Senate File 2213 - Introduced

SENATE FILE 2213
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SF 2107)

A BILL FOR

An Act relating to Medicaid program improvement, and including effective date and retroactive applicability provisions.

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

Section 1. LEGISLATIVE FINDINGS —— GOALS AND INTENT.

1. The general assembly finds all of the following:

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

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

c. Strategic planning should include all of the following:

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

(2) Developing a sound methodology for establishing and

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

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

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

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

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

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

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

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

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

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

REVIEW OF PROGRAM INTEGRITY DUTIES

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

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

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

b. Review historical uses of the Medicaid fraud fund created

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

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

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

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

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

2. The department of human services shall submit a report

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

MEDICAID REINVESTMENT FUND

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

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

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

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

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

waiting lists.

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

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

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

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

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

LONG-TERM SERVICES AND SUPPORTS OMBUDSMAN

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

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

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

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

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

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

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

the office of long-term care ombudsman.

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

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

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

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

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

MEDICAL ASSISTANCE ADVISORY COUNCIL

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

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

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

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

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

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

NEW PARAGRAPH. *0g.* The state long-term care ombudsman or the ombudsman's designee.

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

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

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

c. Based upon the deliberations of the council, ~~and~~ the executive committee, and the subcommittees, the executive committee and the subcommittees, respectively, shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. The director shall consider the recommendations offered by the council, ~~and~~ the executive committee, and the subcommittees in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to section 217.3 and in implementation of medical assistance program policies.

HEALTH RESOURCES AND INFRASTRUCTURE

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

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

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

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

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

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

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

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

MEDICAID PROGRAM POLICY IMPROVEMENT

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

1. CONSUMER PROTECTIONS.

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

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

recipient population under fee for service.

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

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

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

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

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

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

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

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

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

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

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

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

2. CHILDREN.

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

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

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

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

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

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

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

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

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

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

3. PROVIDER PARTICIPATION ENHANCEMENT.

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

b. To enhance continuity of care in the provision of

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

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

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

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

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

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

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

(ii) The outpatient ambulatory payment classification base

rates in effect on July 1, 2015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. CAPITATION RATES AND MEDICAL LOSS RATIO.

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

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

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

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

(1) Program integrity activities.

(2) Utilization review activities.

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

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

(5) Provider credentialing activities.

(6) Marketing expenses.

(7) Administrative costs associated with recipient incentives.

(8) Clinical data collection activities.

(9) Claims adjudication expenses.

(10) Customer service or health care professional hotline services addressing nonclinical recipient questions.

(11) Value-added or cost-containment services, wellness programs, disease management, and case management or care coordination programs.

(12) Health quality improvement activities unless specifically approved as a medical cost by state law. Costs of health quality improvement activities included in determining the medical loss ratio shall be only those activities that are independent improvements measurable in individual patients.

(13) Insurer claims review activities.

(14) Information technology costs unless they directly and credibly improve the quality of health care and do not duplicate, conflict with, or fail to be compatible with similar health information technology efforts of providers.

(15) Legal department costs including information technology costs, expenses incurred for review and denial of claims, legal costs related to defending claims, settlements for wrongly denied claims, and costs related to administrative claims handling including salaries of administrative personnel and legal costs.

(16) Taxes unrelated to premiums or the provision of medical care. Only state and federal taxes and licensing or regulatory fees relevant to actual premiums collected, not including such taxes and fees as property taxes, taxes on investment income, taxes on investment property, and capital gains taxes, may be included in determining the medical loss ratio.

e. (1) Provide enhanced guidance and criteria for defining medical and administrative costs, recoveries, and rebates including pharmacy rebates, and the recording, reporting, and recoupment of such costs, recoveries, and rebates realized.

(2) Medicaid managed care organizations shall offset recoveries, rebates, and refunds against medical costs, include

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

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

5. DATA AND INFORMATION, EVALUATION, AND OVERSIGHT.

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

b. Medicaid managed care organizations shall directly capture and retain and shall report actual and detailed medical claims costs and administrative cost data to the department as specified by the department. Medicaid managed care organizations shall allow the department to thoroughly and accurately monitor the medical claims costs and administrative costs data Medicaid managed care organizations report to the department.

c. Conduct regular audits of Medicaid managed care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXPLANATION

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

This bill relates to Medicaid program improvement.

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

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

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

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

The bill clarifies the membership of the medical assistance

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

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

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

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

The bill takes effect upon enactment.