

**House Study Bill 632 - Introduced**

SENATE/HOUSE FILE \_\_\_\_\_  
BY (PROPOSED DEPARTMENT OF  
HUMAN SERVICES BILL)

**A BILL FOR**

1 An Act relating to programs and activities under the purview of  
2 the department of human services.

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

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DIVISION I

HEALTHY AND WELL KIDS IN IOWA — DIRECTOR DUTIES

Section 1. Section 514I.4, subsection 5, Code 2018, is amended by adding the following new paragraphs:

NEW PARAGRAPH. *d.* Collect and track monthly family premiums to assure that payments are current.

NEW PARAGRAPH. *e.* Verify the number of program enrollees with each participating insurer for determination of the amount of premiums to be paid to each participating insurer.

Sec. 2. Section 514I.7, subsection 2, paragraphs g and i, Code 2018, are amended by striking the paragraphs.

DIVISION II

SHARING OF INCARCERATION DATA

Sec. 3. Section 249A.38, Code 2018, is amended to read as follows:

**249A.38 Inmates of public institutions — suspension or termination of medical assistance.**

1. ~~The following conditions shall apply to~~ department shall suspend the eligibility of an individual who is an inmate of a public institution as defined in [42 C.F.R. §435.1010](#), who is enrolled in the medical assistance program at the time of commitment to the public institution, and who remains eligible for medical assistance as an individual except for the individual's institutional status:

~~*a.* The department shall suspend the individual's eligibility for up to the initial twelve months of the period of commitment. The department shall delay the suspension of eligibility for a period of up to the first thirty days of commitment if such delay is approved by the centers for Medicare and Medicaid services of the United States department of health and human services. If such delay is not approved, the department shall suspend eligibility during the entirety of the initial twelve months of the period of commitment. Claims submitted on behalf of the individual under the medical assistance program for covered services provided during the~~

1 ~~delay period shall only be reimbursed if federal financial~~  
2 ~~participation is applicable to such claims.~~

3 ~~b. The department shall terminate an individual's~~  
4 ~~eligibility following a twelve-month period of suspension~~  
5 ~~of the individual's eligibility under paragraph "a", during~~  
6 the period of the individual's commitment to the public  
7 institution.

8 2. a. A public institution shall provide the department and  
9 the social security administration with a monthly report of the  
10 individuals who are committed to the public institution and of  
11 the individuals who are discharged from the public institution.  
12 The monthly report to the department shall include the date  
13 of commitment or the date of discharge, as applicable, of  
14 each individual committed to or discharged from the public  
15 institution during the reporting period. The monthly report  
16 shall be made through the reporting system created by the  
17 department for public, nonmedical institutions to report inmate  
18 populations. Any medical assistance expenditures, including  
19 but not limited to monthly managed care capitation payments,  
20 provided on behalf of an individual who is an inmate of a  
21 public institution but is not reported to the department  
22 in accordance with this subsection, shall be the financial  
23 responsibility of the respective public institution.

24 b. The department shall provide a public institution with  
25 the forms necessary to be used by the individual in expediting  
26 restoration of the individual's medical assistance benefits  
27 upon discharge from the public institution.

28 ~~3. This section applies to individuals as specified in~~  
29 ~~subsection 1 on or after January 1, 2012.~~

30 ~~4. 3.~~ The department may adopt rules pursuant to chapter  
31 17A to implement this section.

32 DIVISION III

33 REPORTS — MEDICAL ASSISTANCE DRUG UTILIZATION REVIEW AND  
34 MEDICAID MANAGED CARE OVERSIGHT

35 Sec. 4. Section 249A.24, subsection 4, Code 2018, is amended

1 by striking the subsection.

2 Sec. 5. 2016 Iowa Acts, chapter 1139, section 93, is amended  
3 to read as follows:

4 SEC. 93. DEPARTMENT OF HUMAN SERVICES — REPORTS. The  
5 department of human services shall submit to the chairpersons  
6 and ranking members of the human resources committees of the  
7 senate and the house of representatives and to the chairpersons  
8 and ranking members of the joint appropriations subcommittee  
9 on health and human services, ~~quarterly reports, and an~~  
10 annual report ~~beginning December 15, 2016, and annually by~~  
11 ~~December 15, thereafter~~ 31, regarding Medicaid program consumer  
12 protections, outcome achievement, and program integrity as  
13 specified in this division. The reports shall be based on and  
14 updated to include the most recent information available. The  
15 reports shall include an executive summary of the information  
16 and data compiled, an analysis of the information and data,  
17 and any trends or issues identified through such analysis,  
18 to the extent such information is not otherwise considered  
19 confidential or protected information pursuant to federal or  
20 state law. The joint appropriations subcommittee on health and  
21 human services shall dedicate a meeting of the subcommittee  
22 during the subsequent session of the general assembly to review  
23 the annual report.

24 1. CONSUMER PROTECTION.

25 The general assembly recognizes the need for ongoing review  
26 of Medicaid member engagement with and feedback regarding  
27 Medicaid managed care. The Iowa high quality health care  
28 initiative shall ensure access to medically necessary services  
29 and shall ensure that Medicaid members are fully engaged in  
30 their own health care in order to achieve overall positive  
31 health outcomes. The consumer protection component of the  
32 reports submitted as required under this section shall be based  
33 on all of the following reports relating to member and provider  
34 services:

35 a. Member enrollment and disenrollment.

1 b. Member grievances and appeals including all of the  
2 following:

3 (1) The percentage of grievances and appeals ~~resolved~~  
4 adjudicated timely.

5 (2) The number of grievances and appeals received.

6 c. Member call center performance including the service  
7 level for members, providers, and pharmacy.

8 d. Prior authorization denials and modifications including  
9 all of the following:

10 (1) The percentage of prior authorizations approved,  
11 denied, and modified.

12 (2) The percentage of prior authorizations processed within  
13 required timeframes.

14 e. Provider network access including key gaps in provider  
15 coverage based on contract time, and distance standards, ~~and~~  
16 ~~market share.~~

17 f. Care coordination and case management, including the  
18 ratio of members to care coordinators or case managers, ~~and~~  
19 ~~the average number of contacts made with members per reporting~~  
20 ~~period.~~

21 g. Level of care and functional assessments, including the  
22 percentage of level of care assessments completed timely.

23 ~~h. Population-specific reporting including all of the~~  
24 ~~following:~~

25 ~~(1) General population, including adults and children.~~

26 ~~(2) Special needs, including adults and children.~~

27 ~~(3) Behavioral health, including adults and children.~~

28 ~~(4) Elderly.~~

29 i. (1) Number of individuals served on the home and  
30 community-based services (HCBS) waivers by waiver type, and  
31 HCBS waiver waiting list reductions or increases.

32 (2) Number of individuals enrolled in 1915(i) HCBS  
33 habilitation services.

34 2. OUTCOME ACHIEVEMENT.

35 The primary focus of the general assembly in moving to

1 Medicaid managed care is to improve the quality of care and  
2 outcomes for Medicaid members. The state has demonstrated  
3 how preventive services and the coordination of care for all  
4 of a Medicaid member's treatment significantly improve the  
5 health and well-being of the state's most vulnerable citizens.  
6 In order to ensure continued improvement, ongoing review of  
7 member outcomes as well as of the process that supports a  
8 strong provider network is necessary. The outcome achievement  
9 component of the reports submitted as required under this  
10 section shall be based on all of the following reports:

11 a. Contract management including all of the following:

12 (1) Claims processing including all of the following:

13 (a) The percentage of claims paid, denied, and disputed, and  
14 the ten most common reasons for claims denials.

15 (b) The percentage of claims adjudicated timely.

16 ~~(2) Encounter data including all of the following:~~

17 ~~(a) Timeliness.~~

18 ~~(b) Completeness.~~

19 ~~(c) Accuracy.~~

20 (3) Value-based purchasing (VBP) enrollment including the  
21 percentage of members covered by a VBP arrangement.

22 (4) Financial information including all of the following:

23 (a) Managed care organization capitation payments.

24 (b) The medical loss ratio, administrative loss ratio, and  
25 underwriting ratio.

26 ~~(c) Program cost savings.~~

27 ~~(5) Utilization of health care services by diagnostic  
28 related group and ambulatory payment classification as well as  
29 total claims volume.~~

30 (6) Utilization of value-added services.

31 (7) Payment of claims by department-identified provider  
32 service type.

33 (8) Utilization of 1915(b)(3) services that are being  
34 provided in lieu of state plan services, including institutions  
35 for mental disease services.

- 1     b. Member health outcomes including all of the following:  
2     (1) Annual health care effectiveness and information set  
3     (HEDIS) performance.  
4     ~~(2) Other quality measures including all of the following:~~  
5     ~~(a) Behavioral health.~~  
6     ~~(b) Children's health outcomes.~~  
7     ~~(c) Prenatal and birth outcomes.~~  
8     ~~(d) Chronic condition management.~~  
9     ~~(e) Adult preventative care.~~  
10    ~~(3) Value index score (VIS) performance.~~  
11    ~~(4) Annual consumer assessment of health care providers and~~  
12    ~~systems (CAHPS) performance.~~  
13    (5) Utilization Annual utilization information including  
14 all of the following:  
15    (a) Inpatient hospital admissions and potential  
16 preventative admissions.  
17    (b) Readmissions.  
18    (c) Outpatient visits.  
19    (d) Emergency department visits and potentially preventable  
20 emergency department visits.  
21    c. Consumer Annual consumer satisfaction survey results.  
22    3. PROGRAM INTEGRITY.  
23    a. The Medicaid program has traditionally included  
24 comprehensive oversight and program integrity controls.  
25 Under Medicaid managed care, federal, state, and contractual  
26 safeguards will continue to be incorporated to prevent, detect,  
27 and eliminate provider fraud, waste, and abuse to maintain a  
28 sustainable Medicaid program. The program integrity component  
29 of the reports submitted as required under this section shall  
30 ~~be based on all of the following reports relating to program~~  
31 ~~integrity:~~  
32    ~~(1) The include the reporting of the level of fraud, waste,~~  
33 ~~and abuse identified by the managed care organizations.~~  
34    ~~(2) Managed care organization adherence to the program~~  
35 ~~integrity plan, including identification of program~~

1 ~~overpayments.~~

2 ~~(3) Notification of the state by the managed care~~  
3 ~~organizations regarding fraud, waste, and abuse.~~

4 ~~(4) The impact of program activities on capitation~~  
5 ~~payments.~~

6 ~~(5) Enrollment and payment information including all of the~~  
7 ~~following:~~

8 ~~(a) Eligibility.~~

9 ~~(b) Third-party liability.~~

10 ~~(6) Managed care organization reserves compared to minimum~~  
11 ~~reserves required by the insurance division of the department~~  
12 ~~of commerce.~~

13 ~~(7) A summary report by the insurance division of the~~  
14 ~~department of commerce including information relating to health~~  
15 ~~maintenance organization licensure, the annual independent~~  
16 ~~audit, insurance division reporting, and reinsurance.~~

17 b. ~~The results of any external quality review organization~~  
18 ~~review annual technical report shall be submitted directly~~  
19 ~~to the governor, the general assembly, and the health policy~~  
20 ~~oversight committee created in [section 2.45](#) posted publicly to~~  
21 ~~the department's website.~~

22 c. ~~The department of human services shall require each~~  
23 ~~Medicaid managed care organization to authorize the national~~  
24 ~~committee for quality assurance (NCQA) to submit directly to~~  
25 ~~the governor, the general assembly, and the health policy~~  
26 ~~oversight committee created in [section 2.45](#), the evaluation~~  
27 ~~report upon which the Medicaid managed care organization's NCQA~~  
28 ~~accreditation was granted, and any subsequent evaluations of~~  
29 ~~the Medicaid managed care organization.~~

30 4. INCLUSION OF INFORMATION FROM OTHER OVERSIGHT ENTITIES.

31 The council on human services, the medical assistance  
32 advisory council, the hawk-i board, the mental health and  
33 disability services commission, and the office of long-term  
34 care ombudsman shall regularly review Medicaid managed care  
35 as it relates to the entity's respective statutory duties.



1 These entities shall submit executive summaries of pertinent  
2 information regarding their deliberations during the prior year  
3 relating to Medicaid managed care to the department of human  
4 services no later than November 15, annually, for inclusion in  
5 the annual report submitted as required under this section.

6 5. PUBLIC POSTING OF INFORMATION REPORTED.

7 The department of human services shall post all of the  
8 reports specified under this section, as the information  
9 becomes available and to the extent such information is not  
10 otherwise considered confidential or protected information  
11 pursuant to federal or state law, on the Iowa health link  
12 internet site.

13 Sec. 6. 2016 Iowa Acts, chapter 1139, sections 95 and 96,  
14 are amended by striking the sections.

15 DIVISION IV

16 IOWA HEALTH AND WELLNESS PLAN REPORT ELIMINATION

17 Sec. 7. Section 249N.8, Code 2018, is amended to read as  
18 follows:

19 **249N.8 Mental health services reports.**

20 The department shall submit ~~all of the following~~ to the  
21 governor and the general assembly:

22 ~~1. Biennially, biennially,~~ a report of the results of  
23 a review, by county and region, of mental health services  
24 previously funded through taxes levied by counties pursuant to  
25 section 331.424A, that are funded during the reporting period  
26 under the Iowa health and wellness plan.

27 ~~2. Annually, a report of the results of a review of the~~  
28 ~~outcomes and effectiveness of mental health services provided~~  
29 ~~under the Iowa health and wellness plan.~~

30 DIVISION V

31 MEDICAID PROGRAM PHARMACY COPAYMENT

32 Sec. 8. 2005 Iowa Acts, chapter 167, section 42, is amended  
33 to read as follows:

34 SEC. 42. COPAYMENTS FOR PRESCRIPTION DRUGS UNDER THE  
35 MEDICAL ASSISTANCE PROGRAM. The department of human services

1 shall require recipients of medical assistance to pay the  
2 following copayments a copayment of \$1 on each prescription  
3 filled for a covered prescription drug, including each refill  
4 of such prescription, ~~as follows:~~

5 ~~1. A copayment of \$1 on each prescription filled for each~~  
6 ~~covered nonpreferred generic prescription drug.~~

7 ~~2. A copayment of \$1 for each covered preferred brand-name~~  
8 ~~or generic prescription drug.~~

9 ~~3. A copayment of \$1 for each covered nonpreferred~~  
10 ~~brand-name prescription drug for which the cost to the state is~~  
11 ~~up to and including \$25.~~

12 ~~4. A copayment of \$2 for each covered nonpreferred~~  
13 ~~brand-name prescription drug for which the cost to the state is~~  
14 ~~more than \$25 and up to and including \$50.~~

15 ~~5. A copayment of \$3 for each covered nonpreferred~~  
16 ~~brand-name prescription drug for which the cost to the state~~  
17 ~~is more than \$50.~~

18 DIVISION VI

19 MEDICAL ASSISTANCE ADVISORY COUNCIL

20 Sec. 9. Section 249A.4B, subsection 2, paragraph a,  
21 subparagraph (17), Code 2018, is amended to read as follows:

22 (17) The Iowa primary care association ~~of rural health~~  
23 ~~clinics.~~

24 Sec. 10. Section 249A.4B, subsection 2, paragraph a,  
25 subparagraphs (27) and (28), Code 2018, are amended by striking  
26 the subparagraphs.

27 Sec. 11. Section 249A.4B, subsection 4, paragraph c, Code  
28 2018, is amended to read as follows:

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

33 Sec. 12. Section 249A.4B, subsection 7, Code 2018, is  
34 amended to read as follows:

35 7. The director shall consider the recommendations offered

1 by the council and the executive committee in the director's  
2 ~~preparation of medical assistance budget recommendations to~~  
3 ~~the council on human services pursuant to section 217.3 and in~~  
4 implementation of medical assistance program policies.

5 DIVISION VII

6 TARGETED CASE MANAGEMENT AND INPATIENT PSYCHIATRIC SERVICES  
7 REIMBURSEMENT

8 Sec. 13. Section 249A.31, Code 2018, is amended to read as  
9 follows:

10 **249A.31 Cost-based reimbursement.**

11 ~~1. Providers of individual case management services for~~  
12 ~~persons with an intellectual disability, a developmental~~  
13 ~~disability, or chronic mental illness shall receive cost-based~~  
14 ~~reimbursement for one hundred percent of the reasonable~~  
15 ~~costs for the provision of the services in accordance with~~  
16 ~~standards adopted by the mental health and disability services~~  
17 ~~commission pursuant to section 225C.6. Effective July 1, 2018,~~  
18 targeted case management services shall be reimbursed based  
19 on a statewide fee schedule amount developed by rule of the  
20 department pursuant to chapter 17A.

21 ~~2. Effective July 1, 2010~~ 2014, the department shall apply  
22 ~~a cost-based reimbursement methodology for reimbursement of~~  
23 ~~psychiatric medical institution for children providers of~~  
24 inpatient psychiatric services for individuals under twenty-one  
25 years of age shall be reimbursed as follows:

26 a. For non-state-owned providers, services shall be  
27 reimbursed according to a fee schedule without reconciliation.

28 b. For state-owned providers, services shall be reimbursed  
29 at one hundred percent of the actual and allowable cost of  
30 providing the service.

31 EXPLANATION

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

34 This bill relates to programs and activities under the  
35 purview of the department of human services (DHS). The bill is

1 organized into divisions.

2 Division I of the bill relates to the healthy and well  
3 kids in Iowa (hawk-i) program by transferring two duties of  
4 the administrative contractor, the capitation process and  
5 member premium collection, to DHS through the Iowa Medicaid  
6 enterprise.

7 Division II of the bill requires public institutions to  
8 provide a monthly report of the individuals who are committed  
9 to the public institution and of the individuals who are  
10 discharged from the public institution to DHS and to the social  
11 security administration. The report to DHS is required to  
12 include the date of commitment or discharge, as applicable,  
13 of each individual committed to or discharged from the public  
14 institution during the reporting period, and the report is to  
15 be made through the reporting system created by DHS for public,  
16 nonmedical institutions to report inmate populations. Any  
17 medical assistance expenditures, including but not limited to  
18 monthly managed care capitation payments, provided on behalf of  
19 an individual who is an inmate of a public institution but is  
20 not reported as required, shall be the financial responsibility  
21 of the respective public institution.

22 Division III of the bill relates to reports relating to  
23 the medical assistance drug utilization review commission and  
24 Medicaid managed care oversight.

25 The division eliminates the requirement that the medical  
26 assistance drug utilization review commission submit an  
27 annual review, including facts and findings, of the drugs  
28 on the department's prior authorization list, to DHS and to  
29 the members of the general assembly's joint appropriations  
30 subcommittee on health and human services.

31 The division also amends provisions in 2016 Iowa Acts  
32 relating to Medicaid managed care oversight, by eliminating  
33 the requirement for quarterly reports and only requiring  
34 an annual report to be submitted by December 31, regarding  
35 Medicaid program consumer protections, outcome achievement, and

1 program integrity. The bill also eliminates the reporting of  
2 certain data elements relative to consumer protections, outcome  
3 achievement, and program integrity, but adds data elements  
4 relating to the number of individuals enrolled in 1915(i)  
5 HCBS habilitation services and the utilization of 1915(b)(3)  
6 services being provided in lieu of state plan services.

7 The division strikes the sections in the 2016 Iowa Acts  
8 relating to program policy improvements and single-case  
9 agreements, resulting in the elimination of program policy  
10 improvements relating to the recovery of costs of services  
11 furnished to a recipient while an appeal is pending,  
12 authorization of a provider to appeal on a recipient's behalf  
13 if the recipient designates the provider as the recipient's  
14 representative, the specification of those professionals to be  
15 included as primary care providers, the prohibition against  
16 more restrictive scope of practice requirements or standards of  
17 practice for primary care providers than those prescribed by  
18 state law, and managed care organization single-case agreements  
19 with out-of-network providers.

20 Division IV of the bill eliminates the requirement that DHS  
21 submit to the governor and the general assembly, annually,  
22 a report of the results of a review of the outcomes and  
23 effectiveness of mental health services provided under the Iowa  
24 health and wellness plan.

25 Division V of the bill eliminates the various copayments for  
26 a covered prescription drug under the Medicaid program based  
27 upon the prescription drug's status, and instead provides that  
28 a recipient of Medicaid is required to pay a copayment of \$1  
29 on each prescription filled for a covered prescription drug,  
30 including each refill of such prescription.

31 Division VI of the bill relates to the medical assistance  
32 advisory council (MAAC). The division amends the membership of  
33 the MAAC by replacing representation by the Iowa association of  
34 rural health clinics with representation by the Iowa primary  
35 care association, and by eliminating representation by the Iowa

1 coalition of home and community-based services for seniors  
2 and the Iowa adult day services association. The division  
3 also eliminates the duty of the MAAC executive council to make  
4 recommendations to the director of human services regarding  
5 the budget of the Medicaid program and also eliminates the  
6 corresponding requirement that the director of human services  
7 consider the recommendations relating to the budget in the  
8 director's preparation of Medicaid budget recommendations to  
9 the council on human services.

10 Division VII of the bill amends the reimbursement provision  
11 for targeted case management under the Medicaid program  
12 which is currently established as cost-based reimbursement  
13 for 100 percent of the reasonable costs for provision of the  
14 services. Under the bill, effective July 1, 2018, targeted  
15 case management will instead be reimbursed based on a statewide  
16 fee schedule amount developed by rule of the department in  
17 accordance with Code chapter 17A.

18 The bill also amends the reimbursement for psychiatric  
19 medical institutions for children to provide that inpatient  
20 psychiatric services for individuals under 21 years of age that  
21 are provided by non-state-owned providers shall be reimbursed  
22 according to a fee schedule without reconciliation and for  
23 state-owned providers, shall be reimbursed at 100 percent of  
24 the actual and allowable cost of providing the service.