Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 73
"Managed Care"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Purpose and Summary

This proposed chapter is the subject of a Red Tape Review pursuant to Executive Order 10. The proposed chapter provides that most Iowa medical assistance program benefits will be provided through managed care.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Medicaid managed care plans, enrollees, and applicants will benefit from the guidance in this proposed chapter.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Almost 700,000 Iowans are covered by Medicaid managed care plans.

- **Qualitative description of impact:**

The proposed rulemaking refines the existing chapter by standardizing the use of acronyms, deleting restrictive terms, and making other perfecting changes.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs in implementing this proposed chapter.

- **Anticipated effect on State revenues:**

There is no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required and appropriate.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 73 and adopt the following **new** chapter in lieu thereof:

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 73
MANAGED CARE

441—73.1(249A) Definitions.

"Appeal" means a review by an MCO or PAHP of an adverse benefit determination as specified in 42 CFR 438.400(b).

"Capitation payment" means a monthly payment to the MCP on behalf of each enrollee for the provision of health or dental services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

"Choice counseling" means the provision of unbiased information on MCPs or provider options and answers to related questions and access to personalized assistance to help members understand the

materials provided by the MCPs or the state, to answer questions about each of the options available, and to facilitate enrollment with an MCP.

"Claim" means a formal request for payment for benefits received or services rendered.

"Clean claim" means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. "Clean claim" does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Code of Federal Regulations" or *"CFR"* means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government, and all references herein are as amended to July 1, 2026.

"Community-based case management" means a collaborative process of planning, facilitation, and advocacy for options and services to meet an enrollee's needs through communication and available resources to promote high-quality, cost-effective outcomes.

"Contract" means a contract between the department and an MCP. These contracts shall meet all applicable requirements of state and federal law, including the requirements of 42 CFR 434.

"Covered services" means physical health, behavioral health, dental, and long-term care services set forth in rule 441—73.5(249A).

"Discharge planning" means the process, which begins at admission, of determining a continued need for treatment services and of developing a plan to address ongoing needs.

"Electronic visit verification system" or *"EVV system"* means an electronic system that providers can check into at the beginning of and check out at the end of each period of service delivery to monitor enrollees' receipt of care.

"Emergency medical condition" means the same as defined in 42 CFR 438.114(a).

"Emergency services" means the same as defined in 42 CFR 438.114(a).

"Enrollee" means a hawki, IHAWP, dental wellness plan or Medicaid member who is eligible for MCP enrollment and has been enrolled with an MCP as described in subrule 73.3(2).

"Enrollment broker" means the entity the department uses to enroll persons in an MCP. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law, including 42 CFR 438.10.

"Hawki program" means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act as amended to July 1, 2026.

"HIPP" means the health insurance premium payment program.

"Home- and community-based services" or *"HCBS"* means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

"Incident reporting" means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

"Iowa health and wellness plan" or *"IHAWP"* means the medical assistance program set forth in 441—Chapter 74.

"Level of care" refers to the amount, type, and intensity of medical care services required to meet an individual's health and safety needs.

"Long-term care" or *"LTC"* means the services of a nursing facility (NF); an ICF/ID; the Woodward state resource center; or services funded through Section 1915(c) HCBS waivers, the Section 1915(i) habilitation program, and the PACE program outlined in 441—Chapter 88.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" in Iowa Code section 514B.1.

"Managed care plan" or *"MCP"* refers to MCOs and PAHPs.

"Mandatory enrollment" means mandatory participation in a managed care plan as specified in subrule 73.3(2).

"Medical loss ratio" means the percentage of capitation payments that is used to pay medical or dental expenses.

"Medically necessary services" means those covered services that are under the terms and conditions of the contract and 42 CFR 438.54(b)(2).

"Member" means any person determined by the department to be eligible for the Medicaid program, hawki program, IHAWP, or dental wellness plan.

"Money Follows the Person (MFP) Rebalancing Demonstration Grant" means a federal grant that will assist Iowa in transitioning individuals from an NF or ICF/ID into the community and in rebalancing long-term care expenditures.

"Needs-based eligibility" means an evaluation to determine and establish an individual's need for habilitation services.

"Network" or *"provider network"* means a group of participating health or dental care providers (both individual and group practitioners) linked through contractual arrangements to the MCP to supply a range of health or dental care services.

"Out-of-network provider" means any provider that is not directly or indirectly employed by or does not have a provider agreement with the MCP or any of its subcontractors pursuant to the contract between the department and the MCP.

"Participating providers" means the providers of covered physical health, behavioral health, dental, and long-term care services that have contracted with a managed care plan.

"Passive enrollment process" means the process by which the department assigns a member to a managed care plan and that, in accordance with 42 CFR 438.54, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care plans.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2.

"Prior authorization" means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

441—73.2(249A) Contracts with a managed care plan (MCP).

73.2(1) The department may enter into a contract with an MCP licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as described in rule 441—73.6(249A).

73.2(2) The department will determine that the MCP meets the following requirements:

a. The MCP shall make available services to enrollees as established in the contract.

b. The MCP shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the MCP's debts if the MCP becomes insolvent. The MCP shall comply with the insurance division of the Iowa department

of insurance and financial services provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The MCP shall attain and maintain accreditation by the National Committee for Quality Assurance (NCQA) or URAC.

73.2(3) If not already accredited, the MCP must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the MCP must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with 191—Chapter 40.

441—73.3(249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All hawki program, IHAWP, and dental wellness plan members shall be subject to mandatory enrollment in an MCP. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in an MCP:

a. Members who are medically needy as described in 441—subrule 75.1(35).

b. Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements pursuant to 441—Chapter 75.

c. Persons who are currently presumptively eligible as defined in 441—Chapter 75.

d. Persons eligible for PACE who voluntarily elect PACE coverage as described in 441—Chapter 88.

e. Persons enrolled in HIPP pursuant to 441—Chapter 75.

f. Persons eligible only for the Medicare savings program as described in 441—Chapters 75 and 76.

g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

h. Persons who have a Medicaid eligibility period that is retroactive as described in 441—Chapter 76.

i. Persons who are inmates of a public institution and ineligible for Medicaid benefits as described in 441—Chapter 75.

j. Persons residing in the Iowa veterans home as described in 801—Chapter 10.

73.3(3) *Enrollment process.* The department will notify members who must be enrolled in an MCP of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438.54.

a. General. Members may receive MCP choice counseling from the enrollment broker. The enrollment broker will provide information about individual MCP benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. Auto-assignment. Effective no earlier than the first day of the month of the member's application to Medicaid, the member will be assigned to an MCP using the department's auto-enrollment process and offered the opportunity to choose from the available MCPs within a time frame specified in the auto-assignment letter.

c. Request to change enrollment. An enrollee may, within 90 days of initial enrollment, request to change enrollment from one MCP and enroll in another MCP. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Enrollment changes are effective no later than the first day of the second month beginning after the date on which the enrollment broker receives the enrollee's written or verbal request.

d. Ongoing enrollment. Enrollees shall remain enrolled with the chosen MCP for a total of 12 months.

e. *Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee will be notified of the option to maintain enrollment with the current MCP or to enroll with a different MCP.

73.3(4) *Benefit reimbursement prior to enrollment.*

a. Prior to the effective date of MCP enrollment, except as provided in paragraph 73.3(4)*"b,"* the department will reimburse providers for covered program benefits pursuant to 441—Chapters 74 through 91, as applicable for eligible members.

b. The MCP shall be responsible for covering newly retroactive Medicaid eligibility periods prior to the effective date of enrollment for babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth.

441—73.4(249A) Disenrollment process.

73.4(1) *Enrollee-requested disenrollment.* An enrollee may request disenrollment with an MCP as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the MCP, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the MCP, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the MCP's grievance system. If the member does not experience resolution, the MCP shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The MCP does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health or dental care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment will be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

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

b. The enrollee becomes ineligible for Medicaid, the hawki program, IHAWP, or the dental wellness plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the MCP will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care plan enrollment.

d. The department has determined that participation in HIPP as described in 441—Chapter 75 is more cost-effective than enrollment in managed health care.

e. The enrollee dies.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care plan-requested disenrollment.* An MCP shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health or dental care needs or change in health or dental care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs. The only exception is when the MCP can document and provide conclusive evidence to the department that the enrollee's continued enrollment seriously impairs the MCP's ability to furnish services to either this particular enrollee or other enrollees. The MCP shall have a multi-level

verification process by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.*

a. The effective date of a department-approved disenrollment will be no later than the first day of the second calendar month beginning after the month in which:

(1) The enrollee requests disenrollment;

(2) The department notifies the enrollee and MCP of disenrollment; or

(3) The MCP requests disenrollment.

b. The enrollee shall remain enrolled in the MCP and the MCP will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the MCO shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

441—73.5(249A) MCP covered services.

73.5(1) *Required services—MCOs.* An MCO shall provide:

a. For all enrolled members, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

(1) Area education agency services.

(2) Dental services not provided in an outpatient hospital setting.

(3) Infant and toddler program services.

(4) Local education agency services.

(5) State of Iowa veterans home services.

(6) Money Follows the Person (MFP) Rebalancing Demonstration Grant-funded services.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

73.5(2) *Community-based case management service.* The MCO is required to provide services that meet requirements specified in the contract.

73.5(3) *Value-added services.* An MCP may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

73.5(4) *Required services—PAHPs.* A PAHP shall provide services to enrollees under the contract with the department and on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates. PAHPs shall provide:

a. For enrollees other than IHAWP enrollees and hawki program enrollees, services as set forth in 441—Chapters 73, 74, 78, and 88 with the exception of the following:

(1) Area education agency services.

(2) Inpatient hospital or institutional services.

(3) Advance directive requirements in dental nonclinical services such as transportation.

(4) Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, the Woodward state resource center, or ICFs/ID).

(5) Inpatient psychiatric care provided at the state-administered mental health institutes.

(6) Services provided at specialized adolescent psychiatric facilities.

(7) Day treatment and partial hospitalization services for persons aged 20 or under.

(8) Enhanced services provided to certain eligible recipients.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

441—73.6(249A) Amount, duration and scope of services.

73.6(1) The MCP shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the department. In accordance with federal funding

requirements, including 42 CFR 438.210(a)(3), the MCP shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The MCP shall not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, as a condition of payment, the MCO shall provide prior authorization for any admissions to an NF, an ICF/ID, a psychiatric medical institution for children (PMIC), and a state-administered mental health institute. Prior MCO approval is also required for all out-of-state placements.

73.6(2) The MCP may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The MCP shall not:

a. Avoid costs for services covered in the contract by referring members to publicly supported health or dental care resources.

b. Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The MCP shall allow each enrollee to choose a health or dental professional, to the extent possible and appropriate, within the MCP's provider network. The MCP shall ensure compliance with the Americans with Disabilities Act (ADA) as amended to July 1, 2026, in the delivery and approval of all services.

441—73.7(249A) Emergency services.

73.7(1) Emergency services shall be available 24 hours a day, seven days a week.

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114, the MCP shall:

a. Cover emergency services without the need for prior authorization and shall not limit reimbursement to network providers.

b. Cover and pay for emergency services regardless of whether the provider that furnishes the services is enrolled with Iowa Medicaid or has a contract with the MCP.

c. Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

d. Cover the medical screening examination provided to a member who presents to an emergency department with an emergency medical condition. This requirement applies to MCOs only.

73.7(3) The MCP shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition.

b. Treatment obtained when a representative of the MCP instructs the enrollee to seek emergency medical services.

441—73.8(249A) Access to service.

73.8(1) The MCP shall ensure enrollees have access to services as specified in the contract. The MCP shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, seven-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health or dental professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

73.8(2) Choice of providers. An enrollee shall use the MCP's provider network unless the MCP has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance

with federal funding requirements, including 42 CFR 431.51(b)(2), the MCO shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers that are not in the MCP network.

73.8(3) Continuity of care. The MCP shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

73.8(4) Adequate service referral support and after-hours call-in coverage. The MCP shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

a. Member helpline. The MCP shall maintain a dedicated toll-free enrollee services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal MCP departments, such as care coordinators.

b. Nurse call line. The MCO shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, seven days a week from trained medical professionals.

73.8(5) The MCP shall ensure that network providers are responsible for providing preventive and primary health or dental care to the enrollee. Primary care providers shall initiate referrals for specialist care, where appropriate, and maintain the continuity of patient care. Primary care providers may be physicians, advanced registered nurse practitioners, or physician assistants, licensed and practicing in accordance with state law.

441—73.9(249A) Incident reporting.

73.9(1) The MCO shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS waivers; for the Section 1915(i) habilitation program; and as required for licensure of programs through the department of inspections, appeals, and licensing.

73.9(2) The MCO shall develop and implement policies and procedures, subject to department review and approval, to:

a. Address and respond to incidents;

b. Report incidents to the appropriate entities in accordance with required time frames; and

c. Track and analyze incidents.

441—73.10(249A) Discharge planning. The MCO shall establish policies and procedures, subject to approval by the department, that protect an enrollee from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The MCO shall facilitate a seamless transition whenever an enrollee transitions between facilities or residences.

441—73.11(249A) Level of care (LOC) assessment.

73.11(1) The department will retain full authority to determine whether the Medicaid LOC or needs-based assessment has been completed in a timely manner by the appointed vendor. The MCO will be notified once an enrolled member's LOC determination has been completed. The LOC and needs-based eligibility assessment process and the requirements are provided in 441—Chapters 75, 78, 81, 82, 83, and 85. HCBS waiver LOC determinations must be consistent with those made for the appropriate institutional LOC under the state plan.

73.11(2) At any time, if the MCO becomes aware the enrollee's functional or medical status has changed in a way that may affect LOC or needs-based eligibility, the MCO shall submit documentation to the department's appointed vendor to conduct an LOC or needs-based assessment. The department-approved tools shall be used to conduct an updated assessment. The updated assessment shall then be submitted to the department for determination of LOC or needs-based eligibility.

441—73.12(249A) Appeal of MCP actions. The MCPs shall have written first-level appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal an MCP action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438, Subpart F.

73.12(1) *MCP appealable actions.* MCP actions that may be appealed by an enrollee may include, as cited in 42 CFR 438.400(b):

a. Denial or limited authorization of a requested service, including the type or level of service.

b. Reduction, suspension, or termination of a previously authorized service.

c. Denial, in whole or in part, of payment of service.

d. Failure to provide services in a timely manner as described by the department.

e. Failure to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b).

f. Denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCP's network related to rural access or capacity.

g. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

73.12(2) *Appeal process.* The MCP first-level appeal process will be approved by the department and shall:

a. Allow for the appeal request to be submitted in writing or verbally.

b. Require acknowledgment of the receipt of a request for an appeal within three working days.

c. Allow for participation by the enrollee and the provider.

d. Provide for resolution of nonexpedited appeals to be concluded within 30 calendar days of receipt of the request unless an extension is requested.

e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402.

f. Ensure that the review will be made by qualified professionals who were not involved with the original action.

g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the MCP through the MCP's first-level appeal process, the enrollee may file an appeal with the department. This process is referred to as a state fair hearing, an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 and federal requirements for a state fair hearing in 42 CFR 438.408(f).

441—73.14(249A) Continuation of benefits. The MCP shall be required to continue the member's benefits during any appeal in accordance with federal funding requirements, including 42 CFR 438.420.

73.14(1) If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

a. The enrollee withdraws the appeal request;

b. Ten calendar days pass after the MCP mailed the notice providing the resolution of the appeal against the enrollee unless the enrollee, within the ten-calendar-day time frame, requests a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or

c. The time period or service limits of a previously authorized service are met.

73.14(2) If the final resolution of the state fair hearing is adverse to the enrollee, that is, it upholds the MCP's action, the MCP may recover the cost of the services furnished to the enrollee

while the appeal was pending, to the extent services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the MCP or state fair hearing administrative law judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize and provide the disputed services promptly and as expeditiously as the member's health or dental condition requires. If the MCP or the state fair hearing ALJ reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the MCP must pay for these services.

441—73.15(249A) Grievances. The MCP shall have policies and procedures for reviewing expressions of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to quality of care or services provided, aspects of interpersonal relations such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested pursuant to 42 CFR 438.400(b). Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.

441—73.16(249A) Written record. All MCP enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances pursuant to 42 CFR 438.416.

441—73.17(249A) Information concerning procedures relating to the review of MCP decisions and actions. The MCP's written procedures for the review of MCP's decisions and actions shall be provided to each new enrollee in a member handbook, to participating providers in a provider manual, and to nonparticipating providers upon request.

441—73.18(249A) Records and reports.

73.18(1) *Records system.* The MCPs shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including 441—Chapter 79 and 42 CFR 456, throughout the course of the contract. The records system shall:

a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.

b. Provide a rationale for, and documentation of, decisions made by the MCP based upon medical necessity.

c. Permit effective professional review for medical audit processes.

d. Facilitate an adequate system for monitoring treatment reimbursed by the MCO, including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) *Content of individual treatment record.* The MCP shall ensure that participating providers maintain an adequate recordkeeping system that includes a complete medical, dental, or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of 441—Chapter 79 and pursuant to federal funding requirements, including 42 CFR 456. MCOs shall require use of an EVV system for personal care services.

73.18(3) *Confidentiality of health care, mental health care, and substance abuse information.* The MCP shall protect and maintain the confidentiality of all protected health information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

73.18(4) *EVV system.* The MCO will participate in EVV planning activities and use the MCO-proposed, department-approved EVV system that will be in place within a time frame determined by the department to ensure compliance with state and federal regulations, including Section 12006 of the Cures Act (42 U.S.C. §1396b(1) as amended to July 1, 2026). Beginning on the dates required

by the department, the MCO shall require personal care providers and home health services to use the MCO EVV system or another EVV system complying with Section 12006 of the Cures Act as amended to July 1, 2026. The MCO shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, home health services, and other services using the EVV system. All EVV data that originates in or passes through the MCO EVV system will be provided to the department in a format and time frame subject to department approval.

441—73.19(249A) 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 MCP. The department or HHS may audit and inspect any records of an MCP, or the subcontractor of the MCP, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, at places, and in a manner as authorized representatives of the department or its designee as HHS may request.

441—73.20(249A) Marketing. MCP marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the MCP and contract terms. The department will approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104.

441—73.21(249A) Enrollee education.

73.21(1) *Use of services.* The MCP shall provide written information to all enrollees on the use of the services the MCP is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of MCP decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7; how to access the state fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

73.21(2) *Outreach to members with special needs.* The MCP shall provide enhanced outreach to members with special needs, including but not limited to persons with a psychiatric disability, an intellectual disability or other cognitive impairments; illiterate persons; non-English-speaking persons; and persons with visual impairments or who are deaf or hard of hearing.

73.21(3) *Patient rights and responsibilities.* The MCP shall have in effect a written statement of patient rights and responsibilities that is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

441—73.22(249A) Payment to the MCP.

73.22(1) *Capitation rate.* In consideration for all services rendered by an MCP under a contract with the department, the MCP will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms described in the MCP contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act as amended to July 1, 2026, regarding the health insurance provider's fee. This capitation rate, inclusive of the amounts withheld and the health insurance provider's fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the MCP meets metrics described in the MCP contract.

73.22(2) *Determination of rate.* The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6, Actuarial Standards

of Practice 49, as amended to July 1, 2026, and other related CMS regulations and generally accepted actuarial principles and practices.

73.22(3) *Third-party liability.* If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical or dental expenses, it is the right and responsibility of the MCP to investigate these third-party resources and attempt to obtain payment.

a. The MCP shall have a time limit determined by the department to attempt to collect from third-party resources.

b. The MCP shall retain all funds collected from third-party resources during the time limit.

c. A complete record of all third-party collections must be maintained and made available to the department on request.

d. In the event that the MCP no longer contracts with the department, the department has the right to seek recovery of any third-party collections not collected by the time the contract ends and retain the funds. This includes but is not limited to subrogation cases.

e. The department has the right to retain all funds collected from third-party resources after the MCP time limit.

73.22(4) *Medical loss ratio.* The MCP shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the MCP.

441—73.23(249A) Claims payment by the MCP.

73.23(1) The MCOs shall pay or deny:

a. Ninety percent of all clean claims within 30 calendar days of receipt,

b. Ninety-nine point five percent of all clean claims within 90 calendar days of receipt, and

c. Ninety-five percent of all claims within 45 calendar days of receipt.

73.23(2) The PAHP shall pay or deny:

a. Ninety percent of all clean claims within 14 calendar days of receipt,

b. Ninety-nine percent of all clean claims within 90 calendar days of receipt, and

c. Ninety-five percent of all claims within 21 calendar days of receipt.

73.23(3) Managed care limits on payment responsibility for services.

a. The MCP is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

b. The MCP has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

c. Payment responsibilities for emergency room services are as provided in rule 441—73.7(249A).

73.23(4) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the MCO is obligated to pay 80 percent of the payment to participating providers.

73.23(5) Timely filing. The in-network provider filing limit shall be no more than 180 days from the date of service.

441—73.24(249A) Quality assurance. The MCP shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

441—73.25(249A) Certifications and program integrity. The MCP shall develop and implement policies, procedures, and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The MCP shall cooperate and collaborate with the department on all program integrity activities. The MCP shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455.

These rules are intended to implement Iowa Code section 249A.4.