

CHAPTER 88  
SPECIALIZED MANAGED CARE PROGRAMS

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter provides for specialized programs of managed care, within the Iowa medical assistance program but outside of managed care pursuant to 441—Chapter 73. Managed care providers under these programs are not required to comply with 441—Chapter 73.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

DIVISION I  
PREPAID HEALTH PLANS

**441—88.1(249A) Definitions.**

“*Capitation rate*” shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical 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 a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP 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.

“*Department*” shall mean the Iowa department of human services.

“*Emergency service*” shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient’s health.

“*Enrollment area*” shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

“*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 PHP staff member receiving the complaint or any complaint received in writing.

“*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), or 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.

“*Managed services*” shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

“*Nonmanaged services*” shall mean medical services covered under regular Medicaid, but which are not covered in the PHP’s contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

“*Prepaid health plan (PHP)*” shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

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

“*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, nonemergency need*” shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.2(249A) Participation.**

**88.2(1) *Contracts with PHPs.*** The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with PHPs.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

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.

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 PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP 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 PHP.*** In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

**88.2(3) *Termination of contract.*** Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. 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 upon, but not limited to, the following:

a. The PHP’s delivery system does not ensure enrolled recipients adequate access to medical services.

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

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

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

*e.* The PHP 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 PHP 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.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.3(249A) Enrollment.**

**88.3(1) Enrollment area.** Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.1(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

**88.3(2) Voluntary enrollment.** When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.3(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.3(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (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 PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

**88.3(3) Mandatory enrollment.** In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

**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 form designated by the managed health care contractor.

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

**88.3(6) Assignment methodology.** When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

*a. Notification.* Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

*b. Limitations.* Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

*c. Household member enrollment.* Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

*d. Assigned recipients who desire another choice.* Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.3(4) and 88.4(2) dealing with effective date.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.4(249A) Disenrollment.**

**88.4(1) Disenrollment request.** An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.3(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

**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 PHP and the PHP 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.** If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for 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 the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete 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 working days.

*a. Request for disenrollment by the recipient.* In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care

programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

*b. Request for disenrollment by the PHP.* With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

- (1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.
- (2) There is evidence of unauthorized use of the PHP identification card.
- (3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

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

- a.* The contract between the department and the PHP is terminated.
- b.* The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.
- c.* The recipient permanently moves outside the PHP's enrollment area.
- d.* The recipient transfers to an eligibility group excluded from PHP 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.

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

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.5(249A) Covered services.**

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

**88.5(2) *Mandatory services.***

*a.* Although the contract may specify additional services covered (with the exception of those defined in 88.5(3)), the PHP 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) Laboratory and X-ray services.
- (7) Early periodic screening, diagnosis and treatment for persons under age 21.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.

*b.* PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

*c.* According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

**88.5(3) *Excluded services.*** Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule

441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

**88.5(4) *Restrictions and limitations.*** If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

**88.5(5) *Recipient use of PHP services.*** An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.5(2) “c,” and rule 441—88.6(249A).

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.6(249A) Emergency services.**

**88.6(1) *Availability of services.*** The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP’s own providers or through arrangements with other providers. In addition, the PHP 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 contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

**88.6(2) *PHP payment liability.*** PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP’s enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP’s enrollment area, the PHP shall pay the facility or person who provided 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 span.*** The PHP 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 to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **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 PHP providers participating in the Medicaid contract.

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

- a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.
- b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more 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 PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

- a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP 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 PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

- a. Twenty-four-hour-a-day telephone 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 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 PHP 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, but not directly provided by the PHP.
- b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.
- c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.8(249A) Grievance procedures.**

**88.8(1) Written procedure.** The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, 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.

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

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

**88.8(4) Appeals to the department.** A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

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

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.9(249A) Records and reports.**

**88.9(1) *Medical records system.*** The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

- a. Identifies each medical record by the departmentally assigned 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 PHPs.

**88.9(2) *Content of individual medical record.*** The PHP 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.*** PHPs 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 the responsible party acting on behalf of the enrolled recipient.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.
- c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).
- d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.
- 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 facility requesting the information.
- f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

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

- a. Annual audited financial statements no later than 120 days after the close of the PHP’s fiscal year.
- b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

**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 PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which 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.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]



**441—88.10(249A) Marketing.**

**88.10(1) *Marketing procedures.*** All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

**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 PHP's marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

**88.10(3) *Marketing presentations.*** The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

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

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.11(249A) Patient education.**

**88.11(1) *Use of services.*** The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

**88.11(2) *Patient rights and responsibilities.*** The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.12(249A) Payment to the PHP.**

**88.12(1) *Capitation rate.*** In consideration for all services rendered by a PHP under a contract with the department, the PHP 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.

**88.12(2) *Determination of rate.*** The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may 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. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.5(3). PHPs electing to share risk with the department will 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 PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

**88.12(4) *Third-party liability.*** If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment.

The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.13(249A) Quality assurance.** The PHP 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.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.14 to 88.20** Reserved.

DIVISION II  
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

**441—88.21(249A) Scope and definitions.**

**88.21(1) Purpose.** A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

- a. Enhance the quality of life and autonomy of frail older adults.
- b. Maximize the dignity of and respect for frail older adults.
- c. Enable frail older adults to live in the community as long as medically and socially feasible.
- d. Preserve and support frail older adults' family units.

**88.21(2) Scope.** PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

**88.21(3) Authorization.** A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

**88.21(4) Definitions.** For purposes of this division:

“*Alternate PACE service site*” means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

“*Capitation rate*” means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

“*CMS*” means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

“*Contract year*” means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

“*Department*” means the Iowa department of human services.

“*Enrollee*” means a person who is enrolled in a PACE program.

“*Federal PACE regulations*” means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

“*Interdisciplinary team*” means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

“*Medicaid enrollee*” means a Medicaid member who is enrolled in a PACE program.

“*Medicare beneficiary*” means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

“*Medicare enrollee*” means a Medicare beneficiary who is enrolled in a PACE program.

“*PACE*” means programs of all-inclusive care for the elderly.

“*PACE center*” means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. “Primary care” shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

“*PACE enrollment agreement*” means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

“*PACE organization*” means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

“*PACE program*” means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

“*PACE program agreement*” means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

“*Service area*” means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

“*Services*” means both items and services provided to an enrollee by the PACE organization.

“*Trial period*” means the first three contract years in which a PACE organization operates under a PACE program agreement.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.22(249A) PACE organization application and waiver process.** This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

**88.22(1) Application requirements.** A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: [http://www.cms.hhs.gov/PACE/06\\_ProviderApplicationandRelatedResources.asp](http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp).

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**88.22(2) Waiver of federal requirements.** A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**88.22(3)** *Review of applications and requests for waiver of federal requirements.* The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

**88.22(4)** *Department action on applications.* Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.23(249A) PACE program agreement.** An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

**88.23(1)** *Content and terms of agreement.*

*a. Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

*b. Optional content.* An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)"a"(5).

(2) Contain any additional terms and conditions agreed to by the parties.

**88.23(2)** *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

**88.23(3) Enforcement of agreement.** If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

- a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.
- b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.
- c. Terminate the PACE program agreement.

**88.23(4) Termination of agreement by the department.**

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph “c” of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department’s determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph “b” of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

**88.23(5) Termination of agreement by PACE organization.** A PACE organization may terminate an agreement after timely notice issued as follows:

a. To CMS and the department, 90 days before termination.

b. To enrollees, 60 days before termination.

**88.23(6) Transitional care during termination.** A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee’s medical records available to new providers.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.24(249A) Enrollment and disenrollment.** A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

**88.24(1) Eligibility for Medicaid enrollees.** To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The person must be eligible for Medicaid pursuant to the provisions in 441—Chapter 75 for persons in a medical institution.

(4) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(5) The department must determine that the person needs the nursing facility level of care.

(6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

*b. Other eligibility requirements.*

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.24(4).

**88.24(2) *Effective date of enrollment.*** A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

**88.24(3) *Duration of enrollment.*** Enrollment continues until the enrollee's death unless either of the following actions occurs:

*a.* The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

*b.* The enrollee is involuntarily disenrolled, as described in subrule 88.24(5).

**88.24(4) *Annual recertification.***

*a.* At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

*b.* Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

**88.24(5) *Involuntary disenrollment.*** An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

*a. Reasons for involuntary disenrollment.* An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.28(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.24(5) "b."

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.24(4) "b."

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

*b. Disruptive or threatening behavior.* “Disruptive or threatening behavior” refers to either of the following:

- (1) Behavior that jeopardizes the enrollee’s health or safety or the safety of others; or
- (2) Consistent refusal by the enrollee to comply with the enrollee’s individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

*c. Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee’s medical record:

- (1) The reasons for proposing to disenroll the enrollee.
- (2) All efforts to remedy the situation.

*d. Noncompliant behavior.* A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee’s behavior jeopardizes the enrollee’s health or safety or the safety of others. “Noncompliant behavior” includes repeated noncompliance with medical advice and repeated failure to keep appointments.

**88.24(6) Effective date of disenrollment.**

*a.* In disenrolling a Medicaid enrollee, the PACE organization must:

- (1) Use the most expedient process allowed under the PACE program agreement;
- (2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and
- (3) Give reasonable advance notice to the enrollee.

*b.* Until the date when enrollment is terminated, the following requirements must be met:

- (1) The PACE organization must continue to furnish all needed services.
- (2) The enrollee must continue to use PACE organization services.

**88.24(7) Documentation of disenrollment.** A PACE organization must meet the following requirements:

*a.* Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

*b.* Make documentation available for review by CMS and the department.

*c.* Use the information on voluntary disenrollments in the PACE organization’s internal quality assessment and performance improvement program.

**88.24(8) Reinstatement in other Medicare and Medicaid programs.** After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee’s reinstatement in other Medicare and Medicaid programs by:

*a.* Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and

*b.* Ensuring that medical records are made available to new providers in a timely manner.

**88.24(9) Reinstatement in PACE.** A previously disenrolled enrollee may be reinstated in a PACE program.

[ARC 0758C, IAB 5/29/13, effective 8/1/13; ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.25(249A) Program services.** A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

**88.25(1) Required services.** The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

*a.* All Medicare-covered items and services.

*b.* All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.

*c.* Other services determined necessary by the enrollee’s interdisciplinary team to improve or maintain the enrollee’s overall health status.

**88.25(2) Excluded services.** The following services are excluded from coverage under PACE:

a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

b. In an inpatient facility:

(1) A private room and private-duty nursing services unless medically necessary; and

(2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

**88.25(3) Service delivery.** The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

(1) The PACE center,

(2) The enrollee's home, and

(3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

**88.25(4) Minimum services furnished at a PACE center.** At a minimum, the following services must be furnished at each primary or alternate PACE center:

a. Primary care, including physician and nursing services.

b. Social services.

c. Restorative therapies, including physical therapy and occupational therapy.

d. Personal care and supportive services.

e. Nutritional counseling.

f. Recreational therapy.

g. Meals.

**88.25(5) Primary care.** Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

a. Managing an enrollee's medical situations; and

b. Overseeing an enrollee's use of medical specialists and inpatient care.

**88.25(6) Out-of-network emergency care.** A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

a. *Definitions.* As used in this subrule, the following definitions apply:

"*Emergency medical condition*" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:



1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

“*Emergency services*” means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization’s service area.

“*Poststabilization care*” means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

“*Urgent care*” means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee’s life or functioning is not in severe jeopardy.

*b. Plan.* A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.
2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

*c. Explanation to enrollee.* The organization must ensure that the enrollee or caregiver, or both, understand:

- (1) When and how to access out-of-network emergency services, and
- (2) That no prior authorization is needed.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.26(249A) Access to PACE services.** An enrollee’s access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee’s health and social status.

**88.26(1) Interdisciplinary team.** A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

*a. Team composition.* The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master’s-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) PACE center manager.
- (9) Home care coordinator.
- (10) Personal care attendant or attendant’s representative.
- (11) Driver or driver’s representative.

*b. Team responsibilities.* Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

- (1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.
- (2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.
- (3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

*c. Exchange of information.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

**88.26(2) Initial assessment.** The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

*a.* Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) Home care coordinator.

*b.* At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

*c.* The assessment of each enrollee must include, but not be limited to, assessment of the following:

- (1) Physical and cognitive function and ability.
- (2) Medication use.
- (3) Enrollee and caregiver preferences for care.
- (4) Socialization and availability of family support.
- (5) Current health status and treatment needs.
- (6) Nutritional status.
- (7) Home environment, including home access and egress.
- (8) Enrollee behavior.
- (9) Psychosocial status.
- (10) Medical and dental status.
- (11) Enrollee language.

**88.26(3) Plan of care.** The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

*a. Development.* The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

*b. Content.* The plan of care must:

- (1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

- (2) Identify measurable outcomes to be achieved.
- c. Documentation.* The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.
- d. Implementation.* The interdisciplinary team shall:
  - (1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and
  - (2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.
- e. Evaluation.* On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

**88.26(4) Reassessment.**

*a. Semiannual reassessment.* On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Recreational therapist or activity coordinator.
- (5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

*b. Annual reassessment.* On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Physical therapist.
- (2) Occupational therapist.
- (3) Dietitian.
- (4) Home care coordinator.

*c. Unscheduled reassessments.* In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

- (1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.26(2) "a" must conduct an in-person reassessment.
- (2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

*d. Changes to plan of care.* Interdisciplinary team members who conduct a reassessment must:

- (1) Reevaluate the enrollee's plan of care.
- (2) Discuss any changes in the plan of care with the interdisciplinary team.
- (3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.
- (4) Document all assessment and reassessment information in the enrollee's medical record.
- (5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

**88.26(5) Procedures for resolving enrollee request to change the plan of care.** The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

*a.* Except as provided in paragraph "b" of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

*b.* The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

- (1) The enrollee or designated representative requests the extension; or
- (2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

*c.* The PACE organization must:

- (1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and
- (2) Provide the specific reasons for the denial in understandable language.

*d.* The PACE organization is responsible for:

- (1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.
- (2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.
- (3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

*e.* If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

*f.* The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—88.27(249A) Program administrative requirements.** A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

**88.27(1) Enrollee rights.** A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

**88.27(2) Data collection, record maintenance, and reporting.** A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

**88.27(3) Quality assessment and performance improvement.** A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

**88.27(4) Federal and state monitoring.**

*a.* The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

- (1) Corrective action required pursuant to 42 CFR Section 460.194; and
- (2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

*b.* The PACE program is subject to sanctions or termination pursuant to subrules 88.23(3) and 88.23(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division II.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.  
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—88.28(249A) Payment.**

**88.28(1) Medicaid payment to PACE organization.** Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

**88.28(2) Liability of Medicaid enrollee.** A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

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

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<sup>◇</sup> Two or more ARCs

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