Senate File 296 - Reprinted

SENATE FILE 296
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SF 71)

(As Amended and Passed by the Senate March 26, 2013)

A BILL FOR

An Act relating to integrated care models for the delivery of health care, including but not limited to required utilization of a medical home by individuals currently and newly eligible for coverage under the Medicaid program and including effective date provisions.

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

Section 1. Section 135.157, subsections 4 and 6, Code 2013, are amended to read as follows:

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 and integrate all medical and nonmedical health-related services across all elements of the health care system and the patient's community as 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.

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~~ health-related needs and, working with a team of health care professionals and providers of medical and nonmedical health-related services, provides for and coordinates appropriate care to address the ~~health~~ health-related needs identified.

Sec. 2. Section 135.158, subsection 2, paragraphs b, c, and d, Code 2013, are amended to read as follows:

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

c. Whole person orientation. The personal provider is responsible for providing for all of a patient's ~~health care~~ health-related needs or taking responsibility for appropriately arranging ~~health care~~ for health-related services provided by other qualified health care professionals and providers of medical and nonmedical health-related services. This responsibility includes ~~health~~ health-related care at all stages of life including provision of preventive care,

acute care, chronic care, ~~preventive services~~ long-term care, transitional care between providers and settings, and end-of-life care. This responsibility includes whole-person care consisting of physical health care including but not limited to oral, vision, and other specialty care, pharmacy management, and behavioral health 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 coordination and integration provides linkages to community and social supports to address social determinants of health, to engage and support patients in managing their own health, and to track the progress of these community and social supports in providing whole-person care. 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.

Sec. 3. Section 135.159, subsections 1, 9, and 11, Code 2013, are amended to read as follows:

1. The department shall administer the medical home system. The department shall collaborate with the department of human services in administering medical homes under the medical assistance program. The department shall adopt rules pursuant to chapter 17A necessary to administer the medical home system, and shall collaborate with the department of human services in adopting rules for medical homes under the medical assistance program.

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, 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. Additionally, the department shall establish requirements for the medical home system to provide linkages to accessible dental homes for adults and older individuals.

11. *Implementation ~~phases~~.*

a. ~~Initial implementation shall require participation in the medical home system of children~~ The department shall collaborate with the department of human services to make medical homes accessible to the greatest extent possible to all of the following no later than January 1, 2015:

(1) Children who are recipients of full benefits under 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 adults*~~

(2) Adults who are recipients of full benefits under the medical assistance program ~~and the expansion population under the IowaCare program. The department shall work with~~ including those adults who are recipients of medical assistance under section 249A.3, subsection 1, paragraph *"v"*.

(3) Medicare and dually eligible Medicare and medical assistance program recipients, to the extent approved by 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.*~~ *b.* The department shall work with the department of administrative services to allow state employees to utilize the medical home system.

~~*d.*~~ *c.* 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.

d. The department shall assist the department of human services in developing a reimbursement methodology to compensate providers participating under the medical assistance program as a medical home.

e. Any integrated care model implemented on or after July 1, 2013, that delivers health care to medical assistance program recipients shall incorporate medical homes as its foundation. The medical home shall act as the catalyst in any such integrated care model to ensure compliance with the purposes, characteristics, and implementation plan requirements specified in sections 135.158 and 135.159, including an emphasis on whole person orientation and coordination and integration of both clinical services and nonclinical community and social supports that address social determinants of health.

Sec. 4. Section 249A.3, subsection 1, Code 2013, is amended by adding the following new paragraphs:

NEW PARAGRAPH. *v.* Beginning January 1, 2014, in accordance with section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, as codified in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), is an individual who is nineteen years of age or older and under sixty-five years of age; is not pregnant; is not entitled to or enrolled for Medicare benefits under part A, or enrolled for Medicare benefits under part B, of Tit. XVIII of the federal Social Security Act; is not otherwise described in section 1902(a)(10)(A)(i) of the federal Social Security Act; is not exempt pursuant to section 1902(k)(3), as codified in 42 U.S.C. § 1396a(k)(3), and whose income as determined under 1902(e)(14) of the federal Social Security Act, as codified in 42 U.S.C. § 1396a(e)(14), does not exceed one hundred thirty-three percent of the poverty line as defined in section 2110(c)(5) of the federal Social Security Act, as codified in 42 U.S.C. § 1397jj(c)(5), for the applicable family size. Notwithstanding any provision to the

contrary, individuals eligible for medical assistance under this paragraph shall receive coverage for benefits pursuant to 42 U.S.C. § 1396u-7(b)(1)(D) which are at a minimum those included in the medical assistance state plan benefit package for individuals otherwise eligible under this subsection 1, and adjusted as necessary to provide the essential health benefits as required pursuant to section 1302 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and as approved by the United States secretary of health and human services. If the methodology for calculating the federal medical assistance percentage for newly eligible individuals under this paragraph, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation before January 1, 2020, in a manner that reduces the percentage of federal assistance to the state, the department of human services shall implement an alternative plan as specified in the medical assistance state plan for coverage of the affected population.

NEW PARAGRAPH. *w.* Beginning January 1, 2014, is an individual who meets all of the following requirements:

(1) Is under twenty-six years of age.

(2) Was in foster care under the responsibility of the state on the date of attaining eighteen years of age or such higher age to which foster care is provided.

(3) Was enrolled in the medical assistance program under this chapter while in such foster care.

Sec. 5. Section 249A.3, subsection 2, paragraph a, subparagraph (9), Code 2013, is amended by striking the subparagraph.

Sec. 6. Section 249J.26, subsection 2, Code 2013, is amended to read as follows:

2. This chapter is repealed ~~October~~ December 31, 2013.

Sec. 7. Section 249J.26, Code 2013, is amended by adding the following new subsection:

NEW SUBSECTION. 3. The department shall prepare a plan for the transition of expansion population members to other health

care coverage options beginning January 1, 2014. The options shall include the option of coverage through the medical assistance program as provided in section 249A.3, subsection 1, paragraph "v", relating to coverage for adults who are nineteen years of age or older and under sixty-five years of age, and the option of coverage through the health benefits exchange established pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152. To the greatest extent possible, the plan shall maintain and incorporate utilization of the existing medical home and service delivery structure as developed under this chapter, including the utilization of federally qualified health centers, public hospitals, and other safety net providers, in providing access to care. The department shall submit the plan to the governor and the general assembly no later than September 1, 2013.

Sec. 8. ADVISORY COUNCIL FOR STATE INNOVATION MODEL INITIATIVE.

1. No later than thirty days after the effective date of this Act, the legislative council shall establish a legislative advisory council to guide the development of the design model and implementation plan for the state innovation model grant awarded by the Centers for Medicare and Medicaid of the United States department of health and human services. The legislative advisory council shall consist of members of the general assembly, members of the governor's advisory committee who developed the grant proposal, and representatives of consumers and health care providers, appointed by the legislative council as necessary to ensure that the process is comprehensive and provides ample opportunity for the variety of stakeholders to participate in the process.

2. The legislative advisory council shall provide oversight throughout the process, shall receive periodic progress reports from the department of human services, and shall approve any

integrated care model and implementation strategies for the medical assistance program presented by the department of human services, and shall prepare proposed legislation to implement the model and the strategies prior to its submission to the general assembly for approval during the 2014 session of the general assembly.

3. The department of human services shall develop the integrated care model based on the goals and strategies included in the state innovation model grant application to improve patient outcomes and satisfaction, while lowering costs, as follows:

a. Goals:

(1) Ensure the coordination of health care delivery for medical assistance program recipients to address the entire spectrum of an individual's physical, behavioral, and mental health needs by targeting at a minimum population health, prevention, health promotion, chronic disease management, disability, and long-term care.

(2) Emphasize whole person orientation and coordination and integration of both clinical and nonclinical care and supports, to provide individuals with the necessary tools to address determinants of health and to empower individuals to be full participants in their own health. The health care delivery model shall focus on addressing population health through primary and team-based care that incorporates the attributes of a medical home as specified in chapter 135, division XXII.

(3) Ensure accessibility of medical assistance program recipients to an adequate and qualified workforce by most efficiently utilizing the skills of the available workforce.

(4) Incorporate appropriate incentives that focus on quality outcomes and patient satisfaction, to move from volume-based to value-based purchasing.

(5) Provide for alignment of payment methods and quality across health care payers to ensure a unified set of outcomes and to recognize, through reimbursement, all participants in

the integrated system of care.

b. Strategies and model designs:

(1) A strategy to implement a multipayer integrated care model methodology across primary health care payers in the state, by aligning performance measures, utilizing a shared savings or other accountable payment methodology, and integrating an information technology platform to support the integrated care model. The strategy shall ensure statewide adoption of integrated care for the medical assistance population; explore the role of managed care plans and expansion of managed care in the medical assistance program as part of the integrated care model; address the special circumstances of areas of the state that are rural, underserved, or have higher rates of health disparities; and seek the participation of the Medicare population in the integrated care model.

(2) A strategy to incorporate long-term care and behavioral health services for the medical assistance population into the integrated care model, through integration of community health and community prevention activities.

(3) A strategy to address population health and health promotion, by investing in approaches to influence modifiable determinants of health such as access to health care, healthy behaviors, socioeconomic factors, and the physical environment that collectively impact the health of the community. The strategy shall address the underlying, pervasive, and multifaceted socioeconomic impediments that medical assistance recipients face in being full participants in their own health.

(4) A multiphase strategy to implement a statewide integrated care model to maximize access to health care for medical assistance program recipients in all areas of the state. The strategy shall incorporate flexible integrated care model options and accountable payment methodologies for participation by various types of providers including individual providers, safety net providers, and nonprofit

and public providers that have long experience in caring for vulnerable populations, into the integrated system.

(5) Implement a stakeholder process. In addition to the oversight and input provided by the legislative advisory council, the department shall hold public local listening sessions throughout the state, collaborate with consumer groups and provider groups, and partner with other state agencies such as the department on aging and the department of public health to elicit input and feedback on the model design.

(6) Develop a multipayer approach including the medical assistance and children's health insurance programs, private payers, and Medicare.

(7) Oversee the administration of the model design project.

(8) Engage providers beyond the large integrated health systems to maximize access to all levels of care within an integrated model program by medical assistance recipients.

4. The department shall submit proposed legislation specifying the model design and implementation plan to the advisory council no later than December 15, 2013.

Sec. 9. LEGISLATIVE COMMISSION ON INTEGRATED CARE MODELS.

1. a. A legislative commission on integrated care models is created for the 2013 Legislative Interim. The legislative services agency shall provide staffing assistance to the commission.

b. The commission shall include 10 members of the general assembly, three appointed by the majority leader of the senate, two appointed by the minority leader of the senate, three appointed by the speaker of the house of representatives, and two appointed by the minority leader of the house of representatives.

c. The commission shall include members of the public appointed by the legislative council who represent consumers, health care providers, hospitals and health systems, and other entities with interest or expertise related to integrated care models.

d. The commission shall include as ex officio members, the director of human services, the commissioner of insurance, the director of public health, and the attorney general, or the individual's designee.

2. The chairpersons of the commission shall be those members of the general assembly so appointed by the majority leader of the senate and the speaker of the house of representatives. Legislative members of the commission are eligible for per diem and reimbursement of actual expenses as provided in section 2.10. Consumers appointed to the commission, are entitled to receive a per diem as specified in section 7E.6 for each day spent in performance of duties as members, and shall be reimbursed for all actual and necessary expenses incurred in the performance of duties as members of the commission.

3. The commission shall do all of the following:

a. Review and make recommendations relating to the formation and operation of integrated care models in the state. The models shall include any care delivery model that integrates providers and incorporates a financial incentive to improve patient health outcomes, improve care, and reduce costs. Integrated care models include but are not limited to patient-centered medical homes, health homes, accountable care organizations (ACOs), ACO-like models, community and regional care networks, and other integrated and accountable care delivery models that utilize value-based financing methodologies and emphasize person-centered, coordinated, and comprehensive care.

b. Review integrated care models created in other states that integrate both clinical services and nonclinical community and social supports utilizing patient-centered medical homes and community care teams as basic components to determine the feasibility of adapting any of these models as a statewide system in Iowa. These models may include but are not limited to the ACO demonstration program based on the Camden Coalition of Healthcare Providers in Camden, New Jersey; the Medical

Home Network in Chicago, Illinois; the Health Commons model in New Mexico; the Accountable Care Collaborative in Colorado; Community Care of North Carolina, in North Carolina; the Blueprint for Health and the Community Health Teams in Vermont; and the Coordinated Care Organizations in Oregon.

c. Recommend the best means of providing care through integrated delivery models throughout the state including to vulnerable populations and how best to incorporate safety net providers, including but not limited to federally qualified health centers, rural health clinics, community mental health centers, public hospitals, and other nonprofit and public providers that have long experience in caring for vulnerable populations, into the integrated system.

d. Review the progress of the development of medical homes as specified in chapter 135, division XXII in the state and make recommendations for development of a statewide infrastructure of actual and virtual medical homes to act as the foundation for integrated care models.

e. Review opportunities under the federal Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 11-148, as amended, for the development of integrated care models including the Medicare Shared Savings Program for accountable care organizations, community-based collaborative care networks that include safety net providers, and consumer-operated and oriented plans. The legislative commission shall also review existing and proposed integrated care models in the state including commercial models and those developed or proposed under the Affordable Care Act including the Medicare Shared Savings Program and the Pioneer ACO to determine the opportunities for expansion or replication.

f. Address the issues relative to integrated care models including those relating to consumer protection including those that relate to confidentiality, quality assurance, grievance procedures, and appeals of patient care decisions; payment methodologies, multipayer alignment, coordination

of funding streams, and financing methods that support full integration of clinical and nonclinical services and providers; organizational, management, and governing structures; access, quality, outcomes, utilization, and other appropriate performance standards; patient attribution or assignment models; health information exchange, data reporting, and infrastructure standards; and regulatory issues including clinical integration limitations, physician self-referral, anti-kickback provisions, gain-sharing, beneficiary inducements, antitrust issues, tax exemption issues, and application of insurance regulations.

4. The legislative commission may request from any state agency or official information and assistance as needed to perform the review and make recommendations.

5. The legislative commission shall submit a final report summarizing the legislative commission's review and making recommendations to the governor and the general assembly by December 15, 2013.

Sec. 10. MEDICAID STATE PLAN.

1. The department of human services shall amend the medical assistance state plan to reflect the provisions relating to the provision of a medical home to medical assistance recipients as provided in this Act.

2. The department of human services shall amend the medical assistance state plan to provide for coverage of adults up to 133 percent of the federal poverty level as provided pursuant to section 249A.3, subsection 1, paragraph "v", as enacted in this Act, beginning January 1, 2014. The state plan amendment shall include a provision specifying that if the methodology for calculating the federal medical assistance percentage for newly eligible individuals under section 249A.3, subsection 1, paragraph "v", as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation before January 1, 2020, in a manner that reduces the percentage of federal assistance to the state, the department of human services shall implement

an alternative plan for coverage of the affected population, to the extent necessary, so that state expenditures remain budget neutral under the modified federal medical assistance percentage relative to the percentage specified for the same fiscal year under section 42 U.S.C. § 1396d(y). The state plan amendment shall provide that implementation by the department of human services of any alternative plan for coverage of the affected population is subject to prior approval of the implementation by statute.

3. The department of human services shall amend the medical assistance state plan to provide that the benchmark benefit plan provided to the newly covered adults under the medical assistance program is the option provided pursuant to 42 U.S.C. § 1396u-7(b)(1)(D) which is at a minimum the coverage included in the medical assistance state plan benefit package for individuals otherwise eligible under section 249A.3, subsection 1, and adjusted as necessary to provide the essential health benefits as required pursuant to section 1302 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and as approved by the United States secretary of health and human services.

Sec. 11. ADOPTION OF RULES. The department of human services shall adopt emergency rules pursuant to section 17A.4, subsection 3, and section 17A.5, subsection 2, paragraph "b", as necessary to implement the provisions of this Act, and the rules shall be effective immediately upon filing unless a later date is specified in the rules. Any rules adopted in accordance with this section shall also be published as a notice of intended action as provided in section 17A.4.

Sec. 12. EFFECTIVE DATE. The following provision or provisions of this Act take effect December 31, 2013:

1. The section of this Act amending section 249A.3, subsection 2, paragraph "a", subparagraph (9).

Sec. 13. EFFECTIVE UPON ENACTMENT. With the exception of the section of this Act amending section 249A.3, subsection

2, paragraph "a", subparagraph (9), this Act, being deemed of immediate importance, takes effect upon enactment.