

Senate File 2305 - Introduced

SENATE FILE 2305
BY COMMITTEE ON GOVERNMENT
OVERSIGHT

(SUCCESSOR TO SSB 3173)

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
7 and older individuals. Iowa, unlike the majority of states,
8 is implementing Medicaid managed care simultaneously across
9 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 HEALTH POLICY OVERSIGHT COMMITTEE

6 Sec. 2. Section 2.45, subsection 6, Code 2016, is amended
7 to read as follows:

8 6. The legislative health policy oversight committee, which
9 shall be composed of ten members of the general assembly,
10 consisting of five members from each house, to be appointed
11 by the legislative council. The legislative health policy
12 oversight committee shall ~~receive updates and review data,~~
13 ~~public input and concerns, and make recommendations for~~
14 ~~improvements to and changes in law or rule regarding Medicaid~~
15 ~~managed care meet at least four times annually to evaluate~~
16 state health policy and provide continuing oversight for
17 publicly funded programs, including but not limited to all
18 facets of the Medicaid and hawk-i programs to, at a minimum,
19 ensure effective and efficient administration of these
20 programs, address stakeholder concerns, monitor program costs
21 and expenditures, and make recommendations relative to the
22 programs.

23 Sec. 3. HEALTH POLICY OVERSIGHT COMMITTEE — SUBJECT
24 MATTER REVIEW FOR 2016 LEGISLATIVE INTERIM. During the 2016
25 legislative interim, the health policy oversight committee
26 created in section 2.45 shall, as part of the committee's
27 evaluation of state health policy and review of all facets
28 of the Medicaid and hawk-i programs, review and make
29 recommendations regarding, at a minimum, all of the following:

30 1. The resources and duties of the office of long-term
31 care ombudsman relating to the provision of assistance to and
32 advocacy for Medicaid recipients to determine the designation
33 of duties and level of resources necessary to appropriately
34 address the needs of such individuals. The committee shall
35 consider the health consumer ombudsman alliance report

1 submitted to the general assembly in December 2015, as well as
2 input from the office of long-term care ombudsman and other
3 entities in making recommendations.

4 2. The health benefits and health benefit utilization
5 management criteria for the Medicaid and hawk-i programs to
6 determine the sufficiency and appropriateness of the benefits
7 offered and the utilization of these benefits.

8 3. Prior authorization requirements relative to benefits
9 provided under the Medicaid and hawk-i programs, including but
10 not limited to pharmacy benefits.

11 4. Consistency and uniformity in processes, procedures,
12 forms, and other activities across all Medicaid and hawk-i
13 program participating insurers and managed care organizations,
14 including but not limited to cost and quality reporting,
15 credentialing, billing, prior authorization, and critical
16 incident reporting.

17 5. Provider network adequacy including the use of
18 out-of-network and out-of-state providers.

19 6. The role and interplay of other advisory and oversight
20 entities, including but not limited to the medical assistance
21 advisory council and the hawk-i board.

22 REVIEW OF PROGRAM INTEGRITY DUTIES

23 Sec. 4. REVIEW OF PROGRAM INTEGRITY DUTIES — WORKGROUP —
24 REPORT.

25 1. The director of human services shall convene a
26 workgroup comprised of members including the commissioner
27 of insurance, the auditor of state, the Medicaid director
28 and bureau chiefs of the managed care organization oversight
29 and supports bureau, the Iowa Medicaid enterprise support
30 bureau, and the medical and long-term services and supports
31 bureau, and a representative of the program integrity unit,
32 or their designees; and representatives of other appropriate
33 state agencies or other entities including but not limited to
34 the office of the attorney general, the office of long-term
35 care ombudsman, and the Medicaid fraud control unit of the

1 investigations division of the department of inspections and
2 appeals. The workgroup shall do all of the following:

3 a. Review the duties of each entity with responsibilities
4 relative to Medicaid program integrity and managed care
5 organizations; review state and federal laws, regulations,
6 requirements, guidance, and policies relating to Medicaid
7 program integrity and managed care organizations; and review
8 the laws of other states relating to Medicaid program integrity
9 and managed care organizations. The workgroup shall determine
10 areas of duplication, fragmentation, and gaps; shall identify
11 possible integration, collaboration and coordination of duties;
12 and shall determine whether existing general state Medicaid
13 program and fee-for-service policies, laws, and rules are
14 sufficient, or if changes or more specific policies, laws, and
15 rules are required to provide for comprehensive and effective
16 administration and oversight of the Medicaid program including
17 under the fee-for-service and managed care methodologies.

18 b. Review historical uses of the Medicaid fraud fund created
19 in section 249A.50 and make recommendations for future uses
20 of the moneys in the fund and any changes in law necessary to
21 adequately address program integrity.

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

33 d. Review the capacity of state agencies, including the need
34 for specialized training and expertise, to address Medicaid
35 and managed care organization program integrity and provide

1 recommendations for the provision of necessary resources and
2 infrastructure, including annual budget projections.

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

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

18 g. Review and make recommendations to prohibit
19 cost-shifting between state and local and public and private
20 funding sources for services and supports provided to Medicaid
21 recipients whether directly or indirectly through the Medicaid
22 program.

23 2. The department of human services shall submit a report
24 of the workgroup to the governor, the health policy oversight
25 committee created in section 2.45, and the general assembly
26 initially, on or before November 15, 2016, and on or before
27 November 15, on an annual basis thereafter, to provide findings
28 and recommendations for a coordinated approach to comprehensive
29 and effective administration and oversight of the Medicaid
30 program including under the fee-for-service and managed care
31 methodologies.

32 MEDICAID REINVESTMENT FUND

33 Sec. 5. NEW SECTION. 249A.4C Medicaid reinvestment fund.

34 1. A Medicaid reinvestment fund is created in the state
35 treasury under the authority of the department. The department

1 of human services shall collect an initial contribution of five
2 million dollars from each of the managed care organizations
3 contracting with the state during the fiscal year beginning
4 July 1, 2015, for an aggregate amount of fifteen million
5 dollars, and shall deposit such amount in the fund to be
6 used for Medicaid ombudsman activities through the office
7 of long-term care ombudsman. Additionally, moneys from
8 savings realized from the movement of Medicaid recipients from
9 institutional settings to home and community-based services,
10 the portion of the capitation rate withheld from and not
11 returned to Medicaid managed care organizations at the end
12 of each fiscal year, any recouped excess of capitation rates
13 paid to Medicaid managed care organizations, any overpayments
14 recovered under Medicaid managed care contracts, and any
15 other savings realized from Medicaid managed care or from
16 Medicaid program cost-containment efforts, with the exception
17 of the total amount attributable to the projected savings from
18 Medicaid managed care based on the initial capitation rates
19 established for the fiscal year beginning July 1, 2015, shall
20 be credited to the Medicaid reinvestment fund.

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

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

35 b. Providing home and community-based services as necessary

1 to rebalance the long-term services and supports infrastructure
2 and to reduce Medicaid home and community-based services waiver
3 waiting lists.

4 *c.* Ensuring that a fully functioning independent Medicaid
5 ombudsman program through the office of long-term care
6 ombudsman is available to provide advocacy services and
7 assistance to eligible and potentially eligible Medicaid
8 recipients.

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

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

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

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

33 MEDICAID OMBUDSMAN

34 Sec. 6. Section 231.44, Code 2016, is amended to read as
35 follows:

1 **231.44 Utilization of resources — assistance and advocacy**
2 **related to long-term services and supports under the Medicaid**
3 **program.**

4 1. The office of long-term care ombudsman ~~may~~ shall
5 utilize its available resources to provide assistance and
6 advocacy services to eligible recipients of long-term services
7 and supports, or individuals seeking long-term services and
8 supports, and the families or legal representatives of such
9 ~~eligible recipients, of long-term services and supports~~
10 ~~provided through~~ individuals under the Medicaid program. Such
11 assistance and advocacy shall include but is not limited to all
12 of the following:

13 a. Assisting ~~recipients~~ such individuals in understanding
14 the services, coverage, and access provisions and their rights
15 under Medicaid managed care.

16 b. Developing procedures for the tracking and reporting
17 of the outcomes of individual requests for assistance, the
18 obtaining of necessary services and supports, and other
19 aspects of the services provided to ~~eligible recipients~~ such
20 individuals.

21 c. Providing advice and assistance relating to the
22 preparation and filing of complaints, grievances, and appeals
23 of complaints or grievances, including through processes
24 available under managed care plans and the state appeals
25 process, relating to long-term services and supports under the
26 Medicaid program.

27 d. Accessing the results of a review of a level of care
28 assessment or reassessment by a managed care organization
29 in which the managed care organization recommends denial or
30 limited authorization of a service, including the type or level
31 of service, the reduction, suspension, or termination of a
32 previously authorized service, or a change in level of care,
33 upon the request of an affected individual.

34 e. Receiving notices of disenrollment or notices that would
35 result in a change in level of care for affected individuals,

1 including involuntary and voluntary discharges or transfers,
2 from the department of human services or a managed care
3 organization.

4 2. A representative of the office of long-term care
5 ombudsman providing assistance and advocacy services authorized
6 under [this section](#) for an individual, shall be provided
7 access to the individual, and shall be provided access to
8 the individual's medical and social records as authorized by
9 the individual or the individual's legal representative, as
10 necessary to carry out the duties specified in [this section](#).

11 3. A representative of the office of long-term care
12 ombudsman providing assistance and advocacy services authorized
13 under [this section](#) for an individual, shall be provided access
14 to administrative records related to the provision of the
15 long-term services and supports to the individual, as necessary
16 to carry out the duties specified in [this section](#).

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

32 5. The department of human services and Medicaid managed
33 care organizations shall inform eligible and potentially
34 eligible Medicaid recipients of the advocacy services and
35 assistance available through the office of long-term care

1 ombudsman and shall provide contact and other information
2 regarding the advocacy services and assistance to eligible and
3 potentially eligible Medicaid recipients as directed by the
4 office of long-term care ombudsman.

5 6. When providing assistance and advocacy services under
6 this section, the office of long-term care ombudsman shall act
7 as an independent agency, and the office of long-term care
8 ombudsman and representatives of the office shall be free of
9 any undue influence that restrains the ability of the office
10 or the office's representatives from providing such services
11 and assistance.

12 7. The office of long-term care ombudsman shall, in addition
13 to other duties prescribed and at a minimum, do all of the
14 following in the furtherance of the provision of advocacy
15 services and assistance under this section:

16 a. Represent the interests of eligible and potentially
17 eligible Medicaid recipients before governmental agencies.

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

24 c. To maintain transparency and accountability for
25 activities performed under this section, including for the
26 purposes of claiming federal financial participation for
27 activities that are performed to assist with administration of
28 the Medicaid program:

29 (1) Have complete and direct responsibility for the
30 administration, operation, funding, fiscal management, and
31 budget related to such activities, and directly employ,
32 oversee, and supervise all paid and volunteer staff associated
33 with these activities.

34 (2) Establish separation-of-duties requirements, provide
35 limited access to work space and work product for only

1 necessary staff, and limit access to documents and information
2 as necessary to maintain the confidentiality of the protected
3 health information of individuals served under this section.

4 (3) Collect and submit, annually, to the governor, the
5 health policy oversight committee created in section 2.45, and
6 the general assembly, all of the following with regard to those
7 seeking advocacy services or assistance under this section:

8 (a) The number of contacts by contact type and geographic
9 location.

10 (b) The type of assistance requested including the name of
11 the managed care organization involved, if applicable.

12 (c) The time frame between the time of the initial contact
13 and when an initial response was provided.

14 (d) The amount of time from the initial contact to
15 resolution of the problem or concern.

16 (e) The actions taken in response to the request for
17 advocacy or assistance.

18 (f) The outcomes of requests to address problems or
19 concerns.

20 ~~4.~~ 8. For the purposes of **this section**:

21 a. *"Institutional setting"* includes a long-term care
22 facility, an elder group home, or an assisted living program.

23 b. *"Long-term services and supports"* means the broad range of
24 health, health-related, and personal care assistance services
25 and supports, provided in both institutional settings and home
26 and community-based settings, necessary for older individuals
27 and persons with disabilities who experience limitations in
28 their capacity for self-care due to a physical, cognitive, or
29 mental disability or condition.

30 **Sec. 7. NEW SECTION. 231.44A Willful interference with**
31 **duties related to long-term services and supports — penalty.**

32 Willful interference with a representative of the office of
33 long-term care ombudsman in the performance of official duties
34 in accordance with section 231.44 is a violation of section
35 231.44, subject to a penalty prescribed by rule. The office

1 of long-term care ombudsman shall adopt rules specifying the
2 amount of a penalty imposed, consistent with the penalties
3 imposed under section 231.42, subsection 8, and specifying
4 procedures for notice and appeal of penalties imposed. Any
5 moneys collected pursuant to this section shall be deposited in
6 the Medicaid reinvestment fund created in section 249A.4C.

7 MEDICAL ASSISTANCE ADVISORY COUNCIL

8 Sec. 8. Section 249A.4B, Code 2016, is amended to read as
9 follows:

10 **249A.4B Medical assistance advisory council.**

11 1. A medical assistance advisory council is created to
12 comply with 42 C.F.R. §431.12 based on section 1902(a)(4) of
13 the federal Social Security Act and to advise the director
14 about health and medical care services under the ~~medical~~
15 assistance Medicaid program, participate in Medicaid policy
16 development and program administration, and provide guidance
17 on key issues related to the Medicaid program, whether
18 administered under a fee-for-service, managed care, or other
19 methodology, including but not limited to access to care,
20 quality of care, and service delivery.

21 a. The council shall have the opportunity for participation
22 in policy development and program administration, including
23 furthering the participation of recipients of the program, and
24 without limiting this general authority shall specifically do
25 all of the following:

26 (1) Formulate, review, evaluate, and recommend policies,
27 rules, agency initiatives, and legislation pertaining to the
28 Medicaid program. The council shall have the opportunity
29 to comment on proposed rules prior to commencement of the
30 rulemaking process and on waivers and state plan amendment
31 applications.

32 (2) Prior to the annual budget development process, engage
33 in setting priorities, including consideration of the scope
34 and utilization management criteria for benefits, beneficiary
35 eligibility, provider and services reimbursement rates, and

1 other budgetary issues.

2 (3) Provide oversight for and review of the administration
3 of the Medicaid program.

4 (4) Ensure that the membership of the council effectively
5 represents all relevant and concerned viewpoints, particularly
6 those of consumers, providers, and the general public; create
7 public understanding; and ensure that the services provided
8 under the Medicaid program meet the needs of the people served.

9 b. The council shall meet ~~no more than~~ at least quarterly,
10 and prior to the next subsequent meeting of the executive
11 committee. ~~The director of public health~~ The public member
12 acting as a co-chairperson of the executive committee and
13 the professional or business entity member acting as a
14 co-chairperson of the executive committee, shall serve as
15 chairperson ~~co-chairpersons~~ of the council.

16 2. The council shall include all of the following voting
17 members:

18 a. The president, or the president's representative, of each
19 of the following professional or business entities, or a member
20 of each of the following professional or business entities,
21 selected by the entity:

22 (1) The Iowa medical society.

23 (2) The Iowa osteopathic medical association.

24 (3) The Iowa academy of family physicians.

25 (4) The Iowa chapter of the American academy of pediatrics.

26 (5) The Iowa physical therapy association.

27 (6) The Iowa dental association.

28 (7) The Iowa nurses association.

29 (8) The Iowa pharmacy association.

30 (9) The Iowa podiatric medical society.

31 (10) The Iowa optometric association.

32 (11) The Iowa association of community providers.

33 (12) The Iowa psychological association.

34 (13) The Iowa psychiatric society.

35 (14) The Iowa chapter of the national association of social

1 workers.

2 (15) The coalition for family and children's services in
3 Iowa.

4 (16) The Iowa hospital association.

5 (17) The Iowa association of rural health clinics.

6 (18) The Iowa primary care association.

7 (19) Free clinics of Iowa.

8 (20) The opticians' association of Iowa, inc.

9 (21) The Iowa association of hearing health professionals.

10 (22) The Iowa speech and hearing association.

11 (23) The Iowa health care association.

12 (24) The Iowa association of area agencies on aging.

13 (25) AARP.

14 (26) The Iowa caregivers association.

15 (27) The Iowa coalition of home and community-based
16 services for seniors.

17 (28) The Iowa adult day services association.

18 (29) Leading age Iowa.

19 (30) The Iowa association for home care.

20 (31) The Iowa council of health care centers.

21 (32) The Iowa physician assistant society.

22 (33) The Iowa association of nurse practitioners.

23 (34) The Iowa nurse practitioner society.

24 (35) The Iowa occupational therapy association.

25 (36) The ARC of Iowa, formerly known as the association for
26 retarded citizens of Iowa.

27 (37) The national alliance ~~for the mentally ill~~ on mental
28 illness of Iowa.

29 (38) The Iowa state association of counties.

30 (39) The Iowa developmental disabilities council.

31 (40) The Iowa chiropractic society.

32 (41) The Iowa academy of nutrition and dietetics.

33 (42) The Iowa behavioral health association.

34 (43) The midwest association for medical equipment services
35 or an affiliated Iowa organization.

1 (44) The Iowa public health association.

2 (45) The epilepsy foundation.

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

16 3. The council shall include all of the following nonvoting
17 members:

18 ~~*e.*~~ *a.* The director of public health, or the director's
19 designee.

20 ~~*d.*~~ *b.* The director of the department on aging, or the
21 director's designee.

22 *c.* The state long-term care ombudsman, or the ombudsman's
23 designee.

24 *d.* The ombudsman appointed pursuant to section 2C.3, or the
25 ombudsman's designee.

26 *e.* The dean of Des Moines university — osteopathic medical
27 center, or the dean's designee.

28 *f.* The dean of the university of Iowa college of medicine,
29 or the dean's designee.

30 *g.* The following members of the general assembly, each for a
31 term of two years as provided in [section 69.16B](#):

32 (1) Two members of the house of representatives, one
33 appointed by the speaker of the house of representatives
34 and one appointed by the minority leader of the house of
35 representatives from their respective parties.

1 (2) Two members of the senate, one appointed by the
2 president of the senate after consultation with the majority
3 leader of the senate and one appointed by the minority leader
4 of the senate.

5 ~~3.~~ 4. a. An executive committee of the council is created
6 and shall consist of the following members of the council:

7 (1) As voting members:

8 (a) Five of the professional or business entity members
9 designated pursuant to subsection 2, paragraph "a", and
10 selected by the members specified under that paragraph.

11 ~~(2)~~ (b) Five of the public members appointed pursuant
12 to subsection 2, paragraph "b", and selected by the members
13 specified under that paragraph. Of the five public members, at
14 least one member shall be a recipient of medical assistance.

15 ~~(3)~~ (2) As nonvoting members:

16 (a) The director of public health, or the director's
17 designee.

18 (b) The director of the department on aging, or the
19 director's designee.

20 (c) The state long-term care ombudsman, or the ombudsman's
21 designee.

22 (d) The ombudsman appointed pursuant to section 2C.3, or the
23 ombudsman's designee.

24 b. The executive committee shall meet on a monthly basis.
25 ~~The director of public health~~ A public member of the executive
26 committee selected by the public members appointed pursuant to
27 subsection 2, paragraph "b", and a professional or business
28 entity member of the executive committee selected by the
29 professional or business entity members appointed pursuant
30 to subsection 2, paragraph "a", shall serve as chairperson
31 co-chairpersons of the executive committee.

32 c. Based upon the deliberations of the council, ~~and the~~
33 executive committee, and the subcommittees, the executive
34 committee, the council, and the subcommittees, respectively,
35 shall make recommendations to the director, to the health

1 policy oversight committee created in section 2.45, to the
2 general assembly's joint appropriations subcommittee on health
3 and human services, and to the general assembly's standing
4 committees on human resources regarding the budget, policy, and
5 administration of the medical assistance program.

6 5. a. The council shall create the following subcommittees,
7 and may create additional subcommittees as necessary to address
8 Medicaid program policies, administration, budget, and other
9 factors and issues:

10 (1) A stakeholder safeguards subcommittee, for which
11 the co-chairpersons shall be a public member of the council
12 appointed pursuant to subsection 2, paragraph "b", and selected
13 by the public members of the council, and a representative
14 of a professional or business entity appointed pursuant to
15 subsection 2, paragraph "a", and selected by the professional or
16 business entity representatives of the council. The mission
17 of the stakeholder safeguards subcommittee is to provide for
18 ongoing stakeholder engagement and feedback on issues affecting
19 Medicaid recipients, providers, and other stakeholders,
20 including but not limited to benefits such as transportation,
21 benefit utilization management, the inclusion of out-of-state
22 and out-of-network providers and the use of single-case
23 agreements, and reimbursement of providers and services.

24 (2) The long-term services and supports subcommittee
25 which shall be chaired by the state long-term care ombudsman,
26 or the ombudsman's designee. The mission of the long-term
27 services and supports subcommittee is to be a resource and to
28 provide advice on policy development and program administration
29 relating to Medicaid long-term services and supports including
30 but not limited to developing outcomes and performance
31 measures for Medicaid managed care for the long-term services
32 and supports population; addressing issues related to home
33 and community-based services waivers and waiting lists; and
34 reviewing the system of long-term services and supports to
35 ensure provision of home and community-based services and the

1 rebalancing of the health care infrastructure in accordance
2 with state and federal law including but not limited to the
3 principles established in Olmstead v. L.C., 527 U.S. 581
4 (1999) and the federal Americans with Disabilities Act and
5 in a manner that reflects a sustainable, person-centered
6 approach to improve health and life outcomes, supports
7 maximum independence, addresses medical and social needs in a
8 coordinated, integrated manner, and provides for sufficient
9 resources including a stable, well-qualified workforce. The
10 subcommittee shall also address and make recommendations
11 regarding the need for an ombudsman function for eligible and
12 potentially eligible Medicaid recipients beyond the long-term
13 services and supports population.

14 (3) The transparency, data, and program evaluation
15 subcommittee which shall be chaired by the director of the
16 university of Iowa public policy center, or the director's
17 designee. The mission of the transparency, data, and program
18 evaluation subcommittee is to ensure Medicaid program
19 transparency; ensure the collection, maintenance, retention,
20 reporting, and analysis of sufficient and meaningful data to
21 provide transparency and inform policy development and program
22 effectiveness; support development and administration of a
23 consumer-friendly dashboard; and promote the ongoing evaluation
24 of Medicaid stakeholder satisfaction with the Medicaid program.

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

32 (5) A health workforce subcommittee, co-chaired by the
33 bureau chief of the bureau of oral and health delivery systems
34 of the department of public health, or the bureau chief's
35 designee, and the director of the national alliance on mental

1 illness of Iowa, or the director's designee. The mission of
 2 the health workforce subcommittee is to assess the sufficiency
 3 and proficiency of the current and projected health workforce;
 4 identify barriers to and gaps in health workforce development
 5 initiatives and health workforce data to provide foundational,
 6 evidence-based information to inform policymaking and resource
 7 allocation; evaluate the most efficient application and
 8 utilization of roles, functions, responsibilities, activities,
 9 and decision-making capacity of health care professionals and
 10 other allied and support personnel; and make recommendations
 11 for improvement in, and alternative modes of, health care
 12 delivery in order to provide a competent, diverse, and
 13 sustainable health workforce in the state. The subcommittee
 14 shall work in collaboration with the office of statewide
 15 clinical education programs of the university of Iowa Carver
 16 college of medicine, Des Moines university, Iowa workforce
 17 development, and other entities with interest or expertise in
 18 the health workforce in carrying out the subcommittee's duties
 19 and developing recommendations.

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

25 c. Subcommittees shall meet at the call of the
 26 co-chairpersons or chairperson of the subcommittee, or at the
 27 request of a majority of the members of the subcommittee.

28 4. 6. For each council meeting, executive committee
 29 meeting, or subcommittee meeting, a quorum shall consist of
 30 fifty percent of the membership qualified to vote. Where a
 31 quorum is present, a position is carried by a majority of the
 32 members qualified to vote.

33 7. For each council meeting, other than those held during
 34 the time the general assembly is in session, each legislative
 35 member of the council shall be reimbursed for actual travel

1 and other necessary expenses and shall receive a per diem
2 as specified in [section 7E.6](#) for each day in attendance, as
3 shall the members of the council, ~~or~~ the executive committee,
4 or a subcommittee, for each day in attendance at a council,
5 executive committee, or subcommittee meeting, who are
6 recipients or the family members of recipients of medical
7 assistance, regardless of whether the general assembly is in
8 session.

9 ~~5.~~ 8. The department shall provide staff support and
10 independent technical assistance to the council, ~~and~~ the
11 executive committee, and the subcommittees.

12 ~~6.~~ 9. The director shall ~~consider~~ comply with the
13 requirements of this section regarding the duties of the
14 council, and the deliberations and recommendations offered
15 by of the council, and the executive committee, and the
16 subcommittees shall be reflected in the director's preparation
17 of medical assistance budget recommendations to the council on
18 human services pursuant to [section 217.3](#), ~~and~~ in implementation
19 of medical assistance program policies, and in administration
20 of the Medicaid program.

21 10. The council, executive committee, and subcommittees
22 shall jointly submit quarterly reports to the health policy
23 oversight committee created in section 2.45 and shall jointly
24 submit a report to the governor and the general assembly
25 initially by January 1, 2017, and annually, therefore,
26 summarizing the outcomes and findings of their respective
27 deliberations and any recommendations including but not limited
28 to those for changes in law or policy.

29 11. The council, executive committee, and subcommittees
30 may enlist the services of persons who are qualified by
31 education, expertise, or experience to advise, consult with,
32 or otherwise assist the council, executive committee, or
33 subcommittees in the performance of their duties. The council,
34 executive committee, or subcommittees may specifically enlist
35 the assistance of entities such as the university of Iowa

1 public policy center to provide ongoing evaluation of the
2 Medicaid program and to make evidence-based recommendations to
3 improve the program. The council, executive committee, and
4 subcommittees shall enlist input from the patient-centered
5 health advisory council created in section 135.159, the mental
6 health and disabilities services commission created in section
7 225C.5, the commission on aging created in section 231.11,
8 the bureau of substance abuse of the department of public
9 health, the Iowa developmental disabilities council, and other
10 appropriate state and local entities to provide advice to the
11 council, executive committee, and subcommittees.

12 12. The department, in accordance with 42 C.F.R. §431.12,
13 shall seek federal financial participation for the activities
14 of the council, the executive committee, and the subcommittees.

15 PATIENT-CENTERED HEALTH RESOURCES AND INFRASTRUCTURE

16 Sec. 9. Section 135.159, subsection 2, Code 2016, is amended
17 to read as follows:

18 2. a. The department shall establish a patient-centered
19 health advisory council which shall include but is not limited
20 to all of the following members, selected by their respective
21 organizations, and any other members the department determines
22 necessary to assist in the ~~department's duties at various~~
23 ~~stages of~~ development of the medical home system and in the
24 transformation to a patient-centered infrastructure that
25 integrates and coordinates services and supports to address
26 social determinants of health and meet population health goals:

27 (1) The director of human services, or the director's
28 designee.

29 (2) The commissioner of insurance, or the commissioner's
30 designee.

31 (3) A representative of the federation of Iowa insurers.

32 (4) A representative of the Iowa dental association.

33 (5) A representative of the Iowa nurses association.

34 (6) A physician and an osteopathic physician licensed
35 pursuant to [chapter 148](#) who are family physicians and members

1 of the Iowa academy of family physicians.

2 (7) A health care consumer.

3 (8) A representative of the Iowa collaborative safety net
4 provider network established pursuant to [section 135.153](#).

5 (9) A representative of the Iowa developmental disabilities
6 council.

7 (10) A representative of the Iowa chapter of the American
8 academy of pediatrics.

9 (11) A representative of the child and family policy center.

10 (12) A representative of the Iowa pharmacy association.

11 (13) A representative of the Iowa chiropractic society.

12 (14) A representative of the university of Iowa college of
13 public health.

14 (15) A representative of the Iowa public health
15 association.

16 (16) A representative of the area agencies on aging.

17 (17) A representative of the mental health and disability
18 services regions.

19 (18) A representative of early childhood Iowa.

20 *b.* Public members of the patient-centered health advisory
21 council shall receive reimbursement for actual expenses
22 incurred while serving in their official capacity only if they
23 are not eligible for reimbursement by the organization that
24 they represent.

25 *c.* (1) Beginning July 1, 2016, the patient-centered health
26 advisory council shall do all of the following:

27 (a) Review and make recommendations to the department and
28 to the general assembly regarding the building of effective
29 working relationships and strategies to support state-level
30 and community-level integration, to provide cross-system
31 coordination and synchronization, and to more appropriately
32 align health delivery models and service sectors, including but
33 not limited to public health, aging and disability services
34 agencies, mental health and disability services regions,
35 social services, child welfare, and other providers, agencies,

1 organizations, and sectors to address social determinants of
2 health, holistic well-being, and population health goals. Such
3 review and recommendations shall include a review of funding
4 streams and recommendations for blending and braiding funding
5 to support these efforts.

6 (b) Assist in efforts to evaluate the health workforce to
7 inform policymaking and resource allocation.

8 (2) The patient-centered health advisory council shall
9 submit a report to the department, the health policy oversight
10 committee created in section 2.45, and the general assembly,
11 initially, on or before December 15, 2016, and on or before
12 December 15, annually, thereafter, including any findings or
13 recommendations resulting from the council's deliberations.

14 HAWK-I PROGRAM

15 Sec. 10. Section 514I.5, subsection 8, paragraph d, Code
16 2016, is amended by adding the following new subparagraph:
17 NEW SUBPARAGRAPH. (17) Occupational therapy.

18 Sec. 11. Section 514I.5, subsection 8, Code 2016, is amended
19 by adding the following new paragraph:

20 NEW PARAGRAPH. m. The definition of medically necessary
21 and the utilization management criteria under the hawk-i
22 program in order to ensure that benefits are uniformly and
23 consistently provided across all participating insurers in
24 the type and manner that reflects and appropriately meets
25 the needs, including but not limited to the habilitative and
26 rehabilitative needs, of the child population including those
27 children with special health care needs.

28 MEDICAID PROGRAM POLICY IMPROVEMENT

29 Sec. 12. DIRECTIVES FOR MEDICAID PROGRAM POLICY
30 IMPROVEMENTS. In order to safeguard the interests of Medicaid
31 recipients, encourage the participation of Medicaid providers,
32 and protect the interests of all taxpayers, the department of
33 human services shall comply with or ensure that the specified
34 entity complies with all of the following and shall amend
35 Medicaid managed care contract provisions as necessary to

1 reflect all of the following:

2 1. CONSUMER PROTECTIONS.

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

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

23 c. Enhance monitoring of the reduction in or suspension
24 or termination of services provided to Medicaid recipients,
25 including reductions in the provision of home and
26 community-based services waiver services or increases in home
27 and community-based services waiver waiting lists. Medicaid
28 managed care organizations shall provide data to the department
29 as necessary for the department to compile periodic reports on
30 the numbers of individuals transferred from state institutions
31 and long-term care facilities to home and community-based
32 services, and the associated savings. Any savings resulting
33 from the transfers as certified by the department shall be
34 deposited in the Medicaid reinvestment fund created in section
35 249A.4C.

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

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

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

31 f. A Medicaid managed care contract shall include a
32 provision for continuity and coordination of care for a
33 consumer transitioning to Medicaid managed care, including
34 maintaining existing provider-recipient relationships and
35 honoring the amount, duration, and scope of a recipient's

1 authorized services based on the recipient's medical history
2 and needs. In the initial transition to Medicaid managed care,
3 to ensure the least amount of disruption, Medicaid managed
4 care organizations shall provide, at a minimum, a one-year
5 transition of care period for all provider types, regardless
6 of network status with an individual Medicaid managed care
7 organization.

8 g. Ensure that a Medicaid managed care organization does
9 not arbitrarily deny coverage for medically necessary services
10 based solely on financial reasons and does not shift the
11 responsibility for provision of services or payment of costs of
12 services to another entity to avoid costs or attain savings.

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

18 i. Require each Medicaid managed care organization to
19 verify the offering and actual utilization of services and
20 supports and value-added services, an individual recipient's
21 encounters and the costs associated with each encounter, and
22 requests and associated approvals or denials of services.
23 Verification of actual receipt of services and supports and
24 value-added services shall, at a minimum, consist of comparing
25 receipt of service against both what was authorized in the
26 recipient's benefit or service plan and what was actually
27 reimbursed. Value-added services shall not be reportable as
28 allowable medical or administrative costs or factored into rate
29 setting, and the costs of value-added services shall not be
30 passed on to recipients or providers.

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

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

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

19 m. Require managed care organizations to allow a recipient
20 to request that the managed care organization enter into
21 a single case agreement with a recipient's out-of-network
22 provider, including a provider outside of the state, to provide
23 for continuity of care when the recipient has an existing
24 relationship with the provider to provide a covered benefit, or
25 to ensure adequate or timely access to a provider of a covered
26 benefit when the managed care organization provider network
27 cannot ensure such adequate or timely access.

28 2. CHILDREN.

29 a. (1) The hawk-i board shall retain all authority
30 specified under chapter 514I relative to the children eligible
31 under section 514I.8 to participate in the hawk-i program,
32 including but not limited to approving any contract entered
33 into pursuant to chapter 514I; approving the benefit package
34 design, reviewing the benefit package design, and making
35 necessary changes to reflect the results of the reviews; and

1 adopting rules for the hawk-i program including those related
2 to qualifying standards for selecting participating insurers
3 for the program and the benefits to be included in a health
4 plan.

5 (2) The hawk-i board shall review benefit plans and
6 utilization review provisions and ensure that benefits provided
7 to children under the hawk-i program, at a minimum, reflect
8 those required by state law as specified in section 514I.5,
9 include both habilitative and rehabilitative services, and
10 are provided as medically necessary relative to the child
11 population served and based on the needs of the program
12 recipient and the program recipient's medical history.

13 (3) The hawk-i board shall work with the department of human
14 services to coordinate coverage and care for the population
15 of children in the state eligible for either Medicaid or
16 hawk-i coverage so that, to the greatest extent possible,
17 the two programs provide for continuity of care as children
18 transition between the two programs or to private health care
19 coverage. To this end, all contracts with participating
20 insurers providing coverage under the hawk-i program and with
21 all managed care organizations providing coverage for children
22 eligible for Medicaid shall do all of the following:

23 (a) Specifically and appropriately address the unique needs
24 of children and children's health delivery.

25 (b) Provide for the maintaining of child health panels that
26 include representatives of child health, welfare, policy, and
27 advocacy organizations in the state that address child health
28 and child well-being.

29 (c) Address early intervention and prevention strategies,
30 the provision of a child health care delivery infrastructure
31 for children with special health care needs, utilization of
32 current standards and guidelines for children's health care
33 and pediatric-specific screening and assessment tools, the
34 inclusion of pediatric specialty providers in the provider
35 network, and the utilization of health homes for children and

1 youth with special health care needs including intensive care
2 coordination and family support and access to a professional
3 family-to-family support system. Such contracts shall utilize
4 pediatric-specific quality measures and assessment tools
5 which shall align with existing pediatric-specific measures
6 as determined in consultation with the child health panel and
7 approved by the hawk-i board.

8 (d) Provide special incentives for innovative and
9 evidence-based preventive, behavioral, and developmental
10 health care and mental health care for children's programs that
11 improve the life course trajectory of these children.

12 (e) Provide that information collected from the
13 pediatric-specific assessments be used to identify health risks
14 and social determinants of health that impact health outcomes.
15 Such data shall be used in care coordination and interventions
16 to improve patient outcomes and to drive program designs that
17 improve the health of the population. Aggregate assessment
18 data shall be shared with affected providers on a routine
19 basis.

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

32 3. PROVIDER PARTICIPATION ENHANCEMENT.

33 a. Ensure that savings achieved through Medicaid managed
34 care does not come at the expense of further reductions in
35 provider rates. The department shall ensure that Medicaid

1 managed care organizations use reasonable reimbursement
2 standards for all provider types and compensate providers for
3 covered services at not less than the minimum reimbursement
4 established by state law applicable to fee for service for a
5 respective provider, service, or product for a fiscal year
6 and as determined in conjunction with actuarially sound rate
7 setting procedures. Such reimbursement shall extend for the
8 entire duration of a managed care contract.

9 b. To enhance continuity of care in the provision of
10 pharmacy services, Medicaid managed care organizations shall
11 utilize the same preferred drug list, recommended drug list,
12 prior authorization criteria, and other utilization management
13 strategies that apply to the state program directly under fee
14 for service and shall apply other provisions of applicable
15 state law including those relating to chemically unique mental
16 health prescription drugs. Reimbursement rates established
17 under Medicaid managed care contracts for ingredient cost
18 reimbursement and dispensing fees shall be subject to and shall
19 reflect provisions of state and federal law, including the
20 minimum reimbursements established in state law for fee for
21 service for a fiscal year.

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

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

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

35 f. (1) A managed care contract entered into on or after

1 July 1, 2015, shall, at a minimum, reflect all of the following
2 provisions and requirements, and shall extend the following
3 payment rates based on the specified payment floor, as
4 applicable to the provider type:

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

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

9 (ii) The outpatient ambulatory payment classification base
10 rates in effect on July 1, 2015.

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

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

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

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

19 (ii) The outpatient cost-to-charge ratio in effect on July
20 1, 2015.

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

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

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

33 (e) Community mental health centers shall receive one
34 hundred percent of the reasonable costs for the provision of
35 services to Medicaid recipients.

1 (f) Federally qualified health centers shall receive
2 cost-based reimbursement for one hundred percent of the
3 reasonable costs for the provision of services to Medicaid
4 recipients.

5 (g) The reimbursement rates for substance-related disorder
6 treatment programs licensed under section 125.13, shall be no
7 lower than the rates in effect for the fiscal year beginning
8 July 1, 2015.

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

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

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

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

1 135.153, into their provider networks.

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

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

17 j. Medicaid managed care organizations shall include
18 provider appeals and grievance procedures that in part allow
19 a provider to file a grievance independently but on behalf
20 of a Medicaid recipient and to appeal claims denials which,
21 if determined to be based on claims for medically necessary
22 services whether or not denied on an administrative basis,
23 shall receive appropriate payment.

24 k. (1) Medicaid managed care organizations shall include
25 as primary care providers any provider designated by the state
26 as a primary care provider, subject to a provider's respective
27 state certification standards, including but not limited to all
28 of the following:

29 (a) A physician who is a family or general practitioner, a
30 pediatrician, an internist, an obstetrician, or a gynecologist.

31 (b) An advanced registered nurse practitioner.

32 (c) A physician assistant.

33 (d) A chiropractor licensed pursuant to chapter 151.

34 (2) A Medicaid managed care organization shall not impose
35 more restrictive, additional, or different scope of practice

1 requirements or standards of practice on a primary care
2 provider than those prescribed by state law as a prerequisite
3 for participation in the managed care organization's provider
4 network.

5 4. CAPITATION RATES AND MEDICAL LOSS RATIO.

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

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

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

21 d. In addition to withholding two percent of a managed
22 care organization's annual capitation payment as a
23 pay-for-performance enforcement mechanism, the department of
24 human services shall also withhold an additional two percent of
25 a managed care organization's annual capitation payment until
26 the department is able to ensure that the respective managed
27 care organization has complied with all requirements relating
28 to data, information, transparency, evaluation, and oversight
29 specified by law, rule, contract, or other basis.

30 e. The department of human services shall collect an initial
31 contribution of five million dollars from each of the managed
32 care organizations contracting with the state during the fiscal
33 year beginning July 1, 2015, for an aggregate amount of fifteen
34 million dollars, and shall deposit such amount in the Medicaid
35 reinvestment fund, as provided in section 249A.4C, as enacted

1 in this Act, to be used for Medicaid ombudsman activities
2 through the office of long-term care ombudsman.

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

- 9 (1) Program integrity activities.
- 10 (2) Utilization review activities.
- 11 (3) Fraud prevention activities beyond the scope of those
12 activities necessary to recover incurred claims.
- 13 (4) Provider network development, education, or management
14 activities.
- 15 (5) Provider credentialing activities.
- 16 (6) Marketing expenses.
- 17 (7) Administrative costs associated with recipient
18 incentives.
- 19 (8) Clinical data collection activities.
- 20 (9) Claims adjudication expenses.
- 21 (10) Customer service or health care professional hotline
22 services addressing nonclinical recipient questions.
- 23 (11) Value-added or cost-containment services, wellness
24 programs, disease management, and case management or care
25 coordination programs.
- 26 (12) Health quality improvement activities unless
27 specifically approved as a medical cost by state law. Costs of
28 health quality improvement activities included in determining
29 the medical loss ratio shall be only those activities that are
30 independent improvements measurable in individual patients.
- 31 (13) Insurer claims review activities.
- 32 (14) Information technology costs unless they directly
33 and credibly improve the quality of health care and do not
34 duplicate, conflict with, or fail to be compatible with similar
35 health information technology efforts of providers.

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

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

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

17 (2) Medicaid managed care organizations shall offset
18 recoveries, rebates, and refunds against medical costs, include
19 only allowable administrative expenses in the determination of
20 administrative costs, report costs related to subcontractors
21 properly, and have complete systems checks and review processes
22 to identify overpayment possibilities.

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

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

28 a. Develop and administer a clear, detailed policy
29 regarding the collection, storage, integration, analysis,
30 maintenance, retention, reporting, sharing, and submission
31 of data and information from the Medicaid managed care
32 organizations and shall require each Medicaid managed care
33 organization to have in place a data and information system to
34 ensure that accurate and meaningful data is available. At a
35 minimum, the data shall allow the department to effectively

1 measure and monitor Medicaid managed care organization
2 performance, quality, outcomes including recipient health
3 outcomes, service utilization, finances, program integrity,
4 the appropriateness of payments, and overall compliance with
5 contract requirements; perform risk adjustments and determine
6 actuarially sound capitation rates and appropriate provider
7 reimbursements; verify that the minimum medical loss ratio is
8 being met; ensure recipient access to and use of services;
9 create quality measures; and provide for program transparency.

10 b. Medicaid managed care organizations shall directly
11 capture and retain and shall report actual and detailed
12 medical claims costs and administrative cost data to the
13 department as specified by the department. Medicaid managed
14 care organizations shall allow the department to thoroughly and
15 accurately monitor the medical claims costs and administrative
16 costs data Medicaid managed care organizations report to the
17 department.

18 c. Any audit of Medicaid managed care contracts shall ensure
19 compliance including with respect to appropriate medical costs,
20 allowable administrative costs, the medical loss ratio, cost
21 recoveries, rebates, overpayments, and with specific contract
22 performance requirements.

23 d. The external quality review organization contracting
24 with the department shall review the Medicaid managed care
25 program to determine if the state has sufficient infrastructure
26 and controls in place to effectively oversee the Medicaid
27 managed care organizations and the Medicaid program in order
28 to ensure, at a minimum, compliance with Medicaid managed
29 care organization contracts and to prevent fraud, abuse, and
30 overpayments. The results of any external quality review
31 organization review shall be submitted to the governor, the
32 general assembly, and the health policy oversight committee
33 created in section 2.45.

34 e. Publish benchmark indicators based on Medicaid program
35 outcomes from the fiscal year beginning July 1, 2015, to

1 be used to compare outcomes of the Medicaid program as
2 administered by the state program prior to July 1, 2015, to
3 those outcomes of the program under Medicaid managed care. The
4 outcomes shall include a comparison of actual costs of the
5 program as administered prior to and after implementation of
6 Medicaid managed care. The data shall also include specific
7 detail regarding the actual expenses incurred by each managed
8 care organization by specific provider line of service.

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

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

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

18 (b) The ten most common reasons for claims denials.
19 Information reported by a managed care contractor relative
20 to claims shall also include the number of claims denied,
21 appealed, and overturned based on provider type and service
22 type.

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

26 (2) The department shall ensure the validity of all
27 information submitted by a Medicaid managed care organization
28 and shall make the monthly reports available to the public.

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

35 i. Medicaid managed care contracts shall align economic

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

14 j. (1) Require consistency and uniformity of processes,
15 procedures, and forms across all Medicaid managed care
16 organizations to reduce the administrative burden to providers
17 and consumers and to increase efficiencies in the program.
18 Such requirements shall apply to but are not limited to
19 areas of uniform cost and quality reporting, uniform prior
20 authorization requirements and procedures, uniform utilization
21 management criteria, centralized, uniform, and seamless
22 credentialing requirements and procedures, and uniform critical
23 incident reporting.

24 (2) The department of human services shall establish a
25 comprehensive provider credentialing process to be recognized
26 and utilized by all Medicaid managed care organization
27 contractors. The process shall meet the national committee for
28 quality assurance and other appropriate standards. The process
29 shall ensure that credentialing is completed in a timely manner
30 without disruption to provider billing processes.

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

1 goods or services provided under a managed care contract.

2 Sec. 13. RETROACTIVE APPLICABILITY. The section of this Act
3 relating to directives for Medicaid program policy improvements
4 applies retroactively to July 1, 2015.

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

7 EXPLANATION

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

10 This bill relates to Medicaid program improvement.

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

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

19 The bill creates a Medicaid reinvestment fund for the
20 deposit of savings related to and realized from Medicaid
21 managed care. Moneys in the fund are subject to appropriation
22 by the general assembly for the Medicaid program and health
23 system transformation.

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

28 The bill clarifies the membership of the medical assistance
29 advisory council and the executive committee, provides for
30 the creation of subcommittees of the council relating to
31 stakeholder safeguards; long-term services and supports;
32 transparency, data, and program evaluation; program integrity;
33 and health workforce.

34 The bill directs the patient-centered health advisory
35 council to recommend more appropriate alignment of health

1 care delivery models and services to provide an integrated,
2 holistic, population health-based approach to health and health
3 care. The bill directs the council to perform an initial
4 review and submit a report by December 15, 2016, to the general
5 assembly, the department of human services, and the health
6 policy oversight committee, and to submit subsequent reports on
7 December 15, annually, thereafter.

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

14 The section of the bill relating to directives for Medicaid
15 program policy improvements is retroactively applicable to July
16 1, 2015.

17 The bill takes effect upon enactment.