

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 managed care organizations participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care organization, consistent with this chapter and with the contract between the department and the managed care organization.

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.

**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 contractor on behalf of each enrollee for the provision of health 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 managed care plans or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the managed care organizations or the state, to answer questions about each of the options available, and to facilitate enrollment with a managed care organization.

*“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 (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 a member’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

*“Contract”* means a contract between the department and a managed care organization. These contracts shall meet all applicable requirements of state and federal law, including the requirements of the Code of Federal Regulations, Title 42 CFR 434 as amended to October 16, 2015.

*“Covered services”* means physical health, behavioral health 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 an enrollee’s continued need for treatment services and of developing a plan to address ongoing needs.

*“Emergency medical condition”* means a physical or behavioral 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, 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.

*“Emergency services”* means covered inpatient and outpatient services that are both furnished by a provider that is qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition.

*“EMTALA”* means the Emergency Medical Treatment and Active Labor Act.

*“Enrollee”* means a HAWK-I, Iowa Health and Wellness Plan or Medicaid member who is eligible for managed care organization enrollment and has been enrolled with a managed care organization as defined in subrule 73.3(2).

*“Enrollment broker”* means the entity the department uses to enroll persons in a managed care organization. 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 October 16, 2015.

*“HAWK-I 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.

*“Health maintenance organization”* means a public or private organization which is licensed as a managed care organization or prepaid health plan under insurance division rules set forth in 191—Chapter 40.

*“HIPP”* means the health insurance premium payment program.

*“Home- and community-based services (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 (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.

“*Mandatory enrollment*” means mandatory participation in a managed care organization as specified in subrule 73.3(2).

“*Medical loss ratio (MLR)*” means the percentage of capitation payments that is used to pay medical expenses.

“*Medically necessary services*” means those covered services that are, under the terms and conditions of the contract, determined through contractor 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, 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 HAWK-I program, the Iowa Health and 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 care providers (both individual and group practitioners) linked through contractual arrangements to the contractor to supply a range of health 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 contractor or any of its subcontractors pursuant to the contract between the department and the contractor.

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

“*Participating providers*” means the providers of covered physical health, behavioral health and long-term care services that have contracted with a managed care organization.

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

“*PMIC*” means a psychiatric medical institution for children.

“*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 2358C, IAB 1/6/16, effective 1/1/16; ARC 4429C, IAB 5/8/19, effective 7/1/19]

**441—73.2(249A) Contracts with a managed care organization.**

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

**73.2(2)** The department shall determine that the managed care organization meets the following requirements:

*a.* The managed care organization shall make available the services it provides to enrollees as established in the contract.

*b.* The managed care organization 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 managed care organization's debts if the managed care organization becomes insolvent. The managed care organization 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 managed care organization shall attain and maintain accreditation by the National Committee on Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

**73.2(3)** If not already accredited, the managed care organization 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 managed care organization 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 which 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 managed care organization, 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 managed care organizations 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 2358C, IAB 1/6/16, effective 1/1/16; ARC 4847C, IAB 1/1/20, effective 6/29/20]

**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 HAWK-I program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

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

*b.* Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).

c. Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).

d. Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).

e. Persons enrolled in the health insurance premium payment program (HIPPP) pursuant to rule 441—75.21(249A).

f. Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).

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.

**73.3(3) Enrollment process.** The department shall notify members who must be enrolled in a managed care organization 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 May 6, 2016.

a. *General.* Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization 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 a managed care organization using the department's passive enrollment process and offered the opportunity to choose from the available managed care organizations 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 managed care organization and enroll in another managed care organization. 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 managed care organization 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 managed care organization or to enroll with a different managed care organization.

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

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

b. The managed care organization 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 2358C, IAB 1/6/16, effective 1/1/16; ARC 4429C, IAB 5/8/19, effective 7/1/19]

**441—73.4(249A) Disenrollment process.**

**73.4(1) Enrollee-requested disenrollment.** An enrollee may request disenrollment with a managed care organization as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, 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 managed care organization, 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 managed care organization's grievance

system. If the member does not experience resolution, the managed care organization 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 managed care organization 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 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 managed care organization is terminated.

b. The enrollee becomes ineligible for Medicaid, the HAWK-I program or the Iowa Health and Wellness Plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the managed care organization will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care organization enrollment. See definition of "enrollee" in rule 441—73.1(249A).

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

e. Death of the enrollee.

f. The enrollee has changed residence to another state.

**73.4(3) *Managed care organization-requested disenrollment.*** A managed care organization shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health care needs or change in health 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 managed care organization's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the managed care organization shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees. The managed care organization shall have methods by which the department is assured that disenrollment is not requested for another reason.

**73.4(4) *Disenrollment effective date.*** 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 managed care organization of disenrollment pursuant to subrule 73.4(2); or (3) the managed care organization requests disenrollment pursuant to subrule 73.4(3). The enrollee shall remain enrolled in the managed care organization and the managed care organization 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 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.5(249A) Covered services.**

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

a. For enrollees other than Iowa Health and Wellness Plan enrollees and HAWK-I 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 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 HAWK-I 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—subrule 78.53(1) 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.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

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

**73.6(1)** The managed care organization shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the agency. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to October 16, 2015, the managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may 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, psychiatric medical institutions 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 managed care organization 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 managed care organization shall not:

- a.* Avoid costs for services covered in the contract by referring members to publicly supported health care resources.
- b.* Deny reimbursement of covered services based on the presence of a preexisting condition.

**73.6(3)** The managed care organization shall allow each enrollee to choose a health professional, to the extent possible and appropriate, within the managed care organization's provider network. The managed care organization shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.

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

#### **441—73.7(249A) Emergency services.**

**73.7(1)** Emergency services shall be available 24 hours a day, 7 days a week.

**73.7(2)** In accordance with federal funding requirements, including 42 CFR 438.114 as amended to October 16, 2015, the managed care organization shall:

- a.* Cover emergency services without the need for prior authorization and may not limit reimbursement to network providers.
- b.* Cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the managed care organization.
- 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 defined by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition.

**73.7(3)** The managed care organization shall not deny payment for:

*a.* Treatment obtained when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would result in placing the health of the enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

*b.* Treatment obtained when a representative of the managed care organization instructs the enrollee to seek emergency medical services.

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

**441—73.8(249A) Access to service.**

**73.8(1)** The managed care organization shall ensure enrollees have access to services as specified in the contract. In general, the managed care organization 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, 7-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 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 managed care organization's provider network unless the managed care organization 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 October 16, 2015, 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 managed care organization's network.

**73.8(3)** Continuity of care. The managed care organization 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 managed care organization 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 managed care organization 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 managed care organization departments, such as to 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, 7 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 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 2358C, IAB 1/6/16, effective 1/1/16; ARC 4392C, IAB 4/10/19, effective 6/1/19]

**441—73.9(249A) Incident reporting.** 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, the Section 1915(i)



Habilitation Program, and as required for licensure of programs through the department of inspections and appeals. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

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

**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 2358C, IAB 1/6/16, effective 1/1/16]

**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 IME 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 IME 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 IME medical services unit for determination of level of care or needs-based eligibility.**

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

**441—73.12(249A) Appeal of managed care organization actions.** The managed care organization shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal a managed care organization action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438.400(b) as amended to October 16, 2015.

**73.12(1) Managed care organization appealable actions.** Managed care organization 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 defined by the department.
- e. Failure of the managed care organization to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended to October 16, 2015.

*f.* For a resident of a rural area that 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.

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

*a.* Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.

*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 October 16, 2015.

*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 2358C, IAB 1/6/16, effective 1/1/16; ARC 3667C, IAB 3/14/18, effective 2/14/18]

**441—73.13(249A) Appeal to department.** If the enrollee is not satisfied with the final decision rendered by the managed care organization through the managed care organization'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 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.14(249A) Continuation of benefits.** The managed care organization 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 October 16, 2015.

**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 MCO mailed the notice providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten-day time frame, has requested 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 have been met.

**73.14(2)** If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the managed care organization's action, the managed care organization 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 managed care organization or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the managed care organization 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 managed care organization must pay for these services.

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

**441—73.15(249A) Grievances.** The managed care organization 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 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.16(249A) Written record.** All 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 2358C, IAB 1/6/16, effective 1/1/16]

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

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

**441—73.18(249A) Records and reports.**

**73.18(1) Records system.** The managed care organization shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including rule 441—79.3(249A) and 42 CFR 456 as amended to October 16, 2015, 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 managed care organization, 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 managed care organization shall ensure that participating providers maintain an adequate record-keeping system that includes a complete medical or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of rule 441—79.3(249A) and pursuant to federal funding requirements, including 42 CFR 456 as amended to October 16, 2015.

**73.18(3) Confidentiality of health care, mental health care, and substance abuse information.** The managed care organization shall protect and maintain the confidentiality of health care, mental health 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 2358C, IAB 1/6/16, effective 1/1/16]

**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 managed care organization. The department or HHS may audit and inspect any records of a managed care organization, or the subcontractor of the managed care organization, 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.

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

**441—73.20(249A) Marketing.** Managed care organization marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the managed care organizations 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 October 16, 2015.

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

**441—73.21(249A) Enrollee education.**

**73.21(1) Use of services.** The managed care organization shall provide written information to all enrollees on the use of services the managed care organization 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 managed care organization 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 managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual or hearing impairments.

**73.21(3) Patient rights and responsibilities.** The managed care organization 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 the packet of enrollment information provided to all new enrollees.

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

**441—73.22(249A) Payment to the managed care organization.**

**73.22(1) Capitation rate.** In consideration for all services rendered by a managed care organization under a contract with the department, the managed care organization 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 defined 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 managed care organization meets metrics defined in the managed care 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 October 16, 2015, 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 expenses, it is the right and responsibility of the managed care organization to investigate these third-party resources and attempt to obtain payment. The managed care organization shall retain all funds collected from third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

**73.22(4) Medical loss ratio.** The managed care organization 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 managed care organization.

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

**441—73.23(249A) Claims payment by the managed care organization.**

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

- a. Ninety percent of all clean claims within 14 calendar days of receipt,
- b. Ninety-nine point five percent of all clean claims within 21 calendar days of receipt, and
- c. One hundred percent of all claims within 90 calendar days of receipt.

**73.23(2)** Limits on payment responsibility for services.

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

*b.* The managed care organization 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 at rule 441—73.7(249A).

**73.23(3)** Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers.  
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.24(249A) Quality assurance.** The managed care organization 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 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.25(249A) Certifications and program integrity.** The managed care organization 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 managed care organization shall cooperate and collaborate with the department on all program integrity activities. The managed care organization shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to October 16, 2015.

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

These rules are intended to implement Iowa Code section 249A.4, 2015 Iowa Acts, Senate File 505, section 12, and 2019 Iowa Acts, House File 766, section 63.

[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]

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