**441—86.15(514I) Participating health plans.**

**86.15(1)** *Licensure.* The participating health plan must be licensed by the division of insurance of the department of commerce to provide health care coverage in Iowa or be an organized delivery system licensed by the director of public health to provide health care coverage.

**86.15(2)** *Services.* The participating health plan shall provide health care coverage for the services specified in rule 441—86.14(514I) to all children determined eligible by the third-party administrator.

*a.* The participating health plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the plan.

*b.* Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

*c.* If a participating plan does not provide statewide coverage, the plan shall participate in every county within the region in which the plan has contracted to provide services in which it is licensed and in which a provider network has been established. Regions are specified in rule 441—86.1(514I).

**86.15(3)** *Premium tax.* Premiums paid to participating health plans by the third-party administrator are exempt from premium tax.

**86.15(4)** *Provider network.* The participating health plan shall establish a network of providers. Providers contracting with the participating health plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

**86.15(5)** *Medical cards.* Medical identification cards shall be issued by the participating health plan to the enrollees for use in securing covered services.

**86.15(6)** *Marketing.*

*a.* Participating health plans may not distribute directly or through an agent or independent contractor any marketing materials.

*b.* All marketing materials require prior approval from the department.

*c.* At a minimum, participating health plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All plan literature and brochures shall be available in English and any other language when enrollment in the plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the plan and shall be made available to the third-party administrator for distribution.

*d.* All health plan literature and brochures shall be approved by the department.

*e.* The participating health plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

*f.* The participating health plan may make marketing presentations at the discretion of the department.

**86.15(7)** *Appeal process.* The participating health plan shall have a written procedure by which enrollees may appeal issues concerning the health care services provided through providers contracted with the plan and which:

*a.* Is approved by the department prior to use.

*b.* Acknowledges receipt of the appeal to the enrollee.

*c.* Establishes time frames which ensure that appeals be resolved within 60 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

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

*e.* Ensures that the decision be made by a physician or clinical peer not previously involved in the case.

*f.* Ensures the confidentiality of the enrollee.

*g.* Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.

*h.* Maintains a log of the appeals which is made available to the department at its request.

*i.* Ensures that the participating health plan's written appeal procedures be provided to each newly covered enrollee.

*j.* Requires that the participating health plan make quarterly reports to the department summarizing appeals and resolutions.

**86.15(8)** *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

**86.15(9)** *Records and reports.* The participating health plan shall maintain records and reports as follows:

*a.* The plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the plan or subcontractor of the plan, as appropriate, must maintain a medical records system that:

(1) Identifies each medical record by HAWK-I enrollee identification number.

(2) Maintains a complete medical record for each enrollee.

(3) Provides a specific medical record on demand.

(4) Meets state and federal reporting requirements applicable to the HAWK-I program.

(5) Maintains the confidentiality of medical records information and releases the information only in accordance with established policy below:

1. All medical records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical records information to physicians, other practitioners, or facilities that are providing services to enrollees under a subcontract with the plan. This provision also applies to specialty providers who are retained by the plan to provide services which are infrequently used, which provide a support system service to the operation of the plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical records information to physicians or facilities providing emergency care pursuant to paragraph 86.15(2)*"b."*

4. Written consent is required for the transmission of the medical records information of a former enrollee to any physician not connected with the plan.

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

6. Medical records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

*b.* Each plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

(1) A list of providers of medical services under the plan.

(2) Rescinded IAB 10/17/01, effective 12/1/01.

(3) Rescinded IAB 10/17/01, effective 12/1/01.

(4) Rescinded IAB 10/17/01, effective 12/1/01.

(5) Encounter data on a monthly basis as required by the department.

(6) Rescinded IAB 10/17/01, effective 12/1/01.

(7) Other information as directed by the department.

*c.* Each plan shall at a minimum provide reports and plan information to the department as follows:

(1) Information regarding the plan's appeal process.

(2) A plan for a health improvement program.

(3) Periodic financial, utilization and statistical reports as required by the department.

(4) Time-specific reports which define activity for child health care, appeals and other designated activities which may, at the department's discretion, vary among plans, depending on the services covered or other differences.

(5) Other information as directed by the department.

**86.15(10)** *Systems.* The participating health plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

**86.15(11)** *Payment to the participating health plan.*

*a.* In consideration for all services rendered by a plan, the plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to the enrollees.

*b.* The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

*c.* The capitation rate does not include any amounts for the recoupment of losses suffered by the plan for risks assumed under the current or any previous contract. The plan accepts the rate as payment in full for the contracted services. Any savings realized by the plan due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the plan.

*d.* If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical expenses, it is the right and responsibility of the plan to investigate these third-party resources and attempt to obtain payment. The plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

**86.15(12)** *Quality assurance.* The plan shall have in effect an internal quality assurance system.