also directs programs within the department of elder affairs and other appropriate agencies and interested parties to collaborate in recommending a public education strategy on long=term living. The division also directs the department of elder affairs in collaboration with the insurance division to implement a long=term care options public education campaign. The bill directs the department of elder affairs to work with other public and private agencies to identify resources to use to continue the work of the aging and disability resource center. The bill requires the department of public health to establish a two=year community coalition for patient treatment wishes across the health care continuum pilot project, utilizing the process based upon the national physicians orders for life sustaining treatment program initiative. The pilot may apply to the chronically ill, frail, and elderly or terminally ill individuals in hospitals, nursing facilities and residential care facilities, and hospices. The department is also to convene an advisory council to develop recommendations for expanding the pilot project statewide. The advisory council is required to hold meetings throughout the state to obtain input regarding the pilot project and its statewide application. Based on information collected, the advisory council is to report its findings and recommendations to the governor and the general assembly by January 1, 2010. The division provides for prioritization of documents relating to health care decision making and provides that in the absence of actual notice of the revocation of the document utilized under the pilot program, if actions are taken which are in accordance with reasonable medical standards, a physician, health care provider or other person may assert the provisions of the pilot program as an absolute defense against any assertion of criminal or civil liability.

DIVISION VIII == OFFICE OF HEALTH CARE QUALITY, COST CONTAINMENT, AND CONSUMER INFORMATION == BUREAU OF HEALTH CARE ACCESS. Division VIII creates the office of health care quality, cost containment, and consumer information and a bureau of health care access within the department of public health.

The bill requires the office of health care quality, cost containment, and consumer information to develop and implement cost=containment measures, provide for coordination of public

and private cost=containment, quality, and safety efforts, carry out other health care price, quality, safety=related research as directed by the governor and the general assembly, develop strategies to contain health care costs, develop strategies to increase the public's role and responsibility in personal health care choices and decisions, develop implementation strategies, develop a method for health care providers to provide a patient with a reasonable estimate of the charges for services, and identify the process and time frames for implementation of any initiatives.

The division directs the bureau of health care access to coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well=qualified, diverse, and sustainable health care workforce in the state. One duty of the bureau is to develop a strategic plan for health care delivery infrastructure and health care workforce resources. The bureau is directed to establish a technical advisory committee to assist in the development of the strategic plan. The strategic plan is to include policies and goals based on specified principles, a health care system assessment and objectives component, a health care facilities and services plan to assess the demand for health care facilities and services, a health care data resources plan, an assessment of emerging trends in health care delivery and technology, a rural health resources plan, and a health care workforce resources plan. The initial plan is to be submitted to the governor and the general assembly by January 1, 2010, with an updated plan to be submitted biennially, thereafter.

DIVISION IX == CERTIFICATE OF NEED PROGRAM. Division IX of the bill relates to the certificate of need program by increasing the number of members of the state health facilities council to seven from five and by requiring that at least one member be a health economist, one an actuary, and one a health care consumer.

DIVISION X == HEALTH CARE TRANSPARENCY. Division X of the bill relates to health care transparency by requiring that hospitals and physicians report quality indicators, annually, to the Iowa health care collaborative. The indicators are to be developed by the collaborative. Additionally, the division directs manufacturers and suppliers of durable medical equipment or medical supplies doing business in the state to submit a price list to the department of human services, annually, for use in comparing prices for such equipment and supplies with rates paid under the medical assistance program.