House File 2716 - Introduced

HOUSE FILE 2716
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO HSB 696)

A BILL FOR

An Act relating to the supplemental nutrition assistance program; the medical assistance program; the special supplemental nutrition program for women, infants, and children; and other public assistance programs under the purview of the department of health and human services.

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

DIVISION I

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

Section 1. NEW SECTION. **135.16E Supplemental nutrition assistance program error rate —— report.**

Beginning with the fiscal quarter that starts on October 1, 2026, and every fiscal quarter thereafter, within thirty calendar days of transmission of data to the food and nutrition services of the United States department of agriculture, the department shall submit a report to the general assembly detailing payment error rates associated with the supplemental nutrition assistance program for the immediately preceding fiscal quarter. For the purposes of this section, *"supplemental nutrition assistance program"* has the same meaning as defined in section 239.1.

Sec. 2. FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM —— WAIVER OF EARNED INCOME RULES.

1. The department of health and human services shall request a waiver from the food and nutrition services of the United States department of agriculture to provide that, for purposes of state administration of the supplemental nutrition assistance program, the earned income under 7 C.F.R. §273.9(c)(7) of household members that meet all of the following criteria shall be excluded from household income:

a. Less than twenty-two years of age.

b. Enrolled in an elementary or secondary school.

c. Resides with a natural parent, adoptive parent, stepparent, or other household member who exercises parental control over the household member described in paragraphs "a" and "b".

2. The department of health and human services shall implement the waiver upon receipt of approval of the waiver from the United States department of agriculture.

Sec. 3. FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM —— WAIVER OF ELIGIBILITY VERIFICATION RULES.

1. The department of health and human services shall

request a waiver from the food and nutrition services of the United States department of agriculture to provide that, for purposes of state administration of the supplemental nutrition assistance program, information from the following automated sources be considered verified upon receipt for purposes of 7 C.F.R. §272.12(c):

a. The national directory of new hires maintained by the office of child support services of the United States office for the administration of children and families.

b. The unemployment insurance benefits data released by the Iowa department of workforce development.

c. The United States social security administration benefits, death, social security number, and citizenship records.

d. The residency and identity data released by the United States department of transportation.

e. The state incarceration data released by the Iowa department of corrections.

f. The automated employment verification service known as work number, or equivalent third-party income verification platforms.

2. The department of health and human services shall implement the waiver upon receipt of approval of the waiver from the United States department of agriculture.

Sec. 4. FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM — WAIVER OF EXPUNGEMENT RULES.

1. The department of health and human services shall request a waiver from the food and nutrition services of the United States department of agriculture to provide that, for purposes of state administration of the supplemental nutrition assistance program, expungement of benefits on a household's electronic benefit account under 7 C.F.R. §274.2(i) be permitted after three months or ninety-one days of inactivity, or of benefits remaining, on the electronic benefit account.

2. The department of health and human services shall

implement the waiver upon receipt of approval of the waiver from the United States department of agriculture.

Sec. 5. FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM —— WAIVER OF PAYMENT QUALITY CONTROL SAMPLING PROCEDURES.

1. The department of health and human services shall request a waiver from the food and nutrition services of the United States department of agriculture to provide that, for purposes of state administration of the supplemental nutrition assistance program, when reporting the state's payment error rate as outlined by 7 C.F.R. §275.14, and food and nutrition services handbooks 310 and 311, the department of health and human services be permitted to report the payment error rate based only on errors directly attributable to the department.

2. The department of health and human services shall implement the waiver upon receipt of approval of the waiver from the United States department of agriculture.

DIVISION II

MEDICAL ASSISTANCE PROGRAM

Sec. 6. Section 249A.3, subsection 2, paragraph a, subparagraph (1), Code 2026, is amended to read as follows:

(1) (a) As allowed under 42 U.S.C. §1396a(a)(10)(A)(ii)(XIII), individuals with disabilities, who are less than sixty-five years of age, who are members of families whose income is less than ~~two hundred fifty~~ three hundred percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, who have earned income and who are eligible for mandatory medical assistance or optional medical assistance under this section if earnings are disregarded. As allowed by 42 U.S.C. §1396a(r)(2), unearned income shall also be disregarded in determining whether an individual is eligible for assistance under this subparagraph. For the purposes of determining the amount of an individual's resources under this subparagraph and as allowed by 42 U.S.C. §1396a(r)(2), a maximum of ten thousand dollars of available

resources for an individual and twenty-one thousand dollars of available resources for a couple shall be disregarded, and any additional resources held in a retirement account, in a pension account, in a medical savings account, or in any other account approved under rules adopted by the department shall also be disregarded.

(b) Individuals eligible for assistance under this subparagraph, whose individual income exceeds one hundred fifty percent of the official poverty guidelines published by the United States department of health and human services for an individual, shall pay a premium. The amount of the premium shall be based on a sliding fee schedule adopted by rule of the department and shall be based on a percentage of the individual's income. ~~The maximum premium payable by an individual whose income exceeds one hundred fifty percent of the official poverty guidelines shall be commensurate with the cost of state employees' group health insurance in this state. The payment to and acceptance by an automated case management system or the department of the premium required under this subparagraph shall not automatically confer initial or continuing program eligibility on an individual.~~ The department shall maintain a page on the department's internet site where individuals can electronically pay any premium owed by an individual to the department. A premium paid to and accepted by the department's premium payment process that is subsequently determined to be untimely or to have been paid on behalf of an individual ineligible for the program shall be refunded to the remitter in accordance with rules adopted by the department. Any unpaid premium shall be a debt owed to the department.

Sec. 7. Section 249A.4, Code 2026, is amended by adding the following new subsections:

NEW SUBSECTION. 15. Submit a report to the general assembly, including the official payment error rate and a summary of the data submitted in the payment error rate

measurement report, within thirty calendar days of receipt by the department of the annual official payment error rate from the centers for Medicare and Medicaid services of the United States department of health and human services.

NEW SUBSECTION. 16. Submit an annual report to the general assembly on or before October 1 on petitions for a waiver, also referred to by the department as exceptions to policy, of rules governing the Medicaid program filed pursuant to the rules of the department. The report must include all the following for the immediately preceding fiscal year:

a. The total number of exceptions to policy granted.

b. The cumulative cost of the exceptions to policy that were granted.

c. The types of exceptions to policy that were granted.

d. Identifiable trends noted by the department including any of the following:

(1) The number of exceptions to policy granted in a particular geographic location.

(2) The types of Medicaid services that were the basis for exceptions to policy.

(3) The Medicaid program eligibility classification of individuals granted Medicaid program exceptions to policy.

Sec. 8. NEW SECTION. **249A.32C Home and community-based service waivers —— rural provider rate increase.**

1. For the purposes of this section, unless context otherwise requires:

a. *"Consumer"* means the same as defined in section 249A.29.

b. *"Rural area"* means a geographical area that is not part of a metropolitan statistical area as designated by the United States office of management and budget.

c. *"Waiver"* means the same as defined in section 249A.29.

2. The base reimbursement rate for a provider of services under a medical assistance program home and community-based services waiver shall be increased to cover the travel time and expenses incurred by the provider to provide services to a

consumer who resides in a rural area.

Sec. 9. NEW SECTION. **249A.32D Waivers —— cost neutrality.**

1. As used in this section, *"cost neutral"* means federal approval of a waiver related to the medical assistance program submitted by the department to the federal government will not result in a net increase in spending for state administration of the medical assistance program.

2. Prior to submitting a request for a waiver to the United States department of health and human services related to the medical assistance program, the department shall conduct an analysis to determine if the waiver is cost neutral. For any waiver that is determined to be not cost neutral, the department shall not submit the request for a waiver unless the waiver has been presented to the general assembly and approved by a majority vote of both houses of the general assembly.

Sec. 10. MEDICAID EXCEPTIONS TO POLICY REVIEW —— REPORT TO GENERAL ASSEMBLY. The department of health and human services shall conduct a review of petitions for a waiver, also referred to by the department as exceptions to policy, of rules governing the Medicaid program granted by the department between January 1, 2020, and January 1, 2026, and shall submit a report on or before December 15, 2026, of the findings of the review. The report shall include all of the following:

1. The total number of exceptions to policy granted.

2. The cumulative cost of the exceptions to policy that were granted.

3. The types of exceptions to policy that were granted.

4. Identifiable trends noted by the department including any of the following:

a. The number of exceptions to policy granted in a particular geographic location.

b. The types of Medicaid services that were the basis for the waiver.

c. The Medicaid program classification of individuals granted exception to policy.

Sec. 11. CONTINGENT EFFECTIVE DATE. The following takes effect contingent upon receipt of federal approval by the department of health and human services from the centers for Medicare and Medicaid services of the United States department of health and human services:

The section of this division of this Act amending section 249A.3, subsection 2, paragraph "a", subparagraph (1), Code 2026, relating to Medicaid eligibility for employed individuals with disabilities.

DIVISION III

ELIGIBILITY FOR CERTAIN PROGRAMS

Sec. 12. NEW SECTION. **234.6A Program eligibility — residency.**

1. As used in this section, *"public assistance program"* means any of the following:

a. The state child care assistance program under section 237A.13.

b. The family investment program under chapter 239B.

c. The medical assistance program under chapter 249A.

d. The supplemental nutrition assistance program administered by the state pursuant to 7 C.F.R. pts. 270 — 283, as amended.

e. The special supplemental nutrition program for women, infants, and children as provided in 42 U.S.C. §1786 et seq.

2. *a.* Unless prohibited under federal law, the department may require from an applicant to a public assistance program proof of at least twelve months of continuous residency within the state including any of the following:

(1) A statement from the applicant attesting to the applicant's reasons for being in the state and length of residency within the state.

(2) A statement from the applicant's employer confirming the applicant's employment in the state.

(3) Any other statement from other persons with knowledge who can attest to the applicant's reasons for being in the

state and length of residency within the state.

(4) A copy of the applicant's most recently filed Iowa state income tax return.

b. Paragraph *"a"* shall not apply to applicants who receive benefits under the federal Social Security Act, 42 U.S.C. §423 et seq.

Sec. 13. Section 239.6, subsection 1, paragraph a, subparagraph (4), Code 2026, is amended to read as follows:

(4) Information maintained by the United States citizenship and immigration services of the United States department of homeland security, including but not limited to information accessible through the systematic alien verification for entitlements online service.

Sec. 14. Section 239.6, subsection 2, Code 2026, is amended by adding the following new paragraph:

NEW PARAGRAPH. *g.* The systematic alien verification for entitlements online service maintained by the United States citizenship and immigration services of the United States department of homeland security or other accessible sources to verify immigration and United States citizenship information.

DIVISION IV

MISCELLANEOUS PUBLIC ASSISTANCE PROGRAMS

Sec. 15. NEW SECTION. **135.16E Special supplemental nutrition program for women, infants, and children —— citizens and qualified aliens.**

The department shall restrict participation in the special supplemental nutrition program for women, infants, and children to citizens and qualified aliens pursuant to section 742 of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193.

Sec. 16. Section 249N.6, subsection 5, Code 2026, is amended by adding the following new paragraph:

NEW PARAGRAPH. *c.* Notwithstanding any other provision of law to the contrary, an Iowa health and wellness plan provider may impose a fee of no more than five dollars on a member based

on the member's failure to attend a scheduled appointment with the provider.

Sec. 17. Section 249N.7, subsection 1, Code 2026, is amended to read as follows:

1. Membership in the Iowa health and wellness plan shall require payment of monthly contributions for members whose household income is at or above ~~fifty~~ one hundred percent of the federal poverty level. Members shall be subject to an eight dollar copayment ~~amounts applicable only to~~ for nonemergency use of a hospital emergency department. Total member cost-sharing, annually, shall align with the cost-sharing limitations requirements for the American health benefits exchanges under the ~~Affordable Care Act~~ One Big Beautiful Bill Act, Pub. L. No. 119-21. ~~Contributions~~ Monthly contributions and copayment amounts for members shall be established by rule of the department.

Sec. 18. Section 249N.7, Code 2026, is amended by adding the following new subsections:

NEW SUBSECTION. 3. Notwithstanding subsection 1, a member who fails to complete all required preventative care services and wellness activities specified during the prior annual membership period shall be subject to a monthly five dollar fee during the subsequent year of membership.

NEW SUBSECTION. 4. Notwithstanding subsection 1, a member whose household income is at or above one hundred percent of the federal poverty level shall be subject to the following copay amounts:

a. A five dollar copay for a diagnostic dental procedure. As used in this paragraph, *"diagnostic dental procedure"* means a dental procedure that is not performed for preventative purposes.

b. A one dollar copay for a prescription drug when a suitable generic equivalent drug approved by the United States food and drug administration is available to the member.

Sec. 19. 2023 Iowa Acts, chapter 104, section 12, subsection

3, is amended to read as follows:

3. Unless otherwise provided in this Act, the department of health and human services shall implement the provisions of this Act in an incremental fashion, beginning July 1, 2023, with ~~a goal of~~ full implementation ~~no later than July 1, 2025~~ completed by January 1, 2027, to minimize duplication of efforts and to maximize coordination with the implementation time frames of other departmental resource enhancements.

Sec. 20. IOWA HEALTH AND WELLNESS PLAN —— MEMBER REENROLLMENT FOLLOWING TERMINATION FOR NONPAYMENT OF MONTHLY CONTRIBUTIONS. The department of human services shall seek approval of an amendment to the section 1115 demonstration waiver for the Iowa health and wellness plan from the centers for Medicare and Medicaid services of the United States department of health and human services to provide the following:

1. An Iowa health and wellness plan member who is subject to payment of a monthly contribution as the result of failure to complete required preventative care services and wellness activities, and whose eligibility for the program is terminated due to nonpayment of monthly contributions, shall be allowed to subsequently reenroll in the program without first paying any outstanding monthly contributions, if the member has not been terminated from the program previously for nonpayment of monthly contributions.

2. If an Iowa health and wellness plan member has been terminated from the program previously for nonpayment of monthly contributions, and is subsequently terminated from the program for nonpayment of monthly contributions owed as a result of failure to complete required preventative care services and wellness activities, the member shall be subject to payment of any outstanding monthly contributions prior to reenrollment in the program.

DIVISION V

PUBLIC ASSISTANCE FRAUD —— REPORT

Sec. 21. NEW SECTION. **10A.404 Fraud in public assistance — report.**

On or before October 1, 2026, and every fiscal year thereafter, the department shall submit a report to the general assembly concerning the department's activities relative to fraud in public assistance programs for the immediately preceding fiscal year. The report shall include but is not limited to a summary of the number of cases investigated, case outcomes, overpayment dollars identified, amount of cost avoidance, and actual dollars recovered.

Sec. 22. NEW SECTION. **10A.404A Fraud in special supplemental nutrition program for women, infants, and children — report.**

On or before November 1, 2026, and by November 1 every fiscal year thereafter, the department shall submit a report to the general assembly concerning the department's activities relative to fraud in the special supplemental nutrition program for women, infants, and children. The report shall include but is not limited to a summary of the number of cases investigated, case outcomes, violation points issued, and actual dollars recovered.

DIVISION VI

HIGH-ACUITY PEDIATRIC WORK GROUP — REPORT

Sec. 23. HIGH-ACUITY PEDIATRIC WORK GROUP — REPORT TO GENERAL ASSEMBLY.

1. The department of health and human services shall convene a work group to examine the unique service needs of high-acuity pediatric recipients of medical assistance under chapter 249A, and high-acuity pediatric members of the healthy and well kids in Iowa program under chapter 514I. The work group shall do all of the following:

a. Identify the barriers that prevent the high-acuity pediatric recipients and members from remaining in the least restrictive environment possible.

b. Develop a proposal for a tiered reimbursement

methodology to provide high-acuity home health services tailored to meet the allowable medical and nonmedical support needs of high-acuity pediatric recipients and members.

2. The work group shall be comprised of at least one representative of a provider of high-acuity home health services, one representative of the Iowa chapter of the American academy of pediatrics, one representative of the Iowa association of community providers, one representative of the Iowa health care association, and other individuals or organizations deemed appropriate by the department.

3. On or before December 1, 2026, the department shall submit a report to the general assembly that includes all of the following:

a. The barriers identified by the work group that prevent high-acuity pediatric recipients and members from remaining in the least restrictive environment possible.

b. The working group's proposed tiered reimbursement methodology and the estimated fiscal impact on affected providers and health care facilities.

4. The department of health and human services shall provide administrative support, including scheduling meetings of the work group as necessary to complete the work of the work group.

DIVISION VII

MEDICAID REIMBURSEMENT RATE —— SPECIAL POPULATION NURSING FACILITIES

Sec. 24. Section 249A.2, Code 2026, is amended by adding the following new subsection:

NEW SUBSECTION. 15. "*Special population nursing facility*" refers to a nursing facility that serves one of the following populations and has been designated as a special population nursing facility by the department:

a. One hundred percent of the residents served are aged thirty and under and require a skilled level of care.

b. Seventy percent of the residents served require a skilled level of care for neurological disorders.

c. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness.

d. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with medical complexity.

Sec. 25. NEW SECTION. **249A.38C Medicaid reimbursement rate — special population nursing facilities.**

The provider reimbursement rate for each special population nursing facility enrolled in Medicaid before July 1, 2025, must be the special population nursing facility's average allowable per diem costs as adjusted for inflation. The inflation factor is based on the most recent centers for Medicare and Medicaid services total skilled nursing facility market basket index. If a special population nursing facility subject to this section increases the special population nursing facility's number of beds or expands to provide additional services on or after July 1, 2025, the reimbursement rate in this section shall apply to such additional beds or services.

EXPLANATION

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

This bill relates to the supplemental nutrition assistance program (SNAP), the medical assistance program (Medicaid), the special supplemental nutrition program for women, infants, and children (WIC), and other public assistance programs under the purview of the department of health and human services (HHS).

DIVISION I — SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM. Beginning October 1, 2026, the bill requires HHS to submit a report to the general assembly every fiscal quarter detailing the payment error rates associated with SNAP for the immediately preceding fiscal quarter.

The bill requires HHS to request waivers of specific

federal SNAP regulations regarding earned income, independent verification of eligibility, expungement of benefits from certain electronic benefit accounts, and determining the state's SNAP payment error rate. HHS shall implement any requested waiver upon receipt of approval of the waiver by the federal government.

DIVISION II —— MEDICAL ASSISTANCE PROGRAM. Under current law, for an individual to be eligible for the Medicaid for employed persons with disabilities (MEPD) program, their household income must be below 250 percent of the federal poverty level (FPL), and the individual must also meet the maximum amount of resources allowed under federal law, with certain resources being disregarded by HHS in determining an individual's MEPD program eligibility. Individuals in the MEPD program pay a set premium every month to HHS on a sliding scale based on household income. A premium payment accepted directly or indirectly through an automated case management system by HHS does not automatically make an individual eligible for MEPD.

The bill requires HHS to extend MEPD eligibility to individuals with household incomes up to 300 percent of the FPL. Moneys in a pension fund are not to be considered by HHS for purposes of determining asset eligibility under MEPD. The bill strikes the maximum MEPD premium payable by individuals whose income exceeds 150 percent of the FPL, and the policy that an individual's MEPD premium payment being accepted directly or indirectly through an automated case management system by HHS does not make the individual automatically eligible for MEPD. The bill provides that HHS must allow for the electronic payment of MEPD premiums through a page maintained on the department's internet site.

The bill requires the director of HHS to submit a report to the general assembly within thirty days of the release of the official Medicaid payment error rate by the federal centers for Medicare and Medicaid services (CMS), detailing the official

Medicaid payment error rate and a summary of the payment error data as submitted to CMS by HHS.

The bill also requires the director of HHS to submit an annual report to the general assembly on or before October 1, 2026, with specific information as detailed in the bill related to certain petitions for a waiver to rules adopted by HHS (exceptions to policy) to administer Medicaid during the immediately preceding fiscal year.

Under current law, the reimbursement rate set by HHS for providers under home and community-based service waiver programs does not cover the provider's travel and other expenses associated with providing care to a resident in a rural area of the state. The bill requires HHS to cover such costs for those providers.

Prior to submission of a request by HHS for certain Medicaid waivers, the bill requires HHS to conduct a cost-neutrality analysis. If the waiver is determined by HHS to not be cost neutral, HHS must seek the approval of the general assembly by majority vote of both houses of the general assembly. "Cost neutral" is defined to mean that approval of a waiver by CMS will not result in a net increase in spending on the administration of Medicaid by the state.

HHS is required to conduct a review of exceptions to policy granted by the department between January 1, 2020, and January 1, 2026. On or before December 15, 2026, the department shall submit a report to the general assembly with specific information about these exceptions as detailed in the bill.

The bill provides that the provisions of the bill related to MEPD take effect contingent upon receipt of federal approval.

DIVISION III —— ELIGIBILITY FOR CERTAIN PROGRAMS. Unless prohibited by federal law, the bill permits HHS, for purposes of determining eligibility for assistance for certain public assistance programs, to require proof of 12 months of continuous residency through documentation as detailed in the bill. HHS may not require proof of residency for people who

are receiving social security benefits. "Public assistance program" is defined as the state child care assistance program, the family investment program, medical assistance program, supplemental nutrition assistance program, and the special nutrition assistance program for women, infants, and children.

The bill requires HHS, prior to determining the initial eligibility of an applicant for, or the ongoing eligibility of a recipient of, public assistance benefits to verify immigration and United States citizenship information of the applicant or recipient through the systematic alien verification for entitlements online service maintained by the United States citizenship and immigration services, or other accessible source.

DIVISION IV —— MISCELLANEOUS PUBLIC ASSISTANCE PROGRAMS. The bill provides that HHS shall restrict participation in WIC to citizens and qualified aliens pursuant to section 742 of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Under current law, a provider under the Iowa health and wellness plan (IHAWP) cannot charge a member a fee for missing an appointment with the provider. Under the bill, IHAWP providers may charge a member up to a $5 fee for missing an appointment. Under current law, members whose household income is at or above 50 percent of the FPL must pay a monthly contribution. The bill changes the requirement to 100 percent of the FPL. Under the bill, all IHAWP members must pay an $8 copayment for nonemergency use of a hospital emergency department. Monthly contributions and copayment amounts are established by HHS by rule.

Under current law, IHAWP members with household incomes between 51 percent and 100 percent of the FPL who fail to complete the required preventative services and wellness services annually are required to pay a monthly contribution of $5, while those members with household incomes in excess of 100 percent of the FPL that fail to complete the required

preventative services and wellness services annually are required to pay a monthly contribution of $10. The bill instead requires any member that fails to complete the required preventative services and wellness services annually to pay a monthly fee of $5 during the subsequent membership year.

The bill requires an IHAWP member whose household income is at or above 100 percent of the FPL to pay a $5 copay for diagnostic dental procedures, and a $1 copay for a prescription drug when an equivalent generic drug is available. The bill defines "diagnostic dental procedure".

Under current law, HHS was to have fully implemented the requirements for public assistance programs pursuant to Code chapter 239 by July 1, 2025. Under the bill, the department must fully implement the requirements by January 1, 2027.

The bill requires HHS to seek approval of an amendment to the section 1115 demonstration waiver for the Iowa health and wellness plan from CMS to provide that an IHAWP member whose eligibility for the program is terminated due to nonpayment of monthly contributions owed as a result of the member's failure to complete required preventative care services and wellness activities will be allowed to subsequently reenroll without first paying any outstanding monthly contributions, if the member has not been terminated from the program previously for nonpayment of monthly contributions. If the IHAWP member has previously been terminated for nonpayment of monthly contributions, the member shall be subject to payment of any outstanding monthly contributions prior to reenrollment.

DIVISION V —— PUBLIC ASSISTANCE FRAUD —— REPORT. The bill requires the department of inspections, appeals, and licensing to submit an annual report on or before October 1, 2026, to the general assembly concerning the department's activities relative to fraud in public assistance programs for the immediately preceding fiscal year. The report shall include a summary of the number of cases investigated, case outcomes, overpayment dollars identified, amount of cost avoidance, and

actual dollars recovered.

The bill requires HHS to submit an annual report on or before November 1 to the general assembly concerning the department's activities relative to fraud in WIC. The report shall include a summary of the number of cases investigated, case outcomes, violation points issued, and actual dollars recovered.

DIVISION VI —— HIGH-ACUITY PEDIATRIC WORK GROUP —— REPORT. Under the bill, HHS is required to convene a work group to identify the unique service needs of high-acuity pediatric Medicaid recipients and members of the healthy and well kids in Iowa (Hawki) program. The work group must identify barriers to the individuals remaining in the least restrictive environment possible, and develop a proposal for a tiered reimbursement methodology to provide high-acuity home health services tailored to meet the allowable medical and nonmedical support needs of such individuals. The required members of the work group are detailed in the bill. The work group shall submit a report to the general assembly on or before December 1, 2026, that outlines barriers identified by the work group to high-acuity pediatric members remaining in the least restrictive environment possible, and provides the estimated fiscal impact of the work group's proposed tiered reimbursement methodology on affected providers and health care facilities. HHS shall provide administrative support to the work group.

DIVISION VII —— MEDICAID REIMBURSEMENT RATE —— SPECIAL POPULATION NURSING FACILITIES. The bill defines "special population nursing facility" (SPNF). The bill requires HHS to set the Medicaid reimbursement rate for certain SPNFs at the average allowable per diem cost adjusted for inflation based on the special nursing facility market basket index. If an SPNF increases the number of beds or expands to provide additional services, such reimbursement rate will also apply to the additional beds or services.