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

PREAMBLE

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

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—88.2(249A) Participation.

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

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

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

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

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

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

(1) Be in writing.

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

(3) List the services covered.

(4) Describe information access and disclosure.

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

(6) Specify the method and rate of reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g. Recipients who are Medicare beneficiaries.

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

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

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

441—88.3(249A) Enrollment.

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

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

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

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

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

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

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

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

88.3(6) *Limitations on enrollment.* Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment

in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

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

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

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

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

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

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

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

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

(4) Reattains eligibility.

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

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

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

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

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

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

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

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

441—88.4(249A) Disenrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—88.5(249A) Covered services.

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

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

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

88.5(2) *Required services.*

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

(1) Inpatient hospital services.
(2) Outpatient hospital services.
(3) Physician services.
(4) Family planning services.
(5) Home health agency services.
(6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.
(7) Laboratory and X-ray services.
(8) Rural health clinic services (where available).
(9) Advanced registered nurse practitioners.
(10) Optometric and ophthalmology services.
(11) Clinic services.
(12) Ambulance services.
(13) Rescinded IAB 11/5/97, effective 1/1/98.
(14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).
(15) Rehabilitation agencies.

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

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

a. Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).
b. Inpatient psychiatric care provided at state-administered mental health institutes.
c. Services provided by the area education agencies.
d. Services provided at psychiatric medical institutions for children.
e. Dental services.
f. Hospice services.
g. Mental health services as defined in rule 441—88.65(249A).
h. Rescinded IAB 8/1/07, effective 9/5/07.
i. Psychiatric services.
j. Infant and toddler program services.
k. Local education agency services.

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

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

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

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

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

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

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

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

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

441—88.7(249A) Access to service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—88.8(249A) Grievance procedures.

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

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

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

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

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

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

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

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

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

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

88.8(6) *Consent for state fair hearing.* Network providers which are contracted and in good standing with a medical managed care organization (MCO) may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[**ARC 0583C**, IAB 2/6/13, effective 4/1/13]

441—88.9(249A) Records and reports.

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

a. Identifies each medical record by state identification number.

b. Identifies the location of every medical record.

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

d. Provides a specific medical record on demand.

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

f. Maintains inactive medical records in a specific place.

g. Permits effective professional review in medical audit processes.

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

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

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

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

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

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide

services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph *"e"* of this subrule.

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

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

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

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

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

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

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

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

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

441—88.10(249A) Marketing.

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

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

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

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

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

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

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

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

441—88.11(249A) Patient education.

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

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

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

441—88.12(249A) Reimbursement.

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

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

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

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

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

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

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other

than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate-setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to **88.20** Reserved.

DIVISION II
PREPAID HEALTH PLANS

441—88.21(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 88.22(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.

441—88.22(249A) Participation.

88.22(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.

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.

88.22(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.

88.22(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.

88.22(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.

441—88.23(249A) Enrollment.

88.23(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—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

88.23(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 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(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.

88.23(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.

88.23(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.

88.23(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.

88.23(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 88.23(4) and 88.24(2) dealing with effective date.

441—88.24(249A) Disenrollment.

88.24(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 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

88.24(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.

88.24(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.

88.24(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—88.21(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.

88.24(5) *No disenrollment for health reasons.* No recipient shall be disenrolled from a PHP because of an adverse change in health status.

441—88.25(249A) Covered services.

88.25(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.

88.25(2) *Mandatory services.*

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(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.

88.25(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.

88.25(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.

88.25(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 88.25(2)*"c,"* and rule 441—88.26(249A).

441—88.26(249A) Emergency services.

88.26(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.

88.26(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.

88.26(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.

441—88.27(249A) Access to service.

88.27(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.

88.27(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.

88.27(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.

88.27(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.

88.27(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.

441—88.28(249A) Grievance procedures.

88.28(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.

88.28(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.

88.28(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.

88.28(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.

88.28(5) *Periodic report to the department.* The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.29(249A) Records and reports.

88.29(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 88.29(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.

88.29(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.

88.29(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.

88.29(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.

88.29(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.

441—88.30(249A) Marketing.

88.30(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.

88.30(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.

88.30(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.

88.30(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.

441—88.31(249A) Patient education.

88.31(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.

88.31(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.

441—88.32(249A) Payment to the PHP.

88.32(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.

88.32(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 88.25(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.

88.32(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.

88.32(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.

441—88.33(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.

441—88.34 to **88.40** Reserved.

DIVISION III
MEDICAID PATIENT MANAGEMENT

441—88.41(249A) Definitions.

"Contract" shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

"Covered eligibles" shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

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

"Designee" shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

"Eligible providers" shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

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

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

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

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

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

"Enrolled recipient" shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

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

"Grievance" shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

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

"Managed health care" shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

"Managed health care review committee" shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

"Mandatory enrollment" shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

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

"Managed services" shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

"Medical service area" means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

"MediPASS" shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

"Nonmanaged services" shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

"Patient management" shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

"Patient manager" shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

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

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

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

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

441—88.42(249A) Eligible recipients.

88.42(1) *Included categories of assistance.* All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient's county of residence shall fulfill the requirements to participate in mandatory project counties.

88.42(2) *Excluded categories of assistance.* The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

a. Medically needy recipients as defined in 441—subrule 75.1(35).

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

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

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

e. Automatic redetermination recipients as defined in rule 441—76.11(249A).

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

g. Recipients who are Medicare beneficiaries.

h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).

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

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

441—88.43(249A) Project area.

88.43(1) *Designation as a mandatory project county.* The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department's freedom of choice waiver from the Centers for Medicare and Medicaid Services.

88.43(2) *Voluntary project counties.* The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

88.43(3) *Expansion to other counties.* Rescinded IAB 11/10/93, effective 11/1/93.

441—88.44(249A) Eligible providers.

88.44(1) *Specialties allowed.* Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

a. Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1)*"d."*

b. Is otherwise eligible to enroll as an Iowa Medicaid provider.

c. Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).

d. Is practicing in one of the following specialties in the medical services area:

(1) Family practice.

(2) General practice.

(3) Pediatrics.

(4) Internal medicine.

(5) Obstetrics and gynecology.

88.44(2) *Clinic or group practice participation.* A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

88.44(3) *Exceptions.* Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

a. If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient's medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2)*"c,"* the department shall contact the provider in question to offer the provider the opportunity to request the exception.

b. Rescinded IAB 11/10/93, effective 11/1/93.

c. Rescinded IAB 11/10/93, effective 11/1/93.

d. The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

e. The following factors shall be taken into account when considering the physician's request:

(1) Mutual agreement between physician and patient regarding the arrangement.

(2) Existence of an already established physician-patient relationship.

(3) Transportation barriers, if requesting a patient manager outside the medical service area.

(4) Customary practice by the specialist to provide primary care.

(5) A new medical condition which necessitates the proposed physician-patient relationship.

441—88.45(249A) Contracting for the provision of patient management.

88.45(1) *Eligibility to contract.* Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

88.45(2) *Contract provisions.* The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

a. The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.

b. The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.

c. The patient manager shall maintain records that at a minimum:

(1) Identify the patient as a patient management recipient.

(2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.

(3) Contain the name, state identification number, age, sex and address of the patient.

(4) Document services provided and where and by whom they are provided.

(5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.

(6) Contain the name of the person making the entry and the date of the contact.

d. The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.

e. The department shall specify the fees and method of payment to patient managers.

f. The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

88.45(3) *Contract compliance.* The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

88.45(4) *Corrective action and sanctions.* The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

88.45(5) *Termination of contract.* The contract may be terminated in any of the following ways:

a. The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.

(1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).

(2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.

b. The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

(1) The department has imposed any sanction described at 441—subrule 79.2(3).

(2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

441—88.46(249A) Enrollment and changes in enrollment.

88.46(1) *Mandatory enrollment.* Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.46(2) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

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

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

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

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

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

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

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

(4) Reattains eligibility.

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

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. Selection of a managed health care provider. A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed

health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Rescinded IAB 5/7/97, effective 7/1/97.

e. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

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

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

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

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

g. Enrollment cycle. Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

88.46(3) *Voluntary enrollment procedures.* Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

a. Recipients shall not be informed at the face-to-face interview that enrollment is required.

b. Notice to recipient shall not include assignment language.

c. Recipients shall not be assigned if no selection is made voluntarily.

d. A managed health care provider must be available for enrollment.

88.46(4) *Effective date.* Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

88.46(5) *Identification card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

88.46(6) *Enrollment limits.*

a. Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

(1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.

(2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.

(3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

b. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

88.46(7) *Reinstatement of patient management status.* When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

441—88.47(249A) Disenrollment.

88.47(1) *Disenrollment request.* An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) 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.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1)*"c"* (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

88.47(2) *Effective date.* Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the

date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

441—88.48(249A) Services.

88.48(1) *Managed services.* Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

a. Inpatient hospital.

b. Outpatient hospital.

c. Home health.

d. Physician (except services provided by an ophthalmologist).

e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).

f. Laboratory, X-ray.

g. Medical supplies.

h. Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.

i. Rescinded IAB 11/5/97, effective 1/1/98.

j. Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

88.48(2) *Nonmanaged services.* Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

88.48(3) *Authorizing managed services.* The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager's absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager's Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager's initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager's approval, the patient manager's number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient's medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

88.48(4) *Special authorizations.* Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The

special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph *"b."*

441—88.49(249A) Grievance procedure. The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

88.49(1) *Written record.* The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

88.49(2) *Formal grievance resolution and response.* The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the recipient, the provider and to the department's patient manager file. Appeal rights shall be included in the response.

88.49(3) *Repeated grievances.* Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

88.49(4) *Quality of care grievances.* In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

88.49(5) *Information concerning grievance procedures.* The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

88.49(6) *Appeals to the department.* A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

441—88.50(249A) Payment.

88.50(1) *Fee.* Patient managers shall be paid a monthly fee of $2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

88.50(2) *Basis for payment.* Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

88.50(3) *Mode of payment.* The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

88.50(4) *Payment limit.* Payment shall be limited to $3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

441—88.51(249A) Utilization review and quality assessment. Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

88.51(1) *Measured services.* Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

88.51(2) *Reports to patient managers.* Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

88.51(3) *Managed health care advisory committee.* Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

a. Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.

b. Assist the department in establishing options for managed health care quality assessment.

c. Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).

d. Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.

e. Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.

f. Prepare or provide educational or informative articles to be used for patient education and health promotion.

441—88.52(249A) Marketing. A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

88.52(1) *Service market.* A MediPASS provider shall distribute any marketing materials to the entire service area or region.

88.52(2) *Prohibition of "cold-call" marketing.* MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

441—88.53 to **88.60** Reserved.

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

441—88.61(249A) Definitions.

"Accredited" shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

"Appeal" shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member's designee, may request review of a certain decision made by the department or the contractor.

"ASAM-PPC-2R" shall mean the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised, published by the American Society of Addiction Medicine in 2001.

"Assertive community treatment (ACT) program" shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

"Capitation rate" shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

"Certification" shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

"Clinical decision review" shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

"Contract" shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

"Contractor" shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

"Coverage group" shall mean a category of members who meet certain common eligibility requirements.

"Covered services" shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

"Department" shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

"Designee" shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

"Director" shall mean the director of the Iowa department of human services.

"Disenrollment" shall mean the removal of an enrollee from the contractor's enrollment list either through loss of eligibility or some other cause.

"Emergency services" shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

"Encounter data" shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

"Enrollee" shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

"Enrollment" shall mean the inclusion of a Medicaid member on a contractor's Medicaid enrollment file.

"Enrollment area" shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

"Fee-for-service" shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

"Grievance" shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor's staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

"Insolvency" shall mean a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

"Integrated mental health services and supports" shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

"Iowa Plan" shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

"Licensed" shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

"Member" shall mean a person determined eligible for Medicaid.

"Mental health services" shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9). At a minimum, covered disorders include the following ranges of the ICD-9: 290-302.9; 306-309.9; and 311-314.9. Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

"MHI" shall mean a state mental health institute operated by the department.

"Open panel" shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

"Participating providers" shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

"Prepaid health plan (PHP)" shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined 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 13, 1991.

"Prior authorization" shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

"Psychosocial necessity" shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.
3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee's clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and the enrollee's choice of provider or treatment location.

"Required services" shall mean mental health and substance abuse treatment services and supports which are not reimbursable though the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

"Retroactive eligibility" shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

"Routine care" shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider.

Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient's life without immediate intervention.

"Service necessity" shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the criteria of the ASAM-PPC-2R. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

"Substance abuse licensed PMIC" shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

"Substance abuse services" shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9), disorders 303 through 305.9, provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

"Targeted case management services" shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

"Third party" shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

"Urgent, nonemergency care" shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient's life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

441—88.62(249A) Participation.

88.62(1) *Contract.* The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, or any portion thereof, with a prepaid health plan.

a. The department shall also determine that the contractor meet the following additional requirements:

(1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.

(2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.

(3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

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

(1) Be in writing.

(2) Specify the duration of the contract period.

(3) List the services which must and may be 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 relationships.

(8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

88.62(2) *Assessment of penalties.* Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.

b. Failure to comply with any provision of the contract.

441—88.63(249A) Enrollment.

88.63(1) *Enrollment area.* The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

88.63(2) *Members subject to enrollment.* All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

88.63(3) *Others to be served.* The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

88.63(4) *Voluntary enrollment.* There will be no voluntary enrollment in the Iowa Plan.

88.63(5) *Effective date.* For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

88.63(6) *Medical card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

441—88.64(249A) Disenrollment.

88.64(1) *Disenrollments by the department.* Disenrollments shall occur when:

a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.

b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.

c. The enrollee dies.

88.64(2) *Effective date.* Disenrollment shall be effective the first day of the month following the month of disenrollment.

88.64(3) *No disenrollment for health reasons.* No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

441—88.65(249A) Covered services.

88.65(1) *Amount, duration, and scope of services.* The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

88.65(2) *Enrollee use of Iowa Plan services.* Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

88.65(3) *Covered, required and optional mental health services.*

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

(1) Ambulance services for psychiatric conditions.

(2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.

(3) Inpatient hospital care for psychiatric conditions.

(4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.

(5) Partial hospitalization.

(6) Day treatment.

(7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.

(8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.

(9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.

(10) Services provided through a community mental health center.

(11) Targeted case management services to persons with chronic mental illness.

(12) Medication management.

(13) Psychiatric nursing services by a home health agency.

(14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.

(15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

(16) Behavioral health intervention as set forth in rule 441—78.12(249A).

(17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.

b. The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

(1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.

(2) Services of a licensed social worker for treatment of mental illness.

(3) Mobile crisis services.

(4) Mobile counseling services.

(5) Integrated mental health services and supports.

(6) Psychiatric rehabilitation services.

(7) Peer support services for persons with chronic mental illness.

(8) Community support services.

(9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.

(10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

88.65(4) *Covered and required substance abuse services.* The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

a. Outpatient services (all Level I services according to the ASAM-PPC-2R).

b. Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).

c. Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).

d. Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).

e. Detoxification.

f. PMIC substance abuse treatment services.

g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.

h. Ambulance services for substance abuse conditions.

i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

88.65(5) *Covered diagnoses.* Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no Axis I diagnosis. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.
2. Substance abuse: 303-305.9.

88.65(6) *Excluded services.* Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

[**ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—88.66(249A) Emergency services.

88.66(1) *Availability of services.* The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

88.66(2) *Payment for emergency room services.* Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

a. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

(1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.

(2) Require authorization of any services beyond those provided in the emergency room.

b. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

88.66(3) *Contractor payment liability.* The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

88.66(4) *Notification and claim filing time spans.* The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall 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. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

441—88.67(249A) Access to service.

88.67(1) *Choice of provider.* Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

88.67(2) *Open panel requirement.* The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

88.67(3) *Requirements for participating provider panel.* The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

a. Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where capability of participating providers to serve specific mental health and substance abuse needs does not exist.

b. Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

88.67(4) *Adequate appointment system.* The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

a. Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

b. Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

c. Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

88.67(5) *Adequate after-hours call-in coverage.* The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

88.67(6) *Adequate referral system.* The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

88.67(7) *Discharge planning.* The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

88.67(8) *Lack of discharge plan.* When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

(1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;

(2) A court order is required to allow placement of the child into the appropriate living arrangement;

(3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or

(4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8)*"a."*

441—88.68(249A) Review of contractor decisions and actions.

88.68(1) *Clinical decision review.* The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.

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

c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.

d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.

e. Ensure the participation of contractor staff with authority to require corrective action.

f. Include at least one level of internal review.

g. Ensure the confidentiality of the enrollee.

88.68(2) *Appeal to department.* Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

88.68(3) *Review of nonclinical decisions.* The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions

shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

a. Allow initiation both verbally and in writing.

b. Require a review conducted by someone other than the person who made the original decision.

c. Require written notice acknowledging the receipt of a complaint or grievance.

d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

88.68(4) *Written record.* All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

88.68(5) *Information concerning procedures relating to the review of contractor decisions and actions.* The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

88.68(6) *Periodic reports to the department.* The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

88.68(7) *Consent for state fair hearing.* Network providers which are contracted and in good standing with the Iowa plan contractor may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[**ARC 0583C**, IAB 2/6/13, effective 4/1/13]

441—88.69(249A) Records and reports.

88.69(1) *Records system.* The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record 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 clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.

c. Permit effective professional review for medical audit processes.

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

e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

88.69(2) *Content of individual treatment record.* The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

88.69(3) *Confidentiality of mental health information.* The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

88.69(4) *Confidentiality of substance abuse information.* The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

88.69(5) *Reports to the department.* The contractor shall submit reports to the department as follows:

a. Encounter data on a monthly basis.

b. Annual audited financial statements no later than 180 days after the close of each contract year.

c. Periodic financial, utilization, and statistical reports as required by the department in the contract.

d. Other reporting requirements as specified in the contract.

88.69(6) *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 contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.70(249A) Marketing. The marketing of Iowa Plan services is prohibited.

441—88.71(249A) Enrollee education.

88.71(1) *Use of services.* The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that 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; statement of consumer rights and responsibilities; out-of-area use of service; availability of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

88.71(2) *Outreach to members with special needs.* The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

88.71(3) *Patient rights and responsibilities.* The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

441—88.72(249A) Payment to the contractor.

88.72(1) *Capitation rate.* In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

88.72(2) *Determination of rate.* The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

88.72(3) *Payment for services to other recipients.* When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

88.72(4) *Third-party liability.* If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

441—88.73(249A) Claims payment.

88.73(1) *Claims payment by contractor.* The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

a. For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.

b. For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.

c. For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

88.73(2) *Limits on payment responsibility for services.*

a. The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.

b. The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.

c. The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.

d. The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.

e. Payment responsibilities for emergency room services are as provided at subrule 88.66(2).

f. Payment responsibility for services provided under the "keep kids safe" policy is set forth at subrule 88.67(8).

88.73(3) *Payment to nonparticipating providers.* In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

88.73(4) *Payment of crossover and copayments.* Rescinded IAB 1/9/02, effective 3/1/02.

441—88.74(249A) Quality assurance. The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

441—88.75(249A) Iowa Plan advisory committee. The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

441—88.76 to **88.80** Reserved.

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

441—88.81(249A) Scope and definitions.

88.81(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.

88.81(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.

88.81(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.

88.81(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.

441—88.82(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.

88.82(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.

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.

88.82(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.

88.82(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.

88.82(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.

441—88.83(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.

88.83(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.

88.83(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.

88.83(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.

88.83(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.

88.83(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.

88.83(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.

441—88.84(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.

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

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

(5) 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 88.84(4).

88.84(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.

88.84(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 88.84(5).

88.84(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.

88.84(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 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(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 88.84(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.

88.84(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.

88.84(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.

88.84(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.

88.84(9) *Reinstatement in PACE.* A previously disenrolled enrollee may be reinstated in a PACE program.

441—88.85(249A) Program services. A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

88.85(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.

88.85(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.

88.85(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.

88.85(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.

88.85(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.

88.85(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.

441—88.86(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.

88.86(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.

88.86(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.

88.86(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.

88.86(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 88.86(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.

88.86(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.

441—88.87(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.

88.87(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.

88.87(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.

88.87(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.

88.87(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 88.83(3) and 88.83(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 V.

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.

441—88.88(249A) Payment.

88.88(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).

88.88(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.

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

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◊ Two or more ARCs

1 Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.