CHAPTER 111
FINANCIAL ASSISTANCE TO ELIGIBLE END-STAGE RENAL DISEASE PATIENTS

[Prior to 7/29/87, Health Department[470] Ch 111]

641—111.1(135) Definitions. For the purpose of these rules, the following definitions shall apply:

"Administrative overpayment" means financial assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

"Agency error" means financial assistance incorrectly paid to or for the client because of action attributed to the department as a result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available.
6. Failure to make prompt revisions in payment following changes in reimbursement rate requiring the changes as of a specific date.

"Client" means a current or former applicant or recipient of financial assistance.

"Client error" means financial assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in paragraph 111.4(4)"1."

"Committee" means the renal disease advisory committee established by Iowa Code section 135.46.

"Department" means the Iowa department of public health.

"Direct expenses" means costs incurred as a result of receiving transplantation or dialysis services.

"Director" means the director of Iowa department of public health.

"End-stage renal disease" means kidney failure which has progressed enough to require dialysis treatment or a kidney transplant to sustain life.

"Exempt financial resources" means:

1. A homestead without regard to its value as defined in these rules;
2. Personal property as defined in these rules;
3. Life insurance which has no cash surrender value;
4. Equity in a motor vehicle;
5. Income earned by dependents of the client not to exceed gross income of $247 monthly;
6. The balance due on sale contract when commercial or farm property or a business is sold on contract. Payments received on the contract, however, shall be considered as gross income;
7. The equity value up to $100,000 of commercial or farm property or of a business as specified in subrule 111.5(3);
8. An equity not to exceed $6,890 in one irrevocable funeral contract or burial trust for each member of the family as defined below. Any amount in excess of $6,890 shall be counted as nonexempt financial resource; and
9. An equity not to exceed $1,500 in one account or fund designated for burial purposes for each member of the family as defined below. Such funds include but are not limited to revocable burial trusts, cash value of life insurance policies, certificates of deposit, trusts.

"Family" includes the following members:

1. Legal spouses including common-law spouses.
2. Natural or adoptive mother or father, or stepmother or stepfather, and children who reside in the same household and are claimed as dependents on income tax return.

"Family income" means money derived from any source (excluding borrowed money or loans obtained for specific uses) available to clients to offset the expenses associated with their end-stage renal disease other than funds provided by this program.

"Financial assistance" means the program funds provided to or on behalf of clients for those expenses directly or indirectly related to their end-stage renal disease as set forth in these rules.

"Financial resources" means personal, public or private assets available to clients to offset the expenses associated with their end-stage renal disease other than funds provided by this program.

"Financial status" means the level of income into which clients are categorized.

"Gross income" means all income received by family members from sources identified by the U.S. Census Bureau in computing gross income, including:

1. Gross income from money wages or salary,
2. Net income from nonfarm self-employment,
3. Net income from farm self-employment,
4. Royalties,
5. Dividends,
6. Interest,
7. Income from estate or trust,
8. Net rental income,
9. Public assistance or welfare payments such as Supplemental Security Income,
10. Pensions (disability or retirement) including but not limited to social security, railroad retirement and Veterans Administration,
11. Periodic annuity payments (including regular insurance payments),
12. Periodic individual retirement account payments,
13. Unemployment compensation,
14. Workers' compensation,
15. Alimony, and
16. Strike benefits.

"Health insurance" means health insurance expense reimbursement policies, and excludes all hospital indemnity policies.

"Homestead" means the dwelling occupied or intended to be occupied by the client as a home during all or part of the period of eligibility applied for. It shall include a garage, if applicable, and only so much of the land surrounding it as is reasonably necessary for use as a home. The word "dwelling" shall encompass a fixed or mobile home located on land or water or any building occupied wholly or in part as a home. When a homestead has more than one dwelling situated thereon, the dwelling shall be considered to be the one in which the client lives the majority of the time.

When a client is confined in a nursing home, extended-care facility or hospital, the client shall be considered as occupying or living on the homestead provided the client does not lease, rent or otherwise receive profits from other persons for the use thereof.

"Indirect expenses" means incurred costs associated with those necessary expenditures which permit the client to receive transplantation or dialysis services which result in direct expenses.

"Medical resources" means a public or private resource which is or may be available to pay all or a part of the medical costs of a client including, but not limited to, the following:

1. Medicare (Title XVIII),
2. Medical Assistance (Title XIX),
3. Health insurance policies and health maintenance organization contracts, whether issued on an individual or a group basis, including coverage carried by an absent or noncustodial parent,
4. The Veterans Administration,
5. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services),
6. Vocational rehabilitation,
7. County relief/state papers,
8. Medically Needy Program, and
9. Qualified Medicare Beneficiary and Special Low-income Medicare Beneficiary Programs.

"Medical status" means the category into which clients are placed who have received a transplant or are dialyzing via:

1. Outpatient hemodialysis,
2. Outpatient machine peritoneal dialysis,
3. Home hemodialysis,
4. Home machine peritoneal dialysis,
5. Continuous ambulatory peritoneal dialysis,
6. Chronic cycling peritoneal dialysis, or
7. Any other medically recognized method of dialysis.

"Nonexempt financial resources" include but are not limited to:

1. Certificates of deposit,
2. Checking accounts,
3. Fund-raising drives,
4. Market value of stocks and bonds,
5. Savings accounts,
6. The equity value exceeding $100,000 of commercial or farm property or of a business as specified in subrule 111.5(3),
7. An equity value exceeding $6,890 in one irrevocable funeral contract or burial trust for each member of the family,
8. An equity value exceeding $1,500 in one account or fund designated for burial purposes for each member of the family. Such funds include but are not limited to revocable burial trusts, cash value of life insurance policies, certificates of deposit, trusts,
9. Individual retirement account, and
10. Taxable capital gains.

"Period of eligibility" means the 12-month maximum time frame for which financial assistance may be approved.

"Personal property" means property of any kind, except real property as defined in these rules, and is limited to household goods and nontaxable personal property.

"Physician" means a person who is licensed under Iowa Code chapter 148, 150 or 150A.

"Program" means the chronic renal disease program conducted by the department.

"Provider" means a professional, public or private organization which provides services, directly or indirectly, for the treatment of end-stage renal disease.

"Real property" means commercial or farm property or a business including machinery and equipment used in the prosecution of ordinary business.

641—111.2(135) Program purpose. The purpose of the program is to provide financial assistance to eligible persons with end-stage renal disease who require lifesaving services for the renal disease but are unable to pay for the service on a continuing basis.

641—111.3(135) Residency requirements.

111.3(1) To be eligible for financial assistance, clients shall be residents of the state of Iowa.

111.3(2) Temporary absence is the absence of a person during which time there is an intent to return. A temporary absence from the state of Iowa shall not be deemed to have interrupted residency requirements.

641—111.4(135) Application procedures.

111.4(1) Persons seeking financial assistance shall apply on forms provided by the department. The address is Chronic Renal Disease Program, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

111.4(2) The date of application shall be the date the application is received by the department.

111.4(3) The department shall approve or deny the application or request additional information within 30 days from the date the application is received. Clients shall be notified by mail of the department's decision.

111.4(4) Approved clients will receive financial assistance for time periods not to exceed 12 months. If during an approved period the client experiences a change in medical or financial status, the department shall be notified in writing within 30 days of the date and nature of the change. Upon receipt of this information,

1. The department shall evaluate the client in accordance with the eligibility criteria identified in these rules.
2. Any subsequent change in financial assistance shall become effective the month following the change in medical or financial status.
3. Clients shall be notified by mail of any change in financial assistance.

111.4(5) Eligibility for financial assistance shall be determined annually on forms provided by the department. The following support documentation shall be submitted to the department and considered a part of the application:

a. Copies of the most recent federal and state income tax returns of the client, the client's spouse, the client's parent(s) or the legal guardian or custodian financially responsible for the care of the client,

b. A copy of the most recent social security benefit statement,

c. A copy of the most recent annual pension or annuity benefit statement,

d. A copy of the most recent annual disability income statement,

e. A copy of Medicare card,

f. A copy of the most recent Medicaid (Title XIX) card,

g. A copy of the most recent Medically Needy Notice of Decision.

641—111.5(135) Consideration of gross income and other financial and medical resources.

111.5(1) All family income and other financial and medical resources available to a client shall be considered in determining eligibility and any financial participation that may be required of the client.

111.5(2) The gross income of a client's spouse shall be considered available to the client in determining the extent of eligibility and financial participation. Similarly, if the client is an unemancipated minor, the family income of the responsible parent(s), guardian or custodian of the minor shall be considered available to the client.

111.5(3) The equity value of commercial or farm property or of a business which is not the homestead owned or controlled by the client, the client's spouse or, if a minor, by the client's responsible parent(s), guardian or custodian, shall be considered as a countable financial resource. Equity value is defined as the current market value of the property or business, less any legal debt. Verification of the current market value and the substantiation of legal debt shall be the responsibility of the client and shall be obtained from a knowledgeable source including, but not limited to:

a. Real estate brokers;

b. The local office of the Farmer's Home Administration (for rural land);

c. A local office for the Agricultural Stabilization and Conservation Service (for rural land);

d. Banks, savings and loan associations, mortgage companies, and similar lending institutions;

e. Officials of local property tax jurisdictions; and

f. County extension services.

Commercial or farm property or a business (which is not the homestead) shall be excluded as a financial resource when the equity value does not exceed $100,000. When the equity value exceeds $100,000, only that amount exceeding the $100,000 limit shall be counted as a financial resource.

111.5(4) Financial assistance shall be approved only for those services or that part of the cost of a given service for which no other financial or medical resource exists. Clients shall take all steps necessary to apply for and, if entitled, accept any other financial or medical resource for which they qualify. Failure to do so, without good cause, shall result in the denial or termination of any financial assistance from this program that would have been covered by the other resource.

111.5(5) Determination of good cause shall be made by the department and shall be based upon information and evidence provided by the client or by one acting on the client's behalf.

111.5(6) Program staff may, for purposes of verification, contact any person or agency referred to in these rules in order to ensure that any financial assistance that may be provided is not or will not be provided when another financial or medical resource exists.

641—111.6(135) Procedures for determining eligibility.

111.6(1) The department shall review all applications for completeness. Applications found to be incomplete shall be returned to the client with appropriate instructions.

111.6(2) If the client is a minor, necessary information shall be provided by the responsible parent, guardian or custodian of the minor.

111.6(3) An application shall be considered complete when the information contained therein enables the department to determine the client's financial status in accordance with the eligibility criteria established by the department. When necessary, program staff will verify resources shown on the application and will inform clients of other resources that may be available to them.

111.6(4) Based on the evaluation of each application, the type(s) of financial assistance provided shall be determined and made known to the client by mail. Financial assistance shall be effective on the first day of the month in which the complete application was received.

111.6(5) The criteria that follow shall be utilized to determine the client's financial status and eligibility:

a. All income shall be included in the determination of gross income. In regard to nonexempt financial resources, $2,000 will be disregarded for the first family member plus $1,000 for each additional family member living in the home.

b. Two financial status categories based on percentage increases of the most current Department of Health and Human Services poverty income guidelines as published in the Federal Register shall be used. Each range is increased proportionately by the number of family members. The financial status category into which the client falls for eligibility purposes is determined upon evaluation of the client's gross income and other financial and medical resources.

(1) Financial category 1 is defined as clients whose gross income and other resources are within 200 percent of federal poverty level and are eligible for the maximum reimbursement rate.

(2) Financial category 2 is defined as clients whose gross income and other resources are within 201 to 250 percent of federal poverty level and are eligible for 50 percent of the maximum reimbursement rate.

641—111.7(135) Financial assistance.

111.7(1) Financial assistance for charges incurred for the provision of dialysis and kidney transplantation shall be limited to a dialysis and transplantation facility which meets the requirements of the Secretary of Health and Human Services as an approved end-stage renal disease (ESRD) provider under Section 226(g), Title II of the Social Security Act. The types of financial assistance that may be provided shall be limited to the expense categories listed below depending upon the financial and medical resources available to the client.

a. Pharmaceuticals. Take-home legend (prescription) and nonlegend (nonprescription) drugs and other related medical supplies ordered by a physician and not covered by any other resource. Pharmaceuticals include vitamins, but do not include food supplements. Drug reimbursement shall be limited to:

(1) Generic drug only, from the AA/AB list unless medically indicated due to special needs specifically ordered by the physician.

(2) The average wholesale price as listed in the Medi-Span Formulary Price Guide plus a $1 filling fee.

(3) A minimum of a 30-day supply and a maximum of a 90-day supply for maintenance medications.

(4) Based on the formulary for legend and nonlegend drugs established by the department and updated at least annually by the program with recommendations provided by the advisory committee. Any charges that exceed the reimbursed amount shall be the responsibility of the client.

b. Travel. To and from a Medicare-approved ESRD facility for outpatient dialysis, three months of home dialysis training, transplantation and the three months of posttransplant care following the date of discharge. Transportation cost shall be calculated at 10 cents per mile for all nonpublic transportation. When a client must travel by cab or other means of public transportation service, cost shall be at the rate normally charged for any fare-paying passenger not to exceed $20 per round trip.

c. Health insurance and Medicare.

(1) Premiums for health insurance policies and enrollment fees for health maintenance organization contracts. When a client has family coverage, whether issued on an individual or group basis, program payment shall be limited to the portion of the premium or enrollment fee paid on behalf of the client. This does not include hospital indemnity policies.

(2) Premiums for Medicare.

111.7(2) Financial assistance for the services listed with percent of coverages as defined by subrule 111.7(1) shall receive reimbursement at a rate determined annually by May 1 prior to the beginning of the fiscal year on July 1 by the department with the advice and assistance of the committee.

111.7(3) Should program appropriations be insufficient to meet all eligible requests for financial assistance, it shall be the responsibility of the department, with the advice and assistance of the committee, to take appropriate and necessary action to ensure that program expenses not exceed program funds. This action may include, but need not be limited to:

a. Reducing the amount(s) and type(s) of financial assistance provided to each client;

b. Setting a maximum limit on the amount of financial assistance which may be provided to each client; or

c. Limiting the number of clients who may be approved to receive financial assistance.

641—111.8(135) Transfer or disposal of resources at less than fair market value. In determining eligibility for financial assistance, resources that have been given away or sold or otherwise transferred or disposed of 18 months prior to the month of application at less than fair market value for the purpose of establishing eligibility for financial assistance shall still be counted as resources at their fair market value as specified by subrule 111.5(3).

641—111.9(135) Payment procedures.

111.9(1) Clients shall submit claims for approved financial assistance items on forms provided by the department with sufficient documentation to clearly support the amount(s) claimed.

111.9(2) Providers may submit claims for direct reimbursement on forms other than those provided by the department as long as those forms contain information equivalent to that required by the department.

111.9(3) Claims shall be reviewed for appropriateness and accuracy based upon the client's medical and financial status at the time services were provided.

111.9(4) Reimbursement may be made directly to the client.

111.9(5) Reimbursement may be made directly to the provider.

111.9(6) The date of the claim is the date of service for which reimbursement is requested.

641—111.10(135) Recovery.

111.10(1) The department may recover from a client all funds incorrectly expended to or on behalf of the client. The incorrect expenditures may result from client or agency error, or administrative overpayment.

111.10(2) All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery; and the reason for the incorrect expenditure.

111.10(3) Recovery shall be made from the client or parent(s) of a child under the age of 21 when the parents completed the application and had responsibility for reporting changes.

111.10(4) The repayment of incorrectly expended funds shall be made to the department.

111.10(5) The client shall have the right to appeal the amount of funds subject to recovery under the provisions of rule 111.11(135).

641—111.11(135) Denial, suspension, revocation or reduction of financial assistance.

111.11(1) The department may deny, suspend, revoke or reduce financial assistance based upon eligibility and financial criteria and other pertinent rules within this chapter. Notification will be mailed at least ten calendar days before the date the action becomes effective and includes:

1. A statement of what action is being taken.
2. The reasons for the intended action.
3. An explanation of the client's right to appeal.

111.11(2) Provided that rule changes affecting the types or limitations of financial assistance are made in accordance with the rule-making process pursuant to Iowa Code chapter 17A, the appeal provisions of this rule shall not apply to any action taken pursuant to subrule 111.7(3).

111.11(3) Notwithstanding subrule 111.11(2), upon receipt of a notice of denial, suspension, revocation, or reduction, the client may request an appeal. The appeal shall be made in writing to the department within 15 days from the date of the department's notice. The address is Chronic Renal Disease Program, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 15-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, suspension, revocation, or reduction of financial assistance has been or will be removed. If no request for appeal is received within the 15-day time period, the department's notice of denial, suspension, revocation, or reduction of financial assistance shall become the department's final agency action.

111.11(4) Continued financial assistance is subject to recovery by the department if its action is sustained. This recovery is not an appealable issue.

111.11(5) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the client shall also be provided to the department of inspections and appeals.

111.11(6) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

111.11(7) After the hearing, or upon default of the aggrieved party, the hearing officer shall affirm, modify or set aside the denial, suspension, revocation, or reduction of financial assistance.

111.11(8) When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 111.11(9).

111.11(9) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

111.11(10) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions, and rules.

b. All evidence received or considered and all other submissions by recording or transcript.

c. A statement of all matters officially noticed.

d. All questions and offers of proof, objections, and rulings thereon.

e. All proposed findings and exceptions.

f. The proposed decision and order of the administrative law judge.

111.11(11) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

111.11(12) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

111.11(13) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is Chronic Renal Disease Program, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

111.11(14) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

These rules are intended to implement Iowa Code section 135.47.

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