House File 2539 - Reprinted

HOUSE FILE _____
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO HSB 757)

Passed House, Date _____ Passed Senate, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to health care reform including health care coverage intended for children and adults, health information technology, end=of=life care decision making, preexisting conditions and dependent children coverage, medical homes, prevention and chronic care management, a buy=in provision for certain individuals under the medical assistance program, disease prevention and wellness initiatives, health care transparency, and including an applicability provision.

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

HF 2539
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DIVISION I
HEALTH CARE COVERAGE INTENT

Section 1. DECLARATION OF INTENT.

1. It is the intent of the general assembly, as funding becomes available, to progress toward achievement of the goal that all Iowans have health care coverage which meets certain standards of quality and affordability with the initial priority being that all children have such health care coverage by December 31, 2010.

2. It is the intent of the general assembly that if sufficient funding is available, and if federal reauthorization of the state children's health insurance program provides sufficient federal allocations to the state and authorization to cover such children as an option under the state children's health insurance program, the department of human services shall expand coverage under the state children's health insurance program to cover children with family incomes up to three hundred percent of the federal poverty level, with appropriate cost sharing established for families with incomes above two hundred percent of the federal poverty level.

3. It is the intent of the general assembly that the department of human services, in consultation with state and national experts, develop an operational plan to provide health care coverage for all children in the state by building upon the current state children's health insurance program. The operational plan shall be completed by January 1, 2010, and submitted to the general assembly for review.

4. It is the intent of the general assembly that the department of human services, in consultation with state and national experts, develop an operational plan to provide health care coverage to all adults. The operational plan shall be completed by January 1, 2013, and submitted to the general assembly for review.

5. It is the intent of the general assembly to promote continued dialogue between the Iowa comprehensive health insurance association and other interested parties to address the issues of preexisting conditions and the affordability of health care coverage.

DIVISION II
IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM
DIVISION XXI
IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

Sec. 2. NEW SECTION. 135.154 DEFINITIONS.

As used in this division, unless the context otherwise requires:

1. "Board" means the state board of health created pursuant to section 136.1.

2. "Department" means the department of public health.

3. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

4. "Health information technology" means the application of information processing, involving both computer hardware and software, that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication, decision making, quality, safety, and efficiency of clinical practice, and may include but is not limited to:

a. An electronic health record that electronically compiles and maintains health information that may be derived from multiple sources about the health status of an individual and may include a core subset of each care delivery organization's electronic medical record such as a continuity of care record or a continuity of care document, computerized physician order entry, electronic prescribing, or clinical decision support.

b. A personal health record through which an individual and any other person authorized by the individual can maintain and manage the individual's health information.

c. An electronic medical record that is used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery organization, is the legal record of the patient's encounter with the care delivery organization, and is owned by the care delivery organization.

d. A computerized provider order entry function that permits the electronic ordering of diagnostic and treatment services, including prescription drugs.

e. A decision support function to assist physicians and other health care providers in making clinical decisions by providing electronic alerts and reminders to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments.

f. Tools to allow for the collection, analysis, and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction, and other health care=related performance measures.

5. "Interoperability" means the ability of two or more systems or components to exchange information or data in an accurate, effective, secure, and consistent manner and to use the information or data that has been exchanged and includes but is not limited to:

a. The capacity to connect to a network for the purpose of exchanging information or data with other users.

b. The ability of a connected, authenticated user to demonstrate appropriate permissions to participate in the instant transaction over the network.

c. The capacity of a connected, authenticated user to access, transmit, receive, and exchange usable information with other users.

6. "Recognized interoperability standard" means interoperability standards recognized by the office of the national coordinator for health information technology of the United States department of health and human services.

Sec. 3. NEW SECTION. 135.155 IOWA ELECTRONIC HEALTH == PRINCIPLES == GOALS.

1. Health information technology is rapidly evolving so that it can contribute to the goals of improving access to and quality of health care, enhancing efficiency, and reducing costs.

2. To be effective, the health information technology system shall comply with all of the following principles:

a. Be patient=centered and market=driven.

b. Be based on approved standards developed with input from all stakeholders.

c. Protect the privacy of consumers and the security and confidentiality of all health information.

d. Promote interoperability.

e. Ensure the accuracy, completeness, and uniformity of data.

3. Widespread adoption of health information technology is critical to a successful health information technology system and is best achieved when all of the following occur:

a. The market provides a variety of certified products from which to choose in order to best fit the needs of the user.

b. The system provides incentives for health care professionals to utilize the health information technology and provides rewards for any improvement in quality and efficiency resulting from such utilization.

c. The system provides protocols to address critical problems.

d. The system is financed by all who benefit from the improved quality, efficiency, savings, and other benefits that result from use of health information technology.

Sec. 4. NEW SECTION. 135.156 ELECTRONIC HEALTH INFORMATION == DEPARTMENT DUTIES == ADVISORY COUNCIL.

1. a. The department shall direct a public and private collaborative effort to promote the adoption and use of health information technology in this state in order to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals with comprehensive, real=time medical information to provide continuity of care and make the best health care decisions. The department shall provide oversight for the development, implementation, and coordination of an interoperable electronic health records system, telehealth expansion efforts, the health information technology infrastructure, and other health information technology initiatives in this state. The department shall be guided by the principles and goals specified in section 135.155.

b. All health information technology efforts shall endeavor to represent the interests and meet the needs of consumers and the health care sector, protect the privacy of individuals and the confidentiality of individuals' information, promote physician best practices, and make information easily accessible to the appropriate parties. The system developed shall be consumer=driven, flexible, and expandable.

2. The department shall do all of the following:

a. Establish a technical advisory group which shall consist of the representatives of entities involved in the electronic health records system task force established pursuant to section 217.41A, Code 2007, a licensed practicing physician, a consumer, and any other members the department determines necessary to assist in the department's duties at various stages of development of the electronic health information system. Executive branch agencies shall also be included as necessary to assist in the duties of the department. Public members of the technical advisory group shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent. Any legislative members shall be paid the per diem and expenses specified in section 2.10.

b. Adopt a statewide health information technology plan by January 1, 2009. In developing the plan, the department shall seek the input of providers, payers, and consumers. Standards and policies developed for the plan shall promote and be consistent with national standards developed by the office of the national coordinator for health information technology of the United States department of health and human services and shall address or provide for all of the following:

(1) The effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvement. The department shall adopt requirements for interoperable electronic health records in this state including a recognized interoperability standard.

(2) Education of the public and health care sector about the value of health information technology in improving patient care, and methods to promote increased support and collaboration of state and local public health agencies, health care professionals, and consumers in health information technology initiatives.

(3) Standards for the exchange of health care information.

(4) Policies relating to the protection of privacy of patients and the security and confidentiality of patient information.

(5) Policies relating to information ownership.

(6) Policies relating to governance of the various facets of the health information technology system.

(7) A single patient identifier or alternative mechanism

to share secure patient information. If no alternative mechanism is acceptable to the department, all health care professionals shall utilize the mechanism selected by the department by January 1, 2010.

(8) A standard continuity of care record and other issues related to the content of electronic transmissions. All health care professionals shall utilize the standard continuity of care record by January 1, 2010.

(9) Requirements for electronic prescribing.

(10) Economic incentives and support to facilitate participation in an interoperable system by health care professionals.

c. Identify existing and potential health information technology efforts in this state, regionally, and nationally, and integrate existing efforts to avoid incompatibility between efforts and avoid duplication.

d. Coordinate public and private efforts to provide the network backbone infrastructure for the health information technology system. In coordinating these efforts, the department shall do all of the following:

(1) Adopt policies to effectuate the logical cost effective usage of and access to the state=owned network, and support of telecommunication carrier products, where applicable.

(2) Consult with the Iowa communications network, private fiberoptic networks, and any other communications entity to seek collaboration, avoid duplication, and leverage opportunities in developing a backbone network.

(3) Establish protocols to ensure compliance with any applicable federal standards.

(4) Determine costs for accessing the network at a level that provides sufficient funding for the network.

e. Promote the use of telemedicine.

(1) Examine existing barriers to the use of telemedicine and make recommendations for eliminating these barriers.

(2) Examine the most efficient and effective systems of technology for use and make recommendations based on the findings.

f. Address the workforce needs generated by increased use of health information technology.

g. Adopt rules in accordance with chapter 17A to implement all aspects of the statewide plan and the network.

h. Coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in this state.

i. Seek and apply for any federal or private funding to assist in the implementation and support of the health information technology system and make recommendations for funding mechanisms for the ongoing development and maintenance costs of the health information technology system.

j. Identify state laws and rules that present barriers to the development of the health information technology system and recommend any changes to the governor and the general assembly.

3. Recommendations and other activities resulting from the duties authorized for the department under this section shall require approval by the board prior to any subsequent action or implementation.

Sec. 5. Section 8D.13, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 20. Access shall be offered to the Iowa hospital association for the collection, maintenance, and dissemination of health and financial data for hospitals and for hospital educational services. The Iowa hospital association shall be responsible for all costs associated with becoming part of the network, as determined by the commission.

Sec. 6. Section 136.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 11. Perform those duties authorized pursuant to section 135.156.

Sec. 7. Section 217.41A, Code 2007, is repealed.

DIVISION III

END=OF=LIFE CARE DECISION MAKING

Sec. 8. NEW SECTION. 231.62 END=OF=LIFE CARE DECISION MAKING.

1. The department shall consult with the Iowa medical society, the Iowa end=of=life coalition, the Iowa hospice organization, the university of Iowa palliative care program, and other health care professionals whose scope of practice includes end=of=life care to develop educational and patient=centered information on end=of=life care for

terminally ill patients and health care professionals.

2. For the purposes of this section, "end=of=life care" means care provided to meet the physical, psychological, social, spiritual, and practical needs of terminally ill patients and their caregivers.

DIVISION IV

HEALTH CARE COVERAGE

Sec. 9. NEW SECTION. 505.31 REIMBURSEMENT ACCOUNTS.

The commissioner of insurance shall assist employers with twenty=five or fewer employees with implementing and administering plans under section 125 of the Internal Revenue Code, including medical expense reimbursement accounts and dependent care accounts. The commissioner shall provide information about the assistance available to small employers on the insurance division's internet site.

Sec. 10. Section 509.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 8. A provision that the insurer will permit continuation of existing coverage for an unmarried dependent child of an insured or enrollee who so elects, at least through the age of twenty=five years old or so long as the dependent child maintains full=time status as a student in an accredited institution of postsecondary education, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Sec. 11. Section 513C.7, subsection 2, paragraph a, Code 2007, is amended to read as follows:

~~a.~~ The individual basic or standard health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition shall not be defined more restrictively than any of the following:

~~(1)~~ a. A condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage.

~~(2)~~ b. A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

~~(3)~~ c. A pregnancy existing on the effective date of coverage.

Sec. 12. Section 513C.7, subsection 2, paragraph b, Code 2007, is amended by striking the paragraph.

Sec. 13. NEW SECTION. 514A.3B ADDITIONAL REQUIREMENTS.

1. An insurer which accepts an individual for coverage under an individual policy or contract of accident and health insurance shall waive any time period applicable to a preexisting condition exclusion or limitation period requirement of the policy or contract with respect to particular services in an individual health benefit plan for the period of time the individual was previously covered by qualifying previous coverage as defined in section 513C.3 that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty=three days prior to the effective date of the new policy or contract. For purposes of this section, periods of coverage under medical assistance provided pursuant to chapter 249A or 514I, or Medicare coverage provided pursuant to Title XVIII of the federal Social Security Act shall not be counted with respect to the sixty=three=day requirement.

2. An insurer issuing an individual policy or contract of accident and health insurance which provides coverage for dependent children of the insured shall permit continuation of coverage for an unmarried dependent child of an insured or enrollee who so elects, at least through the age of twenty=five years old or so long as the dependent child maintains full=time status as a student in an accredited institution of postsecondary education, whichever occurs last, at a premium established in accordance with the insurer's rating practices.

Sec. 14. APPLICABILITY. This division of this Act applies to policies or contracts of accident and health insurance delivered or issued for delivery or continued or renewed in this state on or after July 1, 2008.

DIVISION V

MEDICAL HOME

DIVISION XXII

MEDICAL HOME

Sec. 15. NEW SECTION. 135.157 DEFINITIONS.

As used in this chapter, unless the context otherwise requires:

1. "Board" means the state board of health created pursuant to section 136.1.

2. "Department" means the department of public health.

3. "Health care professional" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

4. "Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health=related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health=related services to promote continuity of care; and has all of the characteristics specified in section 135.158.

5. "National committee for quality assurance" means the nationally recognized, independent nonprofit organization that measures the quality and performance of health care and health care plans in the United States; provides accreditation, certification, and recognition programs for health care plans and programs; and is recognized in Iowa as an accrediting organization for commercial and Medicaid=managed care organizations.

6. "Personal provider" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health needs, and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.

7. "Primary care" means health care which emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.

8. "Primary care provider" means any of the following who provide primary care:

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

b. An advanced registered nurse practitioner.

c. A physician assistant.

Sec. 16. NEW SECTION. 135.158 MEDICAL HOME PURPOSES == CHARACTERISTICS.

1. The purposes of a medical home are the following:

a. To reduce disparities in health care access, delivery, and health care outcomes.

b. To improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage and to provide for the sustainability of the health care system.

c. To provide a tangible method to document if each Iowan has access to health care.

2. A medical home has all of the following characteristics:

a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.

b. A provider=directed medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.

c. Whole person orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end=of=life care.

d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

e. Quality and safety. The following are quality and safety components of the medical home:

(1) Provider=directed medical practices advocate for their patients to support the attainment of optimal, patient=centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.

(2) Evidence=based medicine and clinical decision=support tools guide decision making.

(3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient=centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

g. Payment. The payment system appropriately recognizes the added value provided to patients who have a patient=centered medical home. The payment structure framework of the medical home provides all of the following:

(1) Reflects the value of provider and nonprovider staff and patient=centered care management work that is in addition to the face=to=face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of physician work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee=for=service payments for face=to=face visits. Payments for health care management services that are in addition to the face=to=face visit do not result in a reduction in the payments for face=to=face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider=guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

Sec. 17. NEW SECTION. 135.159 MEDICAL HOME SYSTEM == ADVISORY COUNCIL == DEVELOPMENT AND IMPLEMENTATION.

1. The department shall administer the medical home system. The department shall adopt rules pursuant to chapter 17A necessary to administer the medical home system.

2. a. The department shall establish an advisory council which shall include but is not limited to all of the following members, selected by their respective organizations, and any other members the department determines necessary to assist in the department's duties at various stages of development of the medical home system:

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

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

(3) A representative of health insurers.

(4) A representative of the Iowa dental association.

(5) A representative of the Iowa nurses association.

(6) A physician licensed pursuant to chapter 148 and a physician licensed pursuant to chapter 150 who are family physicians and members of the Iowa academy of family physicians.

(7) A health care consumer.

(8) A representative of the Iowa collaborative safety net provider network established pursuant to section 135.153.

(9) A representative of the governor's developmental disabilities council.

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

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

(12) A representative of the Iowa pharmacy association.

(13) A representative of the Iowa chiropractic society.

b. Public members of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent.

3. The department shall develop a plan for implementation of a statewide medical home system. The initial phase shall focus on providing a medical home for children, beginning with those children who are recipients of the medical assistance program. The second phase shall focus on providing a medical home to the expansion population under the IowaCare program and to adult recipients of medical assistance. The third phase shall focus on providing a medical home to other adults. The department, in collaboration with parents, schools, communities, health plans, and providers, shall endeavor to increase healthy outcomes for children and adults by linking the children and adults with a medical home, identifying health improvement goals for children and adults, and linking reimbursement strategies to increasing healthy outcomes for children and adults. The plan shall provide that the medical home system shall do all of the following:

a. Coordinate and provide access to evidence=based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well=child health services.

b. Provide access to appropriate specialty care and inpatient services.

c. Provide quality=driven and cost=effective health care.

d. Provide access to pharmacist=delivered medication reconciliation and medication therapy management services, where appropriate.

e. Promote strong and effective medical management including but not limited to planning treatment strategies, monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of service.

f. Emphasize patient and provider accountability.

g. Prioritize local access to the continuum of health care services in the most appropriate setting.

h. Establish a baseline for medical home goals and establish performance measures that indicate a child or adult has an established and effective medical home. For children, these goals and performance measures may include but are not limited to childhood immunizations rates, well=child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and oral health service utilization.

i. For children, coordinate with and integrate guidelines, data, and information from existing newborn and child health programs and entities, including but not limited to the healthy opportunities to experience, success=healthy families Iowa program, the community empowerment program, the center for congenital and inherited disorders screening and health care programs, standards of care for pediatric health guidelines, the office of multicultural health established in section 135.12, the oral health bureau established in section 135.15, and other similar programs and services.

4. The department shall develop an organizational structure for the medical home system in this state. The organizational structure plan shall integrate existing resources, provide a strategy to coordinate health care services, provide for monitoring and data collection on medical homes, provide for training and education to health care professionals and families, and provide for transition of children to the adult medical care system. The organizational structure may be based on collaborative teams of stakeholders throughout the state such as local public health agencies, the collaborative safety net provider network established in section 135.153, or a combination of statewide organizations. Care coordination may be provided through regional offices or through individual provider practices. The organizational structure may also include the use of telemedicine resources,

and may provide for partnering with pediatric and family practice residency programs to improve access to preventive care for children. The organizational structure shall also address the need to organize and provide health care to increase accessibility for patients including using venues more accessible to patients and having hours of operation that are conducive to the population served.

5. The department shall adopt standards and a process to certify medical homes based on the national committee for quality assurance standards. The certification process and standards shall provide mechanisms to monitor performance and to evaluate, promote, and improve the quality of health of and health care delivered to patients through a medical home. The mechanism shall require participating providers to monitor clinical progress and performance in meeting applicable standards and to provide information in a form and manner specified by the department. The evaluation mechanism shall be developed with input from consumers, providers, and payers. At a minimum the evaluation shall determine any increased quality in health care provided and any decrease in cost resulting from the medical home system compared with other health care delivery systems. The standards and process shall also include a mechanism for other ancillary service providers to become affiliated with a certified medical home.

6. The department shall adopt education and training standards for health care professionals participating in the medical home system.

7. The department shall provide for system simplification through the use of universal referral forms, internet=based tools for providers, and a central medical home internet site for providers.

8. The department shall recommend a reimbursement methodology and incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In developing the recommendations for incentives, the department shall consider, at a minimum, providing incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the recommendations for the reimbursement system, the department shall analyze, at a minimum, the feasibility of all of the following:

a. Reimbursement under the medical assistance program to promote wellness and prevention, provide care coordination, and provide chronic care management.

b. Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations.

c. Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and primary care services.

d. Increased funding for efforts to transform medical practices into certified medical homes, including emphasizing the implementation of the use of electronic health records.

e. Targeted reimbursement to providers linked to health care quality improvement measures established by the department.

f. Reimbursement for specified ancillary support services such as transportation for medical appointments and other such services.

g. Providing reimbursement for medication reconciliation and medication therapy management service, where appropriate.

9. The department shall coordinate the requirements and activities of the medical home system with the requirements and activities of the dental home for children as described in section 249J.14, subsection 7, and shall recommend financial incentives for dentists and nondental providers to promote oral health care coordination through preventive dental intervention, early identification of oral disease risk, health care coordination and data tracking, treatment, chronic care management, education and training, parental guidance, and oral health promotions for children.

10. The department shall integrate the recommendations and policies developed by the prevention and chronic care management advisory council into the medical home system.

11. Implementation phases.

a. Initial implementation shall require participation in the medical home system of children who are recipients of the medical assistance program. The department shall work with the department of human services and shall recommend to the general assembly a reimbursement methodology to compensate

providers participating under the medical assistance program for participation in the medical home system.

b. The department shall work with the department of human services to expand the medical home system to adult recipients of medical assistance and the expansion population under the IowaCare program. The department shall work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system.

c. The department shall work with the department of administrative services to allow state employees to utilize the medical home system.

d. The department shall work with insurers and self=insured companies, if requested, to make the medical home system available to individuals with private health care coverage.

12. The department shall provide oversight for all certified medical homes. The department shall review the progress of the medical home system and recommend improvements to the system, as necessary.

13. The department shall annually evaluate the medical home system and make recommendations to the governor and the general assembly regarding improvements to and continuation of the system.

14. Recommendations and other activities resulting from the duties authorized for the department under this section shall require approval by the board prior to any subsequent action or implementation.

Sec. 18. Section 136.3, Code 2007, is amended by adding the following new subsection:

NEW SUBSECTION. 12. Perform those duties authorized pursuant to section 135.159.

Sec. 19. Section 249J.14, subsection 7, Code 2007, is amended to read as follows:

7. DENTAL HOME FOR CHILDREN. By ~~July 1, 2008~~ December 31, 2010, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings, ~~and~~ preventive ~~care identified in the oral health standards~~ services, diagnostic services, treatment services, and emergency services as defined under the early and periodic screening, diagnostic, and treatment program.

DIVISION VI

PREVENTION AND CHRONIC CARE MANAGEMENT

DIVISION XXIII

PREVENTION AND CHRONIC CARE MANAGEMENT

Sec. 20. NEW SECTION. 135.160 DEFINITIONS.

For the purpose of this division, unless the context otherwise requires:

1. "Board" means the state board of health created pursuant to section 136.1.

2. "Chronic care" means health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.

3. "Chronic care information system" means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.

4. "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self=care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence=based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

5. "Chronic care plan" means a plan of care between an individual and the individual's principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient's own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.

6. "Chronic care resources" means health care professionals, advocacy groups, health departments, schools of public health and medicine, health plans, and others with expertise in public health, health care delivery, health care financing, and health care research.

7. "Chronic condition" means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.

8. "Department" means the department of public health.

9. "Director" means the director of public health.

10. "Eligible individual" means a resident of this state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance, is a member of the expansion population pursuant to chapter 249J, or is an inmate of a correctional institution in this state.

11. "Health care professional" means health care professional as defined in section 135.157.

12. "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

13. "State initiative for prevention and chronic care management" or "state initiative" means the state's plan for developing a chronic care organizational structure for prevention and chronic care management, including coordinating the efforts of health care professionals and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self=care efforts, providing systemic support for the health care professional=patient relationship and options for channeling chronic care resources and support to health care professionals, providing for community development and outreach and education efforts, and coordinating information technology initiatives with the chronic care information system.

Sec. 21. NEW SECTION. 135.161 PREVENTION AND CHRONIC CARE MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management.

2. The director may accept grants and donations and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative or as federal law directs.

3. a. The director shall establish and convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence=based prevention and chronic care management strategies into the public and private health care systems, including the medical home system. Public members of the advisory council shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

b. The advisory council shall elicit input from a variety of health care professionals, health care professional organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.

c. The advisory council shall submit initial recommendations to the director for the state initiative for prevention and chronic care management no later than July 1, 2009. The recommendations shall address all of the following:

(1) The recommended organizational structure for integrating prevention and chronic care management into the private and public health care systems. The organizational structure recommended shall align with the organizational structure established for the medical home system developed pursuant to division XXII. The advisory council shall also review existing prevention and chronic care management strategies used in the health insurance market and in private and public programs and recommend ways to expand the use of such strategies throughout the health insurance market and in the private and public health care systems.

(2) A process for identifying leading health care professionals and existing prevention and chronic care management programs in the state, and coordinating care among these health care professionals and programs.

(3) A prioritization of the chronic conditions for which prevention and chronic care management services should be provided, taking into consideration the prevalence of specific chronic conditions and the factors that may lead to the development of chronic conditions; the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals; the availability of workable, evidence=based approaches to chronic care for the chronic condition; and public input into the selection process. The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and shall also specify a timeline for inclusion of additional specific chronic conditions in the initiative.

(4) A method to involve health care professionals in identifying eligible patients for prevention and chronic care management services, which includes but is not limited to the use of a health risk assessment.

(5) The methods for increasing communication between health care professionals and patients, including patient education, patient self=management, and patient follow=up plans.

(6) The educational, wellness, and clinical management protocols and tools to be used by health care professionals, including management guideline materials for health care delivery.

(7) The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks such as the best in class estimates utilized in the national healthcare quality report of the agency for health care research and quality of the United States department of health and human services, to provide performance feedback for health care professionals and information on the quality of health care, including patient satisfaction and health status outcomes.

(8) Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of health care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

(9) Methods to involve public and private groups, health care professionals, insurers, third=party administrators, associations, community and consumer groups, and other entities to facilitate and sustain the initiative.

(10) Alignment of any chronic care information system or other information technology needs with other health care information technology initiatives.

(11) Involvement of appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

(12) Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care professionals, health insurers, and the public.

(13) A method to periodically determine the percentage of health care professionals who are participating, the success of the empowerment=of=patients approach, and any results of health outcomes of the patients participating.

(14) A means of collaborating with the health professional licensing boards pursuant to chapter 147 to review prevention and chronic care management education provided to licensees, as appropriate, and recommendations regarding education resources and curricula for integration into existing and new education and training programs.

4. Following submission of initial recommendations to the director for the state initiative for prevention and chronic care management by the advisory council, the director shall submit the state initiative to the board for approval. Subject to approval of the state initiative by the board, the department shall initially implement the state initiative among the population of eligible individuals. Following

initial implementation, the director shall work with the department of human services, insurers, health care professional organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in the state. The advisory council shall continue to review and make recommendations to the director regarding improvements to the initiative. Any recommendations are subject to approval by the board.

5. The director of the department of human services shall obtain any federal waivers or state plan amendments necessary to implement the prevention and chronic care management initiative within the medical assistance and IowaCare populations.

Sec. 22. NEW SECTION. 135.162 CLINICIANS ADVISORY PANEL.

1. The director shall convene a clinicians advisory panel to advise and recommend to the department clinically appropriate, evidence=based best practices regarding the implementation of the medical home as defined in section 135.157 and the prevention and chronic care management initiative pursuant to section 135.161. The director shall act as chairperson of the advisory panel.

2. The clinicians advisory panel shall consist of nine members representing licensed medical health care providers selected by their respective professional organizations. Terms of members shall begin and end as provided in section 69.19. Any vacancy shall be filled in the same manner as regular appointments are made for the unexpired portion of the regular term. Members shall serve terms of three years. A member is eligible for reappointment for three successive terms.

3. The clinicians advisory panel shall meet on a quarterly basis to receive updates from the director regarding strategic planning and implementation progress on the medical home and the prevention and chronic care management initiative and shall provide clinical consultation to the department regarding the medical home and the initiative.

DIVISION VII

FAMILY OPPORTUNITY ACT

Sec. 23. 2007 Iowa Acts, chapter 218, section 126, subsection 1, is amended to read as follows:

1. a. The provision in this division of this Act relating to eligibility for certain persons with disabilities under the medical assistance program shall ~~only~~ be implemented ~~if~~ when the department of human services determines that sufficient funding is available ~~in appropriations made in this Act, in combination with federal allocations to the state, for the state children's health insurance program, in excess of the amount needed to cover the current and projected enrollment under the state children's health insurance program~~. ~~If such a determination is made, the department of human services shall transfer funding from the appropriations made in this Act for the state children's health insurance program, not otherwise required for that program, to the appropriations made in this Act for medical assistance, as necessary, to implement such provision of this division of this Act.~~

b. The department shall notify the general assembly and the Code editor when the contingency in paragraph "a" occurs.

DIVISION VIII

MEDICAL ASSISTANCE QUALITY IMPROVEMENT

Sec. 24. NEW SECTION. 249A.36 MEDICAL ASSISTANCE QUALITY IMPROVEMENT COUNCIL.

1. A medical assistance quality improvement council is established. The council shall evaluate the clinical outcomes and satisfaction of consumers and providers with the medical assistance program. The council shall coordinate efforts with the costs and quality performance evaluation completed pursuant to section 249J.16.

2. a. The council shall consist of seven voting members appointed by the majority leader of the senate, the minority leader of the senate, the speaker of the house, and the minority leader of the house of representatives. At least one member of the council shall be a consumer and at least one member shall be a medical assistance program provider. An individual who is employed by a private or nonprofit organization that receives one million dollars or more in compensation or reimbursement from the department, annually, is not eligible for appointment to the council. The members shall serve terms of three years beginning and ending as provided in section 69.19, and appointments shall comply with sections 69.16 and 69.16A. Members shall receive

reimbursement for actual expenses incurred while serving in their official capacity and may also be eligible to receive compensation as provided in section 7E.6. Vacancies shall be filled by the original appointing authority and in the manner of the original appointment. A person appointed to fill a vacancy shall serve only for the unexpired portion of the term.

b. The members shall select a chairperson, annually, from among the membership. The council shall meet at least quarterly and at the call of the chairperson. A majority of the members of the council constitutes a quorum. Any action taken by the council must be adopted by the affirmative vote of a majority of its voting membership.

c. The department shall provide administrative support and necessary supplies and equipment for the council.

3. The council shall consult with and advise the Iowa Medicaid enterprise in establishing a quality assessment and improvement process.

a. The process shall be consistent with the health plan employer data and information set developed by the national committee for quality assurance and with the consumer assessment of health care providers and systems developed by the agency for health care research and quality of the United States department of health and human services. The council shall also coordinate efforts with the Iowa healthcare collaborative to create consistent quality measures.

b. The process may utilize as a basis the medical assistance and state children's health insurance quality improvement efforts of the centers for Medicare and Medicaid services of the United States department of health and human services.

c. The process shall include assessment and evaluation of both managed care and fee=for=service programs, and shall be applicable to services provided to adults and children.

d. The initial process shall be developed and implemented by December 31, 2008, with the initial report of results to be made available to the public by June 30, 2009. Following the initial report, the council shall submit a report of results to the governor and the general assembly, annually, in January.

DIVISION IX
PREVENTION AND WELLNESS
INITIATIVES

Sec. 25. Section 135.27, Code 2007, is amended by striking the section and inserting in lieu thereof the following:

135.27 IOWA HEALTHY COMMUNITIES INITIATIVE == GRANT PROGRAM.

1. PROGRAM GOALS. The department shall establish a grant program to energize local communities to transform the existing culture into a culture that promotes healthy lifestyles and leads collectively, community by community, to a healthier state. The grant program shall expand an existing healthy communities initiative to assist local boards of health, in collaboration with existing community resources, to build community capacity in addressing the prevention of chronic disease that results from risk factors including being overweight and obesity.

2. DISTRIBUTION OF GRANTS. The department shall distribute the grants on a competitive basis and shall support the grantee communities in planning and developing wellness strategies and establishing methodologies to sustain the strategies. Grant criteria shall be consistent with the existing statewide initiative between the department and the department's partners that promotes increased opportunities for physical activity and healthy eating for Iowans of all ages, or its successor, and the statewide comprehensive plan developed by the existing statewide initiative to increase physical activity, improve nutrition, and promote healthy behaviors. Grantees shall demonstrate an ability to maximize local, state, and federal resources effectively and efficiently.

3. DEPARTMENTAL SUPPORT. The department shall provide support to grantees including capacity=building strategies, technical assistance, consultation, and ongoing evaluation.

4. ELIGIBILITY. Local boards of health representing a coalition of health care providers and community and private organizations are eligible to submit applications.

Sec. 26. NEW SECTION. 135.27A GOVERNOR'S COUNCIL ON PHYSICAL FITNESS AND NUTRITION.

1. A governor's council on physical fitness and nutrition is established consisting of twelve members appointed by the

governor who have expertise in physical activity, physical fitness, nutrition, and promoting healthy behaviors. At least one member shall be a representative of elementary and secondary physical education professionals, at least one member shall be a health care professional, at least one member shall be a registered dietician, at least one member shall be recommended by the department of elder affairs, and at least one member shall be an active nutrition or fitness professional. In addition, at least one member shall be a member of a racial or ethnic minority. The governor shall select a chairperson for the council. Members shall serve terms of three years beginning and ending as provided in section 69.19. Appointments are subject to sections 69.16 and 69.16A. Members are entitled to receive reimbursement for actual expenses incurred while engaged in the performance of official duties. A member of the council may also be eligible to receive compensation as provided in section 7E.6.

2. The council shall assist in developing a strategy for implementation of the statewide comprehensive plan developed by the existing statewide initiative to increase physical activity, improve physical fitness, improve nutrition, and promote healthy behaviors. The strategy shall include specific components relating to specific populations and settings including early childhood, educational, local community, worksite wellness, health care, and older Iowans. The initial draft of the implementation plan shall be submitted to the governor and the general assembly by December 1, 2008.

3. The council shall assist the department in establishing and promoting a best practices internet site. The internet site shall provide examples of wellness best practices for individuals, communities, workplaces, and schools and shall include successful examples of both evidence=based and nonscientific programs as a resource.

4. The council shall provide oversight for the governor's physical fitness challenge. The governor's physical fitness challenge shall be administered by the department and shall provide for the establishment of partnerships with communities or school districts to offer the physical fitness challenge curriculum to elementary and secondary school students. The council shall develop the curriculum, including benchmarks and rewards, for advancing the school wellness policy through the challenge.

Sec. 27. SMALL BUSINESS QUALIFIED WELLNESS PROGRAM TAX CREDIT == PLAN. The department of public health, in consultation with the division of insurance of the department of commerce and the department of revenue, shall develop a plan to provide a tax credit to small businesses that provide qualified wellness programs to improve the health of their employees. The plan shall include specification of what constitutes a small business for the purposes of the qualified wellness program, the minimum standards for use by a small business in establishing a qualified wellness program, the criteria and a process for certification of a small business qualified wellness program, and the process for claiming a small business qualified wellness program tax credit. The department of public health shall submit the plan including any recommendations for changes in law to implement a small business qualified wellness program tax credit to the governor and the general assembly by December 15, 2008.

DIVISION X

HEALTH CARE TRANSPARENCY

DIVISION V

HEALTH CARE TRANSPARENCY

Sec. 28. NEW SECTION. 135.45 HEALTH CARE TRANSPARENCY == REPORTING REQUIREMENTS.

1. A hospital licensed pursuant to chapter 135B and a physician licensed pursuant to chapter 148, 150, or 150A shall report quality indicators, annually, to the Iowa healthcare collaborative as defined in section 135.40. The indicators shall be developed by the Iowa healthcare collaborative in accordance with evidence=based practice parameters and appropriate sample size for statistical validation.

2. A manufacturer or supplier of durable medical equipment or medical supplies doing business in the state shall submit a price list to the department of human services, annually, for use in comparing prices for such equipment and supplies with rates paid under the medical assistance program. The price lists submitted shall be made available to the public.