Senate File 2213 - Reprinted

SENATE FILE 2213
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SF 2107)

(As Amended and Passed by the Senate March 2, 2016)

A BILL FOR

An Act relating to Medicaid program improvement, and including effective date and retroactive applicability provisions.

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

Section 1. LEGISLATIVE FINDINGS —— GOALS AND INTENT.

1. The general assembly finds all of the following:

a. In the majority of states, Medicaid managed care has been introduced on an incremental basis, beginning with the enrollment of low-income children and parents and proceeding in stages to include nonelderly persons with disabilities and older individuals. Iowa, unlike the majority of states, is implementing Medicaid managed care hastily and simultaneously across a broad and diverse population that includes individuals with complex health care and long-term services and supports needs, making these individuals especially vulnerable to receiving inappropriate, inadequate, or substandard services and supports.

b. The success or failure of Medicaid managed care in Iowa depends on proper strategic planning and strong oversight, and the incorporation of the core values, principles, and goals of the strategic plan into Medicaid managed care contractual obligations. While Medicaid managed care techniques may create pathways and offer opportunities toward quality improvement and predictability in costs, if cost savings and administrative efficiencies are the primary goals, Medicaid managed care may instead erect new barriers and limit the care and support options available, especially to high-need, vulnerable Medicaid recipients. A well-designed strategic plan and effective oversight ensure that cost savings, improved health outcomes, and efficiencies are not achieved at the expense of diminished program integrity, a reduction in the quality or availability of services, or adverse consequences to the health and well-being of Medicaid recipients.

c. Strategic planning should include all of the following:

(1) Guidance in establishing and maintaining a robust and appropriate workforce and a provider network capable of addressing all of the diverse, distinct, and wide-ranging treatment and support needs of Medicaid recipients.

(2) Developing a sound methodology for establishing and

adjusting capitation rates to account for all essential costs involved in treating and supporting the entire spectrum of needs across recipient populations.

(3) Addressing the sufficiency of information and data resources to enable review of factors such as utilization, service trends, system performance, and outcomes.

(4) Building effective working relationships and developing strategies to support community-level integration that provides cross-system coordination and synchronization among the various service sectors, providers, agencies, and organizations to further holistic well-being and population health goals.

d. While the contracts entered into between the state and managed care organizations function as a mechanism for enforcing requirements established by the federal and state governments and allow states to shift the financial risk associated with caring for Medicaid recipients to these contractors, the state ultimately retains responsibility for the Medicaid program and the oversight of the performance of the program's contractors. Administration of the Medicaid program benefits by managed care organizations should not be viewed by state policymakers and state agencies as a means of divesting themselves of their constitutional and statutory responsibilities to ensure that recipients of publicly funded services and supports, as well as taxpayers in general, are effectively served.

e. Overseeing the performance of Medicaid managed care contractors requires a different set of skills than those required for administering a fee-for-service program. In the absence of the in-house capacity of the department of human services to perform tasks specific to Medicaid managed care oversight, the state essentially cedes its responsibilities to private contractors and relinquishes its accountability to the public. In order to meet these responsibilities, state policymakers must ensure that the state, including the department of human services as the state Medicaid agency, has

the authority and resources, including the adequate number of qualified personnel and the necessary tools, to carry out these responsibilities, provide effective administration, and ensure accountability and compliance.

f. State policymakers must also ensure that Medicaid managed care contracts contain, at a minimum, clear, unambiguous performance standards, operating guidelines, data collection, maintenance, retention, and reporting requirements, and outcomes expectations so that contractors and subcontractors are held accountable to clear contract specifications.

g. As with all system and program redesign efforts undertaken in the state to date, the assumption of the administration of Medicaid program benefits by managed care organizations must involve ongoing stakeholder input and earn the trust and support of these stakeholders. Medicaid recipients, providers, advocates, and other stakeholders have intimate knowledge of the people and processes involved in ensuring the health and safety of Medicaid recipients, and are able to offer valuable insight into the barriers likely to be encountered as well as propose solutions for overcoming these obstacles. Local communities and providers of services and supports have firsthand experience working with the Medicaid recipients they serve and are able to identify factors that must be considered to make a system successful. Agencies and organizations that have specific expertise and experience with the services and supports needs of Medicaid recipients and their families are uniquely placed to provide needed assistance in developing the measures for and in evaluating the quality of the program.

2. It is the intent of the general assembly that the Medicaid program be implemented and administered, including through Medicaid managed care policies and contract provisions, in a manner that safeguards the interests of Medicaid recipients, encourages the participation of Medicaid providers,

and protects the interests of all taxpayers, while attaining the goals of Medicaid modernization to improve quality and access, promote accountability for outcomes, and create a more predictable and sustainable Medicaid budget.

HEALTH POLICY OVERSIGHT COMMITTEE

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

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

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

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

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

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

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

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

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

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

REVIEW OF PROGRAM INTEGRITY DUTIES

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID REINVESTMENT FUND

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

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

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

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

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

b. Providing home and community-based services as necessary

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

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

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

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

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

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

MEDICAID OMBUDSMAN

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

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

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

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

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

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

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

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

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

2. A representative of the office of long-term care ombudsman providing assistance and advocacy services authorized under this section for an individual, shall be provided access to the individual, and shall be provided access to the individual's medical and social records as authorized by the individual or the individual's legal representative, as necessary to carry out the duties specified in this section.

3. A representative of the office of long-term care ombudsman providing assistance and advocacy services authorized under this section for an individual, shall be provided access to administrative records related to the provision of the long-term services and supports to the individual, as necessary to carry out the duties specified in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAL ASSISTANCE ADVISORY COUNCIL

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

249A.4B Medical assistance advisory council.

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

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

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

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

other budgetary issues.

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

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

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

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

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

(1) The Iowa medical society.

(2) The Iowa osteopathic medical association.

(3) The Iowa academy of family physicians.

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

(5) The Iowa physical therapy association.

(6) The Iowa dental association.

(7) The Iowa nurses association.

(8) The Iowa pharmacy association.

(9) The Iowa podiatric medical society.

(10) The Iowa optometric association.

(11) The Iowa association of community providers.

(12) The Iowa psychological association.

(13) The Iowa psychiatric society.

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

workers.

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

(16) The Iowa hospital association.

(17) The Iowa association of rural health clinics.

(18) The Iowa primary care association.

(19) Free clinics of Iowa.

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

(21) The Iowa association of hearing health professionals.

(22) The Iowa speech and hearing association.

(23) The Iowa health care association.

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

(25) AARP.

(26) The Iowa caregivers association.

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

(28) The Iowa adult day services association.

(29) Leading age Iowa.

(30) The Iowa association for home care.

(31) The Iowa council of health care centers.

(32) The Iowa physician assistant society.

(33) The Iowa association of nurse practitioners.

(34) The Iowa nurse practitioner society.

(35) The Iowa occupational therapy association.

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

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

(38) The Iowa state association of counties.

(39) The Iowa developmental disabilities council.

(40) The Iowa chiropractic society.

(41) The Iowa academy of nutrition and dietetics.

(42) The Iowa behavioral health association.

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

(44) The Iowa public health association.

(45) The epilepsy foundation.

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

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

~~*c.*~~ *a.* The director of public health, or the director's designee.

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

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

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

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

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

g. The following members of the general assembly, each for a term of two years as provided in section 69.16B:

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

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

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

(1) As voting members:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~6.~~ 9. The director shall ~~consider~~ comply with the requirements of this section regarding the duties of the council, and the deliberations and recommendations ~~offered by~~ of the council, ~~and~~ the executive committee, and the subcommittees shall be reflected in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to section 217.3, ~~and~~ in implementation of medical assistance program policies, and in administration of the Medicaid program.

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

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

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

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

PATIENT-CENTERED HEALTH RESOURCES AND INFRASTRUCTURE

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

2. *a.* The department shall establish a patient-centered health 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 and in the transformation to a patient-centered infrastructure that integrates and coordinates services and supports to address social determinants of health and meet population health goals:

(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 the federation of Iowa insurers.

(4) A representative of the Iowa dental association.

(5) A representative of the Iowa nurses association.

(6) A physician and an osteopathic physician licensed pursuant to chapter 148 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 Iowa 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.

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

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

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

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

(18) A representative of early childhood Iowa.

b. Public members of the patient-centered health 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.

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

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

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

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

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

HAWK-I PROGRAM

Sec. 10. Section 514I.5, subsection 8, paragraph d, Code 2016, is amended by adding the following new subparagraph:

NEW SUBPARAGRAPH. (17) Occupational therapy.

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

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

MEDICAID PROGRAM POLICY IMPROVEMENT

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

reflect all of the following:

1. CONSUMER PROTECTIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. CHILDREN.

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

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

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

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

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

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

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

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

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

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

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

3. PROVIDER PARTICIPATION ENHANCEMENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

135.153, into their provider networks.

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

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

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

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

(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.

(d) A chiropractor licensed pursuant to chapter 151.

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

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

4. CAPITATION RATES AND MEDICAL LOSS RATIO.

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

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

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

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

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

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

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

(1) Program integrity activities.

(2) Utilization review activities.

(3) Fraud prevention activities beyond the scope of those activities necessary to recover incurred claims.

(4) Provider network development, education, or management activities.

(5) Provider credentialing activities.

(6) Marketing expenses.

(7) Administrative costs associated with recipient incentives.

(8) Clinical data collection activities.

(9) Claims adjudication expenses.

(10) Customer service or health care professional hotline services addressing nonclinical recipient questions.

(11) Value-added or cost-containment services, wellness programs, disease management, and case management or care coordination programs.

(12) Health quality improvement activities unless specifically approved as a medical cost by state law. Costs of health quality improvement activities included in determining the medical loss ratio shall be only those activities that are independent improvements measurable in individual patients.

(13) Insurer claims review activities.

(14) Information technology costs unless they directly and credibly improve the quality of health care and do not duplicate, conflict with, or fail to be compatible with similar health information technology efforts of providers.

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

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

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

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

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

5. DATA AND INFORMATION, EVALUATION, AND OVERSIGHT.

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

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

b. Medicaid managed care organizations shall directly capture and retain and shall report actual and detailed medical claims costs and administrative cost data to the department as specified by the department. Medicaid managed care organizations shall allow the department to thoroughly and accurately monitor the medical claims costs and administrative costs data Medicaid managed care organizations report to the department.

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

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

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

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

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

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

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

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

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

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

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

i. Medicaid managed care contracts shall align economic

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

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

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

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

goods or services provided under a managed care contract.

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

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