

House File 2199 - Introduced

HOUSE FILE 2199

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A BILL FOR

1 An Act relating to Medicaid program improvement, and including
2 effective date and retroactive applicability provisions.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. LEGISLATIVE FINDINGS — GOALS AND INTENT.

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

3 a. In the majority of states, Medicaid managed care has
4 been introduced on an incremental basis, beginning with the
5 enrollment of low-income children and parents and proceeding
6 in stages to include nonelderly persons with disabilities and
7 older individuals. Iowa, unlike the majority of states, is
8 implementing Medicaid managed care hastily and simultaneously
9 across a broad and diverse population that includes individuals
10 with complex health care and long-term services and supports
11 needs, making these individuals especially vulnerable to
12 receiving inappropriate, inadequate, or substandard services
13 and supports.

14 b. The success or failure of Medicaid managed care in Iowa
15 depends on proper strategic planning and strong oversight, and
16 the incorporation of the core values, principles, and goals
17 of the strategic plan into Medicaid managed care contractual
18 obligations. While Medicaid managed care techniques may create
19 pathways and offer opportunities toward quality improvement and
20 predictability in costs, if cost savings and administrative
21 efficiencies are the primary goals, Medicaid managed care may
22 instead erect new barriers and limit the care and support
23 options available, especially to high-need, vulnerable Medicaid
24 recipients. A well-designed strategic plan and effective
25 oversight ensure that cost savings, improved health outcomes,
26 and efficiencies are not achieved at the expense of diminished
27 program integrity, a reduction in the quality or availability
28 of services, or adverse consequences to the health and
29 well-being of Medicaid recipients.

30 c. Strategic planning should include all of the following:

31 (1) Guidance in establishing and maintaining a robust
32 and appropriate workforce and a provider network capable of
33 addressing all of the diverse, distinct, and wide-ranging
34 treatment and support needs of Medicaid recipients.

35 (2) Developing a sound methodology for establishing and

1 adjusting capitation rates to account for all essential costs
2 involved in treating and supporting the entire spectrum of
3 needs across recipient populations.

4 (3) Addressing the sufficiency of information and data
5 resources to enable review of factors such as utilization,
6 service trends, system performance, and outcomes.

7 (4) Building effective working relationships and developing
8 strategies to support community-level integration that provides
9 cross-system coordination and synchronization among the various
10 service sectors, providers, agencies, and organizations to
11 further holistic well-being and population health goals.

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

26 e. Overseeing the performance of Medicaid managed care
27 contractors requires a different set of skills than those
28 required for administering a fee-for-service program. In the
29 absence of the in-house capacity of the department of human
30 services to perform tasks specific to Medicaid managed care
31 oversight, the state essentially cedes its responsibilities
32 to private contractors and relinquishes its accountability
33 to the public. In order to meet these responsibilities,
34 state policymakers must ensure that the state, including the
35 department of human services as the state Medicaid agency, has

1 the authority and resources, including the adequate number of
2 qualified personnel and the necessary tools, to carry out these
3 responsibilities, provide effective administration, and ensure
4 accountability and compliance.

5 f. State policymakers must also ensure that Medicaid
6 managed care contracts contain, at a minimum, clear,
7 unambiguous performance standards, operating guidelines,
8 data collection, maintenance, retention, and reporting
9 requirements, and outcomes expectations so that contractors
10 and subcontractors are held accountable to clear contract
11 specifications.

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

31 2. It is the intent of the general assembly that the
32 Medicaid program be implemented and administered, including
33 through Medicaid managed care policies and contract provisions,
34 in a manner that safeguards the interests of Medicaid
35 recipients, encourages the participation of Medicaid providers,

1 and protects the interests of all taxpayers, while attaining
2 the goals of Medicaid modernization to improve quality and
3 access, promote accountability for outcomes, and create a more
4 predictable and sustainable Medicaid budget.

5 REVIEW OF PROGRAM INTEGRITY DUTIES

6 Sec. 2. REVIEW OF PROGRAM INTEGRITY DUTIES — WORKGROUP —
7 REPORT.

8 1. The director of human services shall convene a
9 workgroup comprised of members including the commissioner
10 of insurance, the auditor of state, the Medicaid director
11 and bureau chiefs of the managed care organization oversight
12 and supports bureau, the Iowa Medicaid enterprise support
13 bureau, and the medical and long-term services and supports
14 bureau, and a representative of the program integrity unit,
15 or their designees; and representatives of other appropriate
16 state agencies or other entities including but not limited to
17 the office of the attorney general, the office of long-term
18 care ombudsman, and the Medicaid fraud control unit of the
19 investigations division of the department of inspections and
20 appeals. The workgroup shall do all of the following:

21 a. Review the duties of each entity with responsibilities
22 relative to Medicaid program integrity and managed care
23 organizations; review state and federal laws, regulations,
24 requirements, guidance, and policies relating to Medicaid
25 program integrity and managed care organizations; and review
26 the laws of other states relating to Medicaid program integrity
27 and managed care organizations. The workgroup shall determine
28 areas of duplication, fragmentation, and gaps; shall identify
29 possible integration, collaboration and coordination of duties;
30 and shall determine whether existing general state Medicaid
31 program and fee-for-service policies, laws, and rules are
32 sufficient, or if changes or more specific policies, laws, and
33 rules are required to provide for comprehensive and effective
34 administration and oversight of the Medicaid program.

35 b. Review historical uses of the Medicaid fraud fund created

1 in section 249A.50 and make recommendations for future uses
2 of the moneys in the fund and any changes in law necessary to
3 adequately address program integrity.

4 c. Review medical loss ratio provisions relative to
5 Medicaid managed care contracts and make recommendations
6 regarding, at a minimum, requirements for the necessary
7 collection, maintenance, retention, reporting, and sharing of
8 data and information by Medicaid managed care organizations
9 for effective determination of compliance, and to identify
10 the costs and activities that should be included in the
11 calculation of administrative costs, medical costs or benefit
12 expenses, health quality improvement costs, and other costs and
13 activities incidental to the determination of a medical loss
14 ratio.

15 d. Review the capacity of state agencies, including the need
16 for specialized training and expertise, to address Medicaid
17 and managed care organization program integrity and provide
18 recommendations for the provision of necessary resources and
19 infrastructure, including annual budget projections.

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

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

35 2. The department of human services shall submit a report

1 of the workgroup to the governor and the general assembly
2 on or before November 15, 2016, to provide findings and
3 recommendations for a coordinated approach to comprehensive and
4 effective administration and oversight of the Medicaid program.

5 MEDICAID REINVESTMENT FUND

6 Sec. 3. NEW SECTION. **249A.4C Medicaid reinvestment fund.**

7 1. A Medicaid reinvestment fund is created in the state
8 treasury under the authority of the department. Moneys from
9 savings realized from the movement of Medicaid recipients from
10 institutional settings to home and community-based services,
11 the portion of the capitation rate withheld from and not
12 returned to Medicaid managed care organizations at the end
13 of each fiscal year, any recouped excess of capitation rates
14 paid to Medicaid managed care organizations, any overpayments
15 recovered under Medicaid managed care contracts, and any other
16 savings realized from Medicaid managed care or from Medicaid
17 program cost-containment efforts, shall be credited to the
18 Medicaid reinvestment fund.

19 2. Notwithstanding section 8.33, moneys credited to
20 the fund from any other account or fund shall not revert to
21 the other account or fund. Moneys in the fund shall only
22 be used as provided in appropriations from the fund for
23 the Medicaid program and for health system transformation
24 and integration, including but not limited to providing
25 the necessary infrastructure and resources to protect the
26 interests of Medicaid recipients, maintaining adequate provider
27 participation, and ensuring program integrity. Such uses may
28 include but are not limited to:

29 a. Ensuring appropriate reimbursement of Medicaid
30 providers to maintain the type and number of appropriately
31 trained providers necessary to address the needs of Medicaid
32 recipients.

33 b. Providing home and community-based services as necessary
34 to rebalance the long-term services and supports infrastructure
35 and to reduce Medicaid home and community-based services waiver

1 waiting lists.

2 *c.* Ensuring that a fully functioning independent long-term
3 services and supports ombudsman program is available to provide
4 advocacy services and assistance to Medicaid recipients.

5 *d.* Ensuring adequate and appropriate capacity of the
6 department of human services as the single state agency
7 designated to administer and supervise the administration of
8 the Medicaid program, to ensure compliance with state and
9 federal law and program integrity requirements.

10 *e.* Addressing workforce issues to ensure a competent,
11 diverse, and sustainable health care workforce and to
12 improve access to health care in underserved areas and among
13 underserved populations, recognizing long-term services and
14 supports as an essential component of the health care system.

15 *f.* Supporting innovation, longer-term community
16 investments, and the activities of local public health
17 agencies, aging and disability resource centers and service
18 agencies, mental health and disability services regions, social
19 services, and child welfare entities and other providers of
20 and advocates for services and supports to encourage health
21 system transformation and integration through a broad range of
22 prevention strategies and population-based approaches to meet
23 the holistic needs of the population as a whole.

24 3. The department shall establish a mechanism to measure and
25 certify the amount of savings resulting from Medicaid managed
26 care and Medicaid program cost-containment activities and shall
27 ensure that such realized savings are credited to the fund and
28 used as provided in appropriations from the fund.

29 LONG-TERM SERVICES AND SUPPORTS OMBUDSMAN

30 Sec. 4. Section 231.44, subsection 1, Code 2016, is amended
31 by adding the following new paragraphs:

32 NEW PARAGRAPH. *d.* Accessing the results of a review
33 of a level of care or a needs-based eligibility assessment
34 or reassessment by a managed care organization in which
35 the managed care organization recommends denial or limited

1 authorization of a service, including the type or level
2 of service, the reduction, suspension, or termination of a
3 previously authorized service, or a change in level of care,
4 upon the request of the individual receiving long-term services
5 and supports.

6 NEW PARAGRAPH. e. Receiving and reviewing for Medicaid
7 recipients who receive long-term services and supports notices
8 of disenrollment from a managed care organization or notices
9 that would result in a change in such recipient's level of care
10 setting, including involuntary and voluntary discharges or
11 transfers of a recipient.

12 Sec. 5. Section 231.44, Code 2016, is amended by adding the
13 following new subsections:

14 NEW SUBSECTION. 3A. The office of long-term care ombudsman
15 and representatives of the office, when providing assistance
16 and advocacy services authorized under this section, shall be
17 considered a health oversight agency as defined in 45 C.F.R.
18 §164.501 for the purposes of health oversight activities
19 as described in 45 C.F.R. §164.512(d) including access to
20 Medicaid recipients' health records and other appropriate
21 information, including from the department of human services
22 or the applicable Medicaid managed care organization, as
23 necessary to fulfill the duties specified under this section.
24 The department of human services, in collaboration with the
25 office of long-term care ombudsman, shall adopt rules to ensure
26 compliance by affected entities with this subsection and to
27 ensure recognition of the office of long-term care ombudsman
28 as a duly authorized and identified agent or representative of
29 the state.

30 NEW SUBSECTION. 3B. The department of human services and
31 Medicaid managed care organizations shall inform Medicaid
32 recipients of the advocacy services and assistance available
33 through the office of long-term care ombudsman and shall
34 provide contact and other information regarding the advocacy
35 services and assistance to Medicaid recipients as directed by

1 the office of long-term care ombudsman.

2 NEW SUBSECTION. 3C. The office of long-term care ombudsman
3 shall act as an independent agency in providing advocacy
4 services and assistance under this section. The office of
5 long-term care ombudsman shall, in addition to other duties
6 prescribed and, at a minimum, do all of the following in
7 the furtherance of the provision of advocacy services and
8 assistance under this section:

9 a. Represent the interests of Medicaid program recipients
10 before governmental agencies and seek administrative, legal,
11 and other remedies for the recipient.

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

17 Sec. 6. NEW SECTION. **231.44A Willful interference with**
18 **duties related to long-term services and supports — penalty.**

19 Willful interference with a representative of the office of
20 long-term care ombudsman in the performance of official duties
21 in accordance with section 231.44 is a violation of section
22 231.44, subject to a penalty prescribed by rule. The office
23 of long-term care ombudsman shall adopt rules specifying the
24 amount of a penalty imposed, consistent with the penalties
25 imposed under section 231.42, subsection 8, and specifying
26 procedures for notice and appeal of penalties imposed. Any
27 moneys collected pursuant to this section shall be deposited in
28 the Medicaid reinvestment fund created in section 249A.4C.

29 **MEDICAL ASSISTANCE ADVISORY COUNCIL**

30 Sec. 7. Section 249A.4B, subsection 1, Code 2016, is amended
31 to read as follows:

32 1. A medical assistance advisory council is created to
33 comply with 42 C.F.R. §431.12 based on section 1902(a)(4) of
34 the federal Social Security Act and to advise the director
35 about health and medical care services under the medical

1 assistance program. The council shall meet ~~no more than~~ at
2 least quarterly. The director of public health shall serve as
3 chairperson of the council.

4 Sec. 8. Section 249A.4B, subsection 2, paragraph b, Code
5 2016, is amended to read as follows:

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

19 Sec. 9. Section 249A.4B, subsection 2, Code 2016, is amended
20 by adding the following new paragraph:

21 NEW PARAGRAPH. *og.* The state long-term care ombudsman or
22 the ombudsman's designee.

23 Sec. 10. Section 249A.4B, subsection 3, paragraph a, Code
24 2016, is amended by adding the following new subparagraph:

25 NEW SUBPARAGRAPH. (4) The state long-term care ombudsman or
26 the ombudsman's designee.

27 Sec. 11. Section 249A.4B, subsection 3, paragraph c, Code
28 2016, is amended to read as follows:

29 *c.* Based upon the deliberations of the council, and the
30 executive committee, and the subcommittees, the executive
31 committee and the subcommittees, respectively, shall make
32 recommendations to the director regarding the budget, policy,
33 and administration of the medical assistance program.

34 Sec. 12. Section 249A.4B, Code 2016, is amended by adding
35 the following new subsections:

1 NEW SUBSECTION. 3A. a. The council shall create
2 the following subcommittees, and may create additional
3 subcommittees as necessary to address medical assistance
4 program policies, administration, budget, and other factors and
5 issues:

6 (1) The stakeholder safeguards subcommittee, for which
7 the co-chairpersons shall be a member of the council who is a
8 current recipient or family member of a recipient of medical
9 assistance or who represents a consumer advocacy entity, and a
10 member of the council who represents a professional or business
11 entity, both selected by the executive committee. The mission
12 of the stakeholder safeguards subcommittee is to provide for
13 ongoing stakeholder engagement and feedback on issues affecting
14 Medicaid recipients, providers, and other stakeholders.

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

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

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

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

24 *c.* Subcommittees shall meet at the call of the chairperson
25 of the subcommittee or at the request of a majority of the
26 members of the subcommittee.

27 NEW SUBSECTION. 7. The council, executive committee, and
28 subcommittees shall jointly submit a report to the governor and
29 the general assembly by January 1, annually, summarizing the
30 outcomes and findings of their respective deliberations and any
31 recommendations including but not limited to those for changes
32 in law or policy.

33 NEW SUBSECTION. 8. The council, executive committee,
34 and subcommittees may enlist the services of persons who are
35 qualified by education, expertise, or experience to advise,

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

16 Sec. 13. Section 249A.4B, subsections 4, 5, and 6, Code
17 2016, are amended to read as follows:

18 4. For each council meeting, other than those held during
19 the time the general assembly is in session, each legislative
20 member of the council shall be reimbursed for actual travel
21 and other necessary expenses and shall receive a per diem as
22 specified in [section 7E.6](#) for each day in attendance, as shall
23 the members of the council, ~~or~~ the executive committee, or
24 a subcommittee who are recipients or the family members of
25 recipients of medical assistance, regardless of whether the
26 general assembly is in session.

27 5. The department shall provide staff support and
28 independent technical assistance to the council, ~~and~~ the
29 executive committee, and the subcommittees.

30 6. The director shall consider the recommendations
31 offered by the council, ~~and~~ the executive committee, and
32 the subcommittees in the director's preparation of medical
33 assistance budget recommendations to the council on human
34 services pursuant to [section 217.3](#) and in implementation of
35 medical assistance program policies.

1 HEALTH RESOURCES AND INFRASTRUCTURE

2 Sec. 14. PATIENT-CENTERED HEALTH ADVISORY COUNCIL —
3 ASSESSMENT OF HEALTH RESOURCES AND INFRASTRUCTURE.

4 1. The patient-centered health advisory council created
5 in section 135.159 shall assess the capacity of the health
6 care infrastructure and resources in the state and recommend
7 more appropriate alignment with broad systems changes, the
8 increasing array of care delivery models such as the expansion
9 of Medicaid managed care, accountable care organizations, and
10 public health modernization, and a more integrated, holistic,
11 prevention-based and population-based approach to health and
12 health care. The assessment shall also address the sufficiency
13 and proficiency of the existing health-related workforce and
14 the potential of braiding and blending funding streams to
15 support the holistic needs of the population.

16 2. Initially, the council shall do all of the following:

17 a. Assess the potential for integration and coordination
18 of various service delivery sectors including public health,
19 aging and disability services agencies, mental health and
20 disability services regions, social services, child welfare,
21 and other such sectors and shall make recommendations for
22 such integration and coordination to more efficiently and
23 effectively address consumer needs.

24 b. Assess funding streams, including Medicaid funding,
25 and make recommendations to blend or braid funding to support
26 prevention and population health strategies in addressing the
27 holistic well-being of consumers.

28 c. Assess current and projected health workforce
29 availability to determine the most efficient application
30 and utilization of the roles, functions, responsibilities,
31 activities, and decision-making capacity of health care
32 professionals and other allied and support personnel, and make
33 recommendations for improvement and alternative modes of health
34 care delivery.

35 3. The council shall submit a report of its findings and

1 recommendations regarding the initial assessments specified
2 in subsection 2 to the governor and the general assembly by
3 January 1, 2017. The council shall submit subsequent reports
4 relating to additional assessments of and recommendations
5 relating to the health care infrastructure and resources on or
6 before January 1, annually, thereafter.

7 MEDICAID PROGRAM POLICY IMPROVEMENT

8 Sec. 15. DIRECTIVES FOR MEDICAID PROGRAM POLICY
9 IMPROVEMENTS. In order to safeguard the interests of Medicaid
10 recipients, encourage the participation of Medicaid providers,
11 and protect the interests of all taxpayers, the department of
12 human services shall comply with or ensure that the specified
13 entity complies with all of the following and shall amend
14 Medicaid managed care contract provisions as necessary to
15 reflect all of the following:

16 1. CONSUMER PROTECTIONS.

17 a. In accordance with 42 C.F.R. §438.420, a Medicaid managed
18 care organization shall continue a recipient's benefits during
19 an appeal process. If, as allowed when final resolution of
20 an appeal is adverse to the Medicaid recipient, the Medicaid
21 managed care organization chooses to recover the costs of the
22 services furnished to the recipient while an appeal is pending,
23 the Medicaid managed care organization shall provide adequate
24 prior notice of potential recovery of costs to the recipient at
25 the time the appeal is filed, and any costs recovered shall be
26 remitted to the department of human services and deposited in
27 the Medicaid reinvestment fund created in section 249A.4C.

28 b. Ensure that each Medicaid managed care organization
29 provides, at a minimum, all the benefits and services deemed
30 medically necessary that were covered, including to the
31 extent and in the same manner and subject to the same prior
32 authorization criteria, by the state program directly under
33 fee for service prior to January 1, 2016. Benefits covered
34 through Medicaid managed care shall comply with the specific
35 requirements in state law applicable to the respective Medicaid

1 recipient population under fee for service.

2 c. Enhance monitoring of the reduction in or suspension
3 or termination of services provided to Medicaid recipients,
4 including reductions in the provision of home and
5 community-based services waiver services or increases in home
6 and community-based services waiver waiting lists. Medicaid
7 managed care organizations shall provide data to the department
8 as necessary for the department to compile periodic reports on
9 the numbers of individuals transferred from state institutions
10 and long-term care facilities to home and community-based
11 services, and the associated savings. Any savings resulting
12 from the transfers as certified by the department shall be
13 deposited in the Medicaid reinvestment fund created in section
14 249A.4C.

15 d. (1) Require each Medicaid managed care organization to
16 adhere to reasonableness and service authorization standards
17 that are appropriate for and do not disadvantage those
18 individuals who have ongoing chronic conditions or who require
19 long-term services and supports. Services and supports for
20 individuals with ongoing chronic conditions or who require
21 long-term services and supports shall be authorized in a manner
22 that reflects the recipient's continuing need for such services
23 and supports, and limits shall be consistent with a recipient's
24 current needs assessment and person-centered service plan.

25 (2) In addition to other provisions relating to
26 community-based case management continuity of care
27 requirements, Medicaid managed care contractors shall provide
28 the option to the case manager of a Medicaid recipient who
29 retained the case manager during the six months of transition
30 to Medicaid managed care, if the recipient chooses to continue
31 to retain that case manager beyond the six-month transition
32 period and if the case manager is not otherwise a participating
33 provider of the recipient's managed care organization provider
34 network, to enter into a single case agreement to continue to
35 provide case management services to the Medicaid recipient.

1 e. Ensure that Medicaid recipients are provided care
2 coordination and case management by appropriately trained
3 professionals in a conflict-free manner. Care coordination and
4 case management shall be provided in a patient-centered and
5 family-centered manner that requires a knowledge of community
6 supports, a reasonable ratio of care coordinators and case
7 managers to Medicaid recipients, standards for frequency of
8 contact with the Medicaid recipient, and specific and adequate
9 reimbursement.

10 f. A Medicaid managed care contract shall include a
11 provision for continuity and coordination of care for a
12 consumer transitioning to Medicaid managed care, including
13 maintaining existing provider-recipient relationships and
14 honoring the amount, duration, and scope of a recipient's
15 authorized services based on the recipient's medical history
16 and needs. In the initial transition to Medicaid managed care,
17 to ensure the least amount of disruption, Medicaid managed
18 care organizations shall provide, at a minimum, a one-year
19 transition of care period for all provider types, regardless
20 of network status with an individual Medicaid managed care
21 organization.

22 g. Ensure that a Medicaid managed care organization does
23 not arbitrarily deny coverage for medically necessary services
24 based solely on financial reasons.

25 h. Ensure that dental coverage, if not integrated into
26 an overall Medicaid managed care contract, is part of the
27 overall holistic, integrated coverage for physical, behavioral,
28 and long-term services and supports provided to a Medicaid
29 recipient.

30 i. Require each Medicaid managed care organization to
31 collect, maintain, retain, and share data as necessary to
32 inform monitoring activities including but not limited to
33 verifying the offering and actual utilization of services and
34 supports and value-added services, an individual recipient's
35 encounters and the costs associated with each encounter, and

1 requests and associated approvals or denials of services.
2 Verification of actual receipt of services and supports and
3 value-added services shall, at a minimum, consist of comparing
4 receipt of service against both what was authorized in the
5 recipient's benefit or service plan and what was actually
6 reimbursed. Value-added services shall not be reportable as
7 allowable medical or administrative costs or factored into rate
8 setting, and the costs of value-added services shall not be
9 passed on to recipients or providers.

10 j. Provide periodic reports to the governor and the general
11 assembly regarding changes in quality of care and health
12 outcomes for Medicaid recipients under managed care compared to
13 quality of care and health outcomes of the same populations of
14 Medicaid recipients prior to January 1, 2016.

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

27 l. Require Medicaid managed care organizations to survey
28 Medicaid recipients, to collect satisfaction data using a
29 uniform instrument, and to provide a detailed analysis of
30 recipient satisfaction as well as various metrics regarding the
31 volume of and timelines in responding to recipient complaints
32 and grievances as directed by the department of human services.

33 2. CHILDREN.

34 a. The hawk-i board created under section 514I.5 shall
35 provide recommendations to the director of human services

1 relating to the application of Medicaid managed care to the
2 child population. At a minimum, the board shall:

3 (1) Require that all Medicaid managed care organization
4 contracts specifically and appropriately address the unique
5 needs of children and children's health care delivery.

6 (a) Medicaid managed care organizations shall maintain
7 child health panels that include representatives of child
8 health, welfare, policy, and advocacy organizations in the
9 state that address child health and child well-being.

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

26 (c) Medicaid managed care contracts shall provide special
27 incentives for innovative and evidence-based preventive,
28 behavioral, and developmental health care and mental health
29 care for children's programs that improve the life course
30 trajectory of those children.

31 (d) The information collected from the pediatric-specific
32 assessments shall be used to identify health risks and social
33 determinants of health that impact health outcomes. Medicaid
34 managed care organizations and providers shall use this data in
35 care coordination and interventions to improve patient outcomes

1 and to drive program designs that improve the health of the
2 population. Medicaid managed care organizations shall share
3 aggregate assessment data with providers on a routine basis.

4 (2) Review benefit plans and utilization review provisions
5 and ensure that benefits provided to children under Medicaid
6 managed care, at a minimum, reflect those required by state law
7 as specified in section 514I.5 and are provided as medically
8 necessary relative to the child population served and based on
9 the needs of the program recipient and the program recipient's
10 medical history.

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

23 3. PROVIDER PARTICIPATION ENHANCEMENT.

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

35 b. To enhance continuity of care in the provision of

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

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

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

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

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

31 (a) In calculating the rates for prospective payment system
32 hospitals, the following base rates shall be used:

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

35 (ii) The outpatient ambulatory payment classification base

1 rates in effect on July 1, 2015.

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

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

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

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

10 (ii) The outpatient cost-to-charge ratio in effect on July
11 1, 2015.

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

13 (c) Critical access hospitals shall receive cost-based
14 reimbursement for one hundred percent of the reasonable costs
15 for the provision of services to Medicaid recipients.

16 (d) Critical access hospitals shall submit annual cost
17 reports and managed care contractors shall submit annual
18 payment reports to the department of human services. The
19 department shall reconcile the critical access hospital's
20 reported costs with the managed care contractor's reported
21 payments. The department shall require the managed care
22 contractor to retroactively reimburse a critical access
23 hospital for underpayments.

24 (2) For managed care contract periods subsequent to the
25 initial contract period, base rates for prospective payment
26 system hospitals and critical access hospitals shall be
27 calculated using the base rate for the prior contract period
28 plus 3 percent. Prospective payment system hospital and
29 critical access hospital base rates shall at no time be less
30 than the previous contract period's base rates.

31 (3) A managed care contract shall require out-of-network
32 prospective payment system hospital and critical access
33 hospital payment rates to meet or exceed ninety-nine percent of
34 the rates specified for the respective in-network hospitals in
35 accordance with this paragraph "f".

1 g. If the department of human services collects ownership
2 and control information from Medicaid providers pursuant to 42
3 C.F.R. §455.104, a managed care organization under contract
4 with the state shall not also require submission of this
5 information from approved enrolled Medicaid providers.

6 h. (1) Ensure that a Medicaid managed care organization
7 develops and maintains a provider network of qualified
8 providers who meet state licensing, credentialing, and
9 certification requirements, as applicable, which network shall
10 be sufficient to provide adequate access to all services
11 covered and for all populations served under the managed
12 care contract. Medicaid managed care organizations shall
13 incorporate existing and traditional providers, including
14 but not limited to those providers that comprise the Iowa
15 collaborative safety net provider network created in section
16 135.153, into their provider networks.

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

28 i. Medicaid managed care organizations shall provide an
29 enrolled Medicaid provider approved by the department of
30 human services the opportunity to be a participating network
31 provider.

32 j. Medicaid managed care organizations shall include
33 provider appeals and grievance procedures that in part allow
34 a provider to file a grievance independently but on behalf
35 of a Medicaid recipient and to appeal claims denials which,

1 if determined to be based on claims for medically necessary
2 services whether or not denied on an administrative basis,
3 shall receive appropriate payment.

4 4. CAPITATION RATES AND MEDICAL LOSS RATIO.

5 a. Capitation rates shall be developed based on all
6 reasonable, appropriate, and attainable costs. Costs that are
7 not reasonable, appropriate, or attainable, including but not
8 limited to improper payment recoveries, shall not be included
9 in the development of capitated rates.

10 b. Capitation rates for Medicaid recipients falling within
11 different rate cells shall not be expected to cross-subsidize
12 one another and the data used to set capitation rates shall
13 be relevant and timely and tied to the appropriate Medicaid
14 population.

15 c. Any increase in capitation rates for managed care
16 contractors is subject to prior statutory approval and shall
17 not exceed three percent over the existing capitation rate
18 in any one-year period or five percent over the existing
19 capitation rate in any two-year period.

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

26 (1) Program integrity activities.

27 (2) Utilization review activities.

28 (3) Fraud prevention activities beyond the scope of those
29 activities necessary to recover incurred claims.

30 (4) Provider network development, education, or management
31 activities.

32 (5) Provider credentialing activities.

33 (6) Marketing expenses.

34 (7) Administrative costs associated with recipient
35 incentives.

- 1 (8) Clinical data collection activities.
- 2 (9) Claims adjudication expenses.
- 3 (10) Customer service or health care professional hotline
4 services addressing nonclinical recipient questions.
- 5 (11) Value-added or cost-containment services, wellness
6 programs, disease management, and case management or care
7 coordination programs.
- 8 (12) Health quality improvement activities unless
9 specifically approved as a medical cost by state law. Costs of
10 health quality improvement activities included in determining
11 the medical loss ratio shall be only those activities that are
12 independent improvements measurable in individual patients.
- 13 (13) Insurer claims review activities.
- 14 (14) Information technology costs unless they directly
15 and credibly improve the quality of health care and do not
16 duplicate, conflict with, or fail to be compatible with similar
17 health information technology efforts of providers.
- 18 (15) Legal department costs including information
19 technology costs, expenses incurred for review and denial of
20 claims, legal costs related to defending claims, settlements
21 for wrongly denied claims, and costs related to administrative
22 claims handling including salaries of administrative personnel
23 and legal costs.
- 24 (16) Taxes unrelated to premiums or the provision of medical
25 care. Only state and federal taxes and licensing or regulatory
26 fees relevant to actual premiums collected, not including such
27 taxes and fees as property taxes, taxes on investment income,
28 taxes on investment property, and capital gains taxes, may be
29 included in determining the medical loss ratio.
- 30 e. (1) Provide enhanced guidance and criteria for defining
31 medical and administrative costs, recoveries, and rebates
32 including pharmacy rebates, and the recording, reporting, and
33 recoupment of such costs, recoveries, and rebates realized.
- 34 (2) Medicaid managed care organizations shall offset
35 recoveries, rebates, and refunds against medical costs, include

1 only allowable administrative expenses in the determination of
2 administrative costs, report costs related to subcontractors
3 properly, and have complete systems checks and review processes
4 to identify overpayment possibilities.

5 (3) Medicaid managed care contractors shall submit
6 publically available, comprehensive financial statements to
7 verify that the minimum medical loss ratio is being met and
8 shall be subject to periodic audits.

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

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

27 b. Medicaid managed care organizations shall directly
28 capture and retain and shall report actual and detailed
29 medical claims costs and administrative cost data to the
30 department as specified by the department. Medicaid managed
31 care organizations shall allow the department to thoroughly and
32 accurately monitor the medical claims costs and administrative
33 costs data Medicaid managed care organizations report to the
34 department.

35 c. Conduct regular audits of Medicaid managed care

1 contracts according to a routine, ongoing schedule to ensure
2 compliance including with respect to appropriate medical costs,
3 allowable administrative costs, the medical loss ratio, cost
4 recoveries, rebates, overpayments, and compliance with specific
5 contract performance requirements.

6 d. Following completion of the initial year of
7 implementation of Medicaid managed care, the department shall
8 hire an independent performance auditor to perform an audit of
9 the Medicaid managed care program and participating Medicaid
10 managed care organizations to determine if the state has
11 sufficient infrastructure and controls in place to effectively
12 oversee the Medicaid managed care organizations and the
13 Medicaid program to ensure, at a minimum, compliance with
14 Medicaid managed care organization contracts and to prevent
15 fraud, abuse, and overpayments. The results of the audit shall
16 be submitted to the governor, the general assembly, and the
17 health policy oversight committee created in section 2.45.

18 e. Publish benchmark indicators based on Medicaid program
19 outcomes from the fiscal year beginning July 1, 2015, to
20 be used to compare outcomes of the Medicaid program as
21 administered by the state program prior to July 1, 2015, to
22 those outcomes of the program under Medicaid managed care. The
23 outcomes shall include a comparison of actual costs of the
24 program as administered prior to and after implementation of
25 Medicaid managed care.

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

30 g. (1) Require managed care contractors to track and report
31 on a monthly basis to the department of human services, all of
32 the following:

33 (a) The number and details relating to prior authorization
34 requests and denials.

35 (b) The ten most common reasons for claims denials.

1 Information reported by a managed care contractor relative
2 to claims shall also include the number of claims denied,
3 appealed, and overturned based on provider type and service
4 type.

5 (c) Utilization of health care services by diagnostic
6 related group and ambulatory payment classification as well as
7 total claims volume.

8 (2) The department shall make the monthly reports available
9 to the public.

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

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

30 j. Require consistency and uniformity of processes,
31 procedures, and forms across all Medicaid managed care
32 organizations to reduce the administrative burden to providers
33 and consumers and to increase efficiencies in the program.
34 Such requirements shall apply to but are not limited to
35 areas of uniform cost and quality reporting, uniform prior

1 authorization requirements and procedures, centralized,
2 uniform, and seamless credentialing requirements and
3 procedures, and uniform critical incident reporting.

4 k. Medicaid managed care organizations and any entity with
5 which a managed care organization contracts for the performance
6 of services shall disclose at no cost to the department all
7 discounts, incentives, rebates, fees, free goods, bundling
8 arrangements, and other agreements affecting the net cost of
9 goods or services provided under a managed care contract.

10 Sec. 16. RETROACTIVE APPLICABILITY. The section of this Act
11 relating to directives for Medicaid program policy improvements
12 applies retroactively to July 1, 2015.

13 Sec. 17. EFFECTIVE UPON ENACTMENT. This Act, being deemed
14 of immediate importance, takes effect upon enactment.

15 EXPLANATION

16 The inclusion of this explanation does not constitute agreement with
17 the explanation's substance by the members of the general assembly.

18 This bill relates to Medicaid program improvement.

19 The bill provides legislative findings, goals, and the
20 intent for the program.

21 The bill provides for a review of program integrity
22 activities by a workgroup, required to make recommendations
23 to the governor and general assembly by November 15, 2016, to
24 provide findings and recommendations for a coordinated approach
25 to provide for comprehensive and effective administration of
26 program integrity activities to support such a system.

27 The bill creates a Medicaid reinvestment fund for the
28 deposit of savings related to and realized from Medicaid
29 managed care. Moneys in the fund are subject to appropriation
30 by the general assembly for the Medicaid program.

31 The bill provides additional duties for and authority to
32 the office of long-term care ombudsman relating to providing
33 advocacy services and assistance for Medicaid recipients who
34 receive long-term services and supports.

35 The bill clarifies the membership of the medical assistance

1 advisory council and the executive committee, provides for
2 the creation of subcommittees of the council relating to
3 stakeholder safeguards; long-term services and supports;
4 transparency, data, and program evaluation; and program
5 integrity.

6 The bill directs the patient-centered health advisory
7 council to assess the health resources and infrastructure
8 of the state to recommend more appropriate alignment with
9 changes in health care delivery and the integrated, holistic,
10 population health-based approach to health and health care.
11 The bill directs the council to perform an initial review and
12 submit a report by January 1, 2017, to the governor and the
13 general assembly, and to submit subsequent reports on January
14 1, annually, thereafter.

15 The bill directs the department of human services and other
16 appropriate entities to undertake specific tasks relating to
17 Medicaid program policy improvement in the areas of consumer
18 protections, children, provider participation enhancement,
19 capitation rates and medical loss ratio, and data and
20 information, evaluation, and oversight.

21 The section of the bill relating to directives for Medicaid
22 program policy improvements is retroactively applicable to July
23 1, 2015.

24 The bill takes effect upon enactment.