CHAPTER 88
MANAGED HEALTH CARE PROVIDERS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), and the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures and recipient enrollment and disenrollment procedures. Services covered or requiring authorization and recipient access to services are specified.

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

"Capitation rate" shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Contract" shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

"Covered services" shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

"Department" shall mean the Iowa department of human services.

"Emergency care" shall mean those medical services rendered for an emergent medical condition or protection of the public health.

"Emergent medical condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient's medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

"Enrolled recipient" shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

"Enrollment area" shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

"Extended-participation program" shall mean a mandatory six-month enrollment period with a managed care entity.

"Federally qualified HMO" shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

"Grievance" shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

"Health maintenance organization (HMO)" shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

"Managed care entity" shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

"Managed health care" shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

"Managed health care review committee" shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

"Mandatory enrollment" shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

"Mandatory project county" shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

"Noncovered services" shall mean services covered under Medicaid which are not included in the HMO's contract with the department. Payment for these services will be made under regular Medicaid procedures.

"Participating providers" shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

"Recipient" shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

"Region" shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

"Routine care" shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient's life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

"Urgent care" shall mean those medical services rendered for an urgent medical condition or protection of the public health.

"Urgent medical condition" shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy.
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

441—88.2(249A) Participation.

88.2(1) *Contracts with HMOs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules 191—Chapter 40.

a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.2(2) *Method of selection of HMO.* In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

a. Request for proposal. Rescinded IAB 11/10/93, effective 11/1/93.

b. Minimum contract requirements. Rescinded IAB 11/10/93, effective 11/1/93.

88.2(3) *Termination of contract.* The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

a. The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

b. The HMO's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of financial solvency on the part of the HMO.

d. There is not substantial compliance with all provisions of the contract.

e. The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.2(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

441—88.3(249A) Enrollment.

88.3(1) *Enrollment area*. Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

88.3(2) *Voluntary enrollment*. When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

88.3(3) *Mandatory enrollment.* Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.3(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4)*"b."* The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

88.3(5) *Identification card.* The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

88.3(6) *Limitations on enrollment.* Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

88.3(7) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

(1) Attains initial eligibility for a covered category of service in a mandatory project county.

(2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.

(3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.

(4) Reattains eligibility.

(5) Has a new member of the household receiving a covered category of assistance.

c. Selection of a managed health care provider. A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

e. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

(1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3)*"a."*

(2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3)*"b."*

(3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

f. Enrollment cycle. Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

441—88.4(249A) Disenrollment.

88.4(1) *Disenrollment request*. Rescinded IAB 5/6/98, effective 7/1/98.

88.4(2) *Effective date*. Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.4(3) *Disenrollment process*. The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

a. Request for disenrollment by the recipient. The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

b. *Request for disenrollment by the HMO.* With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

(1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.

(2) There is evidence of unauthorized use of the HMO identification card.

(3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or "drop-in" requests for service without making appointments.

88.4(4) *Disenrollments by the department*. Disenrollments will occur when:

a. The contract between the department and the HMO is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.

c. The recipient permanently moves outside the HMO's enrollment area.

d. The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

f. The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

88.4(5) *No disenrollment for health reasons.* No recipient will be disenrolled from an HMO because of an adverse change in health status.

441—88.5(249A) Covered services.

88.5(1) *Amount, duration, and scope of services*. Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

a. The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

b. To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

88.5(2) *Required services*.

a. The HMO shall cover as a minimum the following services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Family planning services.

(5) Home health agency services.

(6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.

(7) Laboratory and X-ray services.

(8) Rural health clinic services (where available).

(9) Advanced registered nurse practitioners.

(10) Optometric and ophthalmology services.

(11) Clinic services.

(12) Ambulance services.

(13) Rescinded IAB 11/5/97, effective 1/1/98.

(14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).

(15) Rehabilitation agencies.

b. HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

88.5(3) *Excluded services.* Unless specifically included in the contract, HMOs will not be required to cover:

a. Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).

b. Inpatient psychiatric care provided at state-administered mental health institutes.

c. Services provided by the area education agencies.

d. Services provided at psychiatric medical institutions for children.

e. Dental services.

f. Hospice services.

g. Mental health services as defined in rule 441—88.65(249A).

h. Rehabilitative treatment services.

i. Psychiatric services.

j. Infant and toddler program services.

k. Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

88.5(4) *Restrictions and limitations.* If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

88.5(5) *Recipient use of HMO services.* A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

441—88.6(249A) Emergency and urgent care services.

88.6(1) *Availability of services.* The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

88.6(2) *HMO payment liability.* HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.6(3) *Notification and claim filing time spans*. The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

88.6(4) *Provision of urgent care.* If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

441—88.7(249A) Access to service.

88.7(1) *Choice of provider.* Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

88.7(2) *Medical service delivery sites.* Medical service delivery sites must have the following specific characteristics:

a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.7(3) *Adequate appointment system.* The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.7(4) *Adequate after hours call-in coverage*. The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

a. Twenty-four-hour-a-day phone coverage shall exist.

b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.7(5) *Adequate referral system*. The HMO must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.8(249A) Grievance procedures.

88.8(1) *Written procedure*. The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

88.8(2) *Written record*. All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

88.8(3) *Information concerning grievance procedures.* The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

88.8(4) *Appeals to the department.* A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

88.8(5) *Periodic report to the department*. The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.9(249A) Records and reports.

88.9(1) *Medical records system.* The HMO shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition the HMO must maintain a medical records system which:

a. Identifies each medical record by state identification number.

b. Identifies the location of every medical record.

c. Places medical records in a given order and location.

d. Provides a specific medical record on demand.

e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).

f. Maintains inactive medical records in a specific place.

g. Permits effective professional review in medical audit processes.

h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

i. Meets state and federal reporting requirements applicable to HMOs.

88.9(2) *Content of individual medical record.* The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.9(3) *Confidentiality of records.* HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph *"e"* of this subrule.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).

d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

f. Medical records maintained by subcontractors must meet the requirements of this rule.

88.9(4) *Reports to the department.* Each HMO shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the HMO's fiscal year or other additional terms as specified by the contract.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department's discretion, vary among HMOs, depending on the services covered and other contractual differences.

88.9(5) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—88.10(249A) Marketing.

88.10(1) *General requirements.* An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. Service market. An HMO shall distribute any marketing materials to its entire service area or region.

b. Prohibition of tie-ins. An HMO, or any agency of the entity, may not seek to influence an individual's enrollment with the HMO in conjunction with the sale of any other insurance.

c. Prohibiting marketing fraud. Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. Prohibition of "cold-call" marketing. HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

88.10(2) *Marketing representatives*. Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO's marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

88.10(3) *Marketing presentations*. The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

88.10(4) *Marketing materials*. Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

441—88.11(249A) Patient education.

88.11(1) *Health education procedures*. The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

88.11(2) *Use of services.* The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

88.11(3) *Patient rights and responsibilities*. The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

441—88.12(249A) Reimbursement.

88.12(1) *Capitation rate.* In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

88.12(2) *Determination of rate*. The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.12(3) *Amounts not included in rate*. The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

88.12(4) *Third-party liability.* If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

441—88.13(249A) Quality assurance. The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate-setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to **88.20** Reserved.