TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 73
MANAGED CARE

PREAMBLE

This chapter provides that most Iowa medical assistance program benefits will be provided through managed care. Notwithstanding any provisions of 441—Chapters 74 through 91, program benefits shall be provided through managed care as provided in this chapter. The program benefits provided through managed care will be paid for by the managed care plan participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care plan, consistent with this chapter and with the contract between the department and the managed care plan.

Implementation of managed care pursuant to this chapter is subject to approval by the Secretary of the United States Department of Health and Human Services (Secretary) of any Iowa state plan amendments and any waivers of the requirements of Title XIX of the Social Security Act that are required to allow for federal funding. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements under Title XIX or the terms of the waiver shall prevail.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.1(249A) Definitions.

"Behavioral health services" means mental health and substance use disorder treatment services.

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

"Choice counseling" means the provision of unbiased information on MCPs or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the MCPs or the state, to answer questions about each of the options available, and to facilitate enrollment with an MCP.

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

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

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

"Code of Federal Regulations" or *"CFR"* means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

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

"Contract" means a contract between the department and an MCP. These contracts shall meet all applicable requirements of state and federal law, including the requirements of 42 CFR 434 as amended to July 19, 2022.

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

"Department" means the Iowa department of human services.

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

"Electronic visit verification system" means, with respect to personal care services or home health care services described in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

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

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

"Emergency services" means covered inpatient and outpatient services that are as follows:

1. Furnished by a provider that is qualified to furnish these services.
2. Needed to evaluate or stabilize an emergency medical condition.

"EMTALA" means the Emergency Medical Treatment and Active Labor Act.

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

"Enrollment broker" means the entity the department uses to enroll persons in an MCP. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law, including 42 CFR 438.10 as amended to July 19, 2022.

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

"HIPP" means the health insurance premium payment program.

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

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

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

"Insolvency" means 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.

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

"Level of care" means an evaluation to determine and establish an individual's need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future.

"Long-term care (LTC)" or *"long-term services and supports (LTSS)"* means the services of a nursing facility (NF), an intermediate care facility for persons with an intellectual disability (ICF/ID), state resource centers or services funded through Section 1915(c) home- and community-based services waivers, Section 1915(i) state plan home- and community-based habilitation program and the PACE program.

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

"Managed care plan" or *"MCP"* refers to managed care organizations (MCOs) and prepaid ambulatory health plans (PAHPs).

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

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

"Medically necessary services" means those covered services that are, under the terms and conditions of the contract, determined through MCP utilization management to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member.
2. Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment.
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting.
4. Not primarily for the convenience of the member, the member's physician or other provider; and
5. The most appropriate level of covered services that can safely be provided.

"Medical records" means all medical, dental, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

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

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

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

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

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

"PACE" means the program of all-inclusive care for the elderly.

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

"Passive enrollment process" means the process by which the department assigns a member to a managed care plan and which, in accordance with 42 CFR 438.54 as amended to July 19, 2022, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care plans.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2 as amended to July 19, 2022.

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

"Warm transfer" means a telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

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

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

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

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

b. The MCP shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the MCP's debts if the MCP becomes insolvent. The MCP shall comply with insurance division provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The MCP shall attain and maintain accreditation by the National Committee for Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

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

73.2(4) The contract shall meet the following minimum requirements. The contract shall:

a. Be in writing.

b. Specify the duration of the contract period.

c. List the services that must be covered.

d. Describe service access and provide access information.

e. List conditions for nonrenewal, termination, suspension, and modification.

f. Specify the method and rate of reimbursement.

g. Provide for disclosure of ownership and subcontracted relationships.

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

i. Specify appeal and grievance rights.

j. Specify all operational and service delivery expectations.

k. Specify reporting requirements.

l. Specify requirements for utilization management and quality improvement.

m. Specify requirements for program integrity.

n. Specify termination requirements and assessment of penalties.

o. Require the MCP and the fee-for-service Medicaid program to utilize a uniform prior authorization process.

The process will include forms, information requirements, and time frames.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.3(249A) Enrollment.

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

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

a. Members who are medically needy as described at 441—Chapter 75.

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

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

d. Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as described in Division II of 441—Chapter 88.

e. Persons enrolled in the health insurance premium payment program (HIPP) pursuant to 441—Chapter 75.

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

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

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

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

j. Persons residing in the Iowa Veterans Home as described in rule 801—10.1(35D).

k. Effective July 1, 2017, persons who are eligible only for the family planning waiver as described in 441—Chapter 75.

73.3(3) *Enrollment process.* The department shall notify members who must be enrolled in an MCP of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to July 19, 2022.

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

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

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

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

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

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

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

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

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.4(249A) Disenrollment process.

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

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

b. After the 90 days following the date of the enrollee's enrollment with the MCP, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written

filing of the issue through the MCP's grievance system. If the member does not experience resolution, the MCP shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

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

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

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

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

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

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

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

c. The enrollee transfers to an eligibility group excluded from managed care plan enrollment. "Enrollee" is defined in rule 441—73.1(249A).

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

e. The enrollee dies.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care plan-requested disenrollment.* An MCP shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health or dental care needs or change in health or dental care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs (except when the enrollee's continued enrollment seriously impairs the MCP's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the MCP shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the MCP's ability to furnish services to either this particular enrollee or other enrollees. The MCP shall have methods by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.*

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

(1) The enrollee requests disenrollment pursuant to subrule 73.4(1);

(2) The department notifies the enrollee and MCP of disenrollment pursuant to subrule 73.4(2); or

(3) The MCP requests disenrollment pursuant to subrule 73.4(3).

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

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.5(249A) MCP covered services.

73.5(1) *Required services—MCOs.* A managed care organization shall provide:

a. For enrollees other than Iowa health and wellness plan enrollees and hawki program enrollees, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

(1) Area education agency services.

(2) Dental services not provided in an outpatient hospital setting.
(3) Infant and toddler program services.
(4) Local education agency services.
(5) State of Iowa Veterans Home services.
(6) Money Follows the Person (MFP) Rebalancing Demonstration Grant-funded services.
b. Services as set forth in 441—Chapter 74 for Iowa health and wellness plan enrollees.
c. Services as set forth in 441—Chapter 86 for hawki program enrollees.

73.5(2) *Community-based case management service.* The managed care organization is required to provide services that meet requirements specified in the contract and in 441—Chapter 90.

73.5(3) *Health home services.* The managed care organization is required to provide services that meet the requirements specified in 441—Chapter 78 and as specified in the contract.

73.5(4) *Value-added services.* A managed care organization may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

73.5(5) *Required services—PAHPs.* A PAHP shall provide services to enrollees under the contract with the state agency and on the bases of prepaid capitation payments or other payment arrangements that do not use state plan payment rates. PAHPs shall provide:

a. For enrollees other than Iowa health and wellness plan enrollees and hawki program enrollees, services as set forth in 441—Chapter 73, 74, 78, and 88 with the exception of the following:
(1) Area education agency services.
(2) Inpatient hospital or institutional services.
(3) Advance directive requirements in dental nonclinical services such as transportation.
(4) Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for persons with an intellectual disability).
(5) Inpatient psychiatric care provided at the state-administered mental health institutes.
(6) Services provided at specialized adolescent psychiatric facilities.
(7) Day treatment and partial hospitalization services for persons aged 20 or under.
(8) Enhanced services provided to certain eligible recipients.
b. Services as set forth in 441—Chapter 74 for Iowa health and wellness plan enrollees.
c. Services as set forth in 441—Chapter 86 for hawki program enrollees.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

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

73.6(1) The MCP shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the department. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to July 19, 2022, the MCP shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The MCP shall not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, the managed care organization shall require as a condition of payment managed care organization approval of admissions to a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric medical institution for children, and a mental health institute. Managed care organizations shall also require managed care organization approval of out-of-state placements as a condition of payment.

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

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

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

73.6(3) The MCP shall allow each enrollee to choose a health or dental professional, to the extent possible and appropriate, within the MCP's provider network. The MCP shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.7(249A) Emergency services.

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

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114 as amended to July 19, 2022, the MCP shall:

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

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

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

d. Cover the medical screening examination, as described by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition. This requirement applies to managed care organizations only.

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

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

b. Treatment obtained when a representative of the MCP instructs the enrollee to seek emergency medical services.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.8(249A) Access to service.

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

73.8(2) Choice of providers. An enrollee shall use the MCP's provider network unless the MCP has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to July 19, 2022, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the MCP network.

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

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

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

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

73.8(5) An enrollee's primary care provider shall be responsible for providing preventative and primary health or dental care to the enrollee; for initiating referrals for specialist care, where appropriate; and for maintaining the continuity of patient care. Primary care providers may be physicians, advanced registered nurse practitioners, or physician assistants, licensed and practicing in accordance with state law.

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.9(249A) Incident reporting.

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

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

a. Address and respond to incidents;

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

c. Track and analyze incidents.

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

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

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.11(249A) Level of care assessment and annual reviews. The managed care organization shall establish policies and procedures to ensure the implementation of level of care and needs-based eligibility assessments and reassessments as required in the contract and consistent with the department's level of care and needs-based eligibility assessment process and the requirements provided in 441—Chapters 75, 78, 81, 82, 83, and 85. Waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan.

73.11(1) Initial level of care assessment. Managed care organizations are responsible for conducting level of care and needs-based eligibility assessments for a current enrollee who requires a level of care or a needs-based eligibility assessment. The managed care organization shall perform the assessment using department-approved assessment tools. The results of the assessment shall be submitted to the Iowa Medicaid medical services unit for determination of level of care or needs-based eligibility.

73.11(2) Annual continued stay reviews, continued care reviews and redeterminations. When an enrollee requires a continued stay review, a continued care review or a redetermination, the managed care organization shall use department-approved assessment tools. If the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect the enrollee's level of care or needs-based eligibility, the managed care organization shall submit the assessment findings to the Iowa Medicaid medical services unit for determination of level of care or needs-based eligibility.

73.11(3) At any time, if the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect level of care or needs-based eligibility, the managed care organization shall conduct a level of care or needs-based assessment using the department-approved tools and submit the assessment to the Iowa Medicaid medical services unit for determination of level of care or needs-based eligibility.

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.12(249A) Appeal of MCP actions. The MCPs shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal an MCP action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438, Subpart F, as amended to July 19, 2022.

73.12(1) *MCP appealable actions.* MCP actions that may be appealed include:

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

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

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

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

e. Failure to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended July 19, 2022.

f. For a resident of a rural area who has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.

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

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

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

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

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

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

e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to July 19, 2022.

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

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

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the MCP through the managed care plan's appeal process, the enrollee may appeal an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7.

[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.14(249A) Continuation of benefits. The MCP shall be required to continue the member's benefits during the appeal in accordance with federal funding requirements, including 42 CFR 438.420 as amended to July 19, 2022.

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

a. The enrollee withdraws the appeal request;

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

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

73.14(2) If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the MCP's action, the MCP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the MCP or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize and provide the disputed services promptly and as expeditiously as the member's health or dental condition requires. If the MCP or the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the MCP must pay for these services.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.15(249A) Grievances. The MCP shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.16(249A) Written record. All MCP enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.17(249A) Information concerning procedures relating to the review of MCP decisions and actions. The MCP's written procedures for the review of MCP's decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.18(249A) Records and reports.

73.18(1) *Records system.* The MCPs shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including 441—Chapter 79 and 42 CFR 456 as amended to July 19, 2022, throughout the course of the contract. The records system shall:

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

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

c. Permit effective professional review for medical audit processes.

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

73.18(2) *Content of individual treatment record.* The MCP shall ensure that participating providers maintain an adequate record-keeping system that includes a complete medical, dental, or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of 441—Chapter 79 and pursuant to federal funding requirements, including 42 CFR 456 as amended to July 19, 2022. Beginning January 1, 2021, the managed care organization shall require use of an electronic visit verification system for personal care services.

73.18(3) *Confidentiality of health care, mental health care, and substance abuse information.* The MCP shall protect and maintain the confidentiality of health care, mental health care, dental care and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.19(249A) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the MCP. The department or HHS may audit and inspect any records of an MCP, or the subcontractor of the MCP, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, at

places, and in a manner as authorized representatives of the department, its designee or HHS may request.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.20(249A) Marketing. MCP marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the MCP and contract terms. The department shall approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104 as amended to July 19, 2022.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.21(249A) Enrollee education.

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

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

73.21(3) *Patient rights and responsibilities.* The MCP shall have in effect a written statement of patient rights and responsibilities that is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.22(249A) Payment to the MCP.

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

73.22(2) *Determination of rate.* The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6 as amended to July 19, 2022, Actuarial Standards of Practice 49, and other related CMS regulations and generally accepted actuarial principles and practices.

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

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

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

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

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

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

73.22(4) *Medical loss ratio.* The MCP shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the MCP.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

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

73.23(1) The managed care organizations shall pay or deny:

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

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

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

73.23(2) The PAHP shall pay or deny:

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

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

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

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

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

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

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

73.23(4) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 80 percent of the payment to participating providers.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.24(249A) Quality assurance. The MCP shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

441—73.25(249A) Certifications and program integrity. The MCP shall develop and implement policies, procedures and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The MCP shall cooperate and collaborate with the department on all program integrity activities. The MCP shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to July 19, 2022.
[**ARC 6959C**, IAB 4/5/23, effective 6/1/23]

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

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed Emergency After Notice ARC 3667C (Notice ARC 3514C, IAB 12/20/17), IAB 3/14/18, effective 2/14/18]
[Filed ARC 4392C (Notice ARC 4258C, IAB 1/30/19), IAB 4/10/19, effective 6/1/19]
[Filed ARC 4429C (Notice ARC 4289C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]
[Filed ARC 4847C (Notice ARC 4673C, IAB 9/25/19), IAB 1/1/20, effective 6/29/20]
[Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]
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