

441—88.5 (249A) Covered services.

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

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

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

88.5(2) Required services.

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

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- (13) Rescinded IAB 11/5/97, effective 1/1/98.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

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

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

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- h.* Rescinded IAB 8/1/07, effective 9/5/07.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

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

88.5(4) Restrictions and limitations. If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service

or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

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