**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.

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